

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 1. ADMINISTRATIVE OPERATIONS

[**Authority:** 63 O.S., §§ 5003 through 5016; Federal Social Security Act, Title XIX; 67 O.S., §§ 201 through 216; 74 O.S., §§ 564 through 576; 75 O.S., §§ 250.2 through 257, and 301 through 308.2; Oklahoma Personnel Act; Section 504 of the Rehabilitation Act of 1973; The Americans with Disabilities Act of 1990; Title VI of the Civil Rights Act of 1964; 45 CFR 80 and 84; Age Discrimination Act of 1975, Part 90; 45 CFT 84, Subpart B]
[**Source:** Codified 7-27-95]

SUBCHAPTER 1. ORGANIZATION AND ADMINISTRATION

317:1-1-1. Purpose

(a) The purpose of this Subchapter is to establish policies, procedures and standards that apply to the Oklahoma Health Care Authority ("the Authority").

(b) The Health Care Authority is created for the purpose of making effective the provisions of the Oklahoma Health Care Authority Act ("the Act"). The general administration and responsibility for the proper design, selection or operation of the provisions of the Acts are vested in the Authority [63:5003].

[**Source:** Added at 11 Ok Reg 3605, eff 6-15-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3099, eff 7-27-95]

317:1-1-2. Authority and amending of rules

(a) The authority for the rules in this Title is the Oklahoma Health Care Authority Act. The Act is in Sections 5003 through 5016 of Title 63 of the Oklahoma Statutes. The rules in this Chapter are promulgated by the Authority to establish the Authority's organization and its administration, policies and procedures.

(b) This title may be amended or repealed from time to time and new rules and regulations adopted by the Authority pursuant to the Administrative Procedures Act.

[**Source:** Added at 11 Ok Reg 3605, eff 6-15-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3099, eff 7-27-95 ; Amended at 39 Ok Reg 1402, eff 9-12-22]

317:1-1-3. Amending of rules [REVOKED]

[**Source:** Added at 11 Ok Reg 3605, eff 6-15-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3099, eff 7-27-95 ; Revoked at 39 Ok Reg 1402, eff 9-12-22]

317:1-1-4. Organization and meetings

(a) The Authority Board consists of nine (9) members. Section 5007 of Title 63 of the Oklahoma Statutes (O.S.) provides for their appointment and service.

(b) A chair and a vice-chair shall be elected by a majority of the members of the Board. The terms of office of the chair and vice-chair shall be one (1) year beginning January 1 of each year. A member elected to serve as chair or vice-chair may be elected to serve more than one (1) term. Elections will be held at the last regular meeting before January 1. However, in the event the last regular meeting before January 1 shall be canceled for any reason, the election may be held at a specially-scheduled meeting or, if it is not possible to schedule a special meeting, at the next regularly-scheduled meeting. In the event an election cannot be conducted prior to January 1 of any year, the chair and vice-chair who are in office December 31 shall continue their terms until an election is held.

(c) The chair will preside over meetings and perform other duties as required by the Authority.

(d) A majority of the members of the Board shall constitute a quorum for the transaction of business and for taking any official action. Any action or decision of the Board requires an affirmative vote of at least a majority of the members present [63 O.S. § 5007(D)].

(e) All meetings of the Authority Board will be conducted in accordance with the Open Meeting Act, 25 O.S. §§ 301 - 314.

[Source: Added at 11 Ok Reg 3605, eff 6-15-94 (emergency); Added at 11 Ok Reg 3961, eff 6-29-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3099, eff 7-27-95 ; Amended at 37 Ok Reg 99, eff 10-2-19 (emergency); Amended at 37 Ok Reg 1464, eff 9-14-20]

317:1-1-5. Subcommittees and committees

The Chairman may appoint advisory committees. Such appointments shall be in writing and may be changed as needed, upon written notice to all Authority members.

[Source: Added at 11 Ok Reg 3605, eff 6-15-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3099, eff 7-27-95]

317:1-1-6. Emergency cancellation of meetings

The chair, or the vice-chair in the chair's absence, shall have the power to cancel or reschedule any regular or special meeting of the Authority due to anticipated lack of quorum, inclement weather, or other emergency. Notice thereof shall be filed with the Secretary of State and publicly posted as soon as reasonably possible.

[Source: Added at 11 Ok Reg 3605, eff 6-15-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3099, eff 7-27-95 ; Amended at 37 Ok Reg 99, eff 10-2-19 (emergency); Amended at 37 Ok Reg 1464, eff 9-14-20]

317:1-1-7. Minutes of the Authority

A summary shall be made of all proceedings before the Authority which shall show those members present and absent, all matters considered, all actions taken, and the vote of each member on any motion, and shall be made public on the Authority's website.

[Source: Added at 11 Ok Reg 3605, eff 6-15-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3099, eff 7-27-95 ; Amended at 37 Ok Reg 99, eff 10-2-19 (emergency); Amended at 37 Ok Reg 1464, eff 9-14-

317:1-1-8. Administrator

The Administrator is the chief executive officer of the Oklahoma Health Care Authority and acts for the Authority in all matters provided by law [63:5008]. The Administrator determines the internal organization of the Health Care Authority and employs staff as may be necessary to perform the duties of the Authority as authorized by statute. The Administrator is responsible for the development of all internal policies and procedures necessary for the Authority to carry out its functions and to achieve all short-and long-term agency goals. The powers and duties of the Administrator include supervision of all activities of the Authority, formulation and recommendation of rules for approval or rejection by the Authority Board and enforcement of rules promulgated by the Board. The Administrator is also responsible for directing the preparation of all plans, reports and proposals necessary for the agency's function or as required by law.

[Source: Added at 11 Ok Reg 3605, eff 6-15-94 (emergency); Added at 11 Ok Reg 3961, eff 6-29-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3099, eff 7-27-95 ; Amended at 27 Ok Reg 284, eff 11-3-09 (emergency); Amended at 27 Ok Reg 916, eff 5-13-10]

317:1-1-8.1. Deputy Administrators [REVOKED]

[Source: Added at 11 Ok Reg 3961, eff 6-29-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3099, eff 7-27-95 ; Amended at 13 Ok Reg 33, eff 9-8-95 (emergency); Amended at 13 Ok Reg 1621, eff 5-27-96 ; Revoked at 18 Ok Reg 2556, eff 6-25-01]

317:1-1-9. Location for information and for filing

(a) Any person may obtain information from, make submission to, or make a request of the Authority by writing to: Oklahoma Health Care Authority, 4545 North Lincoln, Suite 124, Oklahoma City, Oklahoma 73105.

(b) Written submissions and requests may be submitted in person between the hours of 8:00 a.m. and 4:30 p.m., Monday through Friday or faxed to (405) 530-3214.

(c) The date on which papers are actually received at the Authority will be recorded as the date of filing.

[Source: Added at 11 Ok Reg 3605, eff 6-15-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3099, eff 7-27-95 ; Amended at 27 Ok Reg 284, eff 11-3-09 (emergency); Amended at 27 Ok Reg 916, eff 5-13-10]

317:1-1-9.1. Compliance with the Open Records Act

Oklahoma Statutes require compliance with the Open Records Act found at 51 O.S. §§ 24A.3-24A.29. The administrative regulations that follow are meant to clarify OHCA procedure and interpretation of state law regarding open records.

(1) Records request.

(A) A form is provided on OHCA's website that may be electronically mailed to the agency to request records from the Oklahoma Health Care Authority. The form may

also be downloaded, completed and mailed to the agency. An open records form can be obtained by writing to the Open Records Coordinator, OHCA Legal Division, PO Drawer, 18497, Oklahoma City, Oklahoma 73154-0497.

(B) The person requesting records may also provide a written narrative at the address noted in paragraph (A). The written request must provide enough detail to allow the agency to ascertain the needs of the requestor. For example, a request asking for "all data relating to provider "b"" is not sufficient for the agency to properly answer the request. The reason the request in this example cannot be answered without further inquiry is that it has no time limitation nor any database information restriction. This type of request will be unavoidably delayed and eventually returned to the sender for additional information.

(C) In the event of any records request (electronic or otherwise) the agency will estimate the work involved in answering the request and bill the requestor either;

- (i) the reasonable direct cost of record copying or mechanical reproduction; or
- (ii) the reasonable cost of record search and the direct cost of record copying (or mechanical reproduction).

(D) The amount in paragraph (C)(i) is charged for all requests that are not solely for commercial purposes or requests that cause an excessive disruption of the essential functions of the public body.

(E) The amount in paragraph (C)(ii) is charged for all requests that are solely for commercial purposes or requests that cause an excessive disruption of the essential functions of the public body.

(F) OHCA generally waives the payment requirement from media searches and government agency searches because it considers these record requests to be matters of public interest.

(G) OHCA generally regards requests for pharmacy or other payment data as requests solely for commercial purposes.

(2) OHCA fees for copying and search.

(A) As required by law, OHCA posts its copying fees and search fees in the Oklahoma County Clerk's office and at its principal place of business.

(B) OHCA also posts its schedule on its public website at www.okhca.org. The legally recognized schedule however, is the schedule posted at its principal place of business and County Clerk's office.

(C) OHCA's fee schedule specifically takes into account the statutory limit of fees for copying and certified copies.

(D) OHCA's fee schedule minimizes costs by using electronic data transmission when possible. Its fee schedule takes into account charges for electronic search

and data devices (such as storage media).

(E) OHCA must receive any fees associated with the fee request before the records will be provided.

(3) **Open records request exceptions.** OHCA may deny record requests in anticipation of litigation against the agency. The Oklahoma Civil Discovery Code is properly used for these requests. OHCA may deny open records requests for the reasons stated in any of the exceptions provided in the Open Records Act. The use of the exceptions is not to thwart the accountability of state government.

(4) **Timeliness of responses.** The agency endeavors to answer all record requests within a reasonable time as required by law. Generally a reasonable period of time is 30 days from receipt of a specific record request depending upon the following factors;

(A) the ability to communicate with the requestor regarding federal or state law redaction requirements;

(B) the workload within the agency regarding open record requests and program activity;

(C) the inability to produce the record with or without redaction;

(D) the specificity of the written request;

(E) payment of the fee; and

(F) the size and complexity of the data request.

[Source: Added at 27 Ok Reg 284, eff 11-3-09 (emergency); Added at 27 Ok Reg 916, eff 5-13-10]

317:1-1-10. Documents and records [REVOKED]

[Source: Added at 11 Ok Reg 3605, eff 6-15-94 (emergency); Added at 11 Ok Reg 3961, eff 6-29-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3099, eff 7-27-95 ; Amended at 13 Ok Reg 33, eff 9-8-95 (emergency); Amended at 13 Ok Reg 1621, eff 5-27-96 ; Amended at 13 Ok Reg 3455, eff 7-16-96 (emergency); Amended at 14 Ok Reg 1750, eff 5-27-97 ; Revoked at 18 Ok Reg 2556, eff 6-25-01 ; Revoked at 27 Ok Reg 284, eff 11-3-09 (emergency); Revoked at 27 Ok Reg 916, eff 5-13-10]

317:1-1-11. Requests for declaratory ruling

(a) Any person may petition the Authority for a declaratory ruling as to the applicability of any of this Chapter or any order of the Authority. The purpose of a declaratory ruling is to explain, or clarify, a rule or an order of the Authority in relation to a particular matter. A request for a declaratory ruling must include the following information:

(1) Name and address of the person making the request;

(2) Name and address of the organization the person represents, if applicable;

(3) A description of the problem or issue which made it necessary to request a declaratory ruling;

(4) The numbers and headings used to identify the rule or the order on which the declaratory ruling is sought.

(b) The Authority will consider each petition submitted and, within a reasonable time after the submission thereof, either deny the petition in writing, stating its reasons for such denial, or issue a declaratory order on the matters contained in the petition.

(c) The Authority Board may provide others with written notice of the request for a declaratory ruling and give them an opportunity to respond in writing within 15 days.

[Source: Added at 11 Ok Reg 3605, eff 6-15-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3099, eff 7-27-95]

317:1-1-12. Requests for rulemaking

(a) Any person may petition the Authority for adoption, amendment, or repeal of any rule of the authority. Such petition must be in writing and must include:

- (1) The name and address of the person requesting the adoption, amendment or repeal of the rule;
- (2) Name and address of the organization the person represents, if applicable;
- (3) Any numbers and headings used to identify an existing rule or to adopt a new rule;
- (4) The proposed language if the request is to amend an existing rule or to adopt a new rule;
- (5) The circumstances which created the need for action; and
- (6) The intended effect of the action.

(b) Response to petition for rule changes. Upon receipt of a petition as described in Subsection (a) both this Section, the Administrator will initiate a study of the requested change through whatever means he or she deems appropriate. If the Authority formally acts upon the petition, the petitioner will be advised of the action in writing as specified by the Administrator. In accordance with 75 O.S. 305, if the Authority does not initiate rulemaking proceedings within 30 calendar days of the petition's submission, the petition shall be deemed to have been denied.

[Source: Added at 11 Ok Reg 3605, eff 6-15-94 (emergency); Added at 11 Ok Reg 3961, eff 6-29-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3099, eff 7-27-95]

317:1-1-13. Rulemaking

The Authority will follow the provisions of Article I of the Administrative Procedures Act, Sections 250.2 to 257 and 301 to 308.2 of Title 75 of the Oklahoma Statutes, in rulemaking proceedings.

[Source: Added at 11 Ok Reg 3605, eff 6-15-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3099, eff 7-27-95]

317:1-1-14. Computation of time

In this Title and in orders issued by the Authority, the word "day" means a calendar day. In computing any period of time prescribed or allowed, the day of the act, or event, from which the period of time begins to run will not be included. The last day of the period will be included, unless it is a Saturday, Sunday, legal holiday, or other day when the Authority is not open for business until 4:30 p.m. In such case, the period will run through the end of the next day the Authority is open until at least 4:30 p.m.

[Source: Added at 11 Ok Reg 3605, eff 6-15-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3099, eff 7-27-95]

317:1-1-15. Legal references

In this Title, italic type means it exactly repeats language from law or another legal document. The specific reference is in brackets following the italics. Language in the rules that restates laws or other legal material in other words is also followed by a reference in brackets, but is not printed in italics.

[Source: Added at 11 Ok Reg 3605, eff 6-15-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3099, eff 7-27-95]

317:1-1-16. Severability

If a court of competent jurisdiction finds any rule or part of a rule in this Title to be unenforceable, it shall not impair or invalidate the remaining rules in this Title; the remaining rules shall be valid and enforceable to the fullest extent allowed by law.

[Source: Added at 11 Ok Reg 3605, eff 6-15-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3099, eff 7-27-95]

317:1-1-17. Purchasing department

The Purchasing Department is the department within the Oklahoma Health Care Authority responsible for the acquisition of goods, equipment and services for the operation of the Oklahoma Health Care Authority and for acquisition of goods, equipment and services necessary for implementation of the SoonerCare Program. All acquisitions of the Purchasing Department are purchased under guidelines approved by the Oklahoma Health Care Authority and in compliance with all applicable state statutes.

[Source: Added at 11 Ok Reg 3961, eff 6-29-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3099, eff 7-27-95 ; Amended at 27 Ok Reg 284, eff 11-3-09 (emergency); Amended at 27 Ok Reg 916, eff 5-13-10]

317:1-1-18. Personnel department [REVOKED]

[Source: Added at 11 Ok Reg 3961, eff 6-29-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3099, eff 7-27-95 ; Revoked at 18 Ok Reg 2556, eff 6-25-01]

317:1-1-19. Legal services

The Office of the Attorney General is authorized by statute to provide legal services as requested by the Authority. The Authority is authorized to develop inter-agency agreements with the Office of the Attorney General to provide legal services and the Attorney General may levy a reasonable fee for these services.

[Source: Added at 11 Ok Reg 3961, eff 6-29-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3099, eff 7-27-95]

SUBCHAPTER 3. FORMAL AND INFORMAL PROCEDURES

317:1-3-1. Purpose

The rules in the Subchapter describe general formal procedures the Authority uses to take action and make decisions.

[Source: Added at 11 Ok Reg 3605, eff 6-15-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3099, eff 7-27-95]

317:1-3-2. Authority may take action

The Authority may take whatever action is consistent with the rules in this Title to carry out the duties of the Authority and accomplish the objectives of any program or activity within its authority. The Authority may use formal procedures, such as hearings, or informal procedures, such as telephone calls, letters, meetings, mediation, investigations or other appropriate methods to resolve concerns. The Administrator may initiate these actions for the Authority.

[Source: Added at 11 Ok Reg 3605, eff 6-15-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3099, eff 7-27-95]

317:1-3-3. Advisory committees

As necessary or required by state or federal plan, the Oklahoma Health Care Authority shall establish advisory boards or committees to assist the Authority.

[Source: Reserved at 11 Ok Reg 3605, eff 6-15-94 (emergency); Added at 12 Ok Reg 1081, eff 4-3-95 (emergency); Added at 12 Ok Reg 3099, eff 7-27-95]

317:1-3-3.1. Drug Utilization Review Board

(a) The Oklahoma SoonerCare Drug Utilization Review (DUR) Board shall be responsible for advising the Chief Executive Officer (hereinafter referred to as the CEO) of the Oklahoma Health Care Authority on retrospective and prospective drug utilization programs and review of pharmacy benefit issues including clinical guideline applications.

(b) The DUR Board Members shall be appointed, and may be reappointed, by the CEO as provided by law.

[Source: Added at 12 Ok Reg 1081, eff 4-3-95 (emergency); Added at 12 Ok Reg 3099, eff 7-27-95 ; Amended at 13 Ok Reg 1197, eff 8-1-95 (emergency); Amended at 13 Ok Reg 1621, eff 5-27-96 ; Amended at 27 Ok Reg 284, eff 11-3-09 (emergency); Amended at 27 Ok Reg 916, eff 5-13-10]

317:1-3-3.2. DUR responsibility for Health Plan proposals for modifying medication coverage [REVOKED]

[Source: Added at 12 Ok Reg 3624, eff 9-8-95 (emergency); Added at 13 Ok Reg 1621, eff 5-27-96 ; Revoked at 27 Ok Reg 284, eff 11-3-09 (emergency); Revoked at 27 Ok Reg 916, eff 5-13-10]

317:1-3-4. State Plan Amendment and Rate Committee

(a) **Definitions.** Unless the context clearly indicates otherwise, the following words and terms when used in this section are defined as follows:

- (1) **Public Process.** means a process as defined by federal law under 42 U.S.C. § 1396(a)(13)A.
- (2) **State Plan Amendment.** means the document described in the Federal Regulations at 42 C.F.R. § 430.10.
- (3) **State Plan Amendment and Rate Committee (SPARC).** means a committee comprised of administrative and executive level staff designated by the Chief Executive Officer for the Oklahoma Health Care Authority. The SPARC facilitates the rate setting process by conducting public hearings at which the public, vendors, and OHCA staff are afforded the opportunity to provide testimony and documented evidence in support of rate recommendations. The SPARC only operates to make recommendations for changes to rates that necessitate a State Plan Amendment and/or Waiver Amendment. Rates that do not necessitate a State Plan Amendment and/or Waiver Amendment do not require a hearing.
- (4) **Rate Change.** means a change that affects the numerical value of payment from the Medicaid agency to the provider including the application of pre-existing factors that increase or decrease a rate. A rate change is not a method change. Rates found in contracts are excluded from the definition of rate change because they are set consensually in a contract. A method or methodology change, as defined below, is not a rate change.
- (5) **Method Change or Methodology Change.** means a change to how the rate is calculated, not the end result of the rate. In Medicaid rate setting the application of pre-existing factors many times, results in rate changes. The application of pre-existing factors, even if it results in a different rate is not a method change. A method change occurs when OHCA adds, subtracts or alters the factors used to construct the rate.

(b) **Meeting of the State Plan Amendment and Rate Committee (SPARC).** In certain instances the SPARC meets to hold public hearings regarding rates set by the Oklahoma Health Care Authority. Under certain provisions of federal law, the agency is required to hold a public hearing to gather public comment regarding proposed method changes or methodology changes regarding the rates it pays its medical providers.

- (1) The SPARC only meets when a method change or methodology change occurs in a rate paid from OHCA to a medical provider.
- (2) The SPARC does not meet to establish any contractually set rate to a contractor or a contractually bid rate nor does the SPARC meet to hear rate changes.

(c) **SPARC public hearing process.**

- (1) The seven person panel conducts an open meeting under the Oklahoma Open Meetings Act.
- (2) The proceedings are recorded.

(3) The panel hears agency presentations of proposals for method changes or methodology changes and considers comments of any member of the public who desires to comment upon the rate. The Chairperson controls both the agency presentation of proposals and the presentation of comments on the proposed method change.

(4) The panel votes to approve or disapprove the proposed method change in the open meeting, but may adjourn the meeting to gather further information, if necessary. The panel also may adjourn for legal advice during the proceeding. The OHCA board will vote to approve or disapprove the rate methodology upon approval by the SPARC.

(d) **Composition of the SPARC.** The Chief Executive Officer appoints officials to serve on the SPARC. Officials may consist of OHCA employees and other state agency employees whose agencies assist in the administration of the Medicaid State Plan and/or Waiver programs. A regular alternate for each official may be approved. In such cases an official is unable to attend a committee meeting, he or she must notify the regular alternate and OHCA Chairperson.

[Source: Reserved at 11 Ok Reg 3605, eff 6-15-94 through 7-14-95 (emergency); Reserved at 12 Ok Reg 3099, eff 7-27-95 ; Revoked at 27 Ok Reg 284, eff 11-3-09 (emergency); Revoked at 27 Ok Reg 916, eff 5-13-10 ; Amended at 34 Ok Reg 605, eff 9-1-17]

317:1-3-5. General complaints [REVOKED]

[Source: Added at 11 Ok Reg 3605, eff 6-15-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3099, eff 7-27-95 ; Amended at 12 Ok Reg 3626, eff 9-8-95 (emergency); Amended at 13 Ok Reg 1621, eff 5-27-96 ; Amended at 13 Ok Reg 3455, eff 7-16-96 (emergency); Amended at 14 Ok Reg 1750, eff 5-27-97 ; Revoked at 23 Ok Reg 759, eff 3-9-06 (emergency); Revoked at 23 Ok Reg 2428, eff 6-25-06]

317:1-3-6. [RESERVED]

[Source: Reserved at 11 Ok Reg 3605, eff 6-15-94 through 7-14-95 (emergency); Reserved at 12 Ok Reg 3099, eff 7-27-95]

317:1-3-7. [RESERVED]

[Source: Reserved at 11 Ok Reg 3605, eff 6-15-94 through 7-14-95 (emergency); Reserved at 12 Ok Reg 3099, eff 7-27-95]

317:1-3-8. [RESERVED]

[Source: Reserved at 11 Ok Reg 3605, eff 6-15-94 through 7-14-95 (emergency); Reserved at 12 Ok Reg 3099, eff 7-27-95]

317:1-3-9. [RESERVED]

[Source: Reserved at 11 Ok Reg 3605, eff 6-15-94 through 7-14-95 (emergency); Reserved at 12 Ok Reg 3099, eff 7-27-95]

317:1-3-10. [RESERVED]

[Source: Reserved at 11 Ok Reg 3605, eff 6-15-94 through 7-14-95 (emergency); Reserved at 12 Ok Reg 3099, eff 7-27-95]

317:1-3-11. [RESERVED]

[Source: Reserved at 11 Ok Reg 3605, eff 6-15-94 through 7-14-95 (emergency); Reserved at 12 Ok Reg 3099, eff 7-27-95]

317:1-3-12. [RESERVED]

[Source: Reserved at 11 Ok Reg 3605, eff 6-15-94 through 7-14-95 (emergency); Reserved at 12 Ok Reg 3099, eff 7-27-95]

317:1-3-13. Hearings (individual proceedings) [REVOKED]

[Source: Added at 11 Ok Reg 3605, eff 6-15-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3099, eff 7-27-95 ; Amended at 12 Ok Reg 3626, eff 9-8-95 (emergency); Amended at 13 Ok Reg 1621, eff 5-27-96 ; Revoked at 13 Ok Reg 3455, eff 7-16-96 (emergency); Revoked at 14 Ok Reg 1750, eff 5-27-97]

317:1-3-14. Representation [REVOKED]

[Source: Added at 11 Ok Reg 3605, eff 6-15-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3099, eff 7-27-95 ; Revoked at 13 Ok Reg 3455, eff 7-16-96 (emergency); Revoked at 14 Ok Reg 1750, eff 5-27-97]

317:1-3-15. Prehearing conference [REVOKED]

[Source: Added at 11 Ok Reg 3605, eff 6-15-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3099, eff 7-27-95 ; Revoked at 13 Ok Reg 3455, eff 7-16-96 (emergency); Revoked at 14 Ok Reg 1750, eff 5-27-97]

317:1-3-16. Informal disposition [REVOKED]

[Source: Added at 11 Ok Reg 3605, eff 6-15-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3099, eff 7-27-95 ; Amended at 13 Ok Reg 1621, eff 5-13-96 ; Revoked at 13 Ok Reg 3455, eff 7-16-96 (emergency); Revoked at 14 Ok Reg 1750, eff 5-27-97]

317:1-3-17. Certificate of mailing [REVOKED]

[Source: Added at 11 Ok Reg 3605, eff 6-15-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3099, eff 7-27-95 ; Revoked at 13 Ok Reg 3455, eff 7-16-96 (emergency); Revoked at 14 Ok Reg 1750, eff 5-27-97]

317:1-3-18. Final order [REVOKED]

[Source: Added at 11 Ok Reg 3605, eff 6-15-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3099, eff 7-27-95 ; Revoked at 13 Ok Reg 3455, eff 7-16-96 (emergency); Revoked at 14 Ok Reg 1750, eff 5-27-97]

317:1-3-19. Scheduling of hearings [REVOKED]

[Source: Added at 11 Ok Reg 3605, eff 6-15-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3099, eff 7-27-95 ; Revoked at 13 Ok Reg 3455, eff 7-16-96 (emergency); Revoked at 14 Ok Reg 1750, eff 5-27-97]

317:1-3-20. Judicial review [REVOKED]

[Source: Added at 11 Ok Reg 3605, eff 6-15-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3099, eff 7-27-95 ; Revoked at 13 Ok Reg 3455, eff 7-16-96 (emergency); Revoked at 14 Ok Reg 1750, eff 5-27-97]

SUBCHAPTER 5. COMPLIANCE WITH SECTION 504 OF THE REHABILITATION ACT OF 1973 [REVOKED]

317:1-5-1. Purpose [REVOKED]

[Source: Added at 11 Ok Reg 3961, eff 6-29-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3099, eff 7-27-95 ; Revoked at 27 Ok Reg 284, eff 11-3-09 (emergency); Revoked at 27 Ok Reg 916, eff 5-13-10]

317:1-5-2. General prohibitions against discrimination [REVOKED]

[Source: Added at 11 Ok Reg 3961, eff 6-29-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3099, eff 7-27-95 ; Revoked at 27 Ok Reg 284, eff 11-3-09 (emergency); Revoked at 27 Ok Reg 916, eff 5-13-10]

317:1-5-3. Qualified individuals with disabilities [REVOKED]

[Source: Added at 11 Ok Reg 3961, eff 6-29-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3099, eff 7-27-95 ; Revoked at 27 Ok Reg 284, eff 11-3-09 (emergency); Revoked at 27 Ok Reg 916, eff 5-13-10]

317:1-5-4. Self evaluation by departments for compliance [REVOKED]

[Source: Added at 11 Ok Reg 3961, eff 6-29-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3099, eff 7-27-95 ; Amended at 16 Ok Reg 2837, eff 7-12-99 ; Revoked at 27 Ok Reg 284, eff 11-3-09 (emergency); Revoked at 27 Ok Reg 916, eff 5-13-10]

317:1-5-5. Preemployment medical examinations [REVOKED]

[Source: Added at 11 Ok Reg 3961, eff 6-29-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3099, eff 7-27-95 ; Revoked at 27 Ok Reg 284, eff 11-3-09 (emergency); Revoked at 27 Ok Reg 916, eff 5-13-10]

SUBCHAPTER 7. COMPLIANCE WITH THE AMERICANS WITH DISABILITIES ACT OF 1990 [REVOKED]

317:1-7-1. Purpose [REVOKED]

[Source: Added at 11 Ok Reg 3961, eff 6-29-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3099, eff 7-27-95 ; Revoked at 27 Ok Reg 284, eff 11-3-09 (emergency); Revoked at 27 Ok Reg 916, eff 5-13-10]

317:1-7-2. Definitions [REVOKED]

[Source: Added at 11 Ok Reg 3961, eff 6-29-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3099, eff 7-27-95 ; Revoked at 27 Ok Reg 284, eff 11-3-09 (emergency); Revoked at 27 Ok Reg 916, eff 5-13-10]

317:1-7-3. The Oklahoma Health Care Authority and the Americans with Disabilities Act [REVOKED]

[Source: Added at 11 Ok Reg 3961, eff 6-29-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3099, eff 7-27-95 ; Amended at 16 Ok Reg 2837, eff 7-12-99 ; Revoked at 27 Ok Reg 284, eff 11-3-09 (emergency); Revoked at 27 Ok Reg 916, eff 5-13-10]

317:1-7-4. Requirement for reasonable accommodation [REVOKED]

[Source: Added at 11 Ok Reg 3961, eff 6-29-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3099, eff 7-27-95 ; Amended at 16 Ok Reg 2837, eff 7-12-99 ; Revoked at 27 Ok Reg 284, eff 11-3-09 (emergency); Revoked at 27 Ok Reg 916, eff 5-13-10]

317:1-7-5. Examples of reasonable accommodation [REVOKED]

[Source: Added at 11 Ok Reg 3961, eff 6-29-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3099, eff 7-27-95 ; Revoked at 27 Ok Reg 284, eff 11-3-09 (emergency); Revoked at 27 Ok Reg 916, eff 5-13-10]

317:1-7-6. Requests for reasonable accommodation [REVOKED]

[Source: Added at 11 Ok Reg 3961, eff 6-29-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3099, eff 7-27-95 ; Amended at 16 Ok Reg 2837, eff 7-12-99 ; Amended at 23 Ok Reg 759, eff 3-9-06 (emergency); Amended at 23 Ok Reg 2428, eff 6-25-06 ; Revoked at 27 Ok Reg 284, eff 11-3-09 (emergency); Revoked at 27 Ok Reg 916, eff 5-13-10]

317:1-7-6.1. Requests to make services accessible [REVOKED]

[Source: Added at 16 Ok Reg 2837, eff 7-12-99 ; Amended at 23 Ok Reg 759, eff 3-9-06 (emergency); Amended at 23 Ok Reg 2428, eff 6-25-06 ; Revoked at 27 Ok Reg 284, eff 11-3-09 (emergency); Revoked at 27 Ok Reg 916, eff 5-13-10]

317:1-7-7. Undue hardship/undue burden [REVOKED]

[Source: Added at 11 Ok Reg 3961, eff 6-29-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3099, eff 7-27-95 ; Revoked at 27 Ok Reg 284, eff 11-3-09 (emergency); Revoked at 27 Ok Reg 916, eff 5-13-10]

317:1-7-8. Retaliation or coercion [REVOKED]

[Source: Added at 11 Ok Reg 3961, eff 6-29-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3099, eff 7-27-95 ; Revoked at 27 Ok Reg 284, eff 11-3-09 (emergency); Revoked at 27 Ok Reg 916, eff 5-13-10]

SUBCHAPTER 9. CIVIL RIGHTS AND NONDISCRIMINATION [REVOKED]

317:1-9-1. Purpose [REVOKED]

[Source: Added at 11 Ok Reg 3961, eff 6-29-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3099, eff 7-27-95 ; Revoked at 27 Ok Reg 284, eff 11-3-09 (emergency); Revoked at 27 Ok Reg 916, eff 5-13-10]

317:1-9-2. Statement of compliance [REVOKED]

[Source: Added at 11 Ok Reg 3961, eff 6-29-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3099, eff 7-27-95 ; Revoked at 27 Ok Reg 284, eff 11-3-09 (emergency); Revoked at 27 Ok Reg 916, eff 5-13-10]

317:1-9-3. Practices prohibited [REVOKED]

[Source: Added at 11 Ok Reg 3961, eff 6-29-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3099, eff 7-27-95 ; Revoked at 27 Ok Reg 284, eff 11-3-09 (emergency); Revoked at 27 Ok Reg 916, eff 5-13-10]

317:1-9-4. Administration of programs [REVOKED]

[Source: Added at 11 Ok Reg 3961, eff 6-29-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3099, eff 7-27-95 ; Revoked at 27 Ok Reg 284, eff 11-3-09 (emergency); Revoked at 27 Ok Reg 916, eff 5-13-10]

317:1-9-5. Dissemination of nondiscriminatory information [REVOKED]

[Source: Added at 11 Ok Reg 3961, eff 6-29-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3099, eff 7-27-95 ; Revoked at 27 Ok Reg 284, eff 11-3-09 (emergency); Revoked at 27 Ok Reg 916, eff 5-13-10]

317:1-9-6. Assignment of responsibility [REVOKED]

[Source: Added at 11 Ok Reg 3961, eff 6-29-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3099, eff 7-27-95 ; Revoked at 27 Ok Reg 284, eff 11-3-09 (emergency); Revoked at 27 Ok Reg 916, eff 5-13-10]

317:1-9-7. Dissemination of rules [REVOKED]

[Source: Added at 11 Ok Reg 3961, eff 6-29-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3099, eff 7-27-95 ; Revoked at 23 Ok Reg 759, eff 3-9-06 (emergency); Revoked at 23 Ok Reg 2428, eff 6-25-06]

317:1-9-8. Execution of compliance reviews [REVOKED]

[Source: Added at 11 Ok Reg 3961, eff 6-29-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3099, eff 7-27-95 ; Revoked at 23 Ok Reg 759, eff 3-9-06 (emergency); Revoked at 23 Ok Reg 2428, eff 6-25-06]

317:1-9-9. Complaints [REVOKED]

[Source: Added at 11 Ok Reg 3961, eff 6-29-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3099, eff 7-27-95 ; Amended at 13 Ok Reg 3455, eff 7-16-96 (emergency); Amended at 14 Ok Reg 1750, eff 5-27-97 ; Revoked at 27 Ok Reg 284, eff 11-3-09 (emergency); Revoked at 27 Ok Reg 916, eff 5-13-10]

317:1-9-10. Employment practices [REVOKED]

[Source: Added at 11 Ok Reg 3961, eff 6-29-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3099, eff 7-27-95 ; Revoked at 27 Ok Reg 284, eff 11-3-09 (emergency); Revoked at 27 Ok Reg 916, eff 5-13-10]

CHAPTER 2. GRIEVANCE PROCEDURES AND PROCESS

[**Authority:** 63 O.S., §§ 5003 through 5016; 42 CFR 431.153, 431.154, 431.205, and 447.253]
[**Source:** Codified 5-27-96]

SUBCHAPTER 1. ADMINISTRATIVE APPEALS

317:2-1-1. Purpose

The purpose of this Chapter is to describe the different types of administrative appeals addressed by the Oklahoma Health Care Authority (OHCA), consistent with the State fair hearing requirements set out in 42 Code of Federal Regulations (C.F.R.) Part 431, Subpart E. The rules explain the step-by-step processes that must be followed by a party seeking redress from the OHCA. The majority of hearings on eligibility issues for members are conducted by the Oklahoma Department of Human Services and are not contained in this Chapter. Hearings will not be granted when the sole issue to be determined is a Federal or State law requiring an automatic change adversely affecting some or all members.

[**Source:** Added at 13 Ok Reg 389, eff 11-14-95 (emergency); Added at 13 Ok Reg 1627, eff 5-27-96 ; Amended at 13 Ok Reg 3559, eff 7-16-96 (emergency); Amended at 14 Ok Reg 1755, eff 5-27-97 ; Amended at 23 Ok Reg 761, eff 3-9-06 (emergency); Amended at 23 Ok Reg 2430, eff 6-25-06 ; Amended at 26 Ok Reg 3020, eff 7-21-09 (emergency); Amended at 27 Ok Reg 925, eff 5-13-10 ; Amended at 28 Ok Reg 1375, eff 6-25-11 ; Amended at 39 Ok Reg 383, eff 12-21-21 (emergency); Amended at 39 Ok Reg 1402, eff 9-12-22]

317:2-1-2. Appeals

(a) Request for appeals.

(1) For the purpose of calculating the timeframe for requesting an administrative appeal of an agency action, the date on the written notice shall not be included. The last day of the timeframe shall be included, unless it is a legal holiday as defined by Title 25 of the Oklahoma Statutes (O.S.) Section (§) 82.1, or any other day the Oklahoma Health Care Authority (OHCA) is closed or closes early, in which case, the timeframe runs until the close of the next full business day.

(2) An appeals request that an aggrieved member or provider sends via mail is deemed filed on the date that the agency receives it.

(b) Member process overview.

(1) The appeals process allows a member to appeal a decision relating to program benefits. Examples are decisions involving medical services, prior authorizations for medical services, or discrimination complaints.

(2) In order to initiate an appeal, the member must file a LD-1 (Member Complaint/Grievance Form) within thirty (30) calendar days of the date the OHCA sends written notice of its action, in accordance with Oklahoma Administrative Code (OAC) 317:2-1-2(a), above, or, in matters in which a formal notice is not sent by the agency, within thirty (30) days of the date on which the member knew or should have known the facts or circumstances

serving as the basis for appeal.

(3) If the LD-1 form is not received timely, the OHCA administrative law judge (ALJ) will cause to be issued a letter stating the appeal will not be heard. In the case of tax warrant intercept appeals, if the LD-1 form is not received by OHCA within the timeframe pursuant to 68 O.S. § 205.2, OHCA similarly will cause to be issued a letter stating the appeal will not be heard because it is untimely.

(4) If the LD-1 form is not completely filled out or if necessary documentation is not included, then the appeal will not be heard.

(5) OHCA will advise members that if assistance is needed in reading or completing the grievance form, arrangements will be made to provide such assistance.

(6) Upon receipt of the member's appeal, a fair hearing before the OHCA ALJ will be scheduled. The member will be notified in writing of the date and time of the hearing. The member, and/or his/her designated authorized representative, must appear at the hearing, either in person or telephonically. The preferred method for a hearing is telephonically, requests for an in-person hearing must be received in writing on OHCA's Form LD-4 (Request for In-Person Hearing) no later than ten (10) calendar days prior to the scheduled hearing date.

(7) The hearing shall be conducted according to OAC 317:2-1-5. The OHCA ALJ's decision may in certain instances be appealed to the CEO of the OHCA, or his or her designated independent ALJ, which is a record review at which the parties do not appear (OAC 317:2-1-13).

(8) Member appeals are ordinarily decided within ninety (90) days from the date on which the member's timely request for a fair hearing is received, unless:

(A) The appellant was granted an expedited appeal pursuant to OAC 317:2-1-2.5;

(B) The OHCA cannot reach a decision because the appellant requests a delay or fails to take a required action, as reflected in the record;

(C) There is an administrative or other emergency beyond OHCA's control, as reflected in the record; or

(D) The appellant filed a request for an appeal of a denied step therapy exception request, pursuant to OAC 317:2-1-18.

(9) Tax warrant intercept appeals will be heard directly by the OHCA ALJ. A decision is normally rendered by the OHCA ALJ within twenty (20) days of the hearing.

(c) Provider process overview.

(1) The proceedings as described in this subsection contain the hearing process for those appeals filed by providers. These appeals encompass all subject matter cases contained in OAC 317:2-1-2(d)(2).

(2) All provider appeals are initially heard by the OHCA ALJ under OAC 317:2-1-2(d)(2).

(A) In order to initiate an appeal, a provider must file the appropriate LD form within thirty (30) calendar days of the date the OHCA sends written notice of its action, in accordance with OAC 317:2-1-2(a), above. LD-2 forms should be used for Program Integrity audit appeals; LD-3 forms are to be used for all other provider appeals.

(B) Except for OHCA Program Integrity audit appeals, if the appropriate LD form is not received timely, the OHCA ALJ will cause a letter to be issued stating that the appeal will not be heard.

(C) A decision ordinarily will be issued by the OHCA ALJ within forty-five (45) days of the close of all evidence in the appeal.

(D) Unless otherwise limited by OAC 317:2-1-7 or 317:2-1-13, the OHCA ALJ's decision is appealable to OHCA's CEO, or his or her designated independent ALJ.

(d) **OHCA ALJ jurisdiction.** The OHCA ALJ has jurisdiction of the following matters:

(1) **Member appeals.**

(A) Discrimination complaints regarding the SoonerCare program;

(B) Appeals which relate to the scope of services, covered services, complaints regarding service or care, enrollment, disenrollment, and reenrollment in the SoonerCare Program;

(C) Fee-for-service appeals regarding the furnishing of services, including prior authorizations;

(D) Appeals which relate to the tax warrant intercept system through the OHCA. Tax warrant intercept appeals will be heard directly by the OHCA ALJ. A decision will be rendered by the OHCA ALJ within twenty (20) days of the hearing;

(E) Proposed administrative sanction appeals pursuant to OAC 317:35-13-7. Proposed administrative sanction appeals will be heard directly by the OHCA ALJ. A decision by the OHCA ALJ will ordinarily be rendered within twenty (20) days of the hearing. This is the final and only appeals process for proposed administrative sanctions;

(F) Appeals which relate to eligibility determinations made by OHCA;

(G) Appeals of insureds participating in Insure Oklahoma which are authorized by OAC 317:45-9-8

(H) Appeals which relate to a requested step therapy protocol exception as provided by 63 O.S. § 7310; and

(I) Requests for State fair hearing arising from a member's appeal of a managed care adverse benefit determination.

(2) **Provider appeals.**

(A) Whether Pre-admission Screening and Resident Review (PASRR) was completed as required by law;

(B) Denial of request to disenroll member from provider's SoonerCare Choice panel;

- (C) Appeals by long-term care facilities for administrative penalty determinations as a result of findings made under OAC 317:30-5-131.2(b)(5)(B) and (d)(8);
- (D) Appeals of Professional Service Contract awards and other matters related to the Central Purchasing Act pursuant to Title 74 O.S. § 85.1 et seq.;
- (E) Drug rebate appeals;
- (F) Provider appeals of OHCA Program Integrity audit findings pursuant to OAC 317:2-1-7. This is the final and only appeals process for appeals of OHCA Program Integrity audit findings;
- (G) Oklahoma Electronic Health Records Incentive program appeals related only to incentive payments, incentive payment amounts, provider eligibility determinations, and demonstration of adopting, implementing, upgrading, and meaningful use eligibility for incentives;
- (H) Supplemental Hospital Offset Payment Program (SHOPP) annual assessment, supplemental payment, fees or penalties as specifically provided in OAC 317:2-1-15; and
- (I) Appeals from any adjustment made to a long-term care facility's cost report pursuant to OAC 317:30-5-132, including any appeal following a request for reconsideration made pursuant to OAC 317:30-5-132.1.
- (J) Request for a State fair hearing arising from provider's appeal of managed care audit findings, for-cause or immediate termination of the provider's managed care contract, or managed care claims denial.

[Source: Added at 13 Ok Reg 389, eff 11-14-95 (emergency); Added at 13 Ok Reg 893, eff 11-21-95 (emergency); Amended at 13 Ok Reg 2301, eff 4-10-96 (emergency); Added at 13 Ok Reg 1627, eff 5-27-96 ; Amended at 13 Ok Reg 3179, eff 6-18-96 (emergency); Amended at 14 Ok Reg 1755, eff 5-27-97 ; Amended at 15 Ok Reg 3771, eff 6-24-98 (emergency); Amended at 16 Ok Reg 1412, eff 5-27-99 ; Amended at 18 Ok Reg 243, eff 11-21-00 (emergency); Amended at 18 Ok Reg 758, eff 1-23-01 (emergency); Amended at 18 Ok Reg 2949, eff 5-17-01 (emergency); Amended at 19 Ok Reg 2120, eff 6-27-02 ; Amended at 20 Ok Reg 1919, eff 5-26-03 ; Amended at 21 Ok Reg 2147, eff 6-25-04 ; Amended at 23 Ok Reg 761, eff 3-9-06 (emergency); Amended at 23 Ok Reg 2430, eff 6-25-06 ; Amended at 24 Ok Reg 300, eff 12-1-06 (emergency); Amended at 24 Ok Reg 869, eff 5-11-07 ; Amended at 27 Ok Reg 702, eff 3-1-10 through 7-14-10 (emergency)¹; Amended at 27 Ok Reg 2733, eff 7-20-10 (emergency); Amended at 28 Ok Reg 7, eff 8-13-10 (emergency); Amended at 28 Ok Reg 259, eff 11-15-10 (emergency); Amended at 28 Ok Reg 1376, eff 6-25-11 ; Amended at 29 Ok Reg 187, eff 11-22-11 (emergency); Amended at 29 Ok Reg 469, eff 5-11-12 ; Amended at 33 Ok Reg 783, eff 9-1-16 ; Amended at 34 Ok Reg 339, eff 12-29-16 (emergency); Amended at 34 Ok Reg 606, eff 9-1-17 ; Amended at 35 Ok Reg 1378, eff 9-14-18 ; Amended at 36 Ok Reg 850, eff 9-1-19 ; Amended at 37 Ok Reg 508, eff 1-6-20 (emergency); Amended at 37 Ok Reg 1465, eff 9-14-20 ; Amended at 38 Ok Reg 401, eff 12-18-20 (emergency); Amended at 38 Ok Reg 958, eff 9-1-21 ; Amended at 39 Ok Reg 392, eff 12-21-21 (emergency); Amended at 39 Ok Reg 1411, eff 9-12-22]

Editor's Note: ¹*This emergency action expired without being superseded by a permanent action. Upon expiration of an emergency amendatory action, the last effective permanent text is reinstated. Therefore, on 7-15-10 (after the 7-14-10 expiration of this emergency action), the text of 317:2-1-2 reverted back to the permanent text that became effective 5-11-07, as last published in the 2009 OAC Supplement,*

and remained as such until amended again by emergency action on 7-20-10.

317:2-1-2.1. Provider appeals and jurisdictional grounds [REVOKED]

[Source: Added at 13 Ok Reg 2301, eff 4-10-96 (emergency); Added at 13 Ok Reg 3559, eff 7-16-96 (emergency); Added at 14 Ok Reg 1755, eff 5-27-97 ; Amended at 14 Ok Reg 2390, eff 5-28-97 (emergency); Amended at 15 Ok Reg 700, eff 12-15-97 (emergency); Amended at 15 Ok Reg 1509, eff 5-11-98 ; Amended at 15 Ok Reg 3771, eff 6-24-98 (emergency); Amended at 16 Ok Reg 1412, eff 5-27-99 ; Revoked at 23 Ok Reg 761, eff 3-9-06 (emergency); Revoked at 23 Ok Reg 2430, eff 6-25-06]

317:2-1-2.2. Recipient appeals [REVOKED]

[Source: Added at 13 Ok Reg 2301, eff 4-10-96 (emergency); Added at 14 Ok Reg 1755, eff 5-27-97 ; Amended at 14 Ok Reg 2390, eff 5-28-97 (emergency); Amended at 15 Ok Reg 1509, eff 5-11-98 ; Amended at 15 Ok Reg 3771, eff 6-24-98 (emergency); Amended at 16 Ok Reg 1412, eff 5-27-99 ; Amended at 18 Ok Reg 967, eff 3-21-01 (emergency); Amended at 19 Ok Reg 2120, eff 6-27-02 ; Amended at 20 Ok Reg 2756, eff 5-26-03 (emergency); Amended at 21 Ok Reg 1318, eff 5-27-04 ; Amended at 21 Ok Reg 2147, eff 6-25-04 ; Revoked at 23 Ok Reg 761, eff 3-9-06 (emergency); Revoked at 23 Ok Reg 2430, eff 6-25-06]

317:2-1-2.3. Other grievance procedures and processes [REVOKED]

[Source: Added at 13 Ok Reg 2301, eff 4-10-96 (emergency); Added at 13 Ok Reg 3559, eff 7-16-96 (emergency); Added at 14 Ok Reg 1755, eff 5-27-97 ; Amended at 15 Ok Reg 3771, eff 6-24-98 (emergency); Amended at 16 Ok Reg 1412, eff 5-27-99 ; Amended at 17 Ok Reg 703, eff 1-13-00 (emergency); Amended at 17 Ok Reg 1177, eff 5-11-00 ; Amended at 20 Ok Reg 2756, eff 5-26-03 (emergency); Amended at 21 Ok Reg 1318, eff 5-27-04 ; Revoked at 23 Ok Reg 761, eff 3-9-06 (emergency); Revoked at 23 Ok Reg 2430, eff 6-25-06]

317:2-1-2.4. Appeal to the Chief Executive Officer [TERMINATED]

[Source: Added at 13 Ok Reg 2301, eff 4-10-96 (emergency); Terminated at 13 Ok Reg 3559, eff 7-16-96 (emergency)]

317:2-1-2.5. Expedited appeals

(a) An Appellant may request an expedited hearing, if the time otherwise permitted for a hearing as described in Oklahoma Administrative Code (OAC) 317:2-1-2(b)(8) could jeopardize the Appellant's life or health or ability to attain, maintain, or regain maximum function. Any request for expedited consideration should be made to the Administrative Law Judge (ALJ), with a copy to the Oklahoma Health Care Authority (OHCA) Legal division and shall be ruled upon within three (3) working days of the date of the request. The request shall specify the reason for the appeal and the specific basis for the Appellant's assertion that a delay will jeopardize the Appellant's life or health.

(b) If the ALJ determines that an expedited hearing is warranted, he or she shall:

- (1) Schedule the matter for hearing pursuant to OAC 317:2-1-5. Telephonic hearings may be scheduled as appropriate under the particular facts of the case; and
- (2) Issue a preliminary or final decision as expeditiously as possible, but no later than three (3) working days the close of the

expedited hearing.

(c) If the ALJ determines that the request does not meet the criteria for expedited consideration, he or she shall:

- (1) Schedule the appeal for hearing within the ordinary timeframe, in accordance with OAC 317:2-1-2(b)(8); and
- (2) Notify the Appellant of the denial orally or through a written notice as described in OAC 317:35-5-66. If oral notification is provided, the ALJ shall issue a written notification within three (3) calendar days of the denial.

[Source: Added at 35 Ok Reg 1378, eff 9-14-18 ; Amended at 37 Ok Reg 1470, eff 9-14-20 ; Amended at 38 Ok Reg 401, eff 12-18-20 (emergency); Amended at 38 Ok Reg 958, eff 9-1-21]

317:2-1-2.6. Continuation of benefits or services pending appeal

(a) In accordance with Section 431.230 of Title 42 of the Code of Federal Regulations, if an Appellant submits a written request for a hearing within ten (10) days of the notice of the adverse agency action, the Appellant may also request that existing benefits or services (hereinafter, collectively referred to as "services") be continued or reinstated until the earlier of dismissal of the appeal, Appellant's withdrawal of the appeal, or an initial hearing decision adverse to the Appellant.

(b) If the Appellant fails to indicate a preference as to continuation or reinstatement of services in a written request for hearing made within ten (10) days of the notice of the adverse agency action, services shall be continued or reinstated. Provided, however, that a SoonerCare member shall not be entitled to continuation or reinstatement of services pending an appeal related to the following:

(1) When a service is denied because the member has exceeded the limit applicable to that service;

(2) When a request for a prior authorization is denied for a prescription drug. However:

(A) The Oklahoma Health Care Authority (OHCA) may authorize a single seventy-two (72) hour emergency supply of the drug, in accordance with Oklahoma Administrative Code (OAC) 317:30-5-77.2;

(B) A SoonerCare provider may initiate a step therapy exception request on behalf of a member, in accordance with OAC 317:30-5-77.4;

(3) When coverage of a prescription drug or service is denied because the requested drug or service is not a category or class of drugs or services covered by OHCA;

(4) When coverage for a prescription drug is denied because the enrollee has been locked into one (1) pharmacy and the member seeks to fill a prescription at another pharmacy; or

(5) When a physician or other licensed health care practitioner has failed to prescribe or order the service or level of service for which continuation or reinstatement is requested.

(c) If services are continued or reinstated during the appeals process and the hearing is not decided in the Appellant's favor, OHCA may seek to recover reimbursement of all services received pending the hearing decision.

[Source: Added at 37 Ok Reg 824, eff 7-1-20 (emergency); Added at 38 Ok Reg 958, eff 9-1-21]

317:2-1-3. Drug rebate appeals [REVOKED]

[Source: Added at 13 Ok Reg 893, eff 11-21-95 (emergency); Revoked at 13 Ok Reg 2301, eff 4-10-96 (emergency); Added at 13 Ok Reg 1627, eff 5-27-96 ; Revoked at 14 Ok Reg 1755, eff 5-27-97]

317:2-1-4. Appeal to the Chief Executive Officer [REVOKED]

[Source: Added at 13 Ok Reg 3559, eff 7-16-96 (emergency); Added at 14 Ok Reg 1755, eff 5-27-97 ; Amended at 15 Ok Reg 3771, eff 6-24-98 (emergency); Amended at 16 Ok Reg 1412, eff 5-27-99 ; Amended at 18 Ok Reg 2951, eff 4-24-01 (emergency); Amended at 19 Ok Reg 2120, eff 6-27-02 ;

317:2-1-5. Hearing procedures

- (a) Hearings will be conducted in an informal manner without formal rules of evidence or procedure, except for hearings under 317:2-1-7.
- (b) No party is required to be represented by an attorney. Members may represent themselves or authorize another party to represent them. A person or entity desiring to represent a member must provide documentation of the consent of the member to be represented by that person or entity. An appeal will be rejected without documentation of representation. Individuals appearing for corporate entities will be deemed to be authorized to represent the corporation in a hearing.
- (c) The docket clerk will send the Appellant and any other necessary party notice which states the hearing location, date, and time.
- (d) The OHCA Administrative Law Judge or designee may:
 - (1) Rule on any requests for extension of time;
 - (2) Hold pre-hearing conferences to settle, simplify, or identify issues in a proceeding or to consider other matters that may end in the expeditious disposition of the proceeding;
 - (3) Require the parties to state their positions concerning the various issues in the proceeding;
 - (4) Require the parties to produce for examination those relevant witnesses and documents under their control;
 - (5) Rule on motions and other procedural items;
 - (6) Regulate the course of the hearing and conduct of the participants;
 - (7) Establish time limits for the submission of motions or memoranda;
 - (8) Impose appropriate sanctions against any person failing to obey an order of the ALJ or authorized under the rules in this Chapter which may include:
 - (A) Refusing to allow the person to assert or oppose designated claims or defenses, or prohibiting that person from introducing designated matters in evidence;
 - (B) Excluding all testimony of an unresponsive or evasive witness; or
 - (C) Expelling the person from further participation in the hearing;
 - (9) Take official notice of any material fact not appearing as evidence in the record, if the fact is among traditional matters of judicial notice;
 - (10) Administer oaths or affirmations;
 - (11) Determine the location of the hearing;
 - (12) Allow either party to request that the hearing be recorded by a court reporter with costs to be borne by the requesting party. The original of such transcription, if ordered, will be given to the ALJ with a copy to be given to the requesting party;
 - (13) Recess and reconvene the hearing;
 - (14) Set and/or limit the time frame of the hearing;
 - (15) Reconsider or rehear a matter for good cause shown; and

(16) Send a copy of the decision by the ALJ to both parties outlining their rights to appeal the decision. The decision letter need not contain findings of fact or conclusions of law.

(e) The burden of proof during the hearing will be upon the appellant and the ALJ will decide the case based upon a preponderance of evidence standard as defined by the Oklahoma Supreme Court. Parties who fail to appear at a hearing, after notification of said hearing date, will have their cases dismissed for failure to prosecute.

(f) Parties may file preliminary motions in the case. Any such motions must be filed within 15 calendar days prior to the hearing date. Response to preliminary motions must be made within 7 calendar days of the date the motion is filed with OHCA. Preliminary motions will be ruled upon 3 days prior to the hearing date.

(g) In any case in which a member requests a continuance, OHCA will not be prejudiced to complete the case within 90 days.

(h) An appeal, or an issue addressed by an appeal, may be dismissed if:

(1) it is moot or there is insufficient evidence to support the allegations;

(2) the appellant fails or refuses to appear for a scheduled meeting;

(3) the appellant refuses to accept a settlement offer which affords the relief he or she could reasonably expect if he or she prevailed in the appeal; or

(4) it is not timely filed or is not within the OHCA's jurisdiction or authority.

[Source: Added at 23 Ok Reg 761, eff 3-9-06 (emergency); Added at 23 Ok Reg 2430, eff 6-25-06 ; Amended at 24 Ok Reg 300, eff 12-1-06 (emergency); Amended at 24 Ok Reg 869, eff 5-11-07 ; Amended at 28 Ok Reg 259, eff 11-15-10 (emergency); Amended at 28 Ok Reg 1376, eff 6-25-11]

317:2-1-6. Other grievance procedures and processes [REVOKED]

[Source: Added at 23 Ok Reg 761, eff 3-9-06 (emergency); Added at 23 Ok Reg 2430, eff 6-25-06 ; Amended at 26 Ok Reg 3020, eff 7-21-09 (emergency); Amended at 27 Ok Reg 925, eff 5-13-10 ; Amended at 27 Ok Reg 2733, eff 7-20-10 (emergency); Amended at 28 Ok Reg 259, eff 11-15-10 (emergency); Amended at 28 Ok Reg 1376, eff 6-25-11 ; Amended at 36 Ok Reg 850, eff 9-1-19 ; Revoked at 37 Ok Reg 508, eff 1-6-20 (emergency); Revoked at 37 Ok Reg 1465, eff 9-14-20]

317:2-1-7. Program Integrity Audit Appeals

All appeals related to audits originating from Program Integrity resulting in overpayments are heard by an Administrative Law Judge (ALJ) pursuant to 56 Oklahoma Statutes (O.S.) § 1011.9.

(1) If the Oklahoma Health Care Authority (OHCA) determines a provider received an overpayment based upon audit findings/report issued pursuant to Oklahoma Administrative Code (OAC) 317:30-3-2.1, the provider may appeal the audit findings/report. If a provider elects to appeal the audit findings/report, the provider must file its appeal with the OHCA's Legal Docket Clerk, using Form LD-2. The LD-2 must be received by the OHCA Legal Docket Clerk within thirty (30) calendar days of the date of the initial audit findings/report or within thirty (30) calendar days of the date of the reconsideration audit

findings/report. The computation of time shall be calculated in accordance with OAC 317:2-1-2(a).

(2) The provider must attach a statement to the LD-2 that specifies what findings and/or claims are being appealed, as well as all factual and legal bases for the appeal. The provider shall attach the following to the LD-2 form:

- (A) Citations for any statute or rule that the provider contends has been violated;
- (B) The provider's name, address, e-mail address, and telephone number;
- (C) The name, address, e-mail address, and telephone number of the provider's authorized representative, if any; and
- (D) The LD-2 must be signed by the provider or provider's authorized representative.

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

(ii) Consistent with Oklahoma rules of practice, an individual provider may appear on his/her own behalf or may be represented by an attorney licensed to practice law within the State of Oklahoma. In the case of an entity, the provider entity must be represented by an attorney licensed to practice within the State of Oklahoma. Attorneys not licensed to practice in Oklahoma must comply with 5 O.S. Art II, Sec. 5, and rules of the Oklahoma Bar Association.

(3) A provider or the provider's authorized representative shall immediately report any change in contact information during the course of the appeal to the OHCA Legal Docket Clerk.

(4) The OHCA, on its own initiative or upon written request of a party, may consolidate or join appeals if to do so will expedite the processing of the appeals and not adversely affect the interest of the parties.

(5) The provider has the burden of proof to prove that the overpayment determination and the errors identified in the audit findings/report are inaccurate. The provider must prove the relief sought by a preponderance of the evidence standard, as defined by the Oklahoma Supreme Court. In adjudicating an appeal under the preponderance of the evidence standard, the ALJ will examine each piece of evidence for relevance, probative value, and credibility, to determine whether the fact to be proven is proved by the greater weight of the evidence.

(6) Within approximately forty-five (45) days of receiving the LD-2, the Legal Docket Clerk will schedule a prehearing conference before an ALJ. This period of time is intended to provide the parties an opportunity to settle the dispute prior to the prehearing. Settlement of audit appeals is encouraged and can begin at any time of the audit appeal process between the provider and OHCA's Legal Division. If a settlement is reached,

the terms shall be set out in writing and signed by both parties and/or their authorized representatives. Unless otherwise warranted, an Agreed Order setting out the terms of the settlement shall be presented to the ALJ for approval. In limited situations, a settlement may be agreed to be a confidential settlement by the parties and will not be submitted as an Agreed Order to the ALJ. In the case of confidential settlements, the Appellant shall file a motion to dismiss the appeal with prejudice which informs the ALJ that the matter has been settled and that the audit appeal is moot.

(7) Audit appeals which are not settled will commence with a prehearing conference before the assigned ALJ as follows:

(A) The prehearing conference shall be informal, structured by the ALJ, and not open to the public. The ALJ shall record the prehearing conference by digital recording.

(i) Each party shall be notified of the date of the prehearing conference at least thirty (30) calendar days prior to the scheduled prehearing conference.

(ii) Each party shall appear in person or through their authorized representative.

(iii) Witnesses, not including a named party, shall not appear at the prehearing conference. Nor shall any witness testimony be presented at the prehearing conference.

(B) A request for continuance of a prehearing conference can be made up to three (3) business days prior to the scheduled prehearing conference date. A lesser period of time may be permitted for good cause shown. The ALJ shall rule on the request and in no case shall a combination of continuance exceed a total of thirty (30) calendar days except for good cause shown.

(C) Within twenty (20) days prior to the prehearing conference, the Appellant provider shall file a prehearing conference statement with the Legal Docket Clerk and provide a copy to the other party; and within ten (10) days prior to the prehearing conference, the OHCA shall file a prehearing conference statement with the docket clerk and provide a copy to the other party. Each party's prehearing conference statement shall include:

(i) A brief statement of its case, including a list of stipulations and legal and factual issues to be heard;

(ii) A list of any witnesses who have direct knowledge of the facts surrounding the issues of the appeal and who are expected to be called at the hearing. The list shall include a brief statement of the testimony each witness will offer;

(iii) A list of all exhibits, together with a copy thereof, which each party intends to offer into evidence at the hearing; and

(iv) Any requests for discovery.

(D) At the prehearing conference, the parties shall clarify and isolate the legal and factual issues involved in the audit appeal.

(E) Each party shall be present, on time, and prepared. Failure to do so may result in dismissal of the appeal or other sanctions unless good cause is shown. A prehearing conference shall not be continued if a party fails to be prepared to identify issues, propose witnesses, or provide exhibits, unless the ALJ finds good cause is shown.

(F) Following the prehearing conference, the ALJ shall issue a Scheduling Order setting forth deadlines for parties to complete discovery, submit briefs as directed by the ALJ, submit prehearing motions, and other deadlines as may be needed. The ALJ should attempt to issue the Scheduling Order within two (2) weeks of the prehearing conference. Upon completion of discovery and the submission of any motions or briefs, the ALJ shall issue a Prehearing Order that shall identify all issues to be presented at the hearing; a final list of witnesses to be called by each party; a final list of exhibits to be used by each party; and the hearing date and anticipated duration of the hearing. The Prehearing Order should be filed by the ALJ no later than ten (10) days prior to the hearing.

(8) The ALJ shall:

(A) Limit all decisions, rulings, and orders to matters directly related to the contested overpayment determination resulting from the audit findings issued pursuant to OAC 317:30-3-2.1 and procedural matters set forth within OAC 317:2-1-7;

(B) Hear and rule on pending requests or motions as expeditiously as possible. This includes setting filing and responsive deadlines in accordance with Title 12 of the Oklahoma Statutes and the Rules for District Courts of Oklahoma. To preserve judicial efficiency, a reply to a response to a motion shall not be filed by a party without leave of Court to do so and such permission shall not be routinely granted;

(C) Rule on whether witnesses have knowledge of the facts at issue;

(D) Rule on whether discovery requests and other motions and requests are relevant;

(E) Rule on whether to grant a party's request to depose a witness. To preserve judicial efficiency, depositions shall not be routinely permitted and shall only be permitted by order of the ALJ;

(F) Strike or deny witnesses, documents, exhibits, discovery requests, and other requests or motions which are cumulative, not relevant, not material, used as a means of harassment, unduly burdensome, or not timely filed; and

- (G) Identify and rule on the specific audit findings being appealed and to be heard at the administrative hearing.
- (9) As the purpose of the administrative process is to expedite a limited appellate review of the audit findings, the ALJ shall ensure a timely resolution of the appeal. The ALJ shall schedule a hearing within ninety (90) days of the prehearing conference. A party may request a continuance of the hearing by motion, which shall only be permitted if the ALJ finds good cause exists and neither party shall be prejudiced by the continuation.
- (10) At the hearing:
- (A) Each party shall appear in person or through their authorized representative.
 - (B) All witnesses must appear in person to provide testimony.
 - (C) All relevant exhibits provided with and specifically identified in each party's prehearing conference statement or final exhibit list, that have not been objected to or stricken by the ALJ, shall be deemed admissible at the hearing.
 - (D) Each party shall provide a sufficient number of copies of its own exhibits at the hearing. This is in addition to any other copies of exhibits that were previously produced prior to the hearing unless otherwise ordered by the ALJ.
 - (E) The hearing will be limited to one (1) day. Each side will be allowed four (4) hours to present its case-in-chief, which is inclusive of any time needed for cross-examination of witnesses by the opposing party. For good cause shown, the ALJ may increase or decrease the time limit for each party to present its case-in-chief, taking into account the time limits of the entire appeal process.
- (11) The ALJ should attempt to make the final hearing decision within 90 days from the date of the hearing. Any appeal of the final order pursuant to 12 O.S. § 951 must be filed with the District Court of Oklahoma County within thirty (30) days.
- (A) The following items shall constitute the record on appeal:
 - (i) all motions and orders filed with the Legal Docket Clerk;
 - (ii) all exhibits admitted during the hearing; and
 - (iii) the transcripts of proceedings, if any.
 - (B) It shall be the duty of the Appellant in any District Court appeal to order a written transcript of proceedings to be used on appeal. The transcript must be ordered within 30 days of the filing of an appeal in the District Court and any costs associated with the preparation of the transcript shall be borne by the Appellant.
- (12) All orders and settlements are non-precedential decisions.
- (13) The prehearing conference, the hearing, and any supplementary hearings or conferences shall be digitally recorded and closed to the public.

(14) The record of the appeal, confidential settlements, and any audio recordings shall remain confidential.

[Source: Added at 23 Ok Reg 761, eff 3-9-06 (emergency); Added at 23 Ok Reg 2430, eff 6-25-06 ; Amended at 26 Ok Reg 525, eff 1-2-09 (emergency); Amended at 26 Ok Reg 2073, eff 6-25-09 ; Amended at 26 Ok Reg 3020, eff 7-21-09 (emergency); Amended at 27 Ok Reg 925, eff 5-13-10 ; Amended at 28 Ok Reg 259, eff 11-15-10 (emergency); Amended at 28 Ok Reg 1376, eff 6-25-11 ; Amended at 31 Ok Reg 1625, eff 9-12-14 ; Amended at 33 Ok Reg 785, eff 9-1-16 ; Amended at 36 Ok Reg 850, eff 9-1-19]

317:2-1-8. Nursing home provider contract appeals [REVOKED]

[Source: Added at 23 Ok Reg 761, eff 3-9-06 (emergency); Added at 23 Ok Reg 2430, eff 6-25-06 ; Amended at 26 Ok Reg 3020, eff 7-21-09 (emergency); Amended at 27 Ok Reg 925, eff 5-13-10 ; Revoked at 33 Ok Reg 785, eff 9-1-16]

317:2-1-9. OHCA's Designated Agent's appeal process for QIO Decisions

The OHCA's Quality Improvement Organization (QIO) conducts an administrative process for those providers it reviews. The process afforded providers by QIO is the only administrative remedy available to providers. The decision issued by the QIO is considered by the OHCA to be a final administrative determination. The final QIO determination is not appealable to the OHCA for any further administrative hearings. After the QIO'S decision, OHCA will recoup the monies paid the provider related to the review.

[Source: Added at 23 Ok Reg 761, eff 3-9-06 (emergency); Added at 23 Ok Reg 2430, eff 6-25-06 ; Amended at 26 Ok Reg 3020, eff 7-21-09 (emergency); Amended at 27 Ok Reg 925, eff 5-13-10]

317:2-1-10. Drug Rebate appeal process

The purpose of this Section is to afford a process to both the manufacturer and the state to administratively resolve drug rebate discrepancies. These rules anticipate discrepancies between the manufacturer and the Oklahoma Health Care Authority (OHCA) which would require the manufacturer to pay a higher rebate or a lower rebate. These regulations provide a mechanism for both informal dispute resolution of drug rebate discrepancies between the manufacturer and OHCA and a mechanism for appeals of drug rebate discrepancies between the manufacturer and OHCA.

(1) The process begins at the end of each calendar quarter when the OHCA mails a copy of the State's past quarter's utilization data to the manufacturer. Utilization data and a billing for rebates will be mailed to the manufacturer within sixty (60) days after the end of each quarter. It is this data which dictates the application of the federal drug rebate formula.

(2) Within thirty (30) days from the date utilization data is sent to the manufacturer, the manufacturer may edit state data and resolve data inconsistencies with the state. The manufacturer may utilize telephone conferences, letters and any other mechanism to resolve data inconsistencies in mutual agreement with the state.

(3) Within thirty (30) days after the utilization data is mailed to the manufacturer, the manufacturer may:

- (A) pay the same amount as billed by the state with the quarterly utilization date;
 - (B) pay an amount which differs from the amount billed by the state with the utilization data and send disputed data information;
 - (C) pay nothing and send no disputed data information;
 - (D) pay nothing and send disputed data information.
- (4) In the event the state receives the rebate amount billed by the 30th day, the dispute ends.
- (5) If after thirty (30) days one of the following events occurs, the state will acknowledge the receipt of the correspondence and review the disputed data:
- (A) the receipt of an amount lower than that billed to the manufacturer;
 - (B) the receipt of disputed data.
- (6) In the event no disputed data is received and no payment is received, interest will be computed in accordance with the provisions of federal law found at 42 United States Code (U.S.C.) § 1396b(d)(5) and will be compounded upon the amount billed from thirty-eight days after the date utilization data is sent.
- (7) In the event a lower amount than billed is paid or in the event disputed data is sent, and no money is received, interest will be computed in accordance with 42 U.S.C. Section 1396b(d)(5) and will be computed from thirty-eight days from the date utilization data is sent to the manufacturer.
- (8) Within seventy (70) days from the date utilization data is sent to the manufacturer, the state will make its final informal review of the disputed data. OHCA will mail a second notice to the manufacturer which will include:
- (A) receipt of the rebate, if any;
 - (B) receipt of the dispute;
 - (C) a statement regarding the interest amount; and
 - (D) a statement regarding the appeal rights of the manufacturer with a copy of the appeal form.
- (9) Within ninety (90) days of the date utilization data is sent to the manufacturer or within thirty (30) days of the date a second notice is mailed to the manufacturer, whichever is sooner, the state or the manufacturer may request a hearing to administratively resolve the matter.
- (10) The administrative appeal of drug rebate discrepancies includes:
- (A) The appeal process will begin by the filing of a form LD-2 by the manufacturer or OHCA.
 - (B) The process afforded the parties will be the process found at OAC 317:2-1-2(c) and (d).
 - (C) With respect to the computation of interest, interest will continue to be computed from the thirty-eight (38) day based upon the policy contained in the informal dispute resolution rules above.

- (D) The Administrative Law Judge's (ALJ) decision will constitute the final administrative decision of the OHCA.
- (E) If the decision of the ALJ affirms the decision of OHCA in whole or in part, payment from the manufacturer must be made within thirty (30) days of the decision. If the decision of the ALJ reverses the decision of the OHCA, the OHCA will make such credit or action within (30) days of the decision of the ALJ.
- (F) The nonpayment of the rebate by the manufacturer within thirty (30) days after the ALJ's decision will be reported to the Centers for Medicare and Medicaid Services and may be the basis of an exclusion action by the OHCA.

[Source: Added at 23 Ok Reg 761, eff 3-9-06 (emergency); Added at 23 Ok Reg 2430, eff 6-25-06 ; Amended at 26 Ok Reg 3020, eff 7-21-09 (emergency); Amended at 27 Ok Reg 925, eff 5-13-10 ; Amended at 36 Ok Reg 850, eff 9-1-19]

317:2-1-11. Medicaid Drug Utilization Review Board (DUR) appeal process

This Section explains the appeal process, pursuant to Title 63 Oklahoma Statutes (O.S.) § 5030.3(B), accorded any party aggrieved by a decision of the Oklahoma Health Care Authority (OHCA) Board or Chief Executive Officer (CEO) concerning a proposed recommendation of the Medicaid Drug Utilization Review Board (DUR).

- (1) The aggrieved party may appeal pursuant to Oklahoma Administrative Code (OAC) 317:2-1-2 et seq. (OHCA Appeals).
- (2) The Board finds that the prescription of Title 63 O.S. § 5030.3(B) is somewhat contradictory with the functions of the DUR Board. More specifically, in most instances, the DUR Board suggests policies that must be rule made. Rules promulgated by the OHCA Board do not lend to an "individual proceeding notice" as contemplated by Article II of the Oklahoma Administrative Procedures Act, specifically, Title 75 O.S. § 309. Thus, in instances where the OHCA Board promulgates rules as a result of policy recommendations by the DUR Board, this Board will consider a party aggrieved by these rules to have filed a Petition for Rulemaking under 75 O.S. § 305. In making this interpretation of 63 O.S. § 5030, the Board will not enforce the last sentence of 75 O.S. § 305. In making this interpretation, the Board finds that it is taking two somewhat conflicting provisions, and combining them to effectuate the intent of the legislature - to provide a hearing to those aggrieved by recommendations by the DUR Board and accepted by the OHCA Board.
- (3) In instances where the DUR Board makes a recommendation accepted by the Board against an individual provider [for example, a recommendation under 42 United States Code 1396r-8(g)(3)(C)(iii)(IV)], OHCA will provide an individual proceeding under the Oklahoma Administrative Procedures Act.
- (4) In any appeal under (1) and (2) of this subsection, the OHCA Board delegates the OHCA ALJ to preside over the above hearing

and present the Board with proposed findings of fact and conclusions of law in accordance with Article II of the Administrative Procedures Act. The OHCA Board may accept the ALJ's written decision, reject it, or amend the recommendations. (5) Appeals filed pursuant to (1) and (2) of this subsection, will be made within thirty (30) days of the OHCA Board's acceptance of the recommendation by the DUR Board. (6) After Proposed Findings of Fact and Conclusions of Law are presented to the OHCA Board, the Board will have a period of 120 days to issue a final administrative order. (7) The Agency's Legal Services Division will construct a form called the LD-3, which will be used for parties to file an action under (1) and (2) of this subsection.

[Source: Added at 23 Ok Reg 761, eff 3-9-06 (emergency); Added at 23 Ok Reg 2430, eff 6-25-06 ; Amended at 26 Ok Reg 3020, eff 7-21-09 (emergency); Amended at 27 Ok Reg 925, eff 5-13-10 ; Amended at 36 Ok Reg 850, eff 9-1-19]

317:2-1-12. For cause and immediate provider contract termination appeals process

This section explains the appeals process for providers whose SoonerCare contracts have been terminated by the Oklahoma Health Care Authority (OHCA) for cause.

(1) **Thirty (30) day for cause termination.** Pursuant to the terms of all provider contracts with the OHCA, either party may terminate the contract for cause with a thirty (30) day written notice to the other party.

(A) **Notice of proposed termination.** The OHCA will provide notice to the provider of the proposed termination of the provider's contract. The written notice of termination will state:

- (i) the reasons for the proposed termination;
- (ii) the date upon which the termination will be effective; and
- (iii) a statement that the provider has a right to OHCA review prior to the termination of the provider's contract.

(B) **Right to OHCA review prior to termination of provider contract.** Before the provider's contract is terminated, the OHCA will give the provider the opportunity to submit documents and written arguments against the termination of the provider's contract. The provider's written response requesting a review must be submitted within thirty (30) days from the date of the notice. If a written response is not received within thirty (30) days, the notice of termination will become final and there will be no further right to review or appeal post-termination.

(C) **Notice of termination.**

- (i) After the OHCA review of the provider's written response, the OHCA will make a final

administrative decision regarding the contract termination.

(ii) Should the OHCA decide that the provider's contract should not be terminated, the provider will be notified in writing of the reasons for the OHCA's decision.

(iii) Should the OHCA make a decision to terminate the provider's contract, the OHCA will send a subsequent notice stating:

(I) the reasons for the decision;

(II) the effective date of the termination of the contract; and

(III) the provider's right to request a post termination panel committee desk review within thirty (30) days of the date of the termination letter.

(2) **Immediate termination.** The OHCA will provide notice to the provider of the termination of the provider's contract. The written notice of termination will state:

(A) the reasons for the proposed termination;

(B) the date upon which the termination will be effective; and

(C) a statement that the provider has a right to appeal the termination of the provider's contract in a post-termination panel committee desk review within thirty (30) days of the date of the termination letter.

(3) **Post-termination panel committee desk review.** After the effective date of the termination of the provider's contract, the provider is entitled to receive a post-termination panel committee desk review. The panel review committee for the OHCA will be comprised of three (3) employees of the OHCA as designated by the Chief Executive Officer or his/her designee. Any OHCA employee who was involved with the underlying investigation of the provider's case for purpose of the termination will not be a panel review committee member. The purpose and scope of the panel committee desk review will be limited to issues raised in the OHCA's letter of termination as the basis of terminating the provider's contract. The panel committee does not have jurisdiction to hear issues not addressed in the termination notice.

(A) The provider must request a panel committee desk review within thirty (30) days of the date of the termination letter. The provider must submit a brief written statement detailing the facts which are refuted by the provider. Any documentation the provider requests consideration of by the panel review committee must also be submitted with the written statement.

(B) The OHCA may submit any additional documents to the panel committee for the desk review that may contradict the documents submitted by the provider for the purposes of the desk review. Any additional

information that OHCA submits to the panel review committee will also be provided to the provider.

(C) The panel review committee will issue a written decision regarding the provider's contract termination approximately sixty (60) days from receipt of the provider's written statement and documentation.

(4) **Sixty (60) day without cause termination.** Pursuant to the terms of all provider contracts with the OHCA, either party may terminate the contract without cause with a sixty (60) day written notice to the other party. As such, there is no right to appeal or review of a sixty (60) day contract termination.

[Source: Added at 23 Ok Reg 761, eff 3-9-06 (emergency); Added at 23 Ok Reg 2430, eff 6-25-06 ; Amended at 26 Ok Reg 3020, eff 7-21-09 (emergency); Amended at 27 Ok Reg 925, eff 5-13-10 ; Amended at 33 Ok Reg 788, eff 9-1-16 ; Amended at 36 Ok Reg 850, eff 9-1-19]

317:2-1-13. Appeal to the chief executive officer

(a) The Oklahoma Health Care Authority offers approximately forty (40) different types of administrative appeals. Some of the appeals are appealable to the chief executive officer (CEO) and some are not. The following appeals are subject to further review upon timely submission of a request for CEO appeal and may be reviewed by the CEO, or his or her designated independent administrative law judge (ALJ), following the decision of the OHCA ALJ:

(1) Appeals under Oklahoma Administrative Code (OAC) 317:2-1-2(d)(1)(A) to (d)(1)(H), with the exception of subsection (d)(1)(E); and

(2) Appeals under OAC 317:2-1-2(d)(2)(A) to (d)(2)(I), with the exceptions of subsections (d)(2)(D),(E),(F),(G), and (I).

(b) Appeals to the CEO must be filed with the OHCA within thirty (30) days of the date of the Order, or decision by OHCA.

(c) No new evidence may be presented to the CEO.

(d) Appeals to the CEO under (a) of this Section may be filed by the provider, member, or agency. The CEO will ordinarily render decisions within sixty (60) days of the receipt of the appeal.

(e) The CEO may only designate an independent ALJ at another state agency, as established in the Oklahoma State Medicaid Plan and approved by the Centers for Medicare and Medicaid Services, to review a CEO appeal.

[Source: Added at 23 Ok Reg 761, eff 3-9-06 (emergency); Added at 23 Ok Reg 2430, eff 6-25-06 ; Amended at 26 Ok Reg 3020, eff 7-21-09 (emergency); Amended at 27 Ok Reg 925, eff 5-13-10 ; Amended at 28 Ok Reg 259, eff 11-15-10 (emergency); Amended at 28 Ok Reg 1376, eff 6-25-11 ; Amended at 33 Ok Reg 783, eff 9-1-16 ; Amended at 36 Ok Reg 850, eff 9-1-19 ; Amended at 37 Ok Reg 508, eff 1-6-20 (emergency); Amended at 37 Ok Reg 1465, eff 9-14-20 ; Amended at 38 Ok Reg 401, eff 12-18-20 (emergency); Amended at 38 Ok Reg 958, eff 9-1-21 ; Amended at 39 Ok Reg 392, eff 12-21-21 (emergency); Amended at 39 Ok Reg 1411, eff 9-12-22]

317:2-1-14. Contract award protest process

(a) **Protest process.** Suppliers who respond to a solicitation issued and awarded by the Authority pursuant to 74 Oklahoma Statutes (O.S.) § 85.5 (N) may protest the award of a contract under such solicitation to the State Purchasing Director. All remedies available to suppliers through

the sealed bid process pursuant to the Oklahoma Central Purchasing Act are also available to online bidders in an online bidding process.

(b) **State Purchasing Director review and determination.** The State Purchasing Director will review the supplier's protest and contract award documents.

(1) The State Purchasing Director may determine to respond to the protest or delegate the responsibility to OHCA by written notice to OHCA.

(2) The State Purchasing Director or OHCA, as applicable, will send to the supplier written notice of the decision to deny or sustain the protest within ten (10) business days of receipt of the protest.

(c) **Supplier appeal of decision to deny protest.** The supplier may appeal a denial of protest by the State Purchasing Director or OHCA to the Office of Management and Enterprise Services (OMES) Director.

(1) The supplier will file such appeal, if at all, within ten (10) business days of the date of the State Purchasing Director's or OHCA's notice of denial pursuant to 75 O.S. § 309 et seq.

(2) The OMES Director may enter an order staying contract performance upon such terms and conditions as the OMES Director determines to be proper. Any request for stay of contract performance must be made in writing and filed during the ten (10) business-day time period in which an appeal may be commenced to the OMES director. The OMES Director shall have continuing jurisdiction to modify any such orders made in connection with a stay during the pendency of the appeal as appropriate under the circumstances presented.

(3) The OMES Director may hear the appeal or assign the supplier's appeal to an administrative law judge (ALJ) retained by OHCA.

(4) Administrative hearings conducted by OMES will be conducted in accordance with the Administrative Procedures Act at 75 O.S. §§ 309 et seq., and the OMES director shall have all powers granted by law, including any powers delegated to an ALJ by this Section.

(5) Whenever the appeal is assigned to an ALJ retained by OHCA, the ALJ will review the appeal for legal authority and jurisdiction. If legal authority and jurisdictional requirements are met, the ALJ shall conduct an administrative hearing according to the hearing practices of OAC 317:2-1-5 and provide proposed findings of fact and conclusions of law to the OMES director.

(6) The OMES director or the ALJ, as applicable, will send written notice to the parties of the final order sustaining or denying the supplier's appeal.

(7) The cost of actions necessary to process a supplier's appeal, together with any other expenses incurred due to the appeal, will be paid by OHCA.

(8) Whenever the appeal is assigned to the ALJ retained by OHCA, the ALJ will:

(A) Establish a scheduling order;

- (B) Establish reasonable procedures such as authorizing pleadings to be filed by facsimile or electronic mail;
- (C) Rule on all interlocutory motions;
- (D) Require briefing of any or all issues;
- (E) Conduct hearings in a forum and manner as determined by the ALJ;
- (F) Rule on the admissibility of all evidence;
- (G) Question witnesses;
- (H) Impose appropriate sanctions against any person failing to obey an order of the ALJ or authorized under the rules in this Chapter which will include:
 - (i) Refusing to allow the person to assert or oppose designated claims or defenses, or prohibiting that person from introducing designated matters in evidence;
 - (ii) Excluding all testimony of an unresponsive or evasive witness; or
 - (iii) Expelling the person from further participation in the hearing;
- (I) Take official notice of any material fact not appearing as evidence in the record, if the fact is among traditional matters of judicial notice;
- (J) Administer oaths or affirmations;
- (K) Determine the location of the hearing and manner in which it will be conducted;
- (L) Allow either party to request that the hearing be recorded by a court reporter with costs to be borne by the requesting party. The original of such transcription, if ordered, will be given to the ALJ with a copy to be given to the requesting party;
- (M) Recess and reconvene the hearing;
- (N) Set and/or limit the time frame of the hearing;
- (O) Make proposed findings of facts and conclusions of law to the OMES Director; and
- (P) Recommend that the OMES Director deny the supplier's appeal or that the contract award be cancelled and rebid.

(d) Supplier appeal of OMES Director decision to deny appeal. If the OMES Director denies a supplier's appeal, the supplier may appeal pursuant to provisions of 75 O.S. §§ 309 et seq.

[Source: Added at 27 Ok Reg 2733, eff 7-20-10 (emergency); Added at 28 Ok Reg 1380, eff 6-25-11 ; Amended at 36 Ok Reg 850, eff 9-1-19 ; Amended at 38 Ok Reg 401, eff 12-18-20 (emergency); Amended at 38 Ok Reg 958, eff 9-1-21 ; Amended at 39 Ok Reg 383, eff 12-21-21 (emergency); Amended at 39 Ok Reg 1402, eff 9-12-22]

317:2-1-15. Supplemental Hospital Offset Payment Program (SHOPP) Appeals

(a) In accordance with Title 63 of the Oklahoma Statutes Section 3241.4 OHCA is authorized to promulgate rules for appeals of annual assessments, fees and penalties to hospitals as defined by the statute.

The rules in this Section describe those appeals rights.

(1) OAC 317:30-5-58 subsections (a) through (e) describe the SHOPP Assessments, fees and the penalties for non-payment of the fee or failure to file a cost report, as set out in 63 Okla. Stat. §§ 3241.3 and 3241.4

(2) Appeals filed under this Section are heard by an Administrative Law Judge (ALJ).

(3) To file an appeal, the provider hospital must file an LD-2 form within thirty (30) days of receipt of the notification from OHCA assessing the annual SHOPP Assessment, a fee or penalty. The penalty, fee or assessment is deducted from the hospital's payment if the assessment is unpaid at the time the appeal is filed. If the hospital prevails in the appeal the amount assessed will be returned to the hospital with their payment.

(4) The hearing will be conducted in accordance with OAC 317:2-1-5.

(b) An individual hospital may appeal an individual assessment at the time of its annual assessment. As provided for above in subsection (3), the appeal must be filed within thirty (30) days of receipt of the notification of assessment by OHCA to the hospital. If the hospital challenges the computation of the hospital's net patient revenue, the assessment rate, or assessment amount then the appeal will proceed in accordance with subsection(4)above.

(c) Individual hospitals that appeal the quarterly assessment are limited to calculation errors in dividing the annual assessment into four parts. Appeals must be filed within thirty 30 days of receipt of the notice of assessment by OHCA to the hospital. The appeal will proceed in accordance with subsection (4) above.

(d) If OHCA determines an overpayment of SHOPP payments has been made to an individual hospital, then the hospital may file an appeal within thirty (30) days of the notice of overpayment. Overpayments are deducted from the hospital's payment. The appeal will proceed in accordance with subsection (4) above.

(e) OHCA recognizes that some individual hospital's claims regarding an inappropriate assessment or overpayment may involve aggregate data. For example an appeal may involve one of the following issues:

- (1) total hospitals in the entire SHOPP pool;
- (2) total hospitals that are exempt from SHOPP;
- (3) total hospitals classified as critical access hospitals;
- (4) total net revenue from all hospitals in the pool;
- (5) the total amount of monies allocated to each pool in the SHOPP; or
- (6) the pro-rata distribution in a pool(s).

(f) If an individual hospital brings an aggregate appeals claim, there are two (2) elements of proof to be met. The ALJ must determine that the hospital can demonstrate by a preponderance of evidence:

- (1) that data was made available before the hospital submitted the appeal; and
- (2) a specific calculation error has been made statewide that can be shown by the hospital.

(g) The "Upper Payment Limit" and the "Upper Payment limit Gap" are not appealable in the administrative process.

[Source: Codified -- ; Added at 29 Ok Reg 187, eff 11-22-11 (emergency); Added at 29 Ok Reg 469, eff 5-11-12]

317:2-1-16. Nursing Facility Supplemental Payment Program appeals [REVOKED]

[Source: Added at 34 Ok Reg 339, eff 12-29-16 (emergency); Added at 34 Ok Reg 608, eff 9-1-17 ; Amended at 35 Ok Reg 515, eff 2-27-18 (emergency); Amended at 35 Ok Reg 1380, eff 9-14-18 ; Amended at 36 Ok Reg 850, eff 9-1-19 ; Revoked at 37 Ok Reg 1467, eff 9-14-20]

317:2-1-17. Long-term care facility cost report appeals

This rule describes a long-term facility's rights to administratively appeal any cost adjustment(s) made by the Oklahoma Health Care Authority (OHCA) to the facility's annual cost report, in accordance with the Oklahoma Administrative Code (OAC) 317:30-5-132, or any cost report reconsideration, in accordance with OAC 317:30-5-132.1.

- (1) The following are appealable issues of the program:
 - (A) Any disputed adjustment(s) that are made by the OHCA to the facility's annual cost report, in accordance with OAC 317:30-5-132(5); or
 - (B) Any disputed cost report adjustment reconsideration decision, made by OHCA's chief financial officer or his/her designee in accordance with OAC 317:30-5-132.1.
- (2) Appeals are heard by the OHCA administrative law judge (ALJ).
- (3) To file an appeal, the provider shall submit an LD-2 form within thirty (30) days of the date of the written notice of the OHCA's report adjustment(s) that resulted from an on-site audit, or a cost report reconsideration decision, as applicable.
- (4) The LD-2 shall only be filed by the provider or the provider's attorney in accordance with five (5) below.
- (5) Consistent with Oklahoma rules of practice, the provider shall be represented by an attorney licensed to practice within the State of Oklahoma. Attorneys not licensed to practice in Oklahoma shall comply with Article II, Section (§) 5 of Title 5 of the Oklahoma Statutes (O.S.), and rules of the Oklahoma Bar Association.
- (6) Parties who fail to appear at a hearing, after notification of said hearing date, will have their cases dismissed for failure to prosecute.
- (7) The long-term care facility has the burden of proof by the preponderance of the evidence standard as defined by the Oklahoma Supreme Court.
- (8) The docket clerk will send the long-term care facility and any other necessary party a notice which states the hearing location, date, and time.
- (9) The ALJ may:

- (A) Identify and rule on issues being appealed which will be determined at the administrative hearing;
 - (B) Require the parties to state their positions concerning appeal issue(s);
 - (C) Require the parties to produce for examination those relevant witnesses and documents under their control;
 - (D) Rule on whether witnesses have knowledge of the facts at issue;
 - (E) Establish time limits for the submission of motions or memoranda;
 - (F) Rule on relevant motions, requests, and other procedural items, limiting all decisions to procedural matters and issues directly related to the contested determination resulting from OAC 317:30-5-132 and/or 317:30-5-132.1;
 - (G) Rule on whether discovery requests are relevant;
 - (H) Strike or deny witnesses, documents, exhibits, discovery requests, and other requests or motions which are cumulative, not relevant, not material, or used as a means of harassment, unduly burdensome, or not timely filed;
 - (I) Schedule pre-hearing conferences to settle, simplify, or identify issues in a proceeding or to consider other matters that may end the appeal;
 - (J) Impose appropriate sanctions against any party failing to obey an order of the ALJ;
 - (K) Rule on any requests for extension of time;
 - (L) Dismiss an issue or appeal if:
 - (i) It is not timely filed or is not within the OHCA's jurisdiction or authority; and/or
 - (ii) It is moot or there is insufficient evidence to support the allegations; and/or
 - (iii) The appellant fails or refuses to appear for a scheduled meeting, conference, or hearing; and/or
 - (iv) The appellant refuses to accept a settlement offer which affords the relief the party could reasonably expect if the party prevailed in the appeal; and/or
 - (M) Set and/or limit the time frame for the hearing.
- (10) After the hearing:
- (A) The ALJ should attempt to make the final hearing decision within ninety (90) days from the date of the hearing and send a copy of the ALJ's decision to both parties outlining their rights to appeal the decision. Any appeal of the final order pursuant to 12 O.S. § 951 shall be filed with the District Court of Oklahoma County within thirty (30) days.
 - (B) It shall be the duty of the appellant in any District Court appeal to order a written transcript of proceedings to be used on appeal, as required by 12 O.S. § 951.
- (11) All orders and settlements are non-precedential decisions.

(12) The hearing shall be digitally recorded.

[Source: Added at 37 Ok Reg 210, eff 10-25-19 (emergency); Added at 37 Ok Reg 1469, eff 9-14-20]

317:2-1-18. Step therapy protocol exception appeals

This rule describes a member's rights to administratively appeal the denial of a requested exception to a step therapy protocol, in accordance with Title 63 of the Oklahoma Statutes (O.S.) § 7310 and Oklahoma Administrative Code (OAC) 317:30-5-77.4.

- (1) Appeals will be heard by the Oklahoma Health Care Authority (OHCA) administrative law judge (ALJ).
- (2) Appeals must be filed by the member within thirty (30) days of the date of the denial of a requested exception. Appeals must be filed electronically using a form LD-5 and must set forth the basis for the appeal. The form LD-5 shall be made available on the OHCA's public website. If the LD-5 is not completely filled out or if necessary documentation is not included, the appeal will not be considered.
- (3) Appeals shall be heard at a time and place and in a manner as may be decided by the ALJ. Hearings may be conducted telephonically.
- (4) The docket clerk will send the member or his/her authorized representative an electronic notice setting forth the location, date, and time of the hearing.
- (5) A member can waive the right to an evidentiary hearing and permit the ALJ to consider and rule on the appeal based upon the parties' submissions.
- (6) The member shall have the burden of proof by the preponderance of the evidence standard as defined by the Oklahoma Supreme Court.
- (7) Absent exigent circumstances, as defined in OAC 317:30-5-77.4(a), the ALJ shall respond to any request for appeal within seventy-two (72) hours of receipt of the request. In the case of exigent circumstances, the ALJ shall respond within twenty-four (24) hours of receipt. Provided, however, that if the timeframe for response ends on a weekend, or on any other day the OHCA is closed or closes early, including, but not limited to, legal holidays as defined by 25 O.S. § 82.1, the timeframe for response shall run until the close of the next full business day. An appeal request that is not responded to within this timeframe shall be deemed granted.
- (8) All orders shall be considered non-precedential decisions.
- (9) The hearing shall be digitally recorded.

[Source: Added at 37 Ok Reg 508, eff 1-6-20 (emergency); Added at 37 Ok Reg 1465, eff 9-14-20]

SUBCHAPTER 3. MEMBER GRIEVANCES AND APPEALS, PROVIDER COMPLAINTS, AND STATE FAIR HEARINGS IN MANAGED CARE

317:2-3-1. Definitions

The following words or terms used in the Subchapter shall have the following meaning, unless the context clearly indicates otherwise:

"Adverse benefit determination" means a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay, or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service or payment for the service is therefore denied, reduced or terminated and in accordance with Title 36 of Oklahoma Statute (O.S.) § 6475.3.

"Appeal" means a review of an adverse benefit determination performed by a managed care entity or according to managed care law, regulations, and contracts.

"Exigent circumstances" means a situation in which a reasonable person applying the appropriate standard would consider a member's health condition to be urgent with identifiable harm that could reasonably be expected to occur if the requested health care service is not provided promptly. The appropriate standard requires the assessment of a member's health condition through application, at minimum, of established, accepted standards of medical practice. Evidence of the member's condition may be demonstrated by indications from the treating provider or from the member's medical record, including but not limited to such information as the member's diagnosis, symptoms, or test results.

"Grievance" means a member's expression of dissatisfaction about any managed care program matter other than an adverse benefit determination and may include, but is not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a managed care entity employee or contracted provider, or failure to respect the member's rights regardless of whether remedial action is requested. A grievance includes a member's right to dispute an extension of time to make an authorization decision when proposed by the managed care entity.

"Health plan" means any person or entity that is licensed as a health maintenance organization (HMO) by the State of Oklahoma to provide or arrange for the delivery of basic health care services to enrollees on a prepaid basis, except for copayments or deductibles for which the enrollee is responsible, or both, that meets the definition of an HMO as delineated in the Oklahoma State Medicaid Plan and that contracts with the State to provide services to enrollees. "Health plan" is synonymous with "health carrier".

"Managed care entity" or "MCE" means any entity permitted under 42 C.F.R. Part 438 to contract with a state for services provided under a risk contract or a nonrisk contract within the state's Medicaid managed care program, including but not limited to managed care organization (MCO), primary care case management (PCCM), primary care case management entity (PCCM entity), prepaid ambulatory health plan (PAHP), and prepaid inpatient health plan (PIHP).

"Managed care organization" or **"MCO"** means the same in these rules as defined at 42 Code of Federal Regulations (C.F.R.) § 438.2.

"Managed care program" or **"managed care"** or **"MCP"** means a health care delivery system organized to manage cost, utilization, and quality that is operated by a state as authorized under sections 1915(a), 1915(b), 1932(a), or 1115(a) of the Social Security Act and relevant state law.

"Member" means an individual eligible for Medicaid in the State of Oklahoma, eligible for a managed care program, and enrolled in a managed care entity. "Member" is synonymous with "health plan enrollee".

"Prepaid ambulatory health plan" or **"PAHP"** means the same in these rules as defined at 42 C.F.R. § 438.2.

"Prepaid inpatient health plan" or **"PIHP"** means the same in these rules as defined at 42 C.F.R. § 438.2.

"Primary care case management" or **"PCCM"** means the same in these rules as defined at 42 C.F.R. § 438.2.

"Primary care case management entity" or **"PCCM entity"** means the same in these rules as defined at 42 C.F.R. § 438.2.

"Prior authorization (PA)" means a requirement that a member, through a provider, obtain the managed care entity's approval before a requested medical service is provided or before services by a non-participating provider are received. Prior authorization is not a guarantee of claims payment; however, failure to obtain prior authorization may result in denial of the claim or reduction in payment of the claim. For purposes of these rules, "prior authorization" is included as a determination of health care services within the term "adverse benefit determination".

"Provider" means a health care or dental provider licensed or certified in this state.

[Source: Added at 39 Ok Reg 383, eff 12-21-21 (emergency); Added at 39 Ok Reg 1402, eff 9-12-22]

317:2-3-2. Timeframes

(a) For the purpose of calculating a timeframe in this Subchapter, the date on the written notice is not included. The last day of the timeframe is included, unless the last day is a legal holiday, as defined by 25 Oklahoma Statutes (O.S.) § 82.1, or any other day OHCA is closed or closes early, in which case, the timeframe runs until the close of the next full business day.

(b) A grievance or appeal a member sends via mail is deemed filed on the date the MCE receives request.

(c) A request for reconsideration or appeal a provider sends via mail is deemed filed on the date the MCE receives the request.

(d) A request for State fair hearing by a member or provider is deemed filed on the date the OHCA receives the request.

[Source: Added at 39 Ok Reg 383, eff 12-21-21 (emergency); Added at 39 Ok Reg 1402, eff 9-12-22]

317:2-3-3. Grievance and appeals system

In accordance with state and federal law, including but not limited to 63 Oklahoma Statutes (O.S.) § 7310 and 42 Code of Federal Regulations (C.F.R.) §§ 438.210, 431.213-14, 438.402, 438.404, 438.408, and 438.410, each MCE will have an established grievance and appeals system by which to receive, process, and resolve grievances and appeals, including requests for extensions of relevant timeframes, and by which to afford parties proper notice.

[Source: Added at 39 Ok Reg 383, eff 12-21-21 (emergency); Added at 39 Ok Reg 1402, eff 9-12-22]

317:2-3-4. Member grievances

(a) Filing.

(1) **Filing with managed care entity.** Except as described in this section, when the member is enrolled in a managed care program, the member initially files a grievance with the managed care entity in which the member is enrolled.

(2) **Exception: Filing with OHCA.** When the member is enrolled in a managed care program and the grievance deals with direct interaction with OHCA or its employees or officers, the member first files the grievance with OHCA as an administrative appeal pursuant to applicable rules set forth at Oklahoma Administrative Code (OAC) 317:2-1-2 et seq.

(b) **Timing.** A member may file a grievance, orally or in writing, at any time.

(c) **Provider's and authorized representative's right to file a grievance.** A provider or an authorized representative may file a grievance on behalf of a member, provided that the provider or authorized representative has obtained the member's written consent to do so. The authorized representative of a deceased member's estate may also be a party to the litigation of a grievance, as applicable.

(d) **Clinical expertise in a grievance decision.** When a grievance involves clinical issues or is related to a denial of an expedited resolution of an appeal, the decision maker(s) of such a grievance will have clinical expertise as discussed at OAC 317:2-3-6.

(e) **Consideration of information in an appeal decision.** The decision maker(s) for any appeal will take into account all comments, documents, records, and other information submitted without regard to whether such information was submitted or considered in the initial determination.

(f) **OHCA-established timeframes for grievance decisions.** A grievance related in any way to the member's health condition will be resolved, with notice provided, as expeditiously as the member's health condition requires.

(1) Per 42 Code of Federal Regulations (C.F.R.) § 438.408, the standard resolution of a grievance will occur within ninety (90) calendar days after the managed care entity receives the grievance.

(2) OHCA sets the standard resolution of a grievance to occur within sixty (60) calendar days, inclusive of any extensions, after the MCE receives the grievance.

- (3) The MCE may extend the timeframe in (f)(2) up to fourteen (14) days if:
- (A) The member requests the extension; or
 - (B) The MCE shows (to the OHCA's satisfaction upon OHCA's request) that there is need for additional information and how the delay is in the member's interest.
- (4) If the MCE extends the timeframes not at the request of the member, it must complete all of the following:
- (A) Make reasonable efforts to give the member prompt oral notice of the delay; and
 - (B) Within two (2) calendar days give the member written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision; and
- (5) The MCE will adhere to all OHCA rules related to grievances, including but not limited to:
- (A) Observing the timeframe for standard resolution of a grievance;
 - (B) Sending acknowledgement of receiving the grievance in writing to the member or the member's authorized representative within ten (10) calendar days of receipt; and
 - (C) Sending written notice conforming with this subchapter to the affected parties within three (3) calendar days following resolution of the grievance.

[Source: Added at 39 Ok Reg 383, eff 12-21-21 (emergency); Added at 39 Ok Reg 1402, eff 9-12-22]

317:2-3-5. Member appeals

(a) Filing.

- (1) **Filing with managed care entity.** Except as described in this Section, when the member is enrolled in a managed care program, the member initially files an appeal with the managed care entity in which the member is enrolled.
- (2) **Exception: Filing with OHCA.** When the member is enrolled in a managed care program, the member initially files administrative appeals with OHCA and follows the appeals rules set forth at Oklahoma Administrative Code (OAC) 317:2-1-2 et seq. whenever the appeal concerns a decision the Oklahoma Health Care Authority (OHCA) made regarding:
- (A) Eligibility for Oklahoma Medicaid;
 - (B) Eligibility for a managed care program;
 - (C) Enrollment into Oklahoma Medicaid;
 - (D) Enrollment, including use of an auto-assignment algorithm, into a managed care entity;
 - (E) Disenrollment from a managed care entity; or
 - (F) Any other matter, so long as OHCA made the decision in the matter.

(b) Timing. A member may file an appeal, orally or in writing, at any time. An administrative appeal or State fair hearing request made to

OHCA shall conform with the requirements of OAC 317:2-1-2 *et seq.* in terms of the manner and timing of any such filing.

(c) **Levels of appeals.** The managed care entity will use only one level of appeals, in accordance with 42 Code of Federal Regulations (C.F.R.) § 438.402.

(d) **Provider's and authorized representative's right to file an appeal.** A provider or an authorized representative may file an appeal on behalf of a member, provided that the provider or authorized representative has obtained the member's written consent to do so. The authorized representative of a deceased member's estate may also be a party to the litigation of an appeal, as applicable.

(e) **Clinical expertise in an appeal decision.** When an appeal involves clinical issues or is related to a denial based on lack of medical necessity, the decision maker(s) of such an appeal will have clinical expertise as discussed at OAC 317:2-3-6.

(f) **Consideration of information in an appeal decision.** The decision maker(s) for any appeal will take into account all comments, documents, records, and other information submitted without regard to whether such information was submitted or considered in the initial determination.

(g) **OHCA-established timeframes for appeals decisions.** An appeal related in any way to the member's health condition will be resolved, with notice provided, as expeditiously as the member's health condition requires.

(1) Per 42 C.F.R. § 438.408, the standard resolution of an appeal will occur within thirty (30) calendar days after the managed care entity receives the appeal.

(2) OHCA establishes the following timeframes for appeals:

(A) Standard resolution of an appeal will occur within thirty (30) calendar days, excluding any extensions, after the managed care entity receives the appeal;

(B) Expedited resolution of an appeal will occur within seventy-two (72) clock-hours after the MCE receives the appeal;

(C) In exigent circumstances, resolution of a step therapy request appeal will occur within twenty-four (24) clock-hours after the MCE receives the appeal; and

(D) In all other circumstances, resolution of a step therapy request appeal will occur within seventy-two (72) clock-hours after the MCE receives the appeal.

(3) The MCE may extend the timeframes in (g)(2)(A) or (B) up to fourteen (14) days if:

(A) The member requests the extension; or

(B) The MCE shows (to the OHCA's satisfaction upon OHCA's request) that there is need for additional information and how the delay is in the member's interest.

(4) If the MCE extends the timeframes not at the request of the member, it must complete all of the following:

(A) Make reasonable efforts to give the member prompt oral notice of the delay;

(B) Within two (2) calendar days give the member written notice of the reason for the decision to extend the

timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision; and (C) Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.

(5) The MCE will adhere to all OHCA policies related to appeals, including but not limited to:

- (A) Observing the timeframes for resolving appeals, including standard resolution, expedited resolution, and resolution of step therapy appeals (in both exigent and other circumstances);
- (B) Sending acknowledgement of receiving the appeal in writing to the member or the member's authorized representative within five (5) calendar days of receipt;
- (C) Sending written notice conforming with this subchapter to the affected parties within three (3) calendar days following resolution of the appeal; and
- (D) Sending documentation, in conformance with OAC 317:2-3-12(d) and any established OHCA forms or processes, to OHCA within fifteen (15) calendar days after a request for State fair hearing.

[Source: Added at 39 Ok Reg 383, eff 12-21-21 (emergency); Added at 39 Ok Reg 1402, eff 9-12-22]

317:2-3-6. External medical review and clinical expertise

(a) **No external medical review.** The Oklahoma Health Care Authority (OHCA) will not offer an external medical review for the purposes of grievances or appeals.

(b) **Clinical expertise standards.** Individuals making the decision for a grievance or appeal regarding an adverse benefit determination will be unbiased with appropriate clinical expertise in treating the member's condition or disease.

(1) Medical review staff of the MCE will be licensed or credentialed health care clinicians with relevant clinical training and/or experience.

(2) All MCEs will use medical review staff for such appeals and shall not use any automated claim review software or other automated functionality for such appeals.

(3) Bias is deemed to exist if an individual making a decision on a grievance or appeal was involved in, or a subordinate of any individual involved in, any previous level of review or decision regarding the subject matter of the grievance or appeal.

(4) Clinical expertise is deemed necessary for decisions makers whenever:

- (A) The denial is based on a lack of medical necessity;
- (B) The grievance is regarding a denial of an expedited resolution an appeal; and
- (C) The grievance or appeal involves clinical issues.

[Source: Added at 39 Ok Reg 383, eff 12-21-21 (emergency); Added at 39 Ok Reg 1402, eff 9-12-22]

317:2-3-7. Obligation to pay costs of services

- (a) In accordance with 42 Code of Federal Regulations (C.F.R.) § 438.420(d), the MCE may recover from the member the costs of services provided to the member while an appeal or State fair hearing is pending:
- (1) To the extent the services were continued solely due to the requirements set forth in 42 C.F.R. §§ 438.420 or 431.230(b); and
 - (2) The final resolution of the appeal or State fair hearing upholds the MCE's adverse benefit determination.
- (b) If OHCA or the MCE reverses a decision to deny, limit, or delay services and these services were not furnished while the appeal or State fair hearing was pending, the MCE will authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires.
- (c) If OHCA or the MCE reverses a decision to deny, limit, or delay services and the member received the disputed services while the appeal or State fair hearing was pending, the MCE will pay for these services.

[Source: Added at 39 Ok Reg 383, eff 12-21-21 (emergency); Added at 39 Ok Reg 1402, eff 9-12-22]

317:2-3-8. Grievances and appeals notice

- (a) The MCE will provide timely written notices per OAC 317:2-3-4 and 317:2-3-5.
- (b) Each notice will conform to the provisions of 42 Code of Federal Regulations (C.F.R.) § 438.10 related to information provided from an MCE to a member.
- (c) At minimum, each notice will:
- (1) Be written in a manner and format that may be easily understood and is readily accessible by members;
 - (2) Use OHCA-developed definitions for terms as those terms are defined in the Model Member Handbook related to the contract;
 - (3) Use a font size no smaller than twelve-point (12-point);
 - (4) Be made available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of members with disabilities or limited English proficiency; and
 - (5) Include a large-print tagline, in minimum eighteen-point (18-point) font, and information on how to request auxiliary aids and services, including the provision of materials in alternative formats.
- (d) Per the delegation choice of 42 C.F.R. § 438.228, OHCA does not delegate responsibility to the MCE for timely notices of action under 42 C.F.R. Part 431, Subpart E.
- (1) OHCA retains all responsibility for timely notices of action under 42 C.F.R. Part 431, Subpart E, including:
 - (A) A termination, suspension of, or reduction in covered benefits or services, when termination, suspension, or reduction is determined by OHCA;
 - (B) A termination, suspension of, or reduction in Medicaid eligibility, when termination, suspension, or reduction is determined by OHCA; and

(C) An increase in beneficiary liability, including determination that a beneficiary will incur a greater amount of medical expenses in order to establish income eligibility or is subject to an increase in premiums or cost sharing charges, when such increase is determined by OHCA.

(2) The foregoing (d)(1) does not apply to:

(A) Any grievance notice required to be sent by the MCE by contract or 42 C.F.R. § 438.408;

(B) Any adverse benefit determination notice based on the termination, suspension, or reduction of authorized covered services, payment denial, or standard, expedited, or untimely service authorization denial or limitation as required to be sent by the MCE by contract or 42 C.F.R. 438.404;

(C) Any appeal resolution notice required to be sent by the MCE by contract or 42 C.F.R. § 438.404 or 438.408; or

(D) Any other notice required to be sent by the MCE by contract or any state or federal law or regulation.

(3) OHCA's decision not to delegate the notices of action required by 42 C.F.R. Part 431 Subpart E applies to any managed care entity under any managed care contract for professional services unless and until this section is revoked.

(4) The random review system required of a state by 42 C.F.R. § 438.228 does not apply to OHCA, because OHCA has not delegated responsibility for the relevant notices of action.

(5) For any notices of action for which OHCA retains responsibility under this section, OHCA will ensure the notice conforms to federal regulations at 42 C.F.R. Part 431, Subpart E, and any applicable requirements under 42 C.F.R. § 438.228. OHCA will send such notices of action by electronic or postal means at least ten (10) days before the date of action, except as permitted when:

(A) OHCA has factual information confirming the death of a beneficiary;

(B) OHCA receives a clear written statement signed by a member that they no longer wish to receive services or that gives information that requires termination or reduction of services and indicates that the member understands that supplying the information will result in termination or reduction of services;

(C) The member has been admitted to an institution where they are ineligible for further services;

(D) The member's whereabouts are unknown and the post office returns, indicating no forwarding address, OHCA mail sent directly to the member; and

(E) The MCE establishes the fact that the member has been accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth.

(6) For any notices of action for which OHCA retains responsibility under this Section, OHCA will ensure the notice

contains:

- (A) A statement of the action OHCA intends to take and the effective date of such action;
 - (B) A clear statement of the specific reasons supporting the intended action, the specific regulations that support or require the action, and an explanation of the member's rights to request a hearing; and
 - (C) An explanation of the circumstances under which benefits continue if a hearing is requested.
- (7) For any notices of action for which OHCA retains responsibility under this section, OHCA will allow the member a reasonable time, not to exceed ninety (90) days from the date the notice is mailed, to request a State fair hearing.

[Source: Added at 39 Ok Reg 383, eff 12-21-21 (emergency); Added at 39 Ok Reg 1402, eff 9-12-22]

317:2-3-9. Exhaustion of managed care entity appeals

(a) **Deemed exhaustion of MCE appeals.** If the MCE fails to adhere to any timing or notice requirements as detailed in 42 C.F.R. § 438.408, the member is deemed to have exhausted the MCE's appeal process, and the member or the member's authorized representative may request a State fair hearing.

(b) **Actual exhaustion of MCE appeals.** Except as allowed in (a), a member or the member's authorized representative may request a State fair hearing only after receiving notice from the MCE upholding an adverse benefit determination and only within one hundred twenty (120) days after the date of the notice of appeal resolution.

(c) **Exhaustion of MCE appeals, determination.** OHCA has sole authority to decide whether MCE appeals have been exhausted for any member. Documentation, as submitted to OHCA by the MCE within fifteen (15) calendar days of the request for State fair hearing, will serve as evidence to deemed exhaustion, actual exhaustion, or no exhaustion of the MCE appeals process.

[Source: Added at 39 Ok Reg 383, eff 12-21-21 (emergency); Added at 39 Ok Reg 1402, eff 9-12-22]

317:2-3-10. Provider complaint system

(a) A participating provider or nonparticipating provider may file a complaint whenever:

- (1) The provider is not satisfied with the MCE's policies and procedures; or
- (2) The provider is not satisfied with a decision made by the MCE that does not impact the provision of services to members.

(b) The MCE will establish and operate a provider complaint system. Such system will:

- (1) Use written policies and procedures for receiving, tracking, dating, storing, responding to, reviewing, reporting, and resolving provider complaints;
- (2) Track receipt and resolution of provider complaints, including requests for reconsideration or appeals;

- (3) Demonstrate sufficient ability to receive provider complaints by telephone, in writing, or in person;
- (4) Designate staff to receive, process, and resolve provider complaints;
- (5) Thoroughly investigate each provider complaint;
- (6) Ensure an escalation process for provider complaints;
- (7) Furnish the provider timely written notification of resolution or results; and
- (8) Maintain a tracking system capable of generating reports to OHCA on provider complaint volume and resolution.

(c) The MCE will operate a reconsideration process whereby providers may request the MCE reconsider a decision the MCE has made or intends to make that is adverse to the provider, including, at minimum, reconsiderations of provider audit findings, reconsiderations of provider agreement termination, and reconsiderations of denied claims.

(1) **Request for reconsideration, denied claims.** The MCE will ask that the provider submits a request for reconsideration of a denied claim within six (6) months after the provider receives notice of the denied claim.

(2) **Request for reconsideration, all other reasons.** The MCE will ask that the provider submits a request for reconsideration within fifteen (15) days after the date the provider receives notice of audit findings, termination of provider agreement, or other actions the MCE permits for reconsideration requests.

(3) **Desk review.** The MCE will conduct the reconsideration through a desk review of the request and all related and available documents.

(4) **Reconsideration resolution.** The MCE will resolve all requests for reconsideration within twenty (20) calendar days of the date the MCE receives the request for reconsideration. The MCE will send a reconsideration resolution notice to the provider within three (3) business days of the MCE finalizing the resolution.

(5) **Notice of Reconsideration Resolution.** The MCE will send a reconsideration resolution notice that contains, at a minimum:

- (A) The date of the notice;
- (B) The action the MCE has made or intends to make;
- (C) The reasons for the action;
- (D) The date the action was made or will be made;
- (E) The citation to statute, regulation, policy, or procedure, if any, upon which the action was based;
- (F) An explanation of the provider's ability to submit an appeal request to the MCE within thirty (30) calendar days of the date recorded on the notice;
- (G) The address and contact information for submitting an appeal;
- (H) The procedures by which the provider may request an appeal regarding the MCE's action;
- (I) The specific change in federal or state law, if any, that requires the action;

(J) The provider's ability to submit a State fair hearing request following completion of the provider appeal process, or, in cases of an action based on a change in law, the circumstances under which a State fair hearing will be granted; and

(K) Any other information required by state or federal statute or regulation, by contract, or by contract-related manual.

(d) The MCE will operate an appeals process whereby a provider may request an appeal of a reconsideration resolution when the underlying matter is based on the MCE's provider audit findings, for-cause or immediate termination of the provider agreement, or a denied claim.

(1) **Request for appeal.** The MCE will require the provider to submit a request for appeal in writing within thirty (30) calendar days after the provider receives notice reconsideration resolution.

(2) **Panel review.** The MCE will conduct the appeal through a panel review including a hearing and review of the request, all related and available documents, and all documents created for or used in connection with the request for reconsideration.

(A) The panel will consist of three (3) or five (5) reviewers, who are employees or officers of the MCE.

(B) Panel members will not have been directly involved with the reconsideration desk review and will not be a subordinate of someone involved directly with the reconsideration desk review.

(C) The panel review hearing will provide the provider or an authorized representative of the provider with a reasonable opportunity to be heard in person or by telecommunications.

(D) The review panel will accept and document any exhibit offered prior to the hearing or during the hearing, so long as the exhibit directly relates to the matter of the appeal.

(E) When the appeal is based on a claim denied on the basis of medical necessity, the following requirements apply:

(i) Medical review staff of the MCE will be licensed or credentialed health care clinicians with relevant clinical training or experience; and

(ii) All MCEs will use medical review staff for such appeals and will not use any automated claim review software or other automated functionality for such appeals.

(3) **Appeal resolution.** The MCE will resolve all appeals within forty-five (45) calendar days of the date the MCE receives the request for appeal. The MCE will send an appeal resolution notice to the provider within three (3) business days of the MCE finalizing the resolution.

(4) **Notice of Appeal Resolution.** The MCE will send an appeal resolution notice that contains, at a minimum:

(A) The date of the notice;

(B) The date of the appeal resolution; and

- (C) For decisions not wholly in the provider's favor:
 - (i) An explanation of the provider's ability to request a State fair hearing within thirty (30) calendar days of the date recorded on the notice;
 - (ii) How to request a State fair hearing, including the OHCA address and contact information for submitting a request;
 - (iii) Details on the right to be represented by counsel at the State fair hearing; and
 - (iv) Any other information required by state or federal statute or regulation, by contract, or by contract-related manual.

(5) **Documentation.** The MCE will furnish to OHCA documentation including all information specified at OAC 317:2-3-13(c)(2) within fifteen (15) calendar days of a provider's request for a State fair hearing.

[Source: Added at 39 Ok Reg 383, eff 12-21-21 (emergency); Added at 39 Ok Reg 1402, eff 9-12-22]

317:2-3-11. Recordkeeping

In compliance with 42 C.F.R. § 438.3(h) and (u), the MCE will maintain records of each grievance and appeal for ten (10) years after the later of the final date of the contract period or the date of completion of any MCE audit by the State, the Centers for Medicare and Medicaid Services (CMS), the Office of the Inspector General, or the Comptroller General. Such records will be part of OHCA's ongoing monitoring and will be used to update and revise OHCA's managed care quality strategy. The record will conform with the content requirements at 42 C.F.R. § 438.416.

[Source: Added at 39 Ok Reg 383, eff 12-21-21 (emergency); Added at 39 Ok Reg 1402, eff 9-12-22]

317:2-3-12. State fair hearing for members

(a) **Right to State fair hearing.** With regard to grievances or appeals first filed with the MCE, a member may request a State fair hearing under 42 C.F.R. 431 Subpart E only after receiving notice from the MCE upholding an adverse benefit determination. The member will have one-hundred twenty (120) days from the date of the adverse benefit determination notice to request a State fair hearing. Refer to 42 C.F.R. §§ 438.402(c)(1)(i) and 438.408(f)(1).

(b) **MCE policies and procedures.** The MCE will implement established policies and procedures that allow a member described in (a) to initiate a State fair hearing process after having exhausted the MCE's appeals process or after the member is deemed to have exhausted the process due to the MCE's failure to adhere to notice and timing requirements.

(c) **Member's request for a State fair hearing.** The MCE will allow the member to request a State fair hearing either through an established MCE process or through an established OHCA process. Any MCE process will ensure that notice of the request for State fair hearing is communicated in writing to the OHCA contracting officer within twenty-

four (24) clock-hours of receiving the request.

(d) **MCE documentation obligation.** The MCE will provide documentation to the member, the member's authorized representative, OHCA, and the Office of Administrative Hearings.

(1) **Timing.** The MCE will provide the documentation described in this subsection:

(A) Within twenty-four (24) clock-hours after receiving notification of the request for State fair hearing relating to a step therapy request; or

(B) Within fifteen (15) calendar days after notification of the request for State fair hearing in all other circumstances.

(2) **Information.** Documentation will include, at minimum, the following information:

(A) The name and address of the member and, if applicable, the member's authorized representative;

(B) A summary statement concerning why the member has filed a request for State fair hearing;

(C) A brief chronological summary of the MCE's action in relationship to the matter underlying the member's request for State fair hearing;

(D) The member's appeal request, along with any supporting documentation, if received by the MCE;

(E) Any applicable correspondence between the MCE and the member, including system notes entered by one or more MCE employees based on one or more telephone conversations with the member;

(F) All exhibits offered at any hearing held with the MCE;

(G) All documents the MCE used to reach its decision;

(H) A statement of the legal basis for the MCE's decision;

(I) A citation of the applicable policies and/or legal authorities relied upon by the MCE in making its decision;

(J) A copy of the notice which notified the member of the decision in question;

(K) The names and titles of any MCE employees who will serve as witnesses at the State fair hearing; and

(L) Any other information requested by the member, the member's authorized representative, OHCA, or the Office of Administrative Hearings when the information relates to the State fair hearing or any matter giving rise to the State fair hearing.

(e) **MCE staffing.** The MCE will maintain a sufficient level of staffing to competently perform the functions, requirements, roles, and duties involved in State fair hearing support, including but not limited to documentation, summarization of the arguments presented, and ensuring timely notice and delivery of documents to all parties.

(f) **Performance targets.** OHCA may set performance targets related to State fair hearing requests that are resolved upholding the MCE's original determination when and as OHCA deems necessary or appropriate.

(g) **Post-transition obligations.** After termination or expiration of the managed care contract, the MCE will remain responsible for State fair hearings related to dates of service prior to the contract termination or expiration, including but not limited to the provision of records and representation at State fair hearings.

(h) **Cost of services.** If the State fair hearing officer reverses the MCE's decision to deny authorization of services and the member received the disputed services while the State fair hearing was pending, the MCE will pay for those disputed services.

[Source: Added at 39 Ok Reg 383, eff 12-21-21 (emergency); Added at 39 Ok Reg 1402, eff 9-12-22]

317:2-3-13. State fair hearing for providers

(a) **Right to State fair hearing.** With regard to provider audit findings, for-cause and immediate termination of the provider's agreement, and claims denial, a provider may request a State fair hearing within thirty (30) calendar days of the MCE's notice of appeal resolution when that resolution does not favor the provider.

(b) **Information for providers.** As a part of the MCE's provider complaint system, the MCE will provide information to providers on how to request a State fair hearing via filing the appropriate form with the OHCA Docket Clerk.

(c) **MCE documentation obligation.** The MCE will provide documentation to the provider, OHCA, and the Office of Administrative Hearings.

(1) **Timing.** The MCE will provide the documentation described in this subsection within fifteen (15) calendar days after notification of the request for State fair hearing.

(2) **Information.** Documentation will include, at minimum, the following information:

- (A) The name and address of the provider;
- (B) A summary statement concerning why the provider has filed a request for State fair hearing;
- (C) A brief chronological summary of the MCE's action in relationship to the matter underlying the provider's request for State fair hearing;
- (D) The provider's appeal request, along with any supporting documentation, if received by the MCE;
- (E) Any applicable correspondence between the MCE and the provider, including system notes entered by one or more MCE employees based on one or more telephone conversations with the provider;
- (F) All exhibits offered at any hearing held with the MCE;
- (G) All documents the MCE used to reach its decision;
- (H) A statement of the legal basis for the MCE's decision;
- (I) A citation of the applicable policies and/or legal authorities relied upon by the MCE in making its decision;
- (J) A copy of the notice which notified the provider of the decision in question;

(K) The names and titles of any MCE employees who will serve as witnesses at the State fair hearing; and
(L) Any other information requested by the provider, OHCA, or the Office of Administrative Hearings when the information relates to the State fair hearing or any matter giving rise to the State fair hearing.

[Source: Added at 39 Ok Reg 383, eff 12-21-21 (emergency); Added at 39 Ok Reg 1402, eff 9-12-22]

317:2-3-14. Administrative Law Judge (ALJ) jurisdiction

The ALJ has jurisdiction of the following matters:

- (1) **Member State fair hearing.** The ALJ has jurisdiction to hear any State fair hearing arising from a member's MCE appeal of an adverse benefit determination.
- (2) **Provider State fair hearing.** The ALJ has jurisdiction to hear any State fair hearing arising from a provider's appeal of audit findings, for-cause or immediate termination of the provider's contract with the MCE, or claims denial.

[Source: Added at 39 Ok Reg 383, eff 12-21-21 (emergency); Added at 39 Ok Reg 1402, eff 9-12-22]

CHAPTER 10. PURCHASING

[**Authority:** 51 O.S., §§ 24A.1 et seq.; 57 O.S., § 549.1; 74 O.S., §§ 85.32, 85.45, and 3001]
[**Source:** Codified 7-27-95]

317:10-1-1. Purpose

(a) The purpose of this Chapter is to describe the rules governing the contracting and purchasing requirements of the Oklahoma Health Care Authority (OHCA), as directed by 74 O.S. § 85.39. OHCA maintains two (2) internal units that are responsible for the acquisition of goods, equipment, non-professional services, and professional services for the operation of OHCA.

(b) The rules of this Chapter are superseded by the Office of Management and Enterprise Services (OMES) [Oklahoma Administrative Code (OAC) 260:115,] as amended from time to time, whenever OMES has final authority on an acquisition. When an acquisition is made by OMES, the OMES purchasing rules at OAC 260:115 apply. When an acquisition is made by OHCA, the rules of this Chapter should be read in conjunction with the OMES rules.

[**Source:** Added at 11 Ok Reg 3613, eff 6-15-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3111, eff 7-27-95 ; Amended at 16 Ok Reg 3403, eff 7-1-99 (emergency); Amended at 17 Ok Reg 1180, eff 5-11-00 ; Amended at 23 Ok Reg 3171, eff 6-7-06 (emergency); Amended at 24 Ok Reg 871, eff 5-11-07 ; Amended at 27 Ok Reg 1668, eff 5-14-10 (emergency); Amended at 28 Ok Reg 1381, eff 6-25-11 ; Amended at 29 Ok Reg 1073, eff 6-25-12 ; Amended at 34 Ok Reg 609, eff 9-1-17 ; Amended at 39 Ok Reg 21, eff 9-7-21 (emergency); Amended at 39 Ok Reg 1413, eff 9-12-22]

317:10-1-2. Definitions

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

"Acquisition" means items, products, materials, supplies, services, and equipment that OHCA acquires by purchase, lease-purchase, lease with option to purchase, or rental.

"Administrative review" means the process by which OHCA ensures that a bid submission is complete and accurate; confirms that the bidder understood the solicitation specifications; and ascertains that all materials and any required signatures are submitted.

"Award" or **"contract award"** means the process by which OHCA formally notifies a bidder that OHCA has accepted the bidder's bid or offer.

"Best and final offer" or **"BAFO"** means a final offer submitted in writing by a bidder initially or after negotiations are completed and containing the bidder's most favorable terms for price, service, and/or products to be delivered.

"Best price" means the lowest available price for the goods and/or services that are subject of a solicitation.

"Best value" means evaluation criteria which may include but is not limited to the acquisition's operational cost a state agency would incur; the quality of the acquisition, or its technical competency; the reliability of the bidder's delivery and implementation schedules; the acquisition's facilitation of data transfer and systems integration; the acquisition's warranties and guarantees and the bidder's return policy;

the bidder's financial stability; the acquisition's adherence to the state agency's planning documents and announced strategic program; the bidder's industry and program experience and record of successful past performance with acquisitions of this complexity; the anticipated acceptance by user groups; and the acquisition's use of proven development methodology, and innovative use of current technologies.

"Bid" means any response to a solicitation, including any and all required forms; required documents and information; and supplemental documents and information.

"Bidder" means an individual, entity, or service vendor that submits a bid in response to a solicitation.

"Bid evaluation" means the process of conducting any evaluative activity that could reasonably be expected to result in determining the value, nature, character, or quality of a bid.

"Bid evaluator" means an employee or officer of the State of Oklahoma who is actively engaged in Oklahoma Health Care Authority's (OHCA) process to evaluate, score, or select a bid, regardless of whether a contract is awarded to the bid evaluated and/or scored by that employee or officer.

"Bid specifications" means the information OHCA will use for bid evaluation, when such information is exactly detailed within a solicitation and is based on the subject matter of the solicitation, the type of solicitation, and the needs to be met by the supplier(s) awarded a contract from the solicitation.

"Central Purchasing Division" means the Central Purchasing Division of the Office of Management and Enterprise Services (OMES).

"Certification" means the process of a bidder providing OHCA with an official document attesting to a status or level of achievement in response to a solicitation.

"Certified Procurement Officer" or **"CPO"** means a state agency procurement official certified as a procurement officer or analyst by the State Purchasing Director under the provisions of the Oklahoma Central Purchasing Act.

"C.F.R." means the Code of Federal Regulations as may be amended from time to time.

"Chief Executive Officer" or **"CEO"** means the highest-ranking administrator at the OHCA.

"Chief Information Officer" means the chief administrative officer of the Information Services Division of the Office of Management and Enterprise Services.

"Clarification" means a bidder's explanation of all or part of a bid that does not change, alter, or supplement the bid.

"CMS" means the Centers for Medicare & Medicaid Services.

"Closing date/time" means the date and Central Time a solicitation specifies responses must be received by OHCA.

"Competitive solicitation" or **"solicitation"** means an invitation to bid for the provision of goods or services through specified documents submitted to the Central Purchasing Division or a state agency pursuant to terms, conditions, and other requirements of a solicitation. The competitive solicitation process may be electronic when the terms of the solicitation expressly permit electronic submission and the requirements

of applicable statutes and rules are met. When used in this chapter, "competitive solicitation" is synonymous with "invitation to bid," "request for proposal," "request for information," or "request for quotation."

"Conflict plan" means the written statement detailing the accommodations and/or remedies associated with a specific OHCA employee's or officer's conflict of interest in the procurement process or resulting contract.

"Conflict of interest" means a situation in which a person is in a position to derive personal benefit from actions or decisions made in their official capacity, a situation in which the concerns or aims of two (2) different parties are incompatible, a situation prohibited or constrained by law, or a situation that would appear inappropriate to a reasonable individual.

"Contract" means the written and binding agreement between OHCA and the bidder resulting from the competitive solicitation.

"Contracting official" or **"contracting officer"** means the OHCA CEO or the OHCA officer or employee to whom contracting authority has been delegated by the OHCA CEO, unless specified otherwise.

"Contractor" means any individual or entity contracted with OHCA for the provision of any goods or services. A bidder becomes a contractor upon contract award and execution.

"Days" means calendar days unless otherwise specified.

"Debar" or **"debarment"** means action taken by the State Purchasing Director to exclude any business entity from inclusion on the Supplier List, bidding, offering to bid, receiving an award of contract with the state of Oklahoma for acquisitions by state agencies, or a contract the OMES awards or administers. Debarment may also result in cancellation of existing contracts with the State of Oklahoma.

"Employee" or **"officer"** means a natural person that works for OHCA, unless otherwise specified, regardless of title or designation and regardless of manner of appointment, election, or hiring. "Employee or officer" does not mean a member of the Authority Board in the member's capacity as a board member.

"Enrollment activities" means activities performed or conducted by OHCA related to distributing, collecting, or processing enrollment materials, taking enrollments by technological device or in person, or enrolling or disenrolling, including by algorithm, Medicaid beneficiaries with respect to any health plan or managed care services contract.

"Fiscal year" means the period of time from July 1 of a calendar year through June 30 of the succeeding calendar year.

"Former employee" means a natural person whose work as an employee or officer for OHCA ended by any means at some point prior to the currently referenced moment.

"Health plan" means any person or entity that is licensed as a health maintenance organization (HMO) by the state of Oklahoma to provide or arrange for the delivery of basic health care services to enrollees on a prepaid basis, except for copayments or deductibles for which the enrollee is responsible, or both, that meets the definition of an HMO as delineated in the Oklahoma Medicaid State Plan and that contracts with the State to provide services to enrollees.

"Invoice" means an accounting document issued by an individual or entity that details the goods and/or services provided and the amount of money owed for the goods and/or services when the document conforms to all invoicing provisions of the contract and that records the details of the transaction.

"Managed care entity" or **"MCE"** means any entity permitted under 42 C.F.R. Part 438 to contract with a state for services provided under a risk contract or a nonrisk contract within the state's Medicaid managed care program, including but not limited to managed care organization (MCO), primary care case management (PCCM), primary care case management entity (PCCM entity), prepaid ambulatory health plan (PAHP), and prepaid inpatient health plan (PIHP).

"Managed care organization" or **"MCO"** means the same in these rules as defined at 42 C.F.R. § 438.2.

"Managed care program" or **"managed care"** or **"MCP"** means a health care delivery system organized to manage cost, utilization, and quality that is operated by a state as authorized under sections 1915(a), 1915(b), 1932(a), or 1115(a) of the Social Security Act and relevant state law.

"Mandatory specification" means any specification of a solicitation when the terms "shall", "must", "will", or "is required" are used to describe, define, or announce the specification. This definition refers only to the use of such words in a solicitation and does not refer to the use of such words in this chapter.

"Material deficiency" or **"material deviation"** means a bidder's failure to provide information necessary to evaluate a competitive solicitation.

"Medicaid" means the medical assistance program jointly administered by the federal and state governments and authorized by 42 U.S.C. § 1396a to provide health care benefits for certain low-income persons.

"Minor deficiency" or **"minor informality"** means an immaterial defect in a bid or variation in a bid from the exact requirements of a competitive solicitation that may be corrected or waived without prejudice to other bidders. A minor deficiency or informality does not affect the price, quantity, quality, delivery, or conformance to specifications and is negligible in comparison to the total cost or scope of the acquisition.

"Multi-award" means the process by which OHCA formally, by written determination, notifies two or more bidders that OHCA has accepted the bidders' bid to furnish an indefinite quantity or category of item, where more than one supplier is needed to meet the contract requirements for quantity, delivery, service, or product compatibility.

"Non-collusion certification" means a certification submitted by a bidder with any competitive bid or contract executed by the state for goods or services in accordance with 74 O.S. § 85.22.

"Nonresponsive" means a bid or proposal that has been determined not to conform to essential requirements of a solicitation.

"OAC" means the Oklahoma Administrative Code as may be amended from time to time.

"Office of Management and Enterprise Services" or **"Office"** or **"OMES"** means the Oklahoma Office of Management and Enterprise Services.

"Oklahoma Central Purchasing Act" means 74 O.S. §§ 85.1 et seq.

"Oklahoma Health Care Authority" or **"OHCA"** or **"Authority"** means the single state agency designated to administer the medical programs which make available appropriate medical services to eligible individuals through the Title XIX Medicaid Program and which has authority to procure, administer and monitor contracts, issue performance deficiency notices, and assess non-compliance damages.

"OHCA Board" means the board designated by the Oklahoma Legislature to establish policies and adopt and promulgate rules for the OHCA.

"Oklahoma Information Technology (IT) Accessibility Standards" or **"IT Accessibility Standards"** means the accessibility standards adopted by the Office of Management and Enterprise Services (Reference OAC 250:15) to address all technical standard categories of Section 508 of the Rehabilitation Act (Reference 29 U.S.C. § 794d), as amended by the Workforce Investment Act of 1998 (Reference P.L. 105-220, August 7, 1998) and adopted at 62 O.S. §§ 34.28, 34.29, 34.30, and 34.16, to be used by each state agency in procuring, maintaining, or using information technology, and in the development and implementation of custom-designed information technology systems, web sites, and other emerging information technology systems.

"Oral presentation evaluation" means the process, through the bidder's participation in an interactive dialogue or non-interactive presentation, by which OHCA assesses a bidder's capability, past performance, work plans or approaches, staffing resources, transition plans, sample tasks, or fit with the OHCA.

"O.S." or "Okla. Stat." means the Oklahoma Statutes as may be amended from time to time.

"Permissible specification" means any specification in a solicitation when the terms "can", "may", or "should" are used to describe, define, or announce the specification. This definition refers only to the use of such words in a solicitation and does not refer to the use of such words in this chapter.

"Privatize" means to enter into contract for the performance of a duty or function which is currently being performed by a state employee.

"Procurement" means buying, purchasing, renting, leasing, or otherwise acquiring any goods or services. The term also means all functions that pertain to the obtaining of any goods or services, including but not limited to the description of requirements, selection, and solicitation of sources, preparation and award of contracts, and all phases of contract administration.

"Professional services" means services which are predominantly advisory or intellectual in character, involve privatized functions, or involve support rather than supplying equipment, supplies, or other merchandise. Professional services include those services requiring special, usually advanced, education, or skill.

"Prejudice" means the effect on an affected bidder's substantial rights when a procurement decision related to a different bidder, if such decision is found to be in error, would yield a more favorable result for the affected bidder if the decision error were corrected.

"Purchasing" means the Purchasing Department of the Oklahoma Health Care Authority.

"Purchasing manager" means the Purchasing Manager of the Oklahoma Health Care Authority.

"Registered supplier" means a supplier that registers with the Central Purchasing Division pursuant to 74 O.S. § 85.33.

"Remedy" means to cure, alter, correct, or change.

"Request for information" or **"RFI"** means a non-binding procurement practice used to obtain information, comments, and feedback from interested parties or potential suppliers prior to issuing a solicitation.

"Request for proposal" or **"RFP"** means a type of solicitation OHCA or the State Purchasing Director issues to suppliers to request submission of proposals for acquisitions.

"Request for quotation" or **"RFQ"** means a simplified written or oral solicitation OHCA or the State Purchasing Director issues to suppliers to request submission of a quote for acquisitions.

"Requisition number" means an identifier OHCA or OMES assigns to a requisition.

"Responsible supplier" means a supplier who demonstrates capabilities, in all respects, to fully perform the requirements of a contract and which will ensure good faith performance, including but not limited to finances, credit history, experience, integrity, perseverance, reliability, capacity, facilities and equipment, and performance history.

"Responsive" means a bid or proposal that has been determined to conform to the essential requirements of a solicitation.

"Risk contract" means a contract between OHCA and a managed care organization (MCO), prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP), as those terms are defined at 42 C.F.R. § 438.2, under which the contractor assumes risk for the cost of the services covered under the contract and incurs loss if the cost of furnishing the services exceeds the payments under the contract.

"Sole brand acquisition" means an acquisition that by specification restricts the acquisition to one manufacturer or brand name.

"Sole source acquisition" means an acquisition that by specification restricts the acquisition to one supplier.

"Split purchase" means dividing a known quantity or failing to consolidate a known quantity of an acquisition for the purpose of evading a competitive bidding requirement.

"State Purchasing Director" means the director of the Central Purchasing Division of the Office of Management and Enterprise Services appointed by the OMES Director and includes any employee or agent of the State Purchasing Director, acting within the scope of delegated authority. (Reference 74 O.S. § 85.2) Unless otherwise stated, the term includes employees of the Central Purchasing Division and state agency purchasing officials certified by the State Purchasing Director to which

the State Purchasing Director has lawfully delegated authority to act on his or her behalf. In regard to the procurement of information technology or telecommunications, the term means the Chief Information Officer of the Office of Management and Enterprise Services.

"Statement of work" or **"scope of work"** means a detailed description of the work which OHCA requires a contractor or supplier to perform or accomplish.

"Supplier" or **"vendor"** means an individual or business entity that sells or desires to sell acquisitions, including goods and/or services to OHCA. (Reference 74 O.S. § 85.2)

"Supplier list" means a list of individuals or business entities that have registered with the Central Purchasing Division in order to receive notification of solicitations for commodities specified in their registration application.

"Supplier performance evaluation" means information a state agency or OMES Procurement provides to the State Purchasing Director, in a manner the OMES Director prescribes, that documents the quality of service or products provided by a supplier.

"Supplier registration" means a process a supplier uses to register with the Central Purchasing Division to automatically receive solicitations based on a commodity class for a specified period of time.

"Technical proposal evaluation" means the process, based on established criteria and reliant on evaluators' expertise in assessing the strengths and weaknesses of multiple bids, by which OHCA measures the extent to which a bid will meet OHCA's needs.

"U.S.C." means the United States Code as may be amended from time to time.

"Value based" or **"value-based purchasing"** means the intentional linking of cost to the OHCA's perception of the value of goods or services. In a health plan or managed care contract, these terms refer to provider payments made by the health plan or managed care entity based on improved performance by health care providers.

[Source: Added at 11 Ok Reg 3613, eff 6-15-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3111, eff 7-27-95 ; Amended at 16 Ok Reg 3403, eff 7-1-99 (emergency); Amended at 17 Ok Reg 1180, eff 5-11-00 ; Amended at 23 Ok Reg 3171, eff 6-7-06 (emergency); Amended at 24 Ok Reg 871, eff 5-11-07 ; Amended at 27 Ok Reg 1668, eff 5-14-10 (emergency); Amended at 28 Ok Reg 1381, eff 6-25-11 ; Amended at 39 Ok Reg 21, eff 9-7-21 (emergency); Amended at 39 Ok Reg 1413, eff 9-12-22]

317:10-1-3. General contracting and purchasing provisions

(a) All acquisitions made by the Oklahoma Health Care Authority shall be in accordance with the Oklahoma Central Purchasing Act, 74 Okla. Stat. §§ 85.1 et seq., other applicable statutory provisions, Office of Management and Enterprise Services Central Purchasing Rules and the Authority's approved internal purchasing procedures.

(b) When these rules are silent on a relevant issue related to an acquisition made by the Authority, the appropriate OMES rule applies, except that where "State Purchasing Director" is specified, this means "the Authority Certified Procurement Officer making the acquisition and/or the CEO". Where "Purchasing Division" is specified, this means "the Authority".

[Source: Added at 11 Ok Reg 3613, eff 6-15-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3111, eff 7-27-95 ; Amended at 16 Ok Reg 3403, eff 7-1-99 (emergency); Amended at 17 Ok Reg 1180, eff 5-11-00 ; Amended at 23 Ok Reg 3171, eff 6-7-06 (emergency); Amended at 24 Ok Reg 871, eff 5-11-07 ; Amended at 27 Ok Reg 1668, eff 5-14-10 (emergency); Amended at 28 Ok Reg 1381, eff 6-25-11 ; Amended at 34 Ok Reg 609, eff 9-1-17]

317:10-1-4. Vendor registration

Any vendor wishing to do business with the Authority should register on the vendor bidder list maintained by the Central Purchasing Division of the Office of Management and Enterprise Services. The Authority may also send solicitations by request to vendors that are not on the vendor bidder list.

[Source: Added at 11 Ok Reg 3613, eff 6-15-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3111, eff 7-27-95 ; Amended at 16 Ok Reg 3403, eff 7-1-99 (emergency); Amended at 17 Ok Reg 1180, eff 5-11-00 ; Amended at 23 Ok Reg 3171, eff 6-7-06 (emergency); Amended at 24 Ok Reg 871, eff 5-11-07 ; Amended at 27 Ok Reg 1668, eff 5-14-10 (emergency); Amended at 28 Ok Reg 1381, eff 6-25-11 ; Amended at 34 Ok Reg 609, eff 9-1-17]

317:10-1-5. Reports of vendor non-compliance to the Central Purchasing Division, Oklahoma Department of Central Services [REVOKED]

[Source: Added at 11 Ok Reg 3613, eff 6-15-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3111, eff 7-27-95 ; Amended at 13 Ok Reg 3461, eff 7-16-96 (emergency); Amended at 14 Ok Reg 1764, eff 5-27-97 ; Amended at 16 Ok Reg 3403, eff 7-1-99 (emergency); Amended at 17 Ok Reg 1180, eff 5-11-00 ; Amended at 23 Ok Reg 3171, eff 6-7-06 (emergency); Amended at 24 Ok Reg 871, eff 5-11-07 ; Revoked at 27 Ok Reg 1668, eff 5-14-10 (emergency); Revoked at 28 Ok Reg 1381, eff 6-25-11]

317:10-1-6. Vendor samples [REVOKED]

[Source: Added at 11 Ok Reg 3613, eff 6-15-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3111, eff 7-27-95 ; Amended at 16 Ok Reg 3403, eff 7-1-99 (emergency); Amended at 17 Ok Reg 1180, eff 5-11-00 ; Revoked at 27 Ok Reg 1668, eff 5-14-10 (emergency); Revoked at 28 Ok Reg 1381, eff 6-25-11]

317:10-1-7. Submission of bids [REVOKED]

[Source: Added at 11 Ok Reg 3613, eff 6-15-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3111, eff 7-27-95 ; Amended at 16 Ok Reg 3403, eff 7-1-99 (emergency); Amended at 17 Ok Reg 1180, eff 5-11-00 ; Amended at 23 Ok Reg 3171, eff 6-7-06 (emergency); Amended at 24 Ok Reg 871, eff 5-11-07 ; Revoked at 27 Ok Reg 1668, eff 5-14-10 (emergency); Revoked at 28 Ok Reg 1381, eff 6-25-11]

317:10-1-8. Bid openings [REVOKED]

[Source: Added at 11 Ok Reg 3613, eff 6-15-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3111, eff 7-27-95 ; Amended at 16 Ok Reg 3403, eff 7-1-99 (emergency); Amended at 17 Ok Reg 1180, eff 5-11-00 ; Revoked at 27 Ok Reg 1668, eff 5-14-10 (emergency); Revoked at 28 Ok Reg 1381, eff 6-25-11]

317:10-1-9. Bid evaluations [REVOKED]

[Source: Added at 11 Ok Reg 3613, eff 6-15-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3111, eff 7-27-95 ; Amended at 16 Ok Reg 3403, eff 7-1-99 (emergency); Amended at 17 Ok Reg 1180, eff 5-11-00 ; Amended at 23 Ok Reg 3171, eff 6-7-06 (emergency); Amended at 24 Ok Reg 871, eff 5-11-07 ; Revoked at 27 Ok Reg 1668, eff 5-14-10 (emergency); Revoked at 28 Ok Reg 1381, eff 6-25-11]

317:10-1-10. Award of bid [REVOKED]

[Source: Added at 11 Ok Reg 3613, eff 6-15-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3111, eff 7-27-95 ; Amended at 16 Ok Reg 3403, eff 7-1-99 (emergency); Amended at 17 Ok Reg 1180, eff 5-11-00 ; Amended at 23 Ok Reg 3171, eff 6-7-06 (emergency); Amended at 24 Ok Reg 871, eff 5-11-07 ; Revoked at 27 Ok Reg 1668, eff 5-14-10 (emergency); Revoked at 28 Ok Reg 1381, eff 6-25-11]

317:10-1-11. Terms and conditions for acceptable bids [REVOKED]

[Source: Added at 11 Ok Reg 3613, eff 6-15-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3111, eff 7-27-95 ; Amended at 16 Ok Reg 3403, eff 7-1-99 (emergency); Amended at 17 Ok Reg 1180, eff 5-11-00 ; Amended at 23 Ok Reg 3171, eff 6-7-06 (emergency); Amended at 24 Ok Reg 871, eff 5-11-07 ; Revoked at 27 Ok Reg 1668, eff 5-14-10 (emergency); Revoked at 28 Ok Reg 1381, eff 6-25-11]

317:10-1-12. Protest of award

(a) Protests of awards made by OHCA under 74 Okla. Stat. §85.5N are addressed at OAC 317:2-1-1 et seq.

(b) Bidders who wish to protest any other award shall follow the process outlined in the OMES rules at OAC 260:115-3-19.

[Source: Added at 11 Ok Reg 3613, eff 6-15-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3111, eff 7-27-95 ; Amended at 13 Ok Reg 4043, eff 9-17-96 (emergency); Amended at 14 Ok Reg 1764, eff 5-27-97 ; Amended at 16 Ok Reg 3403, eff 7-1-99 (emergency); Amended at 17 Ok Reg 1180, eff 5-11-00 ; Amended at 23 Ok Reg 3171, eff 6-7-06 (emergency); Amended at 24 Ok Reg 871, eff 5-11-07 ; Amended at 27 Ok Reg 1668, eff 5-14-10 (emergency); Amended at 28 Ok Reg 1381, eff 6-25-11 ; Amended at 29 Ok Reg 1073, eff 6-25-12 ; Amended at 34 Ok Reg 609, eff 9-1-17 ; Amended at 39 Ok Reg 21, eff 9-7-21 (emergency); Amended at 39 Ok Reg 1413, eff 9-12-22]

317:10-1-13. Administrative review [REVOKED]

[Source: Added at 11 Ok Reg 3613, eff 6-15-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3111, eff 7-27-95 ; Amended at 13 Ok Reg 3461, eff 7-16-96 (emergency); Amended at 14 Ok Reg 1764, eff 5-27-97 ; Revoked at 16 Ok Reg 3403, eff 7-1-99 (emergency); Revoked at 17 Ok Reg 1180, eff 5-11-00]

317:10-1-14. Group purchasing acquisition [REVOKED]

[Source: Added at 11 Ok Reg 3613, eff 6-15-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3111, eff 7-27-95 ; Revoked at 16 Ok Reg 3403, eff 7-1-99 (emergency); Revoked at 17 Ok Reg 1180, eff 5-11-00]

317:10-1-15. Sole source or sole brand acquisitions [REVOKED]

[Source: Added at 11 Ok Reg 3613, eff 6-15-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3111, eff 7-27-95 ; Amended at 16 Ok Reg 3403, eff 7-1-99 (emergency); Amended at 17 Ok Reg 1180, eff 5-11-00 ; Amended at 23 Ok Reg 3171, eff 6-7-06 (emergency); Amended at 24 Ok Reg 871, eff 5-11-07 ; Revoked at 27 Ok Reg 1668, eff 5-14-10 (emergency); Revoked at 28 Ok Reg 1381, eff 6-25-11]

317:10-1-16. Delegation of authority

The authority to procure needed products and services for OHCA has been delegated to OHCA from the Office of Management and Enterprise Services, Central Purchasing Division. The OHCA Board delegates authority for expenditure of funds to the CEO and other OHCA officers and personnel according to the dollar limits and types of products stated in (1), (2) and (3) of this Section. Within this authority, the CEO may delegate in writing to other specific individuals the responsibility for the performance of the procurement duties.

(1) **Supply and non-professional services acquisitions.** Each division director or supervisor may initiate any supply or non-professional services acquisition which is within his or her authorized division budget and approved by the CEO or designee. Any single acquisition of this kind over \$1,000,000 must be approved by the OHCA Board. A contract amendment that would increase the total original contract acquisition cost to an amount that equals or exceeds \$1,000,000 for a supply or non-professional services contract must be prior approved by the OHCA Board. Any amendment to a contract that would result in a ten percent (10%) or greater increase in the total acquisition cost originally approved by the OHCA Board must be submitted to the OHCA Board for prior approval.

(2) **Professional service contracts.** Acquisitions of professional services must be approved by the CEO or designee. All professional service contracts over \$1,000,000 must be approved by the OHCA Board. A contract amendment that would increase the total original contract acquisition cost to an amount that equals or exceeds \$1,000,000 for a professional service contract must be prior approved by the OHCA Board. Any amendment to a contract that would result in a twenty-five percent (25%) or greater increase or a \$1,000,000 or greater increase in the total acquisition cost originally approved by the OHCA Board must be submitted to the OHCA Board for prior approval. Board approval is not required if the increase in total contract acquisition cost results from the exercise of a price increase methodology, option for additional work, or option to renew that was contained in the previously approved contract.

(3) **Interagency/intergovernmental agreements.** All agreements with another state agency or public agency must be approved by the CEO or designee but are exempt from the OHCA Board approval.

[Source: Added at 11 Ok Reg 3613, eff 6-15-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3111, eff 7-27-95 ; Amended at 16 Ok Reg 3403, eff 7-1-99 (emergency); Amended at 17 Ok Reg 1180, eff 5-11-00 ; Amended at 23 Ok Reg 3171, eff 6-7-06 (emergency); Amended at 24 Ok Reg 871, eff 5-11-07 ; Amended at 27 Ok Reg 1668, eff 5-14-10 (emergency); Amended at 28 Ok Reg 1381, eff 6-25-11 ; Amended at 34 Ok Reg 609, eff 9-1-17 ; Amended at 39 Ok Reg 21, eff 9-7-21 (emergency); Amended at

39 Ok Reg 1413, eff 9-12-22]

317:10-1-17. Acquisitions of \$2,500 or less [REVOKED]

[Source: Added at 11 Ok Reg 3613, eff 6-15-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3111, eff 7-27-95 ; Amended at 16 Ok Reg 3403, eff 7-1-99 (emergency); Amended at 17 Ok Reg 1180, eff 5-11-00 ; Amended at 23 Ok Reg 3171, eff 6-7-06 (emergency); Amended at 24 Ok Reg 871, eff 5-11-07 ; Revoked at 27 Ok Reg 1668, eff 5-14-10 (emergency); Revoked at 28 Ok Reg 1381, eff 6-25-11]

317:10-1-18. Acquisitions in excess of \$2,500 and not exceeding \$10,000 [REVOKED]

[Source: Added at 11 Ok Reg 3613, eff 6-15-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3111, eff 7-27-95 ; Amended at 16 Ok Reg 3403, eff 7-1-99 (emergency); Amended at 17 Ok Reg 1180, eff 5-11-00 ; Amended at 23 Ok Reg 3171, eff 6-7-06 (emergency); Amended at 24 Ok Reg 871, eff 5-11-07 ; Revoked at 27 Ok Reg 1668, eff 5-14-10 (emergency); Revoked at 28 Ok Reg 1381, eff 6-25-11]

317:10-1-18.1. Acquisitions in excess of \$10,000 and not exceeding \$25,000 [REVOKED]

[Source: Added at 16 Ok Reg 3403, eff 7-1-99 (emergency); Added at 17 Ok Reg 1180, eff 5-11-00 ; Amended at 23 Ok Reg 3171, eff 6-7-06 (emergency); Amended at 24 Ok Reg 871, eff 5-11-07 ; Revoked at 27 Ok Reg 1668, eff 5-14-10 (emergency); Revoked at 28 Ok Reg 1381, eff 6-25-11]

317:10-1-18.2. Acquisitions in excess of \$25,000 [REVOKED]

[Source: Added at 16 Ok Reg 3403, eff 7-1-99 (emergency); Added at 17 Ok Reg 1180, eff 5-11-00 ; Amended at 23 Ok Reg 3171, eff 6-7-06 (emergency); Amended at 24 Ok Reg 871, eff 5-11-07 ; Revoked at 27 Ok Reg 1668, eff 5-14-10 (emergency); Revoked at 28 Ok Reg 1381, eff 6-25-11]

317:10-1-19. Professional service contracts [REVOKED]

[Source: Added at 11 Ok Reg 3613, eff 6-15-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3111, eff 7-27-95 ; Amended at 16 Ok Reg 3403, eff 7-1-99 (emergency); Amended at 17 Ok Reg 1180, eff 5-11-00 ; Amended at 23 Ok Reg 3171, eff 6-7-06 (emergency); Amended at 24 Ok Reg 871, eff 5-11-07 ; Revoked at 27 Ok Reg 1668, eff 5-14-10 (emergency); Revoked at 28 Ok Reg 1381, eff 6-25-11]

317:10-1-20. Interagency/Intergovernmental agreements [REVOKED]

[Source: Added at 16 Ok Reg 3403, eff 7-1-99 (emergency); Added at 17 Ok Reg 1180, eff 5-11-00 ; Amended at 23 Ok Reg 3171, eff 6-7-06 (emergency); Amended at 24 Ok Reg 871, eff 5-11-07 ; Revoked at 27 Ok Reg 1668, eff 5-14-10 (emergency); Revoked at 28 Ok Reg 1381, eff 6-25-11]

317:10-1-21. Procurement ethics, prohibited conduct

(a) **Standard of conduct.** The Oklahoma Central Purchasing Act, State Ethics Commission rules, and other state laws contain regulations, prohibitions, and penalties governing procurement ethics. Transactions relating to the public expenditure of funds require the highest degree of public trust and impeccable standards of conduct.

(b) **One (1) year prohibition on certain contracts.** For one (1) year after the employment termination date of any employee or officer, OHCA is prohibited from entering into a sole source contract, a professional service contract, or a contract for the services of that employee or officer.

Refer to 74 O.S. § 85.42(A). An agency may enter into a sole source contract or a contract for professional services at any time with a person who is a qualified interpreter for the deaf. Reference to 74 O.S. § 85.42(D).

(c) **Supplier gratuities.** Employees or officers of the Purchasing and Contracts Development unit, acting within the scope of delegated authority, or any member of their immediate family, under the Oklahoma Central Purchasing Act shall not accept any gift, donation, or gratuity for himself or any member of his immediate family from any supplier or prospective supplier of any acquisition covered by the Oklahoma Central Purchasing Act. This subsection shall not apply to exceptions to the definition of "anything of value" established in rules promulgated by the Oklahoma Ethics Commission.

(d) **State requirement for one (1) year prohibition on certain state officers' or employees' employment with a supplier.** For a period of one (1) year from the date that any contract to privatize is awarded by OHCA, any state officer or employee who exercised discretionary or decision-making authority in awarding a specific contract to privatize is prohibited from becoming an officer or employee of a business organization which is party to that specific contract to privatize. If, within the prohibited period and in violation of state law, any state officer or employee who exercised discretionary or decision-making authority in awarding a specific contract to privatize becomes an officer or employee of a business organization which is party to that specific contract to privatize, then the business organization is prohibited from contracting with OHCA for one (1) year from the date of the violation of state law. Refer to 74 O.S. § 590.

(e) **Agency contract or agreement open for legislative inspection.** Upon request, a contract or any other form of agreement made by OHCA will be open for inspection to any member of the Legislature. OHCA will not direct, put in a contract, or in any way disallow a vendor, client, employer or independent contractor, person, or any other entity from contacting or communicating with any member of the Legislature. Refer to 74 O.S. § 464.1.

(f) **Federal requirement for conflict-of-interest safeguards pertaining to any contract for health plan or managed care services.** Any contract awarded for health plan or managed care services and subject to 42 C.F.R. Part 438 necessitates state conflict-of-interest safeguards at least as effective as those specified at section 27 of the Office of Federal Procurement Policy Act. Refer to 42 C.F.R. § 438.58, citing 41 U.S.C. § 423. In addition to this subsection, OAC 317:10-1-22 describes processes pertaining to the conflict-of-interest safeguards in this section.

(1) The following person(s) shall not, except as provided by law, knowingly disclose a contractor bid or proposal information or source selection information before the award of an OHCA procurement contract to which the information relates:

(A) When such person is:

(i) A present or former employee or officer;

(ii) Acting or has acted for or on behalf of OHCA with respect to a procurement; or

(iii) Advising or has advised OHCA with respect to a procurement; and

(B) By virtue of that office, employment, or relationship has or had access to contractor bid or proposal information or source selection information.

(2) A person shall not, other than as provided by law, knowingly obtain contractor bid or proposal information or source selection information before the award of an OHCA procurement contract to which the information relates.

(3) If an employee or officer who is personally and substantially participating in a procurement under this Section, contacts or is contacted by a procurement bidder regarding possible non-OHCA employment, the employee or officer shall promptly report the contact in writing to the employee's or official's supervisor and to the designated OHCA ethics official (or designee) and either:

(A) Reject the possibility of non-OHCA employment; or
(B) Disqualify himself or herself from further personal and substantial participation in that procurement until such time as OHCA has authorized the employee or official to resume participation in such procurement on the grounds that:

(i) The bidder is no longer a participant in the procurement; or

(ii) All discussions with the bidder regarding possible non-OHCA employment have terminated without an agreement or arrangement for employment.

(4) A former employee or officer shall not accept compensation from a contract-awarded bidder as an employee, officer, director, or consultant of that bidder within a period of one (1) year after such former employee or officer functioned within the scope of employment as:

(A) The procuring contracting officer, the source selection authority, a member of an evaluation committee, or the chief of a financial or technical evaluation team in a procurement in which that contract-awarded bidder was selected for award of a contract in excess of \$10,000,000;

(B) A program manager, deputy program manager, or administrative contracting officer for a contract in excess of \$10,000,000 awarded to that contract-awarded bidder; or

(C) A primary decision maker who personally made one (1) or more of the following decisions on behalf of OHCA:

(i) To award a contract, subcontract, modification of a contract or subcontract, or a task order or delivery order for that contract-awarded bidder valued in excess of \$10,000,000;

(ii) To establish overhead or other rates applicable to a contract or contracts for that contract-awarded bidder valued in excess of \$10,000,000;

(iii) To approve issuance of a contract payment or payments to that contract-awarded bidder valued in excess of \$10,000,000; or
(iv) to pay or settle a claim in excess of \$10,000,000 with that contract-awarded bidder.

(5) A former employee or officer who accepts compensation from any division or affiliate of a contract-awarded bidder that does not produce the same or similar products or services as the entity of the contract-awarded bidder that is responsible for the contract does not violate this section.

(6) With regard to any current or former employee or officer or any bidder who violates this subsection (f), OHCA may take any administrative action and pursue any penalty allowed by state or federal law.

(7) Any employee or officer or former employee or officer may request advice from the appropriate designated OHCA ethics official regarding whether the employee or officer or former employee or officer is or would be precluded by subsection (f)(4) of this section from accepting compensation from a particular contractor.

[Source: Added at 39 Ok Reg 21, eff 9-7-21 (emergency); Added at 39 Ok Reg 1413, eff 9-12-22]

317:10-1-22. Conflicts of interest

(a) **Types of conflicts of interest.** Three (3) types of conflict-of-interest forms may be used for OHCA to clear conflicts related to procurement.

(1) **General conflicts of interest.** OHCA requires all employees or officers to sign general conflict-of-interest forms annually.

(2) **Contract-specific conflicts of interest.** OHCA requires specific employees or officers, as described within this subsection, to sign a contract-specific conflict-of-interest form related to a specific contract when deemed appropriate to meet any applicable federal or state law or regulation and to avoid impropriety or the appearance of impropriety in connection with the procurement process or the administration of the specific contract. The contract-specific conflict-of-interest form will inform the employee or officer of rights and responsibilities related to role as related to a specific contract, including any potential restrictions on future employment or other business connections with the contractor or with OHCA, and will record any conflicts that pre-date the signing of the form or that arise at any point in time thereafter until the contract is terminated.

(3) **Evaluator-specific conflicts of interest.** OHCA requires employees or officers of any agency or department of the State to sign an evaluator-specific conflict-of-interest form, whenever the employee or officer is appointed, selected, or approved as a bid evaluator or performs any duty of a bid evaluator for a specific contract. The evaluator-specific conflict-of-interest form will inform the employee or officer of rights and responsibilities related to the role of bid evaluator, including any potential

restrictions on future employment or other business connection with the contractor or with OHCA, and will record any conflicts that pre-date the signing of the form or that arise at any point in time thereafter until the evaluation is complete and closed. If a bid evaluator is removed from the bid evaluation for any reason, including potential conflict of interest, a substitute bid evaluator with similar expertise will be added to the bid evaluation after signing an evaluator-specific conflict-of-interest form.

(b) **Forms meet or exceed legal standards.** All conflict-of-interest forms shall meet or exceed the applicable legal standards controlling the type of contract and/or type of employee or officer involvement in procurement or administration of a contract, including but not limited to 74 O.S. § 85.42(A), 74 O.S. § 590, and 41 U.S.C. § 423.

(c) **Identification of conflicts of interest.** OHCA will identify conflicts of interest, plan any accommodation, and manage any employee disciplinary action.

(1) The OHCA contracting officer will identify all employee or officer positions required to sign a specific conflict-of-interest form or an evaluator-specific conflict of interest form. For any solicitation for health plan or managed care services, the contracting officer will identify, at minimum, all employees or officers engaged in enrollment activities, when those employees or officers are internally titled manager or above, and all employees and officers engaged as bid evaluators.

(2) OHCA's Human Resources (HR) Department will obtain conflict-of-interest forms:

(A) For general conflict-of-interest forms, from each employee or officer at the time of hiring and annually thereafter.

(B) For contract-specific conflict-of-interest forms, from each employee or officer in an identified position prior to the employee's or officer's participation in contract- or solicitation-specific activities.

(C) For evaluator-specific conflict-of-interest forms, from each employee or officer identified as an evaluator prior to the employee's or officer's participation in evaluation-specific activities.

(3) OHCA HR and OHCA's Legal Department will review the executed conflict-of-interest forms.

(4) If a potential conflict is identified, a conflict plan will be presented to the employee or officer. The conflict plan will include, at minimum, guidelines that the employee or officer must follow to avoid an actual conflict.

(5) The employee or officer will determine if the conflict plan can be accommodated and respond accordingly.

(6) If the accommodation does not resolve the issue, then the employee or officer will face disciplinary action up to and including termination of employment.

(d) **Employee/officer responsibilities.** Each employee or officer has a responsibility to notify OHCA HR within one (1) business day of becoming aware of a potential conflict, regardless of whether the

employee or officer previously executed a conflict-of-interest form. Upon notification, OHCA HR will take appropriate action to identify the potential conflict in writing, either as part of the existing conflict-of-interest form or as a new conflict-of-interest form; develop a conflict plan; and present the conflict plan to the employee or officer.

[Source: Added at 39 Ok Reg 21, eff 9-7-21 (emergency); Added at 39 Ok Reg 1413, eff 9-12-22]

317:10-1-23. Value-based purchasing

(a) Unless otherwise prohibited by law, OHCA may engage in value-based purchasing with regard to any contract for goods, services, or professional services.

(b) Unless otherwise prohibited by law, OHCA may include in any contract for health plan or managed care services any concept of value-based purchasing as to the transaction between OHCA and the health plan or managed care entity.

(c) Unless otherwise prohibited by law, OHCA may include in any contract for health plan or managed care services any concept of value-based purchasing as to the transaction underlying the provision of health care services or items by providers contracted with any health plan or managed care entity.

[Source: Added at 39 Ok Reg 21, eff 9-7-21 (emergency); Added at 39 Ok Reg 1413, eff 9-12-22]

317:10-1-24. Bidder obligations arising from bid submission

(a) **One (1) bid.** Bidders may submit only one bid in response to any solicitation. Except as requested by OHCA, no bid may be changed after the response due date and time. If the bidder needs to change a submitted bid prior to the response due date and time, the bidder will withdraw the originally submitted bid and submit a new bid to OHCA by the response date and time. Bidders may withdraw and resubmit a bid at any time prior to the submission deadline. As part of the resubmission process, the bidder will acknowledge in writing that the resubmitted bid supersedes all previously submitted bids by including the following statement on the superseding bid cover page, "This bid supersedes the bid previously submitted". In the body of the submission transfer, whether by email or otherwise, the resubmitted bid should contain the solicitation number and solicitation response due date and time.

(b) **Bidder duties.** The bidder shall submit any bid:

(1) In strict conformance with the instructions provided to bidders along with a completed "Responding Bidder Information" form and any other forms required by the solicitation;

(2) Electronically;

(3) With a completed certification statement, as described in the solicitation, that uses the bidder's legal name and has been executed by an authorized person with full knowledge and acceptance of all certificate provisions;

(4) According to the "Technical Proposal Requirements" of the solicitation;

(5) With relevant information for a designated contact to receive notice, approvals, and requests that are allowed or required by the terms of the solicitation;

(6) As firm, including a guarantee that unit prices are correct, for a minimum of one hundred eighty (180) days after the solicitation closing date; and

(7) In accordance with 74 O.S. § 85.40, requiring the bidder to include in the total bid price all travel expenses, including but not limited to transportation, lodging, and meals, to be incurred by a bidder in performance of the awarded contract.

(c) **Bidder's acknowledgements.** By submitting a bid, the bidder promises, acknowledges, and agrees that:

(1) The bidder will adhere to any additional terms OHCA deems necessary to the performance of the contract, including but not limited to terms related to the contractor's need to access, process, or store Medicaid beneficiary data;

(2) All costs incurred by a bidder in participating in the procurement process is the sole responsibility of the bidder, and the bidder will not be reimbursed for or awarded damages for such costs;

(3) If a bidder fails to notify the contracting officer of an ambiguity, conflict, discrepancy, omission, or other error in the procurement process or in any of the documents provided by OHCA that is known to the bidder, or that reasonably should be known by the bidder, the bidder accepts the risk of submitting a bid and, if awarded the contract, will not be entitled to additional compensation, relief, or time by reason of the error or its later correction; and

(4) Bidder waives any error in the procurement process or documents which is known to the bidder or reasonably should have been known, and such error will not be the grounds of a bid protest.

(d) **Indemnification.** By submitting a bid, the bidder understands, accepts, acknowledges, and agrees to this paragraph in its entirety. OHCA will not indemnify a bidder, any subcontractor, or any other party to an awarded contract. Any contract between the selected bidder and OHCA will not contain any terms limiting the liability of the bidder or providing indemnification by OHCA in favor of the bidder or any third parties. The State of Oklahoma and its agencies do not hold an individual or a private entity harmless from liability or provide indemnity to a private entity or individual. Any attempt by the bidder to add indemnification or limitation of liability provisions in favor of the bidder or third parties to the definitive contract may render the bidder's bid nonresponsive and subject to rejection. Should OHCA accept a bid that attempts to add indemnification or limitation of liability provisions in favor of the bidder or third parties, such attempts are severable from the remainder of the bid and have no effect on any awarded contract. At no time and in no way will OHCA be deemed to have waived this paragraph through action or inaction.

(e) **Conflict of laws.** With regard to the procurement process to which a bid is submitted and any business relationship or contract resulting from

such procurement process, by submitting a bid, the bidder understands, accepts, acknowledges, and agrees:

- (1) That the undertaking and all matters arising out of or relating to the undertaking, including all protests, claims, causes of action, controversies, or matters in dispute between OHCA and the bidder-whether sounding in contract, tort, statute, regulation, or otherwise-shall be governed by, construed, interpreted, and enforced in accordance with the substantive and procedural laws of the State of Oklahoma, including its statutes of limitations, without giving effect to any choice of law or conflict of laws rules or provisions, whether of the State of Oklahoma or any other jurisdiction, that would cause the application of the laws of any jurisdiction other than the State of Oklahoma;
- (2) To exclude application of the United Nations Convention on Contracts for the International Sale of Goods; and
- (3) That a final judgment in any matter described in (e)(1) of this Section is conclusive and binding and may be enforced in any other jurisdiction.

[Source: Added at 39 Ok Reg 21, eff 9-7-21 (emergency); Added at 39 Ok Reg 1413, eff 9-12-22]

317:10-1-25. Property of the state

Any bid, including all related and submitted documents and information, is part of the public record(s) and is subject to disclosure; unless otherwise specified in the Oklahoma Open Records Act, the Central Purchasing Act, or other applicable law. All material submitted by a bidder becomes the property of the State of Oklahoma upon submission and will be a matter of public record, subject to the procedures for treatment of proprietary information. OHCA has the right to use all concepts described in any bid, regardless of whether such bid is accepted. By any secured means, including electronic transmission via secure file transfer protocol, OHCA has the right to transmit all material submitted as part of or in connection with a bid, including proprietary information, to any professional services contractor then or afterward contracted with OHCA for provision of professional services related to the solicitation, award, or administration of the contract.

[Source: Added at 39 Ok Reg 21, eff 9-7-21 (emergency); Added at 39 Ok Reg 1413, eff 9-12-22]

317:10-1-25.1. Proprietary or confidentiality claims

(a) Unless otherwise specified in the Oklahoma Open Records Act, Central Purchasing Act, or other applicable law, documents and information that a bidder submits as part of or in connection with a bid are public records and subject to disclosure after the contract has been awarded pursuant to OAC 260:115-3-9.

- (1) No portion of a bid shall be considered confidential after award of the contract except, pursuant to 74 O.S. §85.10, information in the bid determined to be confidential by the State Purchasing Director or delegate.

(2) A properly submitted confidentiality claim of a potential awardee is reviewed and determined prior to award.

(3) A properly submitted confidentiality claim of a non-awarded bidder is reviewed and determined only when responding to an open records request concerning the bid.

(b) Among the parties to a solicitation, OHCA is the sole and final determiner of the proprietary or confidential nature of a bid in part or in whole.

(1) OHCA has no responsibility to independently review a bid, including any associated documentation or information, for a potential proprietary or confidentiality claim.

(2) OHCA will not consider a proprietary or confidentiality claim if a bid fails to comply with the requirements of this section, the solicitation, and applicable law, including OAC 260:115-3-9. Nonconforming bids will be subject to disclosure pursuant to State law.

(3) A bidder, who wishes to seek an exemption from disclosure under the Oklahoma Open Records Act or other statutory or regulatory requirements, is responsible for asserting any right of confidentiality that may exist. The OHCA will not assert a right of confidentiality on behalf of a bidder.

(c) To claim any portion of a bid as proprietary or confidential, the bidder will:

(1) Specifically identify what information is considered by the bidder to be confidential;

(2) Enumerate the specific grounds, based on applicable laws, which support treatment of the information as exempt from disclosure;

(3) Explain why disclosure is not in the best interest of the public if the information is incorporated into an awarded contract;

(4) Submit all information considered confidential under separate cover as described below; and

(5) Include, for efficient evaluation, the content considered confidential in applicable sections of the bid.

(d) Any bidder with bid information the bidder considers confidential must submit an additional electronic copy of the bid with the claimed information redacted (marked out to be illegible). The additional copy must be clearly labeled "Redacted Copy." If the bidder provides a copy of its bid with proprietary and confidential information redacted and OHCA appropriately supplies the redacted bid to another party under the Oklahoma Open Records Act or other statutory or regulatory requirements, the bidder agrees to indemnify OHCA and to defend the bidder's interest in protecting the referenced redacted material.

(e) OHCA does not consider as confidential a bid marked in total as proprietary and/or confidential (versus specific documents or portions of documents within a bid). Likewise, unless specifically referenced otherwise in a solicitation, resumes, pricing, marketing materials, business references, additional terms proposed by a bidder, and subcontractor information are not confidential and are not exempt from disclosure under the Oklahoma Open Records Act. The foregoing list is not exhaustive but is intended to address information often marked

confidential that is not exempt from disclosure.

(f) Subject to the provisions of subsections (a)-(e) above, bids will be open for public inspection following contract award.

[Source: Added at 39 Ok Reg 21, eff 9-7-21 (emergency); Added at 39 Ok Reg 1413, eff 9-12-22]

317:10-1-26. Withdrawal from solicitation

(a) At any time prior to the submission deadline of any solicitation, a bidder may withdraw a bid and remove itself from consideration by providing written notification, in the form specified in OAC 260:115-3-13, to the OHCA sole point of contact as identified in the solicitation. OHCA does not permit a bidder to withdraw a bid after the response due date and time except as authorized by the OHCA CEO after the bidder provides sufficient proof that the bidder included a significant error in the bid.

(b) Unless properly withdrawn, the submitted bid is deemed to be a binding offer on the part of the bidder.

[Source: Added at 39 Ok Reg 21, eff 9-7-21 (emergency); Added at 39 Ok Reg 1413, eff 9-12-22]

317:10-1-27. Binding bids

OHCA considers all bids to be firm representations that the responding bidder has carefully investigated and will comply with all OHCA and State terms and conditions relating to the solicitation. A bidder whose bid is accepted for evaluation will be bound by the terms of the solicitation and the contents of the bid for the duration of the solicitation. The bidder will be bound by the terms in its solicitation response unless or until OHCA instructs the bidder to perform any function reflected in the solicitation response in a modified way to the extent it does not substantially alter the specifications or statement of work as defined in the solicitation. Bidders awarded a contract will be governed foremost by applicable law, then by the terms of the solicitation, including any associated model contract, then by any non-rule policy documents created by OHCA for the purposes of interpreting and implementing contract terms.

[Source: Added at 39 Ok Reg 21, eff 9-7-21 (emergency); Added at 39 Ok Reg 1413, eff 9-12-22]

317:10-1-28. Contracting officer's actions

(a) The contracting officer may reject a bid for any valid reason, including but not limited to those listed at OAC 260:115-7-32(8) and the bidder's:

- (1) Failure to submit required information;
- (2) Failure to submit the bid by the response date and time unless OHCA has authorized acceptance of bids due to a significant error or incident that occurred which affected the receipt of a bid, per OAC 260:115-3-11;
- (3) Failure to comply with bidder instructions or solicitation requirements;

- (4) Failure to meet any mandatory specification of the solicitation; however, failure to meet a permissible specification of the solicitation will not be a valid reason to reject a bid;
- (5) Failure to submit the bid by the strict deadline as described by date and time within the solicitation; and
- (6) Attempted or actual inclusion or imposition of terms or conditions that would modify the requirements of the solicitation, require OHCA to indemnify the bidder or a third party, or limit the bidder's liability.

(b) The contracting officer may take any reasonable action with regard to a solicitation, including but not limited to:

- (1) Waiving minor irregularities in any bid if determined to be in the best interest of the State. If granted, a waiver will in no way modify the requirements of the solicitation or the obligations of bidders awarded contracts;
- (2) Awarding a contract based on a solicitation and the bid of any selected bidder;
- (3) Awarding the contract to more than one (1) bidder;
- (4) Rejecting any or all bids received, if deemed to be in the best interest of the State;
- (5) Requesting clarification or correction of any bid;
- (6) Amending any solicitation or any segment of any solicitation;
- (7) Canceling any solicitation, if determined to be in the best interest of the State; or
- (8) Discontinuing the solicitation process at any time prior to contract award.

(c) The contracting officer may question the grade and quality of any acquisition delivered to the agency.

- (1) The contracting officer or delegate has sole discretion in determining whether the acquisition meets the grade and quality specified in the contract.
- (2) If the acquisition fails to meet the contract-specified grade and/or quality, OHCA may take remedial action with the appropriate supplier. Refer to 74 O.S. § 85.6.

[Source: Added at 39 Ok Reg 21, eff 9-7-21 (emergency); Added at 39 Ok Reg 1413, eff 9-12-22]

317:10-1-29. Deficiencies

In accordance with the OAC 260:115-7-32(10), OHCA has the right but is not required to waive minor deficiencies or informalities if OHCA determines the deficiencies or informalities do not prejudice another bidder. OHCA may also permit bidders to cure certain non-substantive deficiencies if there is sufficient time prior to the award of the contract.

[Source: Added at 39 Ok Reg 21, eff 9-7-21 (emergency); Added at 39 Ok Reg 1413, eff 9-12-22]

317:10-1-30. Submission of questions

(a) A bidder may submit written questions by email only to the OHCA sole point of contact as designated in the solicitation and using the "Questions" form, in original format, included in the Bidder's Library.

(b) OHCA will provide written answers to all technical bid and price questions received on or before the dates specified in the solicitation for questions and answers. Answers will be made publicly available in the form of one or more solicitation amendments posted to the Bidder's Library. Only posted answers will be considered official and valid. A bidder will not rely upon, take any action upon, or make any decision based upon any verbal communication with any State employee.

[Source: Added at 39 Ok Reg 21, eff 9-7-21 (emergency); Added at 39 Ok Reg 1413, eff 9-12-22]

317:10-1-31. Bidder's conference

OHCA may hold a bidder's conference at OHCA offices or virtually on the date and time specified in the solicitation. Additional information about the bidder's conference, if any, will be provided in advance of the session.

[Source: Added at 39 Ok Reg 21, eff 9-7-21 (emergency); Added at 39 Ok Reg 1413, eff 9-12-22]

317:10-1-32. Bid evaluation

A responsive bid that is not otherwise rejected will proceed to bid evaluation, which will be conducted in accordance with the solicitation. Within any solicitation, the bid specifications for evaluation will be provided and will be based on the subject matter of the solicitation, the type of solicitation, and the needs to be met by the supplier(s) awarded a contract from the solicitation.

- (1) The bid evaluation may consist of one (1) or more evaluative activities, including but not limited to:
 - (A) Best price review;
 - (B) Best value review;
 - (C) Certifications;
 - (D) Administrative review;
 - (E) Technical proposal evaluation;
 - (F) Oral presentation evaluation; and
 - (G) Any other activity that could reasonably be expected to result in determining the value, nature, character, or quality of the bid.
- (2) Bids responding to request for quotation will be evaluated solely on a "best price" basis.
- (3) Bids responding to request for proposal will be evaluated on a "best value" basis unless the request for proposal specifies otherwise.
- (4) A bidder's past performance may be considered when evaluating a bid.
- (5) No evaluator acting in their role as an evaluator will make any decision regarding procurement, including but not limited to which, if any, bidder(s) will or will not be awarded the contract, whether a bid will or will not be rejected, and whether a solicitation will be continued or canceled. Evaluators, individually or collectively, may provide bid evaluation information and recommendations to the contracting official. A record of

evaluators' numeric scores of bids, made by evaluators individually or collectively, will be maintained as part of the acquisition file.

(6) The contracting official will make all decisions regarding the procurement, including but not limited to which, if any, bidder(s) will or will not be awarded the contract, whether a bid will or will not be rejected, and whether a solicitation will be continued or canceled.

[Source: Added at 39 Ok Reg 21, eff 9-7-21 (emergency); Added at 39 Ok Reg 1413, eff 9-12-22]

317:10-1-33. Contract award

(a) **Time of award.** OHCA will not award a contract at the time of a bid opening but, if at all, only upon completion of the following:

- (1) Bid evaluation;
- (2) Documentation of evaluation on each bid;
- (3) Determination of the lowest and best or best value bidder;
- (4) Verification of Oklahoma and federal debarment status;
- (5) Verification, pursuant to applicable provisions of law, that the supplier is registered with the Secretary of State and maintains appropriate franchise tax payment status pursuant to 68 O.S. §§ 1203 and 1204; and
- (6) Completion of any award-related administrative tasks.

(b) **Award by item.** If the procurement documents do not specify an all or none bid, more than one (1) bidder may be awarded a contract by item or groups of items.

(c) **No contract award.** OHCA may refrain from awarding a contract during any solicitation when:

- (1) No bid meets the requirements of the solicitation;
- (2) All bids exceed fair market value for the acquisition;
- (3) The bid price exceeds available funds available to OHCA;
- (4) OHCA no longer requires the acquisition in the form or manner specified; or
- (5) Not awarding the contract is determined to be in the best interest of the state.

(d) **Evaluation tie.** Whenever it is determined that two (2) or more bids are equal, the contracting officer will determine the successful bid by a coin toss.

(e) **Notification of successful bidder.** OHCA will notify the successful bidder(s), if any, within a reasonable time after determination of the contract award.

[Source: Added at 39 Ok Reg 21, eff 9-7-21 (emergency); Added at 39 Ok Reg 1413, eff 9-12-22]

CHAPTER 15. DIVISION OF HEALTH CARE INFORMATION [REVOKED]

[Authority: 63 O.S., § 1-120]

[Source: Codified 7-27-95]

317:15-1-1. Purpose [REVOKED]

[Source: Added at 11 Ok Reg 3969, eff 6-29-94 (emergency); Added at 11 Ok Reg 4434, eff 7-1-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3119, eff 7-27-95 ; Revoked at 15 Ok Reg 4179, eff 8-5-98 (emergency); Revoked at 16 Ok Reg 1415, eff 5-27-99]

317:15-1-2. General duties and Administration [REVOKED]

[Source: Added at 11 Ok Reg 3969, eff 6-29-94 (emergency); Added at 11 Ok Reg 4434, eff 7-1-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3119, eff 7-27-95 ; Revoked at 15 Ok Reg 4179, eff 8-5-98 (emergency); Revoked at 16 Ok Reg 1415, eff 5-27-99]

317:15-1-3. Definition of information providers [REVOKED]

[Source: Added at 11 Ok Reg 3969, eff 6-29-94 (emergency); Added at 11 Ok Reg 4434, eff 7-1-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3119, eff 7-27-95 ; Revoked at 15 Ok Reg 4179, eff 8-5-98 (emergency); Revoked at 16 Ok Reg 1415, eff 5-27-99]

317:15-1-4. Required information to be collected from information providers [REVOKED]

[Source: Added at 11 Ok Reg 3969, eff 6-29-94 (emergency); Added at 11 Ok Reg 4434, eff 7-1-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3119, eff 7-27-95 ; Revoked at 15 Ok Reg 4179, eff 8-5-98 (emergency); Revoked at 16 Ok Reg 1415, eff 5-27-99]

317:15-1-5. Collection of information from state agencies and information providers [REVOKED]

[Source: Added at 11 Ok Reg 3969, eff 6-29-94 (emergency); Added at 11 Ok Reg 4434, eff 7-1-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3119, eff 7-27-95 ; Revoked at 15 Ok Reg 4179, eff 8-5-98 (emergency); Revoked at 16 Ok Reg 1415, eff 5-27-99]

317:15-1-6. Confidentiality of information [REVOKED]

[Source: Added at 11 Ok Reg 3969, eff 6-29-94 (emergency); Added at 11 Ok Reg 4434, eff 7-1-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3119, eff 7-27-95 ; Revoked at 15 Ok Reg 4179, eff 8-5-98 (emergency); Revoked at 16 Ok Reg 1415, eff 5-27-99]

317:15-1-7. Health Information Advisory Committee [REVOKED]

[Source: Added at 11 Ok Reg 3969, eff 6-29-94 (emergency); Added at 11 Ok Reg 4434, eff 7-1-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3119, eff 7-27-95 ; Revoked at 15 Ok Reg 4179, eff 8-5-98 (emergency); Revoked at 16 Ok Reg 1415, eff 5-27-99]

317:15-1-8. Fees and charges [REVOKED]

[Source: Added at 11 Ok Reg 3969, eff 6-29-94 (emergency); Added at 11 Ok Reg 4434, eff 7-1-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3119, eff 7-27-95 ; Revoked at 15 Ok Reg 4179, eff 8-5-98 (emergency); Revoked at 16 Ok Reg 1415, eff 5-27-99]

CHAPTER 20. EMPLOYEES BENEFITS COUNCIL

[**Authority:** The Oklahoma Health Care Authority Act; 63 O.S., §§ 5003 through 5016]
[**Source:** Codified 7-27-95]

317:20-1-1. Purpose [REVOKED]

[**Source:** Added at 11 Ok Reg 3973, eff 6-29-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3123, eff 7-27-95 ; Revoked at 21 Ok Reg 1322, eff 5-27-04]

317:20-1-2. Authority responsibilities for Employees Benefits Council [REVOKED]

[**Source:** Added at 11 Ok Reg 3973, eff 6-29-94 through 7-14-95 (emergency); Added at 12 Ok Reg 3123, eff 7-27-95 ; Revoked at 21 Ok Reg 1322, eff 5-27-04]

317:20-1-3. Duties of the Authority Administrator [REVOKED]

[**Source:** Added at 11 Ok Reg 3973, eff 6-29-94 (emergency); Added at 12 Ok Reg 1317, eff 3-20-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3123, eff 7-27-95 ; Revoked at 21 Ok Reg 1322, eff 5-27-04]

CHAPTER 25. SOONERCARE CHOICE

[**Authority:** The Oklahoma Health Care Authority Act, 63 O.S., §§ 5003 through 5016; 42 CFR 400]
[**Source:** Codified 7-27-95]

SUBCHAPTER 1. HEALTH PLAN COMPETITIVE BID REQUIREMENTS

317:25-1-1. Purpose [REVOKED]

[**Source:** Added at 12 Ok Reg 745, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3125, eff 7-27-95 (emergency); Amended at 14 Ok Reg 3061, eff 7-1-97 (emergency); Amended at 15 Ok Reg 1511, eff 5-11-98 ; Amended at 16 Ok Reg 3495, eff 7-1-99 (emergency); Amended at 17 Ok Reg 1191, eff 5-11-00 ; Revoked at 21 Ok Reg 2149, eff 6-25-04]

317:25-1-2. Definitions [REVOKED]

[**Source:** Added at 12 Ok Reg 745, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3125, eff 7-27-95 ; Amended at 14 Ok Reg 3061, eff 7-1-97 (emergency); Amended at 15 Ok Reg 1511, eff 5-11-98 ; Amended at 16 Ok Reg 3495, eff 7-1-99 (emergency); Amended at 17 Ok Reg 1191, eff 5-11-00 ; Revoked at 21 Ok Reg 2149, eff 6-25-04]

317:25-1-3. General purchasing provisions [REVOKED]

[**Source:** Added at 12 Ok Reg 745, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3125, eff 7-27-95 ; Amended at 16 Ok Reg 3495, eff 7-1-99 (emergency); Amended at 17 Ok Reg 1191, eff 5-11-00 ; Revoked at 21 Ok Reg 2149, eff 6-25-04]

317:25-1-4. Health Plan registration [REVOKED]

[**Source:** Added at 12 Ok Reg 745, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3125, eff 7-27-95 ; Revoked at 21 Ok Reg 2149, eff 6-25-04]

317:25-1-5. Health Plan retention and removal from bidder list [REVOKED]

[**Source:** Added at 12 Ok Reg 745, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3125, eff 7-27-95 ; Amended at 13 Ok Reg 3465, eff 7-16-96 (emergency); Amended at 14 Ok Reg 1766, eff 5-27-97 ; Amended at 16 Ok Reg 3495, eff 7-1-99 (emergency); Amended at 17 Ok Reg 1191, eff 5-11-00 ; Revoked at 21 Ok Reg 2149, eff 6-25-04]

317:25-1-6. Submission of bids [REVOKED]

[**Source:** Added at 12 Ok Reg 745, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3125, eff 7-27-95 ; Amended at 16 Ok Reg 3495, eff 7-1-99 (emergency); Amended at 17 Ok Reg 1191, eff 5-11-00 ; Revoked at 21 Ok Reg 2149, eff 6-25-04]

317:25-1-7. SOONERCARE Bid openings [REVOKED]

[**Source:** Added at 12 Ok Reg 745, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3125, eff 7-27-95 ; Amended at 13 Ok Reg 585, eff 9-8-95 (emergency); Amended at 13 Ok Reg 1633, eff 5-27-96 ; Revoked at 21 Ok Reg 2149, eff 6-25-04]

317:25-1-8. Award of bid [REVOKED]

[Source: Added at 12 Ok Reg 745, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3125, eff 7-27-95 ; Revoked at 21 Ok Reg 2149, eff 6-25-04]

317:25-1-9. Best and final offer (BFO) or additional negotiation processes [REVOKED]

[Source: Added at 12 Ok Reg 745, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3125, eff 7-27-95 ; Revoked at 21 Ok Reg 2149, eff 6-25-04]

317:25-1-10. Terms and conditions for acceptable bids [REVOKED]

[Source: Added at 12 Ok Reg 745, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3125, eff 7-27-95 ; Revoked at 21 Ok Reg 2149, eff 6-25-04]

317:25-1-11. Challenge of award [REVOKED]

[Source: Added at 12 Ok Reg 745, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3125, eff 7-27-95 ; Revoked at 21 Ok Reg 2149, eff 6-25-04]

317:25-1-12. Administrative review [REVOKED]

[Source: Added at 12 Ok Reg 745, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3125, eff 7-27-95 ; Amended at 13 Ok Reg 3465, eff 7-16-96 (emergency); Amended at 14 Ok Reg 1766, eff 5-27-97 ; Revoked at 21 Ok Reg 2149, eff 6-25-04]

317:25-1-13. Confidentiality [REVOKED]

[Source: Added at 13 Ok Reg 585, eff 9-8-95 (emergency); Added at 13 Ok Reg 1633, eff 5-27-96 ; Revoked at 21 Ok Reg 2149, eff 6-25-04]

SUBCHAPTER 3. HEALTH MAINTENANCE ORGANIZATIONS

317:25-3-1. Health Maintenance Organizations [REVOKED]

[Source: Added at 12 Ok Reg 1319, eff 3-20-95 (emergency); Added at 13 Ok Reg 1633, eff 5-27-96 ; Revoked at 21 Ok Reg 2149, eff 6-25-04]

317:25-3-2. Public managed care plans [REVOKED]

[Source: Added at 12 Ok Reg 1319, eff 3-20-95 (emergency); Added at 13 Ok Reg 1633, eff 5-27-96 ; Amended at 16 Ok Reg 3495, eff 7-1-99 (emergency); Amended at 17 Ok Reg 1191, eff 5-11-00 ; Revoked at 21 Ok Reg 2149, eff 6-25-04]

317:25-3-2.1. Reinsurance [REVOKED]

[Source: Added at 12 Ok Reg 3630, eff 9-8-95 (emergency); Added at 13 Ok Reg 1633, eff 5-27-96 ; Amended at 13 Ok Reg 3465, eff 7-16-96 (emergency); Amended at 14 Ok Reg 1766, eff 5-27-97 ; Revoked at 14 Ok Reg 3061, eff 7-1-97 (emergency); Revoked at 15 Ok Reg 1511, eff 5-11-98]

317:25-3-2.2. Health Care Authority Risk Control Program [REVOKED]

[Source: Added at 16 Ok Reg 1707, eff 3-15-99 (emergency); Added at 17 Ok Reg 1191, eff 5-11-00 ; Revoked at 21 Ok Reg 2149, eff 6-25-04]

317:25-3-3. Quality Assurance credentialing and recredentialing requirements [REVOKED]

[Source: Added at 12 Ok Reg 1319, eff 3-20-95 (emergency); Added at 13 Ok Reg 1633, eff 5-27-96 ; Amended at 14 Ok Reg 3061, eff 7-1-97 (emergency); Amended at 15 Ok Reg 1511, eff 5-11-98 ; Revoked at 21 Ok Reg 2149, eff 6-25-04]

SUBCHAPTER 5. SOONERCARE PLUS

PART 1. GENERAL PROVISIONS

317:25-5-1. Purpose [REVOKED]

[Source: Added at 13 Ok Reg 37, eff 5-12-95 (emergency); Added at 13 Ok Reg 1633, eff 5-27-96 ; Amended at 13 Ok Reg 3565, eff 7-16-96 (emergency); Amended at 14 Ok Reg 1766, eff 5-27-97 ; Amended at 14 Ok Reg 3061, eff 7-1-97 (emergency); Amended at 15 Ok Reg 1511, eff 5-11-98 ; Amended at 15 Ok Reg 3778, eff 7-1-98 (emergency); Amended at 16 Ok Reg 1422, eff 5-27-99 ; Amended at 16 Ok Reg 3495, eff 7-1-99 (emergency); Amended at 17 Ok Reg 1191, eff 5-11-00 ; Revoked at 21 Ok Reg 2149, eff 6-25-04]

317:25-5-2. SoonerCare Plus overview [REVOKED]

[Source: Added at 13 Ok Reg 37, eff 5-12-95 (emergency); Added at 13 Ok Reg 43, eff 6-21-95 (emergency); Added at 13 Ok Reg 2307, eff 4-10-96 (emergency); Added at 13 Ok Reg 1633, eff 5-27-96 ; Amended at 13 Ok Reg 3577, eff 6-18-96 (emergency); Amended at 13 Ok Reg 3565, eff 7-16-96 (emergency); Amended at 14 Ok Reg 1766, eff 5-27-97 ; Amended at 14 Ok Reg 3061, eff 7-1-97 (emergency); Amended at 15 Ok Reg 1511, eff 5-11-98 ; Amended at 15 Ok Reg 3778, eff 7-1-98 (emergency); Amended at 16 Ok Reg 1422, eff 5-27-99 ; Amended at 16 Ok Reg 3495, eff 7-1-99 (emergency); Amended at 17 Ok Reg 1191, eff 5-11-00 ; Revoked at 21 Ok Reg 2149, eff 6-25-04]

317:25-5-3. Definitions [REVOKED]

[Source: Added at 13 Ok Reg 43, eff 6-21-95 (emergency); Added at 13 Ok Reg 1633, eff 5-27-96 ; Amended at 14 Ok Reg 3061, eff 7-1-97 (emergency); Amended at 15 Ok Reg 1511, eff 5-11-98 ; Amended at 16 Ok Reg 3495, eff 7-1-99 (emergency); Amended at 17 Ok Reg 1191, eff 5-11-00 ; Revoked at 21 Ok Reg 2149, eff 6-25-04]

317:25-5-4. Health Plan proposals to the Oklahoma Health Care Authority and the DUR for modifying medication coverage [REVOKED]

[Source: Added at 12 Ok Reg 3632, eff 9-8-95 (emergency); Added at 13 Ok Reg 1633, eff 5-27-96 ; Amended at 13 Ok Reg 3565, eff 7-16-96 (emergency); Amended at 14 Ok Reg 1766, eff 5-27-97 ; Revoked at 21 Ok Reg 2149, eff 6-25-04]

317:25-5-5. Contractor payments to providers [REVOKED]

[Source: Added at 15 Ok Reg 536, eff 9-18-97 (emergency); Added at 15 Ok Reg 1511, eff 5-11-98 ; Amended at 16 Ok Reg 3495, eff 7-1-99 (emergency); Amended at 17 Ok Reg 1191, eff 5-11-00 ; Amended at 19 Ok Reg 530, eff 12-27-01 (emergency); Amended at 19 Ok Reg 2123, eff 6-27-02 ; Revoked at 21 Ok Reg 2149, eff 6-25-04]

PART 3. ENROLLMENT CRITERIA

317:25-5-10. Enrollment in SoonerCare Plus [REVOKED]

[Source: Added at 13 Ok Reg 37, eff 5-12-95 (emergency); Added at 13 Ok Reg 2309, eff 4-10-96 (emergency); Added at 13 Ok Reg 1633, eff 5-27-96 ; Amended at 13 Ok Reg 3577, eff 6-18-96 (emergency); Amended at 13 Ok Reg 3565, eff 7-16-96 ; Amended at 14 Ok Reg 1766, eff 5-27-97 ; Amended at 14 Ok Reg 3061, eff 7-1-97 (emergency); Amended at 15 Ok Reg 1511, eff 5-11-98 ; Amended at 15 Ok Reg 3778, eff 7-1-98 (emergency); Amended at 16 Ok Reg 1422, eff 5-27-99 ; Amended at 16 Ok Reg 3495, eff 7-1-99 (emergency); Amended at 17 Ok Reg 1191, eff 5-11-00 ; Revoked at 21 Ok Reg 2149, eff 6-25-04]

317:25-5-11. Geographic Coverage Areas [REVOKED]

[Source: Added at 13 Ok Reg 37, eff 5-12-95 (emergency); Added at 13 Ok Reg 43, eff 6-21-95 (emergency); Added at 13 Ok Reg 1633, eff 5-27-96 ; Amended at 13 Ok Reg 3565, eff 7-16-96 (emergency); Amended at 14 Ok Reg 1766, eff 5-27-97 ; Amended at 14 Ok Reg 3061, eff 7-1-97 (emergency); Amended at 15 Ok Reg 1511, eff 5-11-98 ; Amended at 15 Ok Reg 3778, eff 7-1-98 (emergency); Amended at 16 Ok Reg 1422, eff 5-27-99 ; Amended at 16 Ok Reg 3495, eff 7-1-99 (emergency); Amended at 17 Ok Reg 1191, eff 5-11-00 ; Amended at 18 Ok Reg 244, eff 11-21-00 (emergency); Amended at 18 Ok Reg 1128, eff 5-11-01 ; Revoked at 21 Ok Reg 2149, eff 6-25-04]

317:25-5-12. Enrollment requirements [REVOKED]

[Source: Added at 13 Ok Reg 37, eff 5-12-95 (emergency); Added at 13 Ok Reg 1633, eff 5-27-96 ; Amended at 13 Ok Reg 3565, eff 7-16-96 (emergency); Amended at 14 Ok Reg 1766, eff 5-27-97 ; Amended at 14 Ok Reg 3061, eff 7-1-97 (emergency); Amended at 15 Ok Reg 1511, eff 5-11-98 ; Amended at 15 Ok Reg 3778, eff 7-1-98 (emergency); Amended at 16 Ok Reg 1422, eff 5-27-99 ; Amended at 16 Ok Reg 3495, eff 7-1-99 (emergency); Amended at 17 Ok Reg 1191, eff 5-11-00 ; Revoked at 21 Ok Reg 2149, eff 6-25-04]

317:25-5-13. Enrollment ineligibility [REVOKED]

[Source: Added at 13 Ok Reg 37, eff 5-12-95 (emergency); Added at 13 Ok Reg 43, eff 6-21-95 (emergency); Added at 13 Ok Reg 47, eff 9-8-95 (emergency); Added at 13 Ok Reg 2307, eff 4-10-96 (emergency); Added at 13 Ok Reg 1633, eff 5-27-96 ; Amended at 13 Ok Reg 3581, eff 6-18-96 (emergency); Amended at 13 Ok Reg 3565, eff 7-16-96 (emergency); Amended at 14 Ok Reg 1766, eff 5-27-97 ; Amended at 14 Ok Reg 3061, eff 7-1-97 (emergency); Amended at 15 Ok Reg 1511, eff 5-11-98 ; Amended at 15 Ok Reg 3778, eff 7-1-98 (emergency); Amended at 16 Ok Reg 1422, eff 5-27-99 ; Amended at 16 Ok Reg 3495, eff 7-1-99 (emergency); Amended at 17 Ok Reg 1191, eff 5-11-00 ; Amended at 20 Ok Reg 2759, eff 7-1-03 (emergency); Revoked at 21 Ok Reg 2149, eff 6-25-04]

317:25-5-14. Availability of plan choices [REVOKED]

[Source: Added at 13 Ok Reg 37, eff 5-12-95 (emergency); Added at 13 Ok Reg 43, eff 6-12-95 (emergency); Added at 13 Ok Reg 1633, eff 5-27-96 ; Amended at 14 Ok Reg 3061, eff 7-1-97 (emergency); Amended at 15 Ok Reg 1511, eff 5-11-98 ; Amended at 15 Ok Reg 3778, eff 7-1-98 (emergency); Amended at 16 Ok Reg 1422, eff 5-27-99 ; Revoked at 21 Ok Reg 2149, eff 6-25-04]

PART 5. ENROLLMENT PROCESS

317:25-5-25. Recipient enrollment process [REVOKED]

[Source: Added at 13 Ok Reg 37, eff 5-12-95 (emergency); Added at 12 Ok Reg 3634, eff 9-8-95 (emergency); Added at 13 Ok Reg 1633, eff 5-27-96 ; Amended at 13 Ok Reg 3566, eff 7-16-96 (emergency); Amended at 14 Ok Reg 2392, eff 2-5-97 (emergency); Amended at 14 Ok Reg 2926, eff 7-11-97 ; Amended at 14 Ok Reg 3061, eff 7-15-97 (emergency); Amended at 15 Ok Reg 1511, eff 5-11-98 ; Amended at 15 Ok Reg 3778, eff 7-1-98 (emergency); Amended at 16 Ok Reg 1422, eff 5-27-99 ; Amended at 16 Ok Reg 3495, eff 7-1-99 (emergency); Amended at 17 Ok Reg 1191, eff 5-11-00 ; Revoked at 21 Ok Reg 2149, eff 6-25-04]

317:25-5-26. Automatic re-enrollment. [REVOKED]

[Source: Added at 13 Ok Reg 37, eff 5-12-95 (emergency); Added at 13 Ok Reg 1633, eff 5-27-96 ; Amended at 13 Ok Reg 2517, eff 6-27-96 ; Amended at 13 Ok Reg 3565, eff 7-16-96 (emergency); Amended at 14 Ok Reg 1766, eff 5-27-97 ; Amended at 14 Ok Reg 3061, eff 7-1-97 (emergency); Amended at 15 Ok Reg 1511, eff 5-11-98 ; Amended at 15 Ok Reg 3778, eff 7-1-98 (emergency); Amended at 16 Ok Reg 1422, eff 5-27-99 ; Revoked at 21 Ok Reg 2149, eff 6-25-04]

317:25-5-27. Primary care provider selection or assignment [REVOKED]

[Source: Added at 13 Ok Reg 37, eff 5-12-95 (emergency); Added at 13 Ok Reg 1633, eff 5-27-96 ; Amended at 14 Ok Reg 3061, eff 7-1-97 (emergency); Amended at 15 Ok Reg 1511, eff 5-11-98 ; Amended at 16 Ok Reg 3495, eff 7-1-99 (emergency); Amended at 17 Ok Reg 1191, eff 5-11-00 ; Revoked at 21 Ok Reg 2149, eff 6-25-04]

317:25-5-28. Disenrollment from a Health Plan by the client [REVOKED]

[Source: Added at 13 Ok Reg 43, eff 6-21-95 (emergency); Added at 13 Ok Reg 37, eff 5-12-96 (emergency); Added at 13 Ok Reg 1633, eff 5-27-96 ; Amended at 13 Ok Reg 3565, eff 7-16-96 (emergency); Amended at 14 Ok Reg 1766, eff 5-27-97 ; Amended at 14 Ok Reg 3061, eff 7-1-97 (emergency); Amended at 15 Ok Reg 1511, eff 5-11-98 ; Amended at 15 Ok Reg 3778, eff 7-1-98 (emergency); Amended at 16 Ok Reg 1422, eff 5-27-99 ; Revoked at 21 Ok Reg 2149, eff 6-25-04]

317:25-5-29. Termination of a client's enrollment by the Health Plan [REVOKED]

[Source: Added at 13 Ok Reg 37, eff 5-12-95 (emergency); Added at 13 Ok Reg 43, eff 6-21-95 (emergency); Added at 13 Ok Reg 1633, eff 5-27-96 ; Amended at 13 Ok Reg 3565, eff 7-16-96 (emergency); Amended at 14 Ok Reg 1766, eff 5-27-97 ; Amended at 14 Ok Reg 3061, eff 7-1-97 (emergency); Amended at 15 Ok Reg 1511, eff 5-11-98 ; Revoked at 21 Ok Reg 2149, eff 6-25-04]

317:25-5-30. Plan benefit package [REVOKED]

[Source: Added at 13 Ok Reg 37, eff 5-12-95 (emergency); Added at 13 Ok Reg 2307, eff 4-10-96 (emergency); Added at 13 Ok Reg 1633, eff 5-27-96 ; Amended at 13 Ok Reg 3581, eff 6-18-96 (emergency); Amended at 13 Ok Reg 3565, eff 7-16-96 (emergency); Amended at 14 Ok Reg 1766, eff 5-27-97 ; Amended at 14 Ok Reg 3061, eff 7-1-97 (emergency); Amended at 15 Ok Reg 1511, eff 5-11-98 ; Amended at 15 Ok Reg 3778, eff 7-1-98 (emergency); Amended at 15 Ok Reg 138, eff 10-14-98 (emergency); Amended at 16 Ok Reg 1422, eff 5-27-99 ; Amended at 16 Ok Reg 3495, eff 7-1-99 (emergency); Amended at 17 Ok Reg 1191, eff 5-11-00 ; Revoked at 21 Ok Reg 2149, eff 6-25-04]

317:25-5-31. Obtaining Medicaid services not covered under the plan [REVOKED]

[Source: Added at 13 Ok Reg 37, eff 5-12-95 (emergency); Added at 13 Ok Reg 43, eff 6-21-95 (emergency); Added at 13 Ok Reg 1633, eff 5-27-96 ; Amended at 13 Ok Reg 3581, eff 6-18-96 (emergency); Amended at 13 Ok Reg 3565, eff 7-16-96 (emergency); Amended at 14 Ok Reg 1766, eff 5-27-97 ; Amended at 14 Ok Reg 3061, eff 7-1-97 (emergency); Amended at 15 Ok Reg 1511, eff 5-11-98 ; Amended at 15 Ok Reg 3778, eff 7-1-98 (emergency); Amended at 16 Ok Reg 1422, eff 5-27-99 ; Amended at 16 Ok Reg 3495, eff 7-1-99 (emergency); Amended at 17 Ok Reg 1191, eff 5-11-00 ; Revoked at 21 Ok Reg 2149, eff 6-25-04]

317:25-5-32. Emergency and family planning services [REVOKED]

[Source: Added at 13 Ok Reg 37, eff 5-12-95 (emergency); Added at 13 Ok Reg 43, eff 6-21-95 (emergency); Added at 13 Ok Reg 1633, eff 5-27-96 ; Amended at 13 Ok Reg 3581, eff 6-18-96 (emergency); Amended at 13 Ok Reg 3565, eff 7-16-96 (emergency); Amended at 14 Ok Reg 1766, eff 5-27-97 ; Amended at 14 Ok Reg 3061, eff 7-1-97 (emergency); Amended at 15 Ok Reg 1511, eff 5-11-98 ; Amended at 15 Ok Reg 3778, eff 7-1-98 (emergency); Amended at 16 Ok Reg 1422, eff 5-27-99 ; Revoked at 21 Ok Reg 2149, eff 6-25-04]

PART 7. PLAN REQUIREMENTS

317:25-5-40. Health Plan Qualifications for Participation [REVOKED]

[Source: Added at 13 Ok Reg 37, eff 5-12-95 (emergency); Added at 13 Ok Reg 43, eff 6-21-95 (emergency); Added at 13 Ok Reg 1633, eff 5-27-96 ; Amended at 13 Ok Reg 3565, eff 7-16-96 (emergency); Amended at 14 Ok Reg 1766, eff 5-27-97 ; Amended at 14 Ok Reg 3061, eff 7-1-97 (emergency); Amended at 15 Ok Reg 1511, eff 5-11-98 ; Amended at 15 Ok Reg 3778, eff 7-1-98 (emergency); Amended at 16 Ok Reg 1422, eff 5-27-99 ; Revoked at 21 Ok Reg 2149, eff 6-25-04]

317:25-5-41. Primary Care Provider (PCP) [REVOKED]

[Source: Added at 13 Ok Reg 37, eff 5-12-95 (emergency); Added at 13 Ok Reg 43, eff 6-21-95 (emergency); Added at 13 Ok Reg 3883, eff 4-30-96 (emergency); Added at 13 Ok Reg 1633, eff 5-27-96 ; Amended at 13 Ok Reg 3565, eff 7-16-96 (emergency); Amended at 14 Ok Reg 1766, eff 5-27-97 ; Amended at 14 Ok Reg 3061, eff 7-1-97 (emergency); Amended at 15 Ok Reg 1511, eff 5-11-98 ; Amended at 16 Ok Reg 138, eff 10-14-98 (emergency); Amended at 16 Ok Reg 1422, eff 5-27-99 ; Amended at 16 Ok Reg 3495, eff 7-1-99 (emergency); Amended at 17 Ok Reg 1191, eff 5-11-00 ; Revoked at 21 Ok Reg 2149, eff 6-25-04]

317:25-5-41.1. Medical residents serving as primary care providers [REVOKED]

[Source: Added at 13 Ok Reg 3883, eff 4-30-96 (emergency); Added at 14 Ok Reg 1766, eff 5-27-97 ; Amended at 14 Ok Reg 3061, eff 7-1-97 (emergency); Amended at 15 Ok Reg 1511, eff 5-11-98 ; Amended at 16 Ok Reg 3495, eff 7-1-99 (emergency); Amended at 17 Ok Reg 1191, eff 5-11-00 ; Revoked at 21 Ok Reg 2149, eff 6-25-04]

PART 9. SPECIAL PROVISIONS

317:25-5-50. Supplemental payments to medical schools [REVOKED]

[Source: Added at 13 Ok Reg 1199, eff 1-9-96 (emergency); Added at 13 Ok Reg 2519, eff 6-27-96 ; Amended at 13 Ok Reg 3565, eff 7-16-96 (emergency); Amended at 14 Ok Reg 1766, eff 5-27-97 ; Revoked at 15 Ok Reg 3678, eff 5-18-98 (emergency); Revoked at 16 Ok Reg 1422, eff 5-27-99]

SUBCHAPTER 7. SOONERCARE

PART 1. GENERAL PROVISIONS

317:25-7-1. Purpose

The purpose of this Subchapter is to describe the rules governing the statewide SoonerCare program. The rules provide assurances that SoonerCare members have adequate access to primary care, while reducing costs and preventing unnecessary and inappropriate utilization.

[Source: Added at 13 Ok Reg 823, eff 10-20-95 (emergency); Added at 13 Ok Reg 587, eff 11-21-95 (emergency); Added at 13 Ok Reg 1633, eff 5-27-96 ; Amended at 14 Ok Reg 3061, eff 7-1-97 (emergency); Amended at 15 Ok Reg 1511, eff 5-11-98 ; Amended at 21 Ok Reg 2149, eff 6-25-04 ; Amended at 26 Ok Reg 401, eff 1-1-09 (emergency); Amended at 26 Ok Reg 2074, eff 6-25-09]

317:25-7-2. SoonerCare Choice: overview

(a) The Oklahoma Health Care Authority (OHCA) operates a Primary Care Case Management (PCCM) system for SoonerCare Choice eligible members. PCCM is a managed care model in which each enrollee has a medical home with a primary care provider (PCP). Enrollees may select their own primary care provider or clinic as their PCP if that provider is enrolled with OHCA as a PCP and as a SoonerCare provider. Those who do not choose a PCP, may be assigned to one (1). Members may change PCPs at any time.

(b) The PCP is paid a monthly care coordination payment in accordance with the conditions in the PCP's SoonerCare Choice contract to provide or otherwise assure the delivery of medically-necessary preventive and primary care medical services, including securing referrals for specialty services and prior authorizations for an enrolled group of eligible members, with the exception of services described in subsection (c) of this Section for which authorization is not required. The PCP assists the member in gaining access to the health care system and monitors the member's condition, health care needs and service delivery.

(c) Services which do not require a referral from a PCP include preventive or primary care services rendered by another SoonerCare contracted provider such as: outpatient behavioral health services; vision services for children; dental services; child abuse/sexual abuse examinations; prenatal and obstetrical services; family planning services; emergency physician and hospital services; chronic disease prevention and management programs and other care coordination programs; and services delivered to Native Americans at Indian Health Service, tribal, or urban Indian clinics. Female members may access a SoonerCare

women's health specialist without a referral for covered routine and preventive health care services. This is in addition to the enrollee's PCP if that source is not a woman's health specialist.

(d) SoonerCare Choice covered services delivered by a PCP are reimbursed at the SoonerCare fee schedule rate under the procedure code established for each individual service. If services are provided or authorized by a PCP, the OHCA does not make SoonerCare Choice payments for services delivered outside the scope of coverage of the SoonerCare Choice program; thus, a referral by a PCP does not guarantee payment.

(e) A PCP may charge a co-payment for services provided to SoonerCare members in accordance with Oklahoma Administrative Code (OAC) 317:30-3-5(d).

(f) Members with chronic conditions may elect to enroll in a health management program to improve their health.

(g) PCPs may elect to participate in Health Access Networks pursuant to Subchapter 9 to improve access to care.

(h) PCPs may elect to participate in a Health Management Program pursuant to Subchapter 11 to improve access to care.

[Source: Added at 13 Ok Reg 823, eff 10-20-95 (emergency); Added at 13 Ok Reg 587, eff 11-21-95 (emergency); Added at 13 Ok Reg 1201, eff 1-9-96 (emergency); Added at 13 Ok Reg 2519, eff 6-27-96 ; Amended at 13 Ok Reg 3565, eff 7-16-96 (emergency); Amended at 14 Ok Reg 745, eff 12-24-96 (emergency); Amended at 14 Ok Reg 1776, eff 5-27-97 ; Amended at 14 Ok Reg 3061, eff 7-1-97 (emergency); Amended at 15 Ok Reg 1511, eff 5-11-98 ; Amended at 17 Ok Reg 425, eff 11-2-99 (emergency); Amended at 17 Ok Reg 1191, eff 5-11-00 ; Amended at 21 Ok Reg 2149, eff 6-25-04 ; Amended at 24 Ok Reg 74, eff 8-2-06 (emergency); Amended at 24 Ok Reg 2057, eff 6-25-07 ; Amended at 26 Ok Reg 401, eff 1-1-09 (emergency); Amended at 26 Ok Reg 2074, eff 6-25-09 ; Amended at 37 Ok Reg 1471, eff 9-14-20]

317:25-7-2.1. Medical residents [REVOKED]

[Source: Added at 13 Ok Reg 3883, eff 4-30-96 (emergency); Added at 14 Ok Reg 1766, eff 5-27-97 ; Revoked at 14 Ok Reg 3061, eff 7-1-97 (emergency); Revoked at 15 Ok Reg 1511, eff 5-11-98]

317:25-7-3. Definitions

The following words and terms, when used in this Subchapter, have the following meaning, unless the context clearly indicates otherwise:

"Aged, Blind and Disabled (ABD)" means the Medicaid covered populations under 42 United States Code (U.S.C.) Section 1396a (a)(10) (A)(i) and (F).

"Board" means the board designated by the Oklahoma legislature to establish policies and adopt and promulgate rules for the Oklahoma Health Care Authority.

"Custody" means the custodial status, as reported by the Oklahoma Department of Human Services.

"Medicaid" means the medical assistance program authorized by 42 U.S.C., Section 1396a et seq. The program provides medical benefits for certain low-income persons. It is jointly administered by the federal and state governments.

"Medicare" means the program defined at 42 U.S.C. § 1395 et seq.

"OHCA" means the Oklahoma Health Care Authority.

"OKDHS" means the Oklahoma Department of Human Services.

"PCCM" means Primary Care Case Management.

"Primary Care Case Management" means a managed care health service delivery system in which health services are delivered and coordinated by Primary Care Providers.

"Primary care provider (PCP)" means a Primary Care Provider, including a provider or physician group, under contract with the OHCA to provide primary care services and case management, including securing all medically-necessary referrals for specialty services and prior authorizations.

"Provider" or **"physician group"** means a partnership, limited partnership, limited liability company, corporation or professional corporation, composed of doctors of medicine and/or doctors of osteopathy and/or advanced practice registered nurses, and/or physician assistants who provide health care of the nature provided by independent practitioners and are permitted by state and federal law and regulations to receive SoonerCare provider payments.

"SoonerCare" means the Medicaid program administered by the OHCA.

"SoonerCare Choice" means a comprehensive medical benefit plan featuring a medical home including a PCP for each member.

[Source: Added at 13 Ok Reg 587, eff 11-21-95 (emergency); Added at 13 Ok Reg 1633, eff 5-27-96 ; Amended at 14 Ok Reg 3061, eff 7-1-97 (emergency); Amended at 15 Ok Reg 1511, eff 5-11-98 ; Amended at 17 Ok Reg 425, eff 11-2-99 (emergency); Amended at 17 Ok Reg 1191, eff 5-11-00 ; Amended at 21 Ok Reg 2149, eff 6-25-04 ; Amended at 26 Ok Reg 401, eff 1-1-09 (emergency); Amended at 26 Ok Reg 2074, eff 6-25-09 ; Amended at 37 Ok Reg 1471, eff 9-14-20]

317:25-7-4. Credentialling and re-credentialling [REVOKED]

[Source: Added at 14 Ok Reg 3061, eff 7-1-97 (emergency); Added at 15 Ok Reg 1511, eff 5-11-98 ; Revoked at 16 Ok Reg 3612, eff 8-3-99 (emergency); Revoked at 17 Ok Reg 1191, eff 5-11-00]

317:25-7-5. Primary care providers (PCPs)

For provision of health care services, the OHCA contracts with qualified PCPs. All providers serving as PCPs must have a valid SoonerCare Fee-for-Service contract as well as an exercised SoonerCare Choice addendum. Additionally, all PCPs, excluding provider or physician groups must agree to accept a minimum capacity of fifty (50) patients; provided, however, this does not guarantee PCPs a minimum patient volume. PCPs are limited to:

(1) **Physicians.** Any physician licensed to practice medicine in the state in which he or she practices who is engaged in a general practice or in family medicine, general internal medicine or general pediatrics may serve as a PCP. Out-of-state PCPs are required to comply with all access standards imposed on Oklahoma physicians, as well as Oklahoma Administrative Code (OAC) 317:30-3-89 through 317:30-3-92.

(2) **Advanced Practice Registered Nurses (APRNs).** APRNs who have prescriptive authority may serve as PCPs for the Primary Care Case Management delivery system if licensed to practice in the state in which he or she practices.

(3) **Physician Assistants (PAs).** PAs may serve as PCPs if licensed to practice in the state in which he or she practices.

(4) **Indian Health Service (IHS) Facilities and Federally Qualified Health Center (FQHC) provider groups and Rural Health Clinics (RHC).**

(A) IHS facilities whose professional staff meet the general requirements in paragraphs (1) through (3) of this Section and the provider participation requirements at OAC 317:30-5-1088 may serve as PCPs.

(B) FQHCs whose professional staff meet the general requirements in paragraphs (1) through (3) of this Section and the provider participation requirements in OAC 317:30- 5-660.2 may serve as PCPs.

(C) RHCs whose professional staff meet the general requirements in paragraphs (1) through (3) of this Section and the provider participation requirements in OAC 317:30- 5-355 may serve as PCPs.

(5) **Provider or physician group capacity and enrollment.**

(A) Provider or physician groups must agree to accept a minimum enrollment capacity of fifty (50) members.

(B) Provider or physician groups must designate a medical director to serve as the primary contact with OHCA.

[Source: Added at 14 Ok Reg 3061, eff 7-1-97 (emergency); Added at 15 Ok Reg 1511, eff 5-11-98 ; Amended at 15 Ok Reg 3778, eff 7-1-98 (emergency); Amended at 16 Ok Reg 138, eff 10-14-98 (emergency); Amended at 16 Ok Reg 1422, eff 5-27-99 ; Amended at 17 Ok Reg 425, eff 11-2-99 (emergency); Amended at 17 Ok Reg 2366, eff 6-26-00 ; Amended at 21 Ok Reg 2149, eff 6-25-04 ; Amended at 24 Ok Reg 2057, eff 6-25-07 ; Amended at 26 Ok Reg 401, eff 1-1-09 (emergency); Amended at 26 Ok Reg 2074, eff 6-25-09 ; Amended at 33 Ok Reg 790, eff 9-1-16 ; Amended at 37 Ok Reg 1471, eff 9-14-20 ; Amended at 40 Ok Reg 359, eff 11-4-22 (emergency); Amended at 40 Ok Reg 2171, eff 9-11-23]

317:25-7-6. Primary Care Provider responsibilities

(a) Under the provisions of the SoonerCare Choice Contract, the contractor is responsible for providing care coordination services for all enrolled members on his/her panel.

(b) PCPs must provide access to medical care twenty-four hours per day, seven days a week, either directly or through coverage arrangements made with other providers, clinics, and/or local hospitals.

[Source: Added at 15 Ok Reg 536, eff 9-18-97 (emergency); Added at 15 Ok Reg 1511, eff 5-11-98 ; Amended at 19 Ok Reg 530, eff 12-27-01 (emergency); Amended at 19 Ok Reg 2123, eff 6-27-02 ; Amended at 21 Ok Reg 2149, eff 6-25-04 ; Amended at 26 Ok Reg 401, eff 1-1-09 (emergency); Amended at 26 Ok Reg 2074, eff 6-25-09]

317:25-7-7. Referrals for specialty services

(a) Primary care physicians (PCPs) are required to assure the delivery of medically necessary preventive and primary care medical services, including securing referrals for specialty services. Some services, as defined in Oklahoma Administrative Code (OAC) 317:25-7-2(c) and OAC 317:25-7-10(b), do not require a referral from the PCP. A PCP referral does not guarantee payment, as all services authorized by the PCP must be in the scope of coverage of the SoonerCare Choice program to be considered compensable.

(b) Pursuant to OAC 317:30-3-1(f), SoonerCare Choice referrals must always be made on the basis of medical necessity. Referrals from the PCP are required prior to receiving the referred service, except for retrospective referrals as deemed appropriate by the PCP.

(c) The PCP and specialty provider are responsible for maintaining appropriate documentation of each referral to support the claims for medically necessary services.

(d) As approved and deemed appropriate, the Oklahoma Health Care Authority (OHCA) may provide administrative referrals for specialty services. Administrative referrals are only provided by the OHCA under special and extenuating circumstances. Administrative referrals should not be requested as a standard business practice. The OHCA will not process retrospective administrative referrals, unless one (1) of the following exceptions applies:

(1) The specialty services are referred from an IHS, tribal, or urban Indian clinic;

(2) The specialty services are referred as the result of an emergency room visit or emergency room follow-up visit; or

(3) The retrospective administrative referral request for specialty services is requested from the OHCA within thirty (30) calendar days of the specialty care date of service.

(A) The referral is requested for urgent/emergent care, including but not limited to, outpatient surgeries, fracture care, and other procedures that require immediate attention.

(B) Annual, routine, and long-term follow up appointments will not be considered for retrospective services. These type of appointment referrals will need to be secured prior to the scheduling of the appointment.

(C) If the retrospective administrative referral is requested within the thirty (30) calendar days, the request must include appropriate documentation for the OHCA to approve the request. Appropriate documentation must include:

(i) Proof that the specialist has attempted to collect a PCP referral from the member's assigned PCP. Documentation should note who the requesting provider communicated with or a copy of the fax verification that was sent to the PCP along with the denial reason; and

(ii) Medical documentation to substantiate that the specialty services are medically necessary pursuant to OAC 317:30-3-1(f).

(e) Nothing in this section is intended to absolve the PCP of their obligations in accordance with the conditions set forth in their PCP SoonerCare Choice contract and the rules delineated in OAC 317:30.

PART 3. ENROLLMENT CRITERIA

317:25-7-10. Enrollment with a Primary Care Provider (PCP)

(a) All SoonerCare Choice members described in Oklahoma Administrative Code (OAC) 317:25-7-12 may enroll with a PCP. SoonerCare Choice applicants have the opportunity to select a PCP during the application process. Enrollment with a PCP may begin any day of the month.

(1) The OHCA offers all members the opportunity to choose a PCP from a directory which lists available PCPs.

(2) When a notice of PCP enrollment is sent to a member, the member is advised of the right to change a PCP at any time.

(b) Members may receive services from a PCP or from a provider to which the member has been referred by a PCP. Notwithstanding this provision, subject to limitations which may be placed on services by the OHCA, members may self-refer for preventive or primary care services rendered by another SoonerCare contracted provider, outpatient behavioral health services, vision services for children, dental services, child abuse/sexual abuse examinations, prenatal and obstetrical services, family planning services, services delivered to Native Americans at Indian Health Service, tribal, or urban Indian clinics, chronic disease prevention and management programs and other care coordination programs, and emergency physician and hospital services.

[Source: Added at 13 Ok Reg 587, eff 11-21-95 (emergency); Added at 13 Ok Reg 2309, eff 4-10-96 (emergency); Added at 13 Ok Reg 1633, eff 5-27-96 ; Amended at 13 Ok Reg 3577, eff 6-18-96 (emergency); Amended at 13 Ok Reg 3565, eff 7-16-96 (emergency); Amended at 14 Ok Reg 745, eff 12-24-96 (emergency); Amended at 14 Ok Reg 1776, eff 5-27-97 ; Amended at 14 Ok Reg 3061, eff 7-1-97 (emergency); Amended at 15 Ok Reg 1511, eff 5-11-98 ; Amended at 17 Ok Reg 425, eff 11-2-99 (emergency); Amended at 17 Ok Reg 1191, eff 5-11-00 ; Amended at 18 Ok Reg 760, eff 1-23-01 (emergency); Amended at 18 Ok Reg 1128, eff 5-11-01 ; Amended at 21 Ok Reg 2149, eff 6-25-04 ; Amended at 24 Ok Reg 74, eff 8-2-06 (emergency); Amended at 24 Ok Reg 2057, eff 6-25-07 ; Amended at 26 Ok Reg 401, eff 1-1-09 (emergency); Amended at 26 Ok Reg 2074, eff 6-25-09 ; Amended at 37 Ok Reg 1471, eff 9-14-20]

317:25-7-11. Geographic coverage areas

The PCCM managed care program is statewide.

[Source: Added at 13 Ok Reg 587, eff 11-21-95 (emergency); Added at 13 Ok Reg 1633, eff 5-27-96 ; Amended at 14 Ok Reg 3061, eff 7-1-97 (emergency); Amended at 15 Ok Reg 1511, eff 5-11-98 ; Amended at 21 Ok Reg 2149, eff 6-25-04]

317:25-7-12. Enrollment/eligibility requirements

(a) Eligible SoonerCare members mandatorily enrolled in SoonerCare Choice include persons categorically related to AFDC; pregnancy-related services; expansion adult; and aged, blind or disabled who are not dually-eligible for SoonerCare and Medicare.

(b) Children in foster care may voluntarily enroll into SoonerCare Choice.

[Source: Added at 13 Ok Reg 587, eff 11-21-95 (emergency); Added at 13 Ok Reg 1633, eff 5-27-96 ; Amended at 14 Ok Reg 3061, eff 7-1-97 (emergency); Amended at 15 Ok Reg 1511, eff 5-11-98 ; Amended at 17 Ok Reg 425, eff 11-2-99 (emergency); Amended at 17 Ok Reg 1191, eff 5-11-00 ; Amended at 26 Ok Reg 401, eff 1-1-09 (emergency); Amended at 26 Ok Reg 2074, eff 6-25-09 ; Amended

at 39 Ok Reg 31, eff 9-7-21 (emergency); Amended at 39 Ok Reg 1425, eff 9-12-22]

317:25-7-13. Enrollment ineligibility

Members in certain categories are excluded from participation in the SoonerCare Choice program. All other members may be enrolled in the SoonerCare Choice program and subject to the provisions of this Subchapter. Members excluded from participation in SoonerCare Choice include:

- (1) Individuals receiving services in a long-term care facility, in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), or through a Home and Community Based Waiver;
- (2) Individuals in the former foster care children's group [see Oklahoma Administrative Code (OAC) 317:35-5-2];
- (3) Individuals in benefit programs with limited scope, such as Tuberculosis, Family Planning, or pregnancy only;
- (4) Non-qualified or ineligible aliens;
- (5) Children in subsidized adoptions;
- (6) Individuals who are dually-eligible for SoonerCare and Medicare; and/or
- (7) Individuals who have other creditable coverage.

[Source: Added at 13 Ok Reg 587, eff 11-21-95 (emergency); Added at 13 Ok Reg 2313, eff 4-10-96 (emergency); Added at 13 Ok Reg 1633, eff 5-27-96 ; Amended at 13 Ok Reg 3581, eff 6-18-96 (emergency); Amended at 13 Ok Reg 3565, eff 7-16-96 (emergency); Amended at 14 Ok Reg 1766, eff 5-27-97 ; Amended at 14 Ok Reg 3061, eff 7-1-97 (emergency); Amended at 15 Ok Reg 1511, eff 5-11-98 ; Amended at 17 Ok Reg 425, eff 11-2-99 (emergency); Amended at 17 Ok Reg 1191, eff 5-11-00 ; Amended at 20 Ok Reg 2759, eff 7-1-03 (emergency); Amended at 21 Ok Reg 2149, eff 6-25-04 ; Amended at 24 Ok Reg 75, eff 8-2-06 (emergency); Amended at 24 Ok Reg 879, eff 5-11-07 ; Amended at 26 Ok Reg 401, eff 1-1-09 (emergency); Amended at 26 Ok Reg 2074, eff 6-25-09 ; Amended at 31 Ok Reg 645, eff 7-1-14 (emergency); Amended at 32 Ok Reg 1022, eff 8-27-15 ; Amended at 37 Ok Reg 1471, eff 9-14-20 ; Amended at 38 Ok Reg 403, eff 12-18-20 (emergency); Amended at 38 Ok Reg 962, eff 9-1-21]

PART 5. ENROLLMENT PROCESS

317:25-7-25. Member enrollment process

(a) SoonerCare eligible individuals whose eligibility is based on one (1) of the aid categories defined in Oklahoma Administrative Code (OAC) 317:25-7-12 are eligible to enroll with a primary care physician (PCP). Parents or guardians will choose on behalf of minor members in the household. Families with more than one (1) enrollee may choose a different PCP for each family member.

(b) Until the effective date of enrollment with a PCP, services for a newborn are reimbursed at a fee-for-service rate. Upon eligibility determination, newborns may enroll with a PCP who is in general practice, family practice, or general pediatrics. Enrollment materials will advise the parent or guardian of the right to change a PCP after the effective date of enrollment.

(c) A description of the PCCM program and the PCP directory are available on the Oklahoma Health Care Authority's (OHCA) website.

(d) For purposes of determining the member's choice of PCP, the most recent PCP selection received by the OHCA determines the PCP with which the member is enrolled, as long as capacity is available. If capacity is not available or the member does not choose, the member is assigned according to the assignment mechanism as defined by the OHCA. A member who is eligible for SoonerCare Choice but is not assigned, may request enrollment with a PCP by contacting the SoonerCare Helpline or through the member's mySoonerCare.org account, if applicable.

(e) PCPs may not refuse an assignment, seek to disenroll a member, or otherwise discriminate against a member on the basis of age, sex, race, physical or mental disability, national origin, or type of illness or condition, unless that condition can be better treated by another provider type, except that Indian Health Service, tribal or urban Indian programs may provide services to members consistent with federal law.

[Source: Added at 13 Ok Reg 587, eff 11-21-95 (emergency); Added at 13 Ok Reg 1633, eff 5-27-96 ; Amended at 13 Ok Reg 3566, eff 7-16-96 (emergency); Amended at 14 Ok Reg 2392, eff 2-5-97 (emergency); Amended at 14 Ok Reg 2926, eff 7-11-97 ; Amended at 14 Ok Reg 3061, eff 7-15-97 (emergency); Amended at 15 Ok Reg 1511, eff 5-11-98 ; Amended at 16 Ok Reg 3612, eff 8-3-99 (emergency); Amended at 17 Ok Reg 1191, eff 5-11-00 ; Amended at 21 Ok Reg 2149, eff 6-25-04 ; Amended at 26 Ok Reg 401, eff 1-1-09 (emergency); Amended at 26 Ok Reg 2074, eff 6-25-09 ; Amended at 37 Ok Reg 1471, eff 9-14-20]

317:25-7-26. Automatic re-enrollment

SoonerCare members who become disenrolled from a PCP solely by virtue of becoming temporarily [for three hundred and sixty-five (365) days or less] ineligible for SoonerCare services, may be re-enrolled with their previously-selected PCP, subject to capacity. The member is notified of the enrollment and any right to disenroll from that PCP or change to another PCP.

[Source: Added at 13 Ok Reg 587, eff 11-21-95 (emergency); Added at 13 Ok Reg 1633, eff 5-27-96 ; Amended at 13 Ok Reg 2517, eff 6-27-96 ; Amended at 13 Ok Reg 3565, eff 7-16-96 (emergency); Amended at 14 Ok Reg 1766, eff 5-27-97 ; Amended at 14 Ok Reg 3061, eff 7-1-97 (emergency); Amended at 15 Ok Reg 1511, eff 5-11-98 ; Amended at 21 Ok Reg 2149, eff 6-25-04 ; Amended at 26 Ok Reg 401, eff 1-1-09 (emergency); Amended at 26 Ok Reg 2074, eff 6-25-09 ; Amended at 37 Ok Reg 1471, eff 9-14-20]

317:25-7-27. Changing Primary care providers (PCPs)

(a) The Oklahoma Health Care Authority (OHCA) is responsible for changing a member's enrollment from one (1) PCP to another:

- (1) Without cause upon the member's request; or
- (2) Upon demonstration of good cause. For purposes of this paragraph, good cause means:

- (A) Those members who are habitually non-compliant with the documented medical directions of the provider; or
- (B) Those members who pose a threat to employees, or other patients of the PCP; or
- (C) As a result of a grievance determination by the OHCA; or
- (D) In those cases where reliable documentation demonstrates that the physician-patient relationship has so deteriorated that continued service would be detrimental to the member, the provider or both; or

- (E) The member's illness or condition would be better treated by another type of provider; or
- (3) when the state imposes an intermediate sanction.
- (b) A written request by the PCP to change the enrollment of a member is acted upon by the OHCA within thirty (30) days of its receipt. The decision to change PCPs for cause is made at the discretion of the OHCA, subject to appeals policies delineated at Oklahoma Administrative Code 317:2-1. The effective date of change is set so as to avoid the issue of abandonment.
- (c) In the event a SoonerCare PCP contract is terminated by OHCA for any reason, or the PCP terminates participation in the SoonerCare Choice program the panel members formerly aligned with the terminating PCP shall be enrolled with a different PCP.

[Source: Added at 13 Ok Reg 587, eff 11-21-95 (emergency); Added at 13 Ok Reg 1633, eff 5-27-96 ; Amended at 13 Ok Reg 3565, eff 7-16-96 (emergency); Amended at 14 Ok Reg 1766, eff 5-27-97 ; Amended at 14 Ok Reg 3061, eff 7-1-97 (emergency); Amended at 15 Ok Reg 1511, eff 5-11-98 ; Amended at 17 Ok Reg 425, eff 11-2-99 (emergency); Amended at 17 Ok Reg 1191, eff 5-11-00 ; Amended at 21 Ok Reg 2149, eff 6-25-04 ; Amended at 26 Ok Reg 401, eff 1-1-09 (emergency); Amended at 26 Ok Reg 2074, eff 6-25-09 ; Amended at 37 Ok Reg 1471, eff 9-14-20]

317:25-7-28. Disenrolling a member from SoonerCare Choice

- (a) The Oklahoma Health Care Authority (OHCA) may disenroll a member from SoonerCare Choice if:
- (1) The member is no longer eligible for SoonerCare Choice services;
 - (2) The member is incarcerated;
 - (3) The member dies;
 - (4) Disenrollment is determined to be necessary by the OHCA;
 - (5) The status of the member changes, rendering him/her ineligible for SoonerCare;
 - (6) The member is authorized to receive services in a nursing facility, in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or through a Home and Community Based Waiver;
 - (7) The member becomes dually-eligible for SoonerCare and Medicare; or
 - (8) The member becomes covered under other creditable coverage.
- (b) The OHCA may disenroll the member at any time if the member is disenrolled for good cause, as it is defined in Oklahoma Administrative Code (OAC) 317:25-7-27. The OHCA will inform the PCP of any disenrollments from his or her member roster.
- (c) OHCA may disenroll a member upon the PCP's request as described in (1) through (5) of this subsection.
- (1) Primary care provider (PCP) may file a written request asking OHCA to take action, including, but not limited to, disenrolling a member when the member:
 - (A) Is physically or verbally abusive to office staff, providers, and/or other patients;
 - (B) Is habitually non-compliant with the documented medical directions of a PCP; or

(C) Regularly fails to arrive for scheduled appointments without cancelling and the PCP has made all reasonable efforts to accommodate the member.

(2) The request from a PCP for disenrollment of a member must include one (1) or more of the following:

(A) Documentation of the difficulty encountered with the member, including the nature, extent, and frequency of abusive or harmful behavior, violence, and/or inability to treat or engage the member;

(B) Identification and documentation of unique religious or cultural issues that may be affecting a PCP's ability to provide treatment effectively to the member; or

(C) Documentation of special assistance or intervention offered.

(3) A PCP may not request disenrollment because of a change in the member's health status, the member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from the member's special needs except when the member's enrollment with a PCP seriously impairs his/her ability to furnish services to this member or other members.

(4) A PCP must document efforts taken to inform the member orally or in writing of any actions that have interfered with the effective provision of covered services, as well as efforts to explain what actions or language of the member are acceptable and unacceptable and the consequences of unacceptable behavior, including disenrollment from a PCP.

(5) The OHCA will give written notice of the disenrollment request to the member.

[Source: Added at 13 Ok Reg 587, eff 11-21-95 (emergency); Added at 13 Ok Reg 1633, eff 5-27-96 ; Amended at 13 Ok Reg 3565, eff 7-16-96 (emergency); Amended at 14 Ok Reg 1766, eff 5-27-97 ; Amended at 14 Ok Reg 3061, eff 7-1-97 (emergency); Amended at 15 Ok Reg 1511, eff 5-11-98 ; Amended at 17 Ok Reg 425, eff 11-2-99 (emergency); Amended at 17 Ok Reg 1191, eff 5-11-00 ; Amended at 21 Ok Reg 2149, eff 6-25-04 ; Amended at 26 Ok Reg 401, eff 1-1-09 (emergency); Amended at 26 Ok Reg 2074, eff 6-25-09 ; Amended at 31 Ok Reg 645, eff 7-1-14 (emergency); Amended at 32 Ok Reg 1022, eff 8-27-15 ; Amended at 37 Ok Reg 1471, eff 9-14-20]

PART 7. COORDINATION AND CONTINUITY OF CARE

317:25-7-29. Screening, diagnosis and preventive benefits [REVOKED]

[Source: Added at 13 Ok Reg 587, eff 11-21-95 (emergency); Added at 13 Ok Reg 1633, eff 5-27-96 ; Amended at 13 Ok Reg 3565, eff 7-16-96 (emergency); Amended at 14 Ok Reg 745, eff 12-24-96 (emergency); Amended at 14 Ok Reg 1776, eff 5-27-97 ; Amended at 14 Ok Reg 3061, eff 7-1-97 (emergency); Amended at 15 Ok Reg 1511, eff 5-11-98 ; Amended at 21 Ok Reg 2149, eff 6-25-04 ; Amended at 26 Ok Reg 401, eff 1-1-09 (emergency); Amended at 26 Ok Reg 2074, eff 6-25-09 ; Revoked at 37 Ok Reg 1471, eff 9-14-20]

317:25-7-30. Obtaining SoonerCare Choice services

(a) Medical services which are not the responsibility of the primary care provider (PCP) to authorize under the care coordination component of SoonerCare Choice, as described in Oklahoma Administrative Code (OAC) 317:25-7-10(b), are obtained in the same manner as under the regular SoonerCare fee-for-service program.

(b) For policy regarding out-of-state transportation for primary and specialty care, refer to OAC 317:30-3-89 through 317:30-3-92.

(c) An American Indian/Alaska Native (AI/AN) eligible SoonerCare member may choose a PCP from the provider directory, including the Indian Health Service (IHS), tribal and urban Indian clinics that participate as SoonerCare PCPs. An AI/AN member in SoonerCare may enroll with a PCP who is not an IHS, tribal, or urban Indian clinic and still use the IHS, tribal, or urban Indian clinic for medical care. A referral from a PCP is needed for services that the clinic cannot provide, except for self-referred services.

(d) If an IHS, tribal, or urban Indian clinic is unable to deliver a service to a SoonerCare enrollee and must refer the member for the service to a non-IHS, tribal, or urban Indian clinic, SoonerCare reimbursement is made only to the specialist when the service has been referred by a PCP, unless PCP authorization is not required under OAC 317:25-7-2 (c).

(e) A PCP is not obligated to provide emergency services and is not responsible for authorization or approval for payment for members seen in the emergency room. A PCP may not require members to seek prior authorization (PA) for emergency services. However, a PCP may provide emergency care in an emergency setting, within his/her legal scope of practice.

(f) A PA is required for some medical procedures, equipment, medications, and specialty services. The PCP and/or requesting provider are responsible for submitting the PA request to SoonerCare. The member and requesting provider will be notified of SoonerCare's decision to authorize the requested services. A PA is not a guarantee of payment.

[Source: Added at 13 Ok Reg 587, eff 11-21-95 (emergency); Added at 13 Ok Reg 1633, eff 5-27-96 ; Amended at 13 Ok Reg 3565, eff 7-16-96 (emergency); Amended at 14 Ok Reg 745, eff 12-24-96 (emergency); Amended at 14 Ok Reg 1776, eff 5-27-97 ; Amended at 14 Ok Reg 3061, eff 7-1-97 (emergency); Amended at 15 Ok Reg 1511, eff 5-11-98 ; Amended at 21 Ok Reg 2149, eff 6-25-04 ; Amended at 26 Ok Reg 401, eff 1-1-09 (emergency); Amended at 26 Ok Reg 2074, eff 6-25-09 ; Amended at 37 Ok Reg 1471, eff 9-14-20]

PART 9. REIMBURSEMENT

317:25-7-40. SoonerCare Choice reimbursement

(a) **Care coordination component.** Participating primary care providers (PCPs) are paid a monthly care coordination payment to assure the delivery of medically-necessary preventive and primary care medical services, including referrals for specialty services for an enrolled group of eligible members. The PCP assists the member in gaining access to the health care system and monitors the member's condition, health care needs and service delivery.

(b) **Visit-based fee-for-service component.** SoonerCare Choice covered services provided by a PCP are reimbursed at the SoonerCare fee schedule rate under the procedure code established for each individual service. To the extent services are authorized by a PCP, the Oklahoma Health Care Authority (OHCA) does not make SoonerCare Choice payments for services delivered outside the scope of coverage of the SoonerCare Choice program. In other words, a referral by a PCP does not guarantee payment.

(c) **Incentive program component.** Subject to the availability of funds, OHCA will develop a bonus payment program to encourage coordination of services, to reward improvement in health outcome and promote efficiency.

(d) **SoonerCare networks.** For every PCP who participates in an OHCA approved Health Access Network, a per-member-per-month payment is established by OHCA and paid to the network.

[Source: Added at 26 Ok Reg 401, eff 1-1-09 (emergency); Added at 26 Ok Reg 2074, eff 6-25-09 ; Amended at 37 Ok Reg 1471, eff 9-14-20]

SUBCHAPTER 9. HEALTH ACCESS NETWORKS

317:25-9-1. Purpose

The purpose of this Subchapter is to describe the rules governing the Health Access Networks (HANs) participating in the statewide SoonerCare program. The rules provide assurances that HANs will work with providers to coordinate and improve the quality of care for SoonerCare members.

[Source: Added at 28 Ok Reg 8, eff 8-13-10 (emergency); Added at 28 Ok Reg 1389, eff 6-25-11 ; Amended at 37 Ok Reg 1471, eff 9-14-20]

317:25-9-2. Requirements

Health Access Networks (HANs) are non-profit, administrative entities that work with providers to coordinate and improve the quality of care for SoonerCare members. The HAN must:

- (1) Be organized for the purpose of restructuring and improving the access, quality, and continuity of care to SoonerCare members;
- (2) Facilitate members' access to all levels of care, including primary, outpatient, specialty, certain ancillary services, and acute inpatient care, within a community or across a broad spectrum of providers across a service region or the state through improved access to specialty care, telehealth, and expended quality improvement strategies;
- (3) Offer care management/care coordination to persons with complex health care needs as specified in the state-HAN provider agreement.

[Source: Added at 28 Ok Reg 8, eff 8-13-10 (emergency); Added at 28 Ok Reg 1389, eff 6-25-11 ; Amended at 31 Ok Reg 1627, eff 9-12-14 ; Amended at 37 Ok Reg 1471, eff 9-14-20]

317:25-9-3. Reimbursement

(a) In order to be eligible for payment, Health Access Networks (HANs) must have on file with the Oklahoma Health Care Authority (OHCA) an approved Provider Agreement. Through this agreement, the HAN assures that OHCA's requirements are met and assures compliance with all applicable federal and state regulations.

(b) The HAN will be reimbursed a per member per month (PMPM) rate based on the number of member months paid to the PCPs affiliated with the HAN. OHCA reserves the right to limit reimbursement based on availability of funds.

[Source: Added at 28 Ok Reg 8, eff 8-13-10 (emergency); Added at 28 Ok Reg 1389, eff 6-25-11 ; Amended at 37 Ok Reg 1471, eff 9-14-20]

SUBCHAPTER 11. HEALTH MANAGEMENT PROGRAM

317:25-11-1. Purpose

The purpose of this Subchapter is to describe the rules governing the Health Management Program (HMP) participating in the statewide SoonerCare program. The rules provide assurances that the HMP will work with providers to coordinate and improve the quality of care for SoonerCare members.

[Source: Added at 37 Ok Reg 1471, eff 9-14-20]

317:25-11-2. Requirements

(a) The Health Management Program (HMP) is a voluntary program offered statewide and serves SoonerCare Choice members ages four (4) through sixty-three (63) with or at risk for chronic illness who are at the highest risk for adverse outcome and increased health care expenditures.

(b) HMP services are grounded in motivational interviewing and evidence-based guidelines. The HMP services are designed by the HMP vendor and approved by the Oklahoma Health Care Authority (OHCA). The HMP vendor's activities may include services delivered directly to SoonerCare Choice members or activities in connection with health care providers that are designed to benefit SoonerCare Choice members.

HMP activities/services can include:

- (1) Health coaching;
- (2) Practice facilitation;
- (3) Health navigation;
- (4) Performance improvement projects; and
- (5) Transition of care assistance.

[Source: Added at 37 Ok Reg 1471, eff 9-14-20]

317:25-11-3. Reimbursement

The Health Management Program (HMP) vendor must have an approved Provider Agreement on file. Through this agreement, the HMP

assures that the Oklahoma Health Care Authority's requirements are met and assures compliance with all applicable federal and state regulations. HMPs are not a service delivery system.

[Source: Added at 37 Ok Reg 1471, eff 9-14-20]

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

[**Authority:** Long-Term Social Security Act; Federal Social Security Act, Title XIX; Titles XVIII and XIX; Child Health Act; Title V; Civil Rights Act of 1964; Rehabilitation Act of 1973 (Part 90); The Oklahoma Health Care Authority Act; Age Discrimination Act of 1975; Education Amendments of 1972, Title IX; P.L. 88-352; P.L. 93-112; P.L. 99-456; P.L. 111-456; 31 U.S.C.A. 6101; Presidential Executive Orders 11246, 11375, and 12549; 42 CFR, §§ 405.2426, 431.54, 416.30-49, 440.100, 440.130, 440.140, 440.170, and 442 (Subparts E and G); 45 CFR, Part 93; 10 O.S., §§ 175.1 and 1415.1; 56 O.S., §§ 162.3, 164(c), and 175; 59 O.S., § 567.3(4); 63 O.S., §§ 1-1901 et seq., 3241.6, and 5003 through 5016; 68 O.S., § 1305; Laws 2002, c.470; 1-1944 through 1-1949 of the Oklahoma State Statutes.]
[**Source:** Codified 7-27-95]

SUBCHAPTER 1. GENERAL PROVISIONS

317:30-1-1. Purpose

(a) The purpose of this Chapter is to detail rules applicable to providers of medical services purchased by the Oklahoma Health Care Authority (OHCA).

(b) This Chapter contains basic information concerning the SoonerCare Program. It is intended for use by all providers of medical and health related services participating in the program. Subchapters one, three and seven are applicable to all medical providers, while Subchapter five consists of rules unique to a specific type of provider, services, or specialty.

(1) The Chapter contains Sections dealing with provider policies, coverage of medical and health services, and other general program policies and procedures applicable to all providers.

(2) Providers and their office staff are urged to familiarize themselves with the contents of this Chapter and to refer to it when questions arise. Use of the Chapter will reduce misunderstandings concerning the coverage and reimbursement of SoonerCare services and the Agency's expectations of providers. As users of the rules in this Chapter, OHCA also solicits suggestions and comments from providers.

(c) As a convenience to providers, the Authority compiles applicable Subchapters and Sections into policy documents which are available to providers at no cost.

[**Source:** Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 39 Ok Reg 1425, eff 9-12-22]

317:30-1-2. Authority responsibility; fiscal agent

(a) As the single State Agency, the Oklahoma Health Care Authority (OHCA) administers the medical programs which make available appropriate medical services to eligible individuals through the Title XIX Medicaid Program. OHCA is directly responsible for administration of the medical programs including development of policy, establishment of payment rates, certain provider hearings, and provider relations.

(b) The Authority contracts with a fiscal agent for operation of the medical claims processing system. The Fiscal Agent is responsible for processing all medical claims for individuals eligible under the

Authority's medical programs and will make payment for services based on established policy and procedures.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95]

317:30-1-3. Description of rules [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 37 Ok Reg 1477, eff 9-14-20 ; Revoked at 39 Ok Reg 1425, eff 9-12-22]

317:30-1-4. Definitions

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

"Adult" means an individual twenty-one (21) years of age or older, unless otherwise specified by statute, regulation, and/or policy adopted by the Oklahoma Health Care Authority (OHCA). For eligibility criteria policy for children and adults, please refer to Oklahoma Administrative Code (OAC) 317:35-5-2.

"Alien" means an individual who does not have United States citizenship and is not a United States national. It is synonymous with the word "noncitizen".

"CMS" means the Centers for Medicaid and Medicaid Services.

"Child" means an individual under twenty-one (21) years of age, unless otherwise specified by statute, regulation, and/or policy adopted by the OHCA. For eligibility criteria policy for children and adults, please refer to OAC 317:35-5-2.

"Diagnosis Related Group" means a patient classification system that relates types of patients treated to the resources they consume.

"Expansion Adult" means an individual defined by 42 Code of Federal Regulations § 435.119 who is age nineteen (19) or older and under sixty-five (65), at or below 133 percent of the federal poverty level (FPL), and who are not categorically related to the aged, blind, and disabled.

"Habilitation" means health care services that are aimed at helping people gain certain new skills, abilities, knowledge and functioning for daily living.

"Noncitizen" means an individual who does not have United States citizenship and is not a United States national. It is synonymous with the word "alien".

"OKDHS" means the Oklahoma Department of Human Services which is also referenced in rules as Department of Human Services (DHS) and Office of Human Services (OHS).

"Rehabilitation" means health care services that help a person to re-gain skills, abilities or knowledge that may have been lost or compromised as a result of acquiring a disability, or due to a change in one's disability or circumstances.

[Source: Added at 37 Ok Reg 1477, eff 9-14-20 ; Amended at 38 Ok Reg 774, eff 7-1-21 (emergency); Amended at 39 Ok Reg 394, eff 12-21-21 (emergency); Amended at 39 Ok Reg 1430, eff 9-12-22]

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-1. Creation and implementation of rules; applicability

(a) Medical rules of the Oklahoma Health Care Authority (OHCA) are set by the OHCA Board. The rules are based upon the recommendations of the Chief Executive Officer of the Authority, the Deputy State Medicaid Director, the State Medicaid Director, OHCA Tribal partners and the OHCA Medical Advisory Committee. The State Medicaid Director is responsible for implementing medical policies and programs and directing the Fiscal Agent regarding proper payment of claims.

(b) Payment to practitioners under Medicaid is made for services clearly identifiable as personally rendered services performed on behalf of a specific member. There are no exceptions to personally rendered services unless specifically set out in coverage guidelines.

(c) Payment is made on behalf of Medicaid eligible individuals for services within the scope of the Authority medical programs. Services cannot be paid under Medicaid for ineligible individuals or for services not covered under the scope of medical programs or that do not meet documentation requirements. These claims will be denied, or in some instances upon post-payment review, payment will be recouped.

(d) Payment to practitioners on behalf of Medicaid eligible individuals is made only for services that are medically necessary and essential to the diagnosis and treatment of the patient's presenting problem. Wellness examinations and diagnostic testing are not covered for adults unless specifically set out in coverage guidelines.

(e) The scope of the medical program for eligible children is the same as for adults except as further set out under Early and Periodic Screening, Diagnostic and Treatment (EPSDT) service guidelines.

(f) Services, provided within the scope of the Oklahoma Medicaid program, shall meet medical necessity criteria. Requests by qualified providers for services in and of itself shall not constitute medical necessity. The OHCA shall serve as the final authority pertaining to all determinations of medical necessity. Some service limits listed within OAC 317:30 can be exceeded for expansion adults, upon meeting medical necessity as determined by OHCA and in alignment with the Oklahoma Medicaid State Plan. Physical therapy, occupational therapy and speech language pathology have hard limits, which are set at forty-five (45) visits for both habilitation and rehabilitation - a cumulative total of 90 visits [fifteen (15) visits of each therapy]. Members must meet medical necessity criteria, prior authorization, and all other documentation requirements. Medical necessity is established through consideration of the following standards:

- (1) Services must be medical in nature and must be consistent with accepted health care practice standards and guidelines for the prevention, diagnosis or treatment of symptoms of illness, disease or disability;

(2) Documentation submitted in order to request services or substantiate previously provided services must demonstrate through adequate objective medical records and other supporting records, evidence sufficient to justify the member's need for the service;

(3) Treatment of the member's condition, disease or injury must be based on reasonable and predictable health outcomes;

(4) Services must be necessary to alleviate a medical condition and must be required for reasons other than convenience for the member, family, or medical provider;

(5) Services must be delivered in the most cost-effective manner and most appropriate setting; and

(6) Services must be appropriate for the member's age and health status and developed for the member to achieve, maintain, or promote functional capacity.

(g) Emergency medical condition means a medical condition including injury manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected, by a reasonable and prudent layperson, to result in placing the patient's health in serious jeopardy, serious impairment to bodily function, or serious dysfunction of any bodily organ or part.

(h) Verbal or written interpretations of policy and procedure in singular instances is made on a case-by-case basis and shall not be binding on this Agency or override its policy of general applicability.

(i) The rules and policies in this Part apply to all providers of service who participate in the program.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 17 Ok Reg 3306, eff 7-28-00 (emergency); Amended at 18 Ok Reg 761, eff 1-23-01 (emergency); Amended at 18 Ok Reg 1130, eff 5-11-01 ; Amended at 38 Ok Reg 774, eff 7-1-21 (emergency); Amended at 39 Ok Reg 394, eff 12-21-21 (emergency); Amended at 39 Ok Reg 1430, eff 9-12-22]

317:30-3-2. Provider agreements

In order to be eligible for payment, providers must have on file with OHCA, an approved Provider Agreement. Through this agreement, the provider certifies all information submitted on claims is accurate and complete, assures that the State Agency's requirements are met and assures compliance with all applicable Federal and State regulations. These agreements are renewed at least every 5 years with each provider.

(1) The provider further assures compliance with Section 1352, Title 31 of the U.S. Code and implemented at 45 CFR Part 93 which provides that if payments pursuant to services provided under Medicaid are expected to exceed \$100,000.00, the provider certifies federal funds have not been used nor will they be used to influence the making or continuation of the agreement to provide services under Medicaid. Upon request, the Authority will furnish a standard form to the provider for the purpose of reporting any non-federal funds used for influencing agreements.

(2) The provider assures in accordance with 31 USC 6101, Executive Order 12549, that they are not presently or have not in

the last three years been debarred, suspended, proposed for debarment or declared ineligible by any Federal department or agency.

(3) For information regarding Provider Agreements or for problems related to a current agreement, contact the Oklahoma Health Care Authority, Provider Enrollment, P.O. Box 54015, Oklahoma City, Oklahoma 73154, or call 1-800-522-0114 option 5 toll free or 405-522-6205 for the Oklahoma City area.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 29 Ok Reg 1073, eff 6-25-12]

317:30-3-2.1. Program Integrity Audits/Reviews

(a) This section applies to all contracted providers. The following words and terms, when used in this Section, shall have the following meaning:

(1) **"Contractor/provider"** means any person or organization that has signed a provider agreement with the Oklahoma Health Care Authority (OHCA).

(2) **"Error Rate"** means the percentage of dollars of audited claims found to be billed in error.

(3) **"Extrapolation"** means the methodology of estimating an unknown value by projecting, with a calculated precision (i.e., margin of error), the results of a probability sample to the universe from which the sample was drawn.

(4) **"Probability sample"** means the standard statistical methodology in which a sample is selected based on the theory of probability (a mathematical theory used to study the occurrence of random events).

(5) **"Sample"** means a statistically valid number of claims obtained from the universe of claims audited/reviewed.

(6) **"Universe"** means all paid claims or types of paid claims audited/reviewed during a specified timeframe.

(b) An OHCA audit/review includes an examination of provider records, by either an on-site or desk audit. Claims may be examined for compliance with provider contracts and/or relevant Federal and State laws and regulations, as well as for practices indicative of fraud, waste, and/or abuse of the SoonerCare program, including, but not limited to, inappropriate coding and consistent patterns of overcharging.

(c) An initial audit/review report contains preliminary findings. Within thirty (30) calendar days of the date of notice regarding the audit/review report, a provider may elect to:

(1) Remit the identified overpayment to the OHCA;

(2) Request informal reconsideration of the initial audit report pursuant to Oklahoma Administrative Code (OAC) 317:30-3-2.1(d); or

(3) Request a formal appeal of the initial audit report pursuant to OAC 317:30-3-2.1(e).

(d) If a provider requests an informal reconsideration, the provider, within thirty (30) calendar days of the date of notice of the audit/review report, shall:

(1) Produce any and all written existing documentation that is relevant to, and could reasonably be used to clarify or rebut, the findings identified in the initial report. Documents submitted for reconsideration shall not be altered or created for purposes of the audit; and

(2) Specifically identify those claims and findings to be reviewed for reconsideration. Any claims or findings not specifically identified by the provider for reconsideration will be deemed to have been waived by the provider for purposes of both the informal reconsideration and the formal appeal, if requested. The reconsideration findings will replace the initial findings and be identified as the final audit report.

(e) A request for an informal reconsideration does not limit a provider's right to a formal appeal as long as any formal appeal of the final audit report is received by the OHCA Legal Docket Clerk within thirty (30) calendar days of the date of notice of the final audit report. However, all claims and findings not specifically identified by the provider upon an informal reconsideration request will be deemed to have been waived by the provider for purposes of a subsequent formal audit appeal. Additionally, the provider must specifically identify each claim to be contested on appeal, and any remaining appealable claim that has not already been waived during the informal reconsideration and is not specifically identified in the initial appeal filing, will be deemed waived on appeal.

(f) If the provider does not request either an informal reconsideration or a formal appeal within the specified timeframe, the initial report will become the final audit report and the provider will be obligated to reimburse OHCA for any identified overpayment, which amount shall be immediately due and payable to OHCA. OHCA may, at its discretion, withhold the overpayment amount from the provider's future payments.

(g) When OHCA conducts a probability sample audit, the sample claims are selected on the basis of recognized and generally accepted sampling methods. If an audit reveals an error rate exceeding ten percent (10%), OHCA shall extrapolate the error rate to the universe of the dollar amount of the audited paid claims.

(1) When using statistical sampling, OHCA uses a sample that is sufficient to ensure a minimum confidence level of ninety-five percent (95%).

(2) When calculating the amount to be recovered, OHCA ensures that all overpayments and underpayments reflected in the probability sample are totaled and extrapolated to the universe from which the sample was drawn.

(3) OHCA does not consider non-billed services or supplies when calculating underpayments and overpayments.

(h) If a probability sample audit reveals an error rate of ten percent (10%) or less, the provider will be required to reimburse OHCA for any overpayments noted during the audit/review.

[Source: Added at 22 Ok Reg 155, eff 10-6-04 (emergency); Added at 21 Ok Reg 2457, eff 7-11-05 ; Amended at 27 Ok Reg 2735, eff 7-20-10 (emergency); Amended at 28 Ok Reg 1391, eff 6-25-11 ; Amended at 33 Ok Reg 795, eff 9-1-16 ; Amended at 34 Ok Reg 622, eff 9-1-17 ; Amended at 36 Ok Reg 864, eff 9-1-19]

317:30-3-3. Group billings

(a) A group/corporation is a business entity under which one or more individual providers practice. A group does not require multiple professional providers. A single provider group is a valid group and would be identified by the business entity name. Providers who are in group affiliations and providers who are incorporated under a Federal Employer Identification Number (FEIN) may be paid as a group or corporation. Unless otherwise notified, payments will be issued to a provider as an independent provider, under the personal Social Security Number. To be paid as a group/corporation, or under the Federal Employer Identification Number, providers must contact OHCA to secure a contract for group/corporation billing. It will be the responsibility of the group/corporation to notify the OHCA of changes when a provider leaves or enters the group/corporation affiliation.

(b) A clinic is a facility or distinct part of a facility used for the diagnosis and treatment of outpatients. Clinics are limited to organizations serving specialized treatment requirements or distinct groups. Clinics are specific to specialized provider types as approved by the OHCA. Clinics must have a specialized current contract with the OHCA. Clinic services are covered under 317:30-5-575 through 317:30-5-578.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 28 Ok Reg 1394, eff 6-25-11]

317:30-3-3.1. Medicaid Income Deferral Program [REVOKED]

[Source: Added at 19 Ok Reg 325, eff 11-14-01 (emergency); Added at 19 Ok Reg 1067, eff 5-13-02 ; Amended at 19 Ok Reg 2937, eff 7-16-02 (emergency); Amended at 20 Ok Reg 1193, eff 5-27-03 ; Revoked at 40 Ok Reg 2172, eff 9-11-23]

317:30-3-4. Electronic fund transfer/direct deposit

Providers must accept Medicaid reimbursement via Electronic Fund Transfer/Direct Deposit. These payments are deposited electronically by the State Treasurer to the financial institution the provider designates during the electronic enrollment process. Providers may change the designated financial institution by submitting an update through the electronic enrollment process, subject to OHCA acceptance.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 31 Ok Reg 1628, eff 9-12-14]

317:30-3-4.1. Uniform Electronic Transaction Act

These rules regulate the format, use, and retention of electronic records and signatures generated, sent, communicated, received, or stored by the Oklahoma Health Care Authority (OHCA), in conformity with the Uniform Electronic Transaction Act, found at Section 15-101 et seq. of Title 12A of the Oklahoma Statutes.

(1) **Use of electronic records and electronic signatures.** The rules regarding electronic records and electronic signatures apply when both parties agree to conduct business electronically.

Nothing in these regulations requires parties to conduct business electronically. However, should a party have the capability and desire to conduct business electronically with the OHCA, then the following guidelines must be adhered to:

(A) Only employees designated by the provider's agency may make entries in the member's medical record. All entries in the member's medical record must be dated and authenticated with a method established to identify the author. The identification method may include computer keys, Private/Public Key Infrastructure (PKIs), voice authentication systems that utilize a personal identification number (PIN) and voice authentication, or other codes. Providers must have a process in place to deactivate an employee's access to records upon termination of employment of the designated employee.

(B) When PKIs, computer key/code(s), voice authentication systems or other codes are used, a signed statement must be completed by the agency's employee documenting that the chosen method is under the sole control of the person using it and further demonstrate that:

- (i) A list of PKIs, computer key/code(s), voice authentication systems or other codes can be verified;
- (ii) All adequate safeguards are maintained to protect against improper or unauthorized use of PKIs, computer keys, or other codes for electronic signatures; and
- (iii) Sanctions are in place for improper or unauthorized use of computer key/code(s), PKIs, voice authentication systems or other code types of electronic signatures.

(C) There must be a specific action by the author to indicate that the entry is verified and accurate. Systems requiring an authentication process include, but are not limited to:

- (i) Computerized systems that require the provider's employee to review the document online and indicate that it has been approved by entering a unique computer key/code capable of verification;
- (ii) A system in which the provider's employee signs off against a list of entries that must be verified in the member's records;
- (iii) A mail system that sends transcripts to the provider's employee for review;
- (iv) A postcard identifying and verifying the accuracy of the record(s) signed and returned by the provider's employee; or
- (v) A voice authentication system that clearly identifies the author by a designated PIN or security code.

(D) Auto-authentication systems that authenticate a report prior to the transcription process do not meet the stated requirements and will not be an acceptable method for the authentication process.

(E) The authentication of an electronic medical record (signature and date entry) is expected on the day the record is completed. If the electronic medical record is transcribed by someone other than the provider, the signature of the rendering provider and date entry is expected within three (3) business days from the day the record is completed. Before any claim is submitted to the OHCA for payment of a provided service, the provider must authenticate the electronic medical records relating to that service.

(F) Records may be edited by designated administrators within the provider's facility. Edits must be in the form of a correcting entry which preserves entries from the original record. Edits must be completed prior to claims submission or no later than forty-five (45) days after the date of service, whichever occurs first.

(G) Use of the electronic signature, for clinical documentation, shall be deemed to constitute a signature and will have the same effect as a written signature on the clinical documentation. The section of the electronic record documenting the service provided must be authenticated by the employee or individual who provided the described service.

(H) Any authentication method for electronic signatures must:

- (i) be unique to the person using it;
- (ii) identify the individual signing the document by name and title;
- (iii) be capable of verification, assuring that the documentation cannot be altered after the signature has been affixed;
- (iv) be under the sole control of the person using it;
- (v) be linked to the data in such a manner that if the data is changed, the signature is invalidated; and
- (vi) provide strong and substantial evidence that will make it difficult for the signer to claim that the electronic representation is not valid.

(I) Failure to properly maintain or authenticate medical records (i.e., signature and date entry) may result in the denial or recoupment of SoonerCare payments.

(2) **Record retention for provider medical records.** Providers must retain electronic medical records and have access to the records in accordance with guidelines found at OAC 317:30-3-15.

(3) **Record retention for documents submitted to OHCA electronically.**

(A) The OHCA's system provides that receivers of electronic information may both print and store the electronic information they receive. The OHCA is the custodian of the original electronic record and will retain that record in accordance with a disposition schedule as referenced by the Records Destruction Act. The OHCA will retain an authoritative copy of the transferable record as described in the Electronic Transaction Act that is unique, identifiable and unalterable.

(i) **Manner and format of electronic signature.**

The manner and format required by the OHCA will vary dependent upon whether the sender of the document is a member or a provider. In the limited case where a provider is a client, the manner and format is dependent upon the function served by the receipt of the record. In the case the function served is a request for services, then the format required is that required by a recipient. In the case the function served is related to payment for services, then the format required is that required by a provider.

(ii) **Member format requirements.** The OHCA will allow members to request SoonerCare services electronically. An electronic signature will be authenticated after a validation of the data on the form by another database or databases.

(iii) **Provider format requirements.** The OHCA will permit providers to contract with the OHCA, check and amend claims filed with the OHCA, and file prior authorization requests with the OHCA. Providers with a social security number or federal employer's identification number will be given a PIN. After using the PIN to access the database, a PIN will be required to transact business electronically.

(B) Providers with the assistance of the OHCA will be required to produce and enforce a security policy that outlines who has access to their data and what transaction employees are permitted to complete as outlined in the policy rules for electronic records and electronic signatures contained in paragraph two (2) of this section.

(C) Third Party billers for providers will be permitted to perform electronic transaction as stated in paragraph two (2) only after the provider authorizes access to the provider's PIN and a power of attorney by the provider is executed.

(4) **Time and place of sending and receipt.** The provisions of the Electronic Transaction Act apply to the time and place of sending and receipt. Should a power failure, internet interruption or internet virus occur, confirmation by the receiving party will be required to establish receipt.

(5) **Illegal representations of electronic transaction.** Any person who fraudulently represents facts in an electronic transaction, acts without authority, or exceeds his or her authority to perform an electronic transaction may be prosecuted under all applicable criminal and civil laws.

[Source: Added at 19 Ok Reg 326, eff 11-14-01 (emergency); Added at 19 Ok Reg 1067, eff 5-13-02 ; Amended at 23 Ok Reg 2461, eff 6-25-06 ; Amended at 28 Ok Reg 1403, eff 6-25-11 ; Amended at 33 Ok Reg 797, eff 9-1-16 ; Amended at 34 Ok Reg 622, eff 9-1-17 ; Amended at 35 Ok Reg 113, eff 10-6-17 (emergency); Amended at 35 Ok Reg 1385, eff 9-14-18]

317:30-3-5. Assignment and cost sharing

(a) **Definitions.** The following words and terms, when used in subsection (c) of this Section, shall have the following meaning, unless the context clearly indicates otherwise:

(1) **"Fee-for-service (FFS) contract"** means the provider agreement specified in Oklahoma Administrative Code (OAC) 317:30-3-2. This contract is the contract between the Oklahoma Health Care Authority (OHCA) and medical providers which provides for a fee with a specified service involved.

(2) **"Outside of the scope of the services"** means all medical benefits outside the set of services defined at OAC 317:25-7 and the provisions of the SoonerCare Choice contracts in the SoonerCare program.

(3) **"Within the scope of services"** means the set of covered services defined at OAC 317:25-7 and the provisions of the SoonerCare Choice contracts in the SoonerCare program.

(b) **Assignment in FFS.** Oklahoma's Medicaid State Plan provides that participation in the medical program is limited to providers who accept, as payment in full, the amounts paid by OHCA plus any deductible, coinsurance, or co-payment required by the State Plan to be paid by the member and make no additional charges to the member or others.

(1) OHCA presumes acceptance of assignment upon receipt of an assigned claim. This assignment, once made, cannot be rescinded, in whole or in part by one party, without the consent of the other party.

(2) Once an assigned claim has been filed, the member must not be billed and the member is not responsible for any balance except the amount indicated by OHCA. The only amount a member may be responsible for is a co-payment, or the member may be responsible for services not covered under the medical programs. In any event, the member should not be billed for charges on an assigned claim until the claim has been adjudicated or other notice of action received by the provider. Any questions regarding amounts paid should be directed to OHCA, Provider Services.

(3) When potential assignment violations are detected, the OHCA will contact the provider to assure that all provisions of the assignment agreement are understood. When there are repeated or uncorrected violations of the assignment agreement, the OHCA is required to suspend further payment to the provider.

(c) **Assignment in SoonerCare.** Any provider who holds a FFS contract and also executes a contract with a provider in the SoonerCare Choice program must adhere to the rules of this subsection regarding assignment.

(1) If the service provided to the member is outside of the scope of the services outlined in the SoonerCare contract, then the provider may bill or seek collection from the member.

(2) In the event there is a disagreement whether the services are in or out of the scope of the contracts referenced in (1) of this subsection, the OHCA shall be the final authority for this decision.

(3) Violation of this provision shall be grounds for a contract termination in the FFS and SoonerCare programs.

(d) **Cost sharing/co-payment.** Section 1902(a)(14) of the Social Security Act permits states to require certain members to share some of the costs of SoonerCare by imposing upon them such payments as enrollment fees, premiums, deductibles, coinsurance, co-payments, or similar cost sharing charges. OHCA requires a co-payment of some SoonerCare members for certain medical services provided through the FFS program. A co-payment is a charge which must be paid by the member to the service provider when the service is covered by SoonerCare. Section 1916(e) of the Act requires that a provider participating in the SoonerCare program may not deny care or services to an eligible individual based on such individual's inability to pay the co-payment. A person's assertion of their inability to pay the co-payment establishes this inability. This rule does not change the fact that a member is liable for these charges, and it does not preclude the provider from attempting to collect the co-payment.

(1) Co-payment is not required of the following members:

(A) Individuals under age twenty-one (21). Each member's date of birth is available on the REVS system or through a commercial swipe card system.

(B) Members in nursing facilities (NF) and intermediate care facilities for individuals with intellectual disabilities (ICF/IID).

(C) Home and Community-Based Services (HCBS) waiver members except for prescription drugs.

(D) American Indian and Alaska Native members, per Section 5006 of the American Recovery and Reinvestment Act of 2009 and as established in the federally-approved Oklahoma Medicaid State Plan.

(E) Individuals who are categorically eligible for SoonerCare through the Breast and Cervical Cancer Treatment program.

(F) Individuals receiving hospice care, as defined in section 1905(o) of the Social Security Act.

(2) Co-payment is not required for the following services:

(A) Family planning services. This includes all contraceptives and services rendered.

(B) Emergency services provided in a hospital, clinic, office, or other facility.

(C) Services furnished to pregnant women.

- (D) Smoking and tobacco cessation counseling and products.
 - (E) Blood glucose testing supplies and insulin syringes.
 - (F) Medication-assisted treatment (MAT) drugs.
- (3) Co-payments are required in an amount not to exceed the federal allowable for the following:
- (A) Inpatient hospital stays.
 - (B) Outpatient hospital visits.
 - (C) Ambulatory surgery visits including free-standing ambulatory surgery centers.
 - (D) Encounters with the following rendering providers:
 - (i) Physicians;
 - (ii) Advanced practice registered nurses;
 - (iii) Physician assistants;
 - (iv) Optometrists;
 - (v) Home health agencies;
 - (vi) Certified registered nurse anesthetists;
 - (vii) Anesthesiologist assistants;
 - (viii) Durable medical equipment providers; and
 - (ix) Outpatient behavioral health providers.
 - (E) Prescription drugs.
 - (F) Crossover claims. Dually eligible Medicare/SoonerCare members must make a co-payment in an amount that does not exceed the federal allowable per visit/encounter for all Part B covered services. This does not include dually eligible HCBS waiver members.
- (4) Medicaid premiums and cost sharing incurred by all individuals in the Medicaid household may not exceed an aggregate limit of five percent (5%) of the family's income applied on a monthly basis, as specified by the agency.
- (5) Providers will be required to refund any co-payment amounts the provider collected from the member in error and/or above the family's aggregate cost sharing maximum.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 14 Ok Reg 3731, eff 9-18-97 (emergency); Amended at 15 Ok Reg 1528, eff 5-11-98 ; Amended at 16 Ok Reg 685, eff 12-28-98 (emergency); Amended at 16 Ok Reg 1429, eff 5-27-99 ; Amended at 16 Ok Reg 3413, eff 7-1-99 (emergency); Amended at 17 Ok Reg 1204, eff 5-11-00 ; Amended at 19 Ok Reg 532, eff 12-27-01 (emergency); Amended at 19 Ok Reg 2124, eff 6-27-02 ; Amended at 20 Ok Reg 374, eff 1-1-03 (emergency); Amended at 20 Ok Reg 1920, eff 6-26-03 ; Amended at 21 Ok Reg 2166, eff 6-25-04 ; Amended at 23 Ok Reg 239, eff 10-3-05 (emergency); Added at 23 Ok Reg 1346, eff 5-25-06 ; Amended at 27 Ok Reg 612, eff 1-14-10 (emergency); Amended at 27 Ok Reg 1427, eff 6-11-10 ; Amended at 28 Ok Reg 9, eff 8-13-10 (emergency); Amended at 28 Ok Reg 1405, eff 6-25-11 ; Amended at 29 Ok Reg 472, eff 5-11-12 ; Amended at 31 Ok Reg 646, eff 7-1-14 (emergency); Amended at 32 Ok Reg 1023, eff 8-27-15 ; Amended at 34 Ok Reg 610, eff 9-1-17 ; Amended at 37 Ok Reg 510, eff 1-6-20 (emergency); Amended at 37 Ok Reg 1479, eff 9-14-20 ; Amended at 38 Ok Reg 962, eff 9-1-21 ; Amended at 38 Ok Reg 962, eff 9-1-21 (emergency); Amended at 39 Ok Reg 1452, eff 9-12-22]

317:30-3-5.1. Usual and customary fees

(a) Providers are required to indicate their usual and customary charge when submitting claims to SoonerCare. The usual and customary charge is the provider's charge for providing the same service to persons not entitled to SoonerCare benefits. For providers using a sliding fee scale, the usual and customary charge is the one that best represents the most

frequently charged amount by the individual provider for the service when provided to non-SoonerCare members. Providers that do not have an established usual and customary charge indicate an amount reasonably related to the provider's cost for providing the service.

(b) Providers may not charge SoonerCare a higher fee than they charge non-SoonerCare patients even if the SoonerCare allowable is greater than the provider's usual and customary fee. Unless otherwise permitted by SoonerCare reimbursement methodology, individual claim payments are limited to the lesser of their usual and customary charge or the SoonerCare allowable.

(c) Providers indicate their usual and customary charge without deducting the co-payment for services that require a member co-payment. When applicable, the co-payment is systematically deducted.

(d) Payment is made based on the amount of the claim submitted, up to the maximum allowable amount.

[Source: Added at 24 Ok Reg 2059, eff 6-25-07 ; Amended at 26 Ok Reg 99, eff 10-1-08 (emergency); Amended at 26 Ok Reg 1059, eff 5-11-09]

317:30-3-6. Utilization review for physician/hospital services

The Surveillance and Utilization Review System (SURS) is used to help identify patterns of inappropriate care and services.

(1) Use of this system enables OHCA to develop a comprehensive profile of any aberrant pattern of practice and reveals suspected instances of fraud or abuse in the SoonerCare Program. Also, the Utilization Review program is a useful tool in detecting the existence of any potential defects in the level of care or service provided under the SoonerCare Program.

(2) OHCA contracts with a Quality Improvement Organization (QIO) to review the length of stay and appropriateness of hospital admissions. Unresolved patterns of non-compliance with medical criteria for admissions, outpatient procedures and length of stay will be referred to OHCA.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 25 Ok Reg 2633, eff 7-25-08]

317:30-3-7. Care assurance validation support review for long term care [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 18 Ok Reg 2557, eff 6-25-01]

317:30-3-8. Pre-billing

Any covered service performed by a medical provider must be billed only after the service has been provided. No service or procedure may be pre-billed.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95]

317:30-3-9. Medical services provided to relatives [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 18 Ok Reg 2565, eff 6-25-01]

317:30-3-10. Sales tax

Under paragraph (i), Section 1305 exemptions, Article 13, Title 68, O.S. 1981, sales to the State of Oklahoma are exempt from sales tax applicable in the State of Oklahoma.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95]

317:30-3-11. Timely filing limitation

(a) According to federal regulations, the Authority must require providers to submit all claims no later than 12 months from the date of service. Federal regulations provide no exceptions to this requirement. For dates of service provided on or after July 1, 2015, the timely filing limit, for SoonerCare reimbursement, is 6 months from the date of service. Payment will not be made on claims when more than 6 months have elapsed between the date the service was provided and the date of receipt of the claim by the Fiscal Agent. A denied claim can be considered proof of timely filing.

(b) Claims may be submitted anytime during the month.

(c) To be eligible for payment under SoonerCare, claims for coinsurance and/or deductible must meet the Medicare timely filing requirements. If a claim for payment under Medicare has been filed in a timely manner, the Fiscal Agent must receive a SoonerCare claim relating to the same services within 90 days after the agency or the provider receives notice of the disposition of the Medicare claim.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 19 Ok Reg 2126, eff 6-27-02 ; Amended at 32 Ok Reg 719, eff 7-1-15 (emergency); Amended at 33 Ok Reg 791, eff 9-1-16]

317:30-3-11.1. Resolution of claim payment

- (a) After the submission of a claim from a provider which had been adjudicated by the Authority, a provider may resubmit the claim under the following rules.
- (b) The provider must have submitted the claim initially under the timely filing requirements found at OAC 317:30-3-11.
- (c) For dates of service provided on or after July 1, 2015, the provider's resubmission of the claim must be received by the Oklahoma Health Care Authority no later than 12 months from the date of service. The only exceptions to the 12 month resubmission claim deadline are the following:
- (1) administrative agency corrective action or agency actions taken to resolve a dispute, or
 - (2) reversal of the eligibility determination, or
 - (3) investigation for fraud or abuse of the provider, or
 - (4) court order or hearing decision.

[Source: Added at 17 Ok Reg 3468, eff 8-31-00 (emergency); Added at 18 Ok Reg 1130, eff 5-11-01 ; Amended at 32 Ok Reg 719, eff 7-1-15 (emergency); Amended at 33 Ok Reg 791, eff 9-1-16]

317:30-3-12. Credits and adjustments

When an overpayment has occurred, the provider should immediately refund the Oklahoma Health Care Authority, by check, to the attention of the Finance Division, P.O. Box 18299, Oklahoma City, OK 73154. In refunding OHCA, be sure to clearly identify the account to which the money is to be applied. The MMIS system has the capability of automatic credits and debits. When an erroneous payment occurs, which results in an overpayment, an automatic recoupment will be made to the provider's account against monies owed to the provider. For more specific information, refer to the Oklahoma Medicaid Provider Billing Manual, Chapter 9: Paid Claim Adjustment Procedures.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 25 Ok Reg 2633, eff 7-25-08]

317:30-3-13. Advance directives

- (a) Effective December 1, 1991, the Omnibus Budget Reconciliation Act of 1990 (OBRA '90) requires certain Medicaid providers (hospitals, nursing facilities, hospices, home health agencies and non-technical medical care) to:
- (1) provide all adult Medicaid patients and residents with written information about their rights under Oklahoma law to make health care decisions, including the right to accept or refuse treatment and the right to execute advance directives;
 - (2) inform patients and residents about the provider's policy on implementing advance directives. The written information required by law must be given out by hospitals at the time of the individual's admission as an inpatient; by nursing facilities when the individual is admitted as a resident; by a home health agency or non-technical care provider in advance of an adult individual

receiving care; and by hospices at the time of initial receipt of hospice care;

(3) document in the patient's medical record whether he/she has signed an advance directive;

(4) not discriminate against an individual based on whether he/she has executed an advance directive; and

(5) provide staff and community education on advance directives.

(b) Out-of-state providers must comply with their respective state laws regarding advance directives.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95]

317:30-3-14. Freedom of choice

(a) **Any Qualified provider.** The Oklahoma Health Care Authority (OHCA) assures that any individual eligible for SoonerCare, may obtain services from any institution, agency, pharmacy, person, or organization that is contracted with OHCA and qualified to perform the services.

(b) **Member lock-in.** SoonerCare members who have demonstrated utilization above the statistical norm, during a 6-month period, may be "locked-in" to a prescriber and/or one pharmacy for medications classified as controlled dangerous substances in accordance with 42 CFR 431.54.

(1) Over-utilization patterns by SoonerCare members may be identified either by referral or by OHCA automated computer systems. SoonerCare records, for a 6-month period, of those identified members are then reviewed. Medical and pharmacy claim histories are reviewed by OHCA pharmacy consultants to determine if the member has unreasonably utilized SoonerCare provider and/or prescription services.

(2) If it is determined that SoonerCare has been over-utilized, the member may be notified, by letter, of the need to select a prescriber and/or pharmacy and of their opportunity for a fair hearing in accordance with OAC 317:2-1-2. If the member does not select a prescriber or pharmacy, one will be selected for the member.

(3) The prescriber and/or pharmacy of choice, unless the aforementioned providers have been identified as having problems with over-utilization, are notified by letter and given an opportunity to accept or decline to be the member's prescriber and/or pharmacy.

(4) When the provider accepts, a confirmation letter is sent to both member and provider showing the effective date of the arrangement.

(5) After the lock-in arrangement is made, the provider may file claims for services provided in accordance with OHCA guidelines.

(6) Locked-in members may obtain emergency services from an emergency room facility for an emergency medical condition or as part of an inpatient admission.

(7) If a claim for a controlled dangerous substance is filed by another pharmacy, the claim will be denied.

(8) A member placed in the lock-in program will remain in lock-in status for a minimum of 24 months. While in lock-in status, the member's usage shall be monitored periodically and shall be reviewed at the end of 24 months.

(9) Following a review, OHCA may elect to continue lock-in for an additional period of up to 24 months, remove the member from lock-in based upon medical necessity, or remove the member based upon program compliance. The member will be provided written notice of OHCA's decision and afforded an opportunity to appeal. OHCA retains the right at any time to impose sanctions in an appropriate case pursuant to OAC 317:35-13-7 or to take other appropriate action for abusive conduct.

(10) The member in the lock-in program may make a request to change providers after the initial three months; when the member moves to a different city or if the member feels irreconcilable differences will prevent necessary medical care. Change of providers based on irreconcilable differences must be approved by OHCA staff or contractor.

(11) OHCA may make a provider change when the provider makes a request for change or may initiate a change anytime it is determined necessary to meet program goals.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 14 Ok Reg 3077, eff 7-1-97 (emergency); Amended at 15 Ok Reg 1528, eff 5-11-98 ; Amended at 20 Ok Reg 2760, eff 5-26-03 (emergency); Amended at 21 Ok Reg 1322, eff 5-27-04 ; Amended at 32 Ok Reg 1025, eff 8-27-15 ; Amended at 33 Ok Reg 794, eff 9-1-16]

317:30-3-15. Record retention

Federal regulations and rules promulgated by the Oklahoma Health Care Authority Board require that the provider retain, for a period of six years, any records necessary to disclose the extent of services the provider, wholly owned supplier, or subcontractor, furnishes to recipients and, upon request, furnish such records to the Secretary of the Department of Health and Human Services. Records in a provider's office must contain adequate documentation of services rendered.

Documentation must include the dated provider's signature and credentials. The provider's signature must be handwritten or electronically submitted if the provider and the Oklahoma Health Care Authority have agreed to conduct transactions by electronic means pursuant to the Uniform Electronic Act. Electronic records and electronic signatures must be in accordance with guidelines found at OAC 317:30-3-4.1. Where reimbursement is based on units of time, it will be necessary that documentation be placed in the member's record as to the beginning and ending times for the service claimed. All records must be legible. Failure to maintain legible records may result in denial of payment or recoupment of payment for services provided when attempts to obtain transcription of illegible records is unsuccessful or the transcription of illegible records appears to misrepresent the services documented. The provider may, after one year from the date of service(s), microfilm or microfiche the records for the remaining five years, as long as the microfilm or microfiche is of a quality that assures that the records

remain legible. Electronic records are acceptable as long as they have a secured signature. Provider (other than individual practitioner) agrees to disclose, upon request, information relating to ownership or control, business transactions and criminal offenses involving any program under Title V of the Child Health Act or Titles, XVIII, XIX, XX, or XXI of the Federal Social Security Act.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 17 Ok Reg 2368, eff 6-26-00 ; Amended at 18 Ok Reg 2565, eff 6-25-01 ; Amended at 23 Ok Reg 2461, eff 6-25-06 ; Amended at 33 Ok Reg 797, eff 9-1-16]

317:30-3-16. Release of medical records

Providers must agree to furnish the medical information necessary for payment of a claim upon request by the Fiscal Agent or OHCA. A release of information for medical records is obtained at the time an application is made for medical assistance. The application specifically states: "For the purpose of determining whether any payment will be made in the behalf of the patient for any medical services, hereafter reported, I do hereby authorize the Authority, or any representative thereof, authorized for the purpose of determining compensability of claims in the patient's behalf, to inspect all hospital and medical records pertaining to such hospitalization or medical services; and I do further authorize the hospital, physician, or other medical provider to release and furnish to the Authority and its representatives, any information shown in such records".

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95]

317:30-3-17. Discrimination laws

The Oklahoma Health Care Authority has assured compliance with the regulations of the Department of Health and Human Services, Title 45, Code of Federal Regulations, Part 80 (which implements Public Law 88-352, Civil Rights Act of 1964, Section 601), Part 84 (which implements Public Law 93-112, Rehabilitation Act of 1973, Section 504), Part 90 (which implements Public Law 94-135, Age Discrimination Act of 1975, Section 301), Title 9 of the Education Amendments of 1972; and Executive Orders 11246 and 11375.

(1) These laws and regulations prohibit excluding from participation in, denying the benefits of, or subjecting to discrimination, under any program or activity receiving Federal Financial Assistance any person on the grounds of race, color, sex, national origin, and qualified person on the basis of handicap, or unless program-enabling legislation permits, on the basis of age. Under these requirements, payment cannot be made to vendors providing care and/or services under Federally-assisted programs conducted by the Authority unless such care and service is provided without discrimination on the grounds of race, color, sex, national origin or handicap or without distinction on the basis of age except as legislatively permitted or required.

(2) Written complaints of noncompliance with any of these laws should be made to the Chief Executive Officer of the Oklahoma Health Care Authority, 4345 North Lincoln Boulevard, Oklahoma City, Oklahoma 73105, or the Secretary of Health and Human Services, Washington, D.C., or both.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 34 Ok Reg 612, eff 9-1-17]

317:30-3-18. Criminal penalties

Section 1909 of the Social Security Act provides criminal penalties for providers or recipients who make false statements or representations or intentionally conceal facts in order to receive payments or benefits. These penalties apply to kickbacks, bribes or rebates to refer or induce purchase of Medicaid compensable services. The penalties also apply to individuals who knowingly and willfully charge for services to recipients an amount in excess of amounts established by the State.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95]

317:30-3-19. Administrative sanctions [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 15 Ok Reg 1083, eff 12-15-97 (emergency); Amended at 15 Ok Reg 1528, eff 5-11-98 ; Amended at 23 Ok Reg 771, eff 3-9-06 (emergency); Amended at 23 Ok Reg 2440, eff 6-25-06 ; Revoked at 34 Ok Reg 617, eff 9-1-17]

317:30-3-19.1. Revocation of enrollment and billing privileges in the Medicaid Program [REVOKED]

[Source: Added at 29 Ok Reg 1073, eff 6-25-12 ; Revoked at 34 Ok Reg 617, eff 9-1-17]

317:30-3-19.2. Denial of application for new or renewed provider enrollment contract based on criminal history [EXPIRED]

[Source: Added at 34 Ok Reg 187, eff 11-22-16 through 9-14-17 (emergency)¹]

Editor's Note: ¹*This emergency action expired without being superseded by a permanent action. Upon expiration of an emergency action enacting a new Section, the Section is no longer effective. Therefore, on 9-15-17 (after the 9-14-17 expiration of the emergency action), Section 317:30-3-19.2 was no longer effective. For the official text of the emergency rule that was effective from 11-22-16 through 9-14-17, see 34 Ok Reg 187.*

317:30-3-19.3. Denial of application for new or renewed provider enrollment contract

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

(1) "**Affiliates**" means persons having a relationship in which any of them directly or indirectly controls or has the ability to control one or more of the others.

(2) "**Applicant**" means providers and/or persons with a five percent or more direct or indirect ownership interest therein, as well as providers' officers, directors, and managing employees.

(3) "**Conviction**" or "**convicted**" means a person has been convicted of a criminal offense pursuant to 42 U.S.C. § 1320a-7(i), or, for civil offenses, has had a judgment of conviction entered against him or her by a Federal, State, or local court, regardless of whether an appeal from the judgment is pending.

(4) "**Person**" means any natural person, partnership, corporation, not-for-profit corporation, professional corporation, or other business entity.

(5) "**Provider**" means any person having or seeking to obtain a valid provider enrollment contract with the Oklahoma Health Care Authority (OHCA) for the purpose of providing services to eligible SoonerCare members and receiving reimbursement therefor.

(b) When deciding whether to approve an application for a new or renewed provider enrollment contract, OHCA may consider the following factors as they relate to the applicant and any of the applicant's affiliates, including, but not limited to:

(1) any false or misleading representation or omission of any material fact or information required or requested by OHCA as part of the application process;

(2) any failure to provide additional information to OHCA after receiving a written request for such additional information;

(3) any false or misleading representation or omission of any material fact in making application for any license, permit, certificate, or registration related to the applicant's profession or business in any State;

(4) any fine, termination, removal, suspension, revocation, denial, consented surrender, censure, sanction, involuntary invalidation of, or other disciplinary action taken against any license, permit, certificate, or registration related to the applicant's profession or business in any State;

(5) any previous or current involuntary surrender, removal, termination, suspension, ineligibility, exclusion, or otherwise involuntary disqualification from participation in Medicaid in any State, or from participation in any other governmental or private medical insurance program, including, but not limited to, Medicare and Workers' Compensation;

(6) any Medicaid or Medicare overpayment of which the applicant has been notified, as determined exclusively by OHCA that was received, but has not made reimbursement, unless such reimbursement is the subject of an OHCA reimbursement agreement that is not in default,;

(7) any previous failure to correct deficiencies in the applicant's business or professional operations after having received notice of the deficiencies from the OHCA or any State or Federal

licensing or auditing authority;

(8) any previous violation of any State or Federal statute or regulation that relates to the applicant's current or past participation in Medicaid, Medicare, or any other governmental or private medical insurance program;

(9) any pending charge or prior conviction of any civil or criminal offense relating to the furnishing of, or billing for, medical care, services, or supplies, or which is considered theft, fraud, or a crime involving moral turpitude;

(10) any pending charge or prior criminal conviction for any felony or misdemeanor offense that could reasonably affect patient care, including, but not limited to, those offenses listed in OAC 317:30-3-19.4;

(11) any denial of a new or renewed provider enrollment contract within the past two (2) years that was based on the applicant's or an affiliate's prior conduct;

(12) any submission of an application that conceals the involvement in the enrolling provider's operation of a person who would otherwise be ineligible to participate in Medicaid or Medicare;

(13) any business entity that is required to register with a State office or agency in order to conduct its operations therein, including, but not limited to, the Oklahoma Secretary of State, any failure to obtain and/or maintain a registration status that is valid, active, and/or in good standing; and

(14) any other factor that impacts the quality or cost of medical care, services, or supplies that the applicant furnishes to SoonerCare members, or otherwise influences the fiscal soundness, effectiveness, or efficiency of the OHCA program.

(c) OHCA shall provide any applicant who is denied a new or renewed provider enrollment contract a written notice of the denial. Any denial shall become effective on the date it is sent to the applicant.

(d) Any OHCA decision to deny a provider's contract application in accordance with this Section shall be a final agency decision that is not administratively appealable.

[Source: Added at 34 Ok Reg 617, eff 9-1-17]

317:30-3-19.4. Application fee, provider screening, and applicants subject to a fingerprint-based criminal background check

Pursuant to Subpart E of Part 455 of Title 42 of the Code of Federal Regulations (C.F.R.), an enrolling or re-enrolling SoonerCare provider must meet the screening requirements described in this rule and pay an application fee if required in the appendix to this rule. See Appendix A at the end of this chapter.

(1) Application fees. The amount of the application fee is the amount established by the Center for Medicare and Medicaid Services (CMS) in accordance with 42 United States Code § 1395cc (j)(2)(C)(i), adjusted for inflation.

(A) Per 42 C.F.R. § 455.460, the application fee shall not apply to the following providers:

- (i) Individual physician or non-physician practitioners;
- (ii) Providers who have enrolled or re-enrolled in Medicare, and have met the provider screening requirements and paid an application fee to CMS or its designee; and
- (iii) Providers who have enrolled or re-enrolled in another state's Medicaid or CHIP program, and have met the provider screening requirements and paid an application fee to the State Medicaid Agency or its designee.
- (iv) A provider must submit documentation to support any claim that it meets the exemption(s) described in paragraph (1)(A)(ii) and/or (1)(A)(iii) of this rule.

(B) The application fee will not be refunded if:

- (i) Enrollment or re-enrollment is denied as a result of failure to meet the provider screening requirements described in this rule; or
- (ii) Enrollment or re-enrollment is denied based on the results of the provider screening.

(2) Risk categories. Federal law requires the OHCA to screen all providers based on a categorical risk level of "limited," "moderate," or "high." If more than one risk level applies to a provider, the highest level of screening is required.

(A) Limited-risk screens include:

- (i) Verification that the provider meets any applicable federal regulations, or state requirements for the provider type;
- (ii) License verification, including state licensure verification in states other than Oklahoma; and
- (iii) Database checks, including, but not limited to, those required by 42 C.F.R. § 455.436.

(B) Moderate-risk screens include:

- (i) All limited-risk screening requirements; and
- (ii) Pre- and post-enrollment site visits by OHCA Provider Enrollment staff to confirm the accuracy of the provider's application and to determine compliance with federal and state enrollment requirements.
- (iii) Enrolled providers must permit the CMS, its agents, its designated contractors, or OHCA to conduct unannounced on-site inspections of any and all provider locations.

(C) High-risk screens include:

- (i) All limited-risk screening requirements;
- (ii) All moderate-risk screening requirements; and
- (iii) A fingerprint-based criminal background check of the provider, or of any person with a five percent

(5%) or more direct or indirect ownership interest in the provider.

(3) OHCA's risk categories. OHCA has adopted the same risk categories as have been established for Medicare providers in 42 C.F.R. § 424.518. For certain Medicaid providers that are not recognized under Medicare, risk categories have been set forth in OHCA's "Appendix A. Risk Levels for Providers," using criteria similar to that used for Medicare providers, in determining the risk of fraud, waste and abuse.

(4) Changes in risk categories. In accordance with 42 C.F.R. § 455.450(e), limited- and moderate-risk providers are moved to the high-risk category whenever:

- (A) OHCA imposes a payment suspension on a provider based on a credible allegation of fraud, waste or abuse;
- (B) The provider has an existing Medicaid overpayment;
- (C) The provider has been excluded by the Office of the Inspector General for the Department of Health and Human Services or any other state's Medicaid program within the previous ten (10) years; or
- (D) OHCA or CMS lifted a temporary moratorium for the particular provider type in the previous six (6) months and a provider that was prevented from enrolling based on the moratorium applies for enrollment within six (6) months from the date the moratorium was lifted.

(5) Fingerprint-based criminal background check. Any applicant subject to a fingerprint-based criminal background check as provided in subsection (2)(C)(iii) of this rule, shall be denied enrollment if he/she has a felonious criminal conviction and may be denied enrollment for a misdemeanor criminal conviction relating, but not limited, to:

- (A) The provision of services under Medicare, Medicaid, or any other Federal or State health care program;
- (B) Homicide, murder, or non-negligent manslaughter;
- (C) Aggravated assault;
- (D) Kidnapping;
- (E) Robbery;
- (F) Abuse, neglect, or exploitation of a child or vulnerable adult;
- (G) Human trafficking;
- (H) Negligence and/or abuse of a patient;
- (I) Forcible rape and/or sexual assault;
- (J) Terrorism;
- (K) Embezzlement, fraud, theft, breach of fiduciary duty, or other financial misconduct; and/or
- (L) Controlled substances, provided the conviction was entered within the preceding ten-year period.

(6) The appropriate screening based on screening risk level must be given to all service locations of an enrolled provider. Providers must disclose all service locations at time of enrollment and notify the agency of changes or additional service locations.

(7) In accordance with 42 C.F.R. § 455.452, the OHCA reserves the right to conduct additional screenings and background checks as is determined necessary.

(8) Any OHCA decision denying an application for contract enrollment based on the applicant's criminal history pursuant to Oklahoma Administrative Code 317:30-3-19.4 shall be a final agency decision that is not administratively appealable. However, nothing in this section shall preclude an applicant whose criminal conviction has been overturned on final appeal, and for whom no other appeals are pending or may be brought, from reapplying for enrollment.

[Source: Added at 34 Ok Reg 617, eff 9-1-17 ; Amended at 36 Ok Reg 858, eff 9-1-19]

317:30-3-19.5. Termination of provider agreements

Pursuant to the terms of the Oklahoma Health Care Authority's (OHCA) Standard Provider Agreement, both OHCA and a provider may terminate the agreement without cause on sixty (60) days' notice, or for-cause on thirty (30) days' notice. In addition, OHCA can terminate the agreement immediately in order to protect the health and safety of members, or upon evidence of fraud (including, but not limited to, a credible allegation of fraud as defined by 42 C.F.R. § 455.2). Conduct that may serve as a basis for a for-cause termination of a provider includes, but is not limited to, any of the following:

(1) **Noncompliance.** The provider is determined not to be in compliance with the enrollment requirements described in Oklahoma Administrative Code (OAC) 317:30-3-2 and 317:30-3-19.3, or in the enrollment application applicable for its provider type. OHCA may, but is not required to, request additional documentation from the provider to determine compliance.

(2) **Provider exclusion, debarment, or suspension.** The provider or any owner, managing employee, authorized or delegated official, medical director, supervising physician, or other health care personnel thereof is:

(A) Excluded from the Medicare, Medicaid, or any other Federal health care program, as defined in 42 C.F.R § 1001.2; or

(B) Debarred, suspended, or otherwise excluded from participating in any other Federal procurement or nonprocurement program or activity.

(3) **Convictions.** Conviction of the provider or any of its affiliates for a Federal or State offense that OHCA has determined to be detrimental to the best interests of the program and its members. Such offenses may include, but are not limited to, those offenses enumerated in OAC 317:30-3-19.3 and OAC 317:30-3-19.4.

(4) **False or misleading information.** The provider submitted or caused to be submitted misleading or false information on its enrollment application to be enrolled or to maintain enrollment in the SoonerCare program. In addition to termination of a contract, offenders may be referred for prosecution, which could result in

finances or imprisonment, or both, in accordance with current law and regulations.

(5) **On-site review.** OHCA determines, upon on-site review, that the provider is no longer operational, able to furnish SoonerCare covered items, or able to safely and adequately render services; or is not meeting SoonerCare enrollment requirements under statute or regulation to supervise treatment of, or to provide SoonerCare covered items or services for SoonerCare members.

(6) **Misuse of billing number.** The provider knowingly sells to or allows another individual or entity to use its billing number. This does not include those providers who enter into a valid reassignment of benefits as specified in 42 U.S.C. § 1396a(a)(32) or a change of ownership as outlined in 42 C.F.R. § 455.104(c) (within thirty-five (35) days of a change in ownership).

(7) **Abuse of billing privileges.** The provider submits a claim or claims for services that reasonably could not have been rendered, or that do not accurately reflect those services actually rendered, to a specific individual on the date of service. These instances include, but are not limited to: upcoding; unbundling of services; services that are purportedly provided to a member who has died prior to the date of service; services that are purportedly provided on a date on which the directing physician or member is not in the State or country or is otherwise physically incapable of providing or receiving the service; or the equipment necessary for testing was not present where the testing is said to have occurred, or was incapable of operating correctly at the supposed time of testing.

(8) **Failure to report.** The provider did not comply with the reporting requirements specified in the SoonerCare Provider Agreement or any applicable State and/or Federal statutes or regulations, including without limitation, changes in the provider's licenses, certifications, and/or accreditations provided at the time of enrollment. Providers shall report and update a change in mailing address within fourteen (14) days of such change.

(9) **Failure to document or provide OHCA access to documentation.**

(A) The provider did not comply with the documentation or OHCA access requirements specified in the SoonerCare Provider Agreement.

(B) OHCA may suspend all SoonerCare payments to a provider who refuses or fails to produce for inspection those financial and other records as are required by 42 C.F.R. § 431.107 and the executed SoonerCare Provider Agreement, until such time as all requested records have been submitted to OHCA for review.

(10) **Adverse audit determinations.** The provider receives an adverse Program Integrity audit that demonstrates fraud, waste, abuse, and/or repeated failure or inability to comply with SoonerCare billing and provision of service requirements.

[Source: Added at 34 Ok Reg 617, eff 9-1-17 ; Amended at 36 Ok Reg 863, eff 9-1-19]

317:30-3-19.6. Complaints related to the Defunding Statutory Rape Cover-up Act

(a) In accordance with Title 56 of the Oklahoma Statutes (O.S.) § 1007.4, the Oklahoma Health Care Authority (OHCA) shall investigate complaints made pursuant to the Defunding Statutory Rape Cover-up Act that are submitted in writing to OHCA's Legal Division, and that include:

- (1) The name and contact information of the person submitting the complaint;
- (2) The name of the health care provider and/or affiliate, as that term is defined by 56 O.S. § 1007.1, who is alleged:
 - (A) To have been found by a court of law to have failed to report statutory rape; or
 - (B) To have failed to report statutory rape where the statutory rape resulted in a conviction against the assailant;
- (3) The name of the SoonerCare member who allegedly was the victim of statutory rape (if the member is an adult), or of the member's parent(s) or legal guardian (if the member is a minor); and
- (4) A short summary of any other relevant information.

(b) A complaint made pursuant to the Defunding Statutory Rape Cover-up Act may result in a denial of an application for a new or renewed provider enrollment contract, pursuant to Oklahoma Administrative Code (OAC) 317:30-3-19.3, or termination of an existing provider agreement, pursuant to OAC 317:30-3-19.5.

(c) A complaint made pursuant to the Defunding Statutory Rape Cover-up Act may also result in a referral to local law enforcement authorities, where appropriate.

[Source: Added at 37 Ok Reg 1478, eff 9-14-20]

317:30-3-20. Claim inquiry procedures (excluding nursing homes and hospitals)

A medical provider may request a review of the amount paid or the non-payment of medical services provided to an eligible member. If the medical provider does not agree with the adjudication of the original claim, he/she may submit an electronic request for review on the Oklahoma Health Care Authority (OHCA) provider portal in accordance with the instructions in the Provider Billing and Procedures Manual, available on OHCA's website, www.okhca.org. Documentation, including but not limited to, supporting medical documentation and/or proof of timely filing as outlined in Oklahoma Administrative Code (OAC) 317:30-3-11, must be included with each submission.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 13 Ok Reg 3585, eff 7-16-96 (emergency); Amended at 14 Ok Reg 1780, eff 5-27-97 ; Amended at 15 Ok Reg 3784, eff 7-1-98 (emergency); Amended at 16 Ok Reg 1429, eff 5-27-99 ; Amended at 23 Ok Reg 771, eff 3-9-06 (emergency); Amended at 23 Ok Reg 2440, eff 6-25-06 ; Amended at 33 Ok Reg 797, eff 9-1-16 ; Amended at 37 Ok Reg 1482, eff 9-14-20]

317:30-3-20.1. Pharmacy grievance procedures and processes [REVOKED]

[Source: Added at 21 Ok Reg 2459, eff 7-11-05 ; Revoked at 28 Ok Reg 1393, eff 6-25-11]

317:30-3-21. Appeals procedures for nursing facilities

Appeal procedures for denial, failure to renew, or termination of a nursing facility agreement are described at OAC317:30-5-124(h). The Oklahoma State Department of Health, by agreement, continues to be responsible for hearings for licensure and certification as the survey agency.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 13 Ok Reg 3585, eff 7-16-96 (emergency); Amended at 14 Ok Reg 1780, eff 5-27-97 ; Amended at 15 Ok Reg 3784, eff 7-1-98 (emergency); Amended at 16 Ok Reg 1429, eff 5-27-99 ; Amended at 23 Ok Reg 771, eff 3-9-06 (emergency); Amended at 23 Ok Reg 2440, eff 6-25-06 ; Amended at 34 Ok Reg 626, eff 9-1-17]

317:30-3-22. Hospital reimbursement rate appeals [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 13 Ok Reg 3585, eff 7-16-96 (emergency); Amended at 14 Ok Reg 1780, eff 5-27-97 ; Revoked at 15 Ok Reg 3784, eff 7-1-98 (emergency); Revoked at 16 Ok Reg 1429, eff 5-27-99]

317:30-3-23. Reconsideration request

If the QIO, upon their initial review determines the admission should be denied, a notice is issued to the facility and the attending physician advising them of the decision and advising them that a reconsideration request may be submitted in accordance with the Medicare time frame. Additional information submitted with the reconsideration request will be reviewed by the QIO who utilizes an independent physician advisor. If the denial decision is upheld through this reconsideration review of additional information, OHCA is informed. At that point OHCA sends a letter to the hospital and physician requesting a refund of the SoonerCare payment previously made on the denied admission. The member is not responsible for denied charges.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 25 Ok Reg 2633, eff 7-25-08]

317:30-3-24. Third party liability

As the Medicaid Agency, the Oklahoma Health Care Authority (OHCA) is the payer of last resort, with few exceptions. When other resources are available, those resources must first be utilized. Exceptions to this policy are those receiving medical treatment through Indian Health Services and those eligible for the Crime Victims Compensation Act. Guidance for third party liability under the Insure Oklahoma program is found in Oklahoma Administrative Code (OAC) 317:45, Insure Oklahoma.

(1) If a member has coverage by an absent parent's insurance program or any other policy holder, that insurance resource must

be used prior to filing a SoonerCare claim. This includes Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO) and any other insuring arrangements that provide a member access to healthcare. Members must comply with all requirements of their primary insurance as well as SoonerCare requirements in order to take advantage of both coverages. For example, a member must comply with the network restrictions of both the primary and SoonerCare plans as well as prior authorization requirements. If the member does not comply with the requirements of the primary plan, he/she will be responsible for the charges incurred. Denials by private insurance companies because the member did not secure a preauthorization or use a participating provider is not a sufficient reason for SoonerCare to make payment. If the provider is aware of private insurance or liability, a claim must first be filed with that source. When private insurance information is known to the OHCA, the eligibility verification system will reflect that information. If payment is denied by the primary insurance, except as stated above, the provider must attach the Explanation of Benefits (EOB), stating the reason for the denial, to the claim submitted to the Fiscal Agent. When payment is received from another source, that payment amount must be reflected on the claim form.

(2) It is possible that other resources are available but are unknown to OHCA. Providers will routinely question SoonerCare members to determine whether any other resources are available. In some instances, coverage may not be obvious, for example, the member may be covered by a policy on which he/she is not the subscriber (e.g., a child whose absent parent maintains medical and hospital coverage).

(3) If the provider receives payment from another source after OHCA has made payment, it is necessary that the provider reimburse OHCA for the SoonerCare payment. The provider may retain the primary insurance payment, if any, that represents payment for services that are not covered services under SoonerCare. By accepting the OHCA's payment, the provider agrees to accept it as payment in full and, therefore, cannot retain any portion of other resource money as payment for reduced charges on covered services. Other than SoonerCare copayments, a provider cannot bill a member for any unpaid portion of the bill or for a claim that is not paid because of provider administrative error. If, after reimbursing OHCA and retaining a portion of the other payment in satisfaction of any non-covered services there is money remaining, it must be refunded to the member.

(4) If a member is covered by a private health insurance policy or plan, he/she is required to inform medical providers of the coverage, including:

- (A) provision of applicable policy numbers;
- (B) assignment payments to medical providers;
- (C) provision of information to OHCA of any coverage changes; and

(D) release of money received from a health insurance plan to the provider if the provider has not already received payment or to the OHCA if the provider has already been paid by the OHCA.

(5) Members are responsible for notifying their providers of the intent to make application for SoonerCare coverage and of any retroactive eligibility determinations. Members may be responsible for any financial liability if they fail to notify the provider of the eligibility determinations and as a result, the provider is unable to secure payment from OHCA.

(6) Members must present evidence of any other health insurance coverage to a medical provider each time services are requested. Members may be responsible for any financial liability if they fail to furnish the necessary information before the receipt of services and as a result, the provider is unable to secure payment from OHCA.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 16 Ok Reg 685, eff 12-28-98 (emergency); Amended at 16 Ok Reg 1429, eff 5-27-99 ; Amended at 27 Ok Reg 293, eff 11-3-09 (emergency); Amended at 27 Ok Reg 929, eff 5-13-10 ; Amended at 27 Ok Reg 2736, eff 7-20-10 (emergency); Amended at 28 Ok Reg 1395, eff 6-25-11 ; Amended at 35 Ok Reg 1382, eff 9-14-18]

317:30-3-25. Crossovers (deductibles, coinsurance, and copays)

(a) **Medicare Part A.** Payment is made for Medicare deductibles, coinsurance, and copays on behalf of eligible individuals according to the methodology outlined in the Oklahoma Medicaid State Plan.

(b) **Medicare Part B.** Payment is made for Medicare deductibles, coinsurance, and copays on behalf of eligible individuals according to the methodology outlined in the Oklahoma Medicaid State Plan.

(c) **Medicare Part C (Medicare Advantage Plans).** Payment is made for Medicare deductibles, coinsurance, and copays on behalf of eligible individuals according to the methodology outlined in the Oklahoma Medicaid State Plan.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 18 Ok Reg 107, eff 11-1-00 (emergency); Amended at 18 Ok Reg 1130, eff 5-11-01 ; Amended at 19 Ok Reg 2922, eff 7-1-02 (emergency); Amended at 20 Ok Reg 1193, eff 5-27-03 ; Amended at 21 Ok Reg 2175, eff 6-25-04 ; Amended at 23 Ok Reg 2460, eff 6-25-06 ; Amended at 26 Ok Reg 248, eff 12-1-08 (emergency); Amended at 26 Ok Reg 1052, eff 5-11-09 ; Amended at 30 Ok Reg 371, eff 1-28-13 (emergency); Amended at 30 Ok Reg 1123, eff 7-1-13 ; Amended at 38 Ok Reg 189, eff 11-2-20 (emergency); Amended at 38 Ok Reg 964, eff 9-1-21]

317:30-3-26. Medicare Physician Payment Reform methodology [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 21 Ok Reg 2175, eff 6-25-04]

317:30-3-27. Telehealth

(a) **Definitions.** The following words and terms, when used in this Section, shall have the following meaning, unless the context clearly indicates otherwise.

(1) **"Remote patient monitoring"** means the use of digital technologies to collect medical and other forms of health data (e.g. vital signs, weight, blood pressure, blood sugar) from individuals in one (1) location and electronically transmit that information securely to health care providers in a different location for assessment and recommendations.

(2) **"School-based services"** means medically necessary health-related and rehabilitative services that are provided by a qualified school provider to a student under the age of twenty-one (21), pursuant to an Individualized Education Program (IEP), in accordance with the Individuals with Disabilities Education Act. See Oklahoma Administrative Code (OAC) 317:30-5-1020.

(3) **"Store and forward technologies"** means the transmission of a patient's medical information from an originating site to the health care provider at the distant site; provided, photographs visualized by a telecommunications system shall be specific to the patient's medical condition and adequate for furnishing or confirming a diagnosis or treatment plan. Store and forward technologies shall not include consultations provided by telephone audio-only communication, electronic mail, text message, instant messaging conversation, website questionnaire, nonsecure video conference, or facsimile transmission.

(4) **"Telehealth"** means the practice of health care delivery, diagnosis, consultation, evaluation and treatment, transfer of medical data or exchange of medical education information by means of a two-way, real-time interactive communication, not to exclude store and forward technologies, between a patient and a health care provider with access to and reviewing the patient's relevant clinical information prior to the telemedicine visit. Telehealth shall not include consultations provided by telephone audio-only communication, electronic mail, text message, instant messaging conversation, website questionnaire, nonsecure video conference, or facsimile transmission.

(5) **"Telehealth medical service"** means, for the purpose of the notification requirements of OAC 317:30-3-27(d)(2), telehealth services that expressly do not include physical therapy, occupational therapy, and/or speech and hearing services.

(b) **Applicability and scope.** The purpose of this Section is to implement telehealth policy that improves access to health care services, while complying with all applicable state and federal laws and regulations. Telehealth services are not an expansion of SoonerCare-covered services, but an option for the delivery of certain covered services. However, if there are technological difficulties in performing an objective, thorough medical assessment, or problems in the member's understanding of telehealth, hands-on-assessment and/or in-person care must be provided for the member. Any service delivered using telehealth technology must be appropriate for telehealth delivery and be of the same quality and otherwise on par with the same service delivered in person. A telehealth encounter must maintain the confidentiality and security of protected health information in accordance with applicable state and federal law, including, but not limited to, 42 Code of Federal Regulations (CFR) Part

2, 45 CFR Parts 160 and 164, and 43A Oklahoma Statutes (O.S.) § 1-109. For purposes of SoonerCare reimbursement, telehealth is the use of interactive audio, video, or other electronic media for the purpose of diagnosis, consultation, or treatment that occurs in real-time and when the member is actively participating during the transmission.

(c) **Requirements.** The following requirements apply to all services rendered via telehealth.

(1) Interactive audio and video telecommunications must be used, permitting encrypted, real-time communication between the physician or practitioner and the SoonerCare member. The telecommunication service must be secure and adequate to protect the confidentiality and integrity of the telehealth information transmitted. As a condition of payment the member must actively participate in the telehealth visit.

(2) The telehealth equipment and transmission speed and image 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 telehealth visit need to be trained in the use of the telehealth equipment and competent in its operation.

(3) The medical or behavioral health related service must be provided at an appropriate site for the delivery of telehealth services. An appropriate telehealth site is one that has the proper security measures in place; the appropriate administrative, physical, and technical safeguards should be in place that ensures the confidentiality, integrity, and security of electronic protected health information. The location of the room for the encounter at both ends should ensure comfort, privacy, and confidentiality. Both visual and audio privacy are important, and the placement and selection of the rooms should consider this. Appropriate telehealth equipment and networks must be used considering factors such as appropriate screen size, resolution, and security. Providers and/or members may provide or receive telehealth services outside of Oklahoma when medically necessary; however, prior authorization may be required, per OAC 317:30-3-89 through 317:30-3-91.

(4) The provider must be contracted with SoonerCare and appropriately licensed or certified, in good standing. Services that are provided must be within the scope of the practitioner's license or certification. If the provider is outside of Oklahoma, the provider must comply with all laws and regulations of the provider's location, including health care and telehealth requirements.

(5) If the member is a minor, the provider must obtain the prior written consent of the member's parent or legal guardian to provide services via telehealth, that includes, at a minimum, the name of the provider; the provider's permanent business office address and telephone number; an explanation of the services to be provided, including the type, frequency, and duration of services. Written consent must be obtained annually, or whenever

there is a change in the information in the written consent form, as set forth above. The parent or legal guardian need not attend the telehealth session unless attendance is therapeutically appropriate. The requirements of subsection OAC 317:30-3-27(c) (5), however, do not apply to telehealth services provided in a primary or secondary school setting.

(6) If the member is a minor, the telehealth provider shall notify the parent or legal guardian that a telehealth service was performed on the minor through electronic communication whether a text message or email.

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

(8) All telehealth activities must comply with Oklahoma Health Care Authority (OHCA) policy, and all other applicable State and Federal laws and regulations, including, but not limited to, 59 O.S. § 478.1.

(9) 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.

(10) There will be no dissemination of any member images or information to other entities without written consent from the member or member's parent or legal guardian, if the member is a minor.

(11) A telehealth service is subject to the same SoonerCare program restrictions, limitations, and coverage which exist for the service when not provided through telehealth; provided, however, that only certain telehealth codes are reimbursable by SoonerCare. For a list of the SoonerCare-reimbursable telehealth codes, refer to the OHCA's Behavioral Health Telehealth Services and Medical Telehealth Services, available on OHCA's website, www.okhca.org.

(12) Where there are established service limitations, the use of telehealth to deliver those services will count towards meeting those noted limitations. Service limitations may be set forth by Medicaid and/or other third party payers.

(d) Additional requirements specific to telehealth services in a school setting. In order for OHCA to reimburse medically necessary telehealth services provided to SoonerCare members in a primary or secondary school setting, all of the requirements in (c) above must be met, with the exception of (c)(5), as well as all of the requirements shown below, as applicable.

(1) **Consent requirements.** Advance parent or legal guardian consent for telehealth services must be obtained for minors, in accordance with 25 O.S. §§ 2004 through 2005. Additional consent requirements shall apply to school-based services provided pursuant to an IEP, per OAC 317:30-5-1020.

(2) **Notification requirements.** For telehealth medical services provided in a primary or secondary school setting, the telehealth practitioner must provide a summary of the service, including, but not limited to, information regarding the exam findings, prescribed or administered medications, and patient instructions, to:

- (A) The SoonerCare member, if he or she is an adult, or the member's parent or legal guardian, if the member is a minor; or
- (B) The SoonerCare member's primary care provider, if requested by the member or the member's parent or legal guardian.

(3) **Requirements specific to physical therapy, occupational therapy, and/or speech and hearing services.** Even though physical therapy, occupational therapy, and/or speech and hearing services are not subject to the notification requirements of OAC 317:30-3-27(d)(2), said services must still comply with all other State and Federal Medicaid requirements, in order to be reimbursable by Medicaid. Accordingly, for those physical therapy, occupational therapy, and/or speech and hearing services that are provided in a primary or secondary school setting, but that are not school-based services (i.e., not provided pursuant to an IEP), providers must adhere to all state and federal requirements relating to prior authorization and prescription or referral, including, but not limited to, 42 C.F.R. § 440.110, OAC 317:30-5-291, 317:30-5-296, and 317:30-5-676.

(e) **Reimbursement.**

- (1) Health care services delivered by telehealth such as Remote Patient Monitoring, Store and Forward, or any other telehealth technology, must be compensable by OHCA in order to be reimbursed.
- (2) Services provided by telehealth must be billed with the appropriate modifier.
- (3) If the technical component of an X-ray, ultrasound or electrocardiogram is performed during a telehealth transmission, the technical component can be billed by the provider that provided that service. The professional component of the procedure and the appropriate visit code should be billed by the provider that rendered that service.
- (4) The cost of telehealth equipment and transmission is not reimbursable by SoonerCare.

(f) **Documentation.**

- (1) Documentation must be maintained by the rendering provider to substantiate the services rendered.
- (2) Documentation must indicate the services were rendered via telehealth, and the location of the services.
- (3) All other SoonerCare documentation guidelines apply to the services rendered via telehealth. 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.

(g) **Final authority.** The OHCA has discretion and the final authority to approve or deny any telehealth services based on agency and/or SoonerCare members' needs.

[Source: Added at 26 Ok Reg 249, eff 1-1-09 (emergency); Added at 26 Ok Reg 1053, eff 5-11-09 ; Amended at 26 Ok Reg 3025, eff 7-21-09 (emergency); Amended at 27 Ok Reg 931, eff 5-13-10 ; Amended at 28 Ok Reg 1397, eff 6-25-11 ; Amended at 30 Ok Reg 1124, eff 7-1-13 ; Amended at 32 Ok Reg 1026, eff 8-27-15 ; Amended at 34 Ok Reg 341, eff 12-29-16 (emergency); Amended at 34 Ok Reg 641, eff 9-1-17 ; Amended at 37 Ok Reg 211, eff 10-25-19 (emergency); Amended at 37 Ok Reg 1483, eff 9-14-20]

317:30-3-28. Oklahoma Electronic Health Records Incentive Program

(a) **Program.** The Oklahoma Electronic Health Records (EHR) Incentive Program is authorized by the American Recovery and Reinvestment Act of 2009. Under this program, SoonerCare providers may qualify for incentive payments if they meet the eligibility guidelines in this section and demonstrate they are engaged in efforts to adopt, implement, upgrade, or meaningfully use certified EHR technology. The Oklahoma EHR Incentive Program is governed by the policy in this section and the Electronic Health Records Program Final Rule issued by the Center for Medicare and Medicaid Services (CMS) in CMS-0033-F and Section 170 of Title 45 of the Code of Federal Regulations (C.F.R.). Providers should also use the EHR program manual as a reference for additional program details.

(b) **Eligible providers.** To qualify for incentive payments, a provider must be an "eligible professional" or an "eligible hospital." Providers who receive incentive payments must have an existing Provider Agreement with the Oklahoma Health Care Authority (OHCA).

(1) **Eligible professionals.** An eligible professional is defined as a physician, a physician assistant practicing in a Federally Qualified Health Center (FQHC) or Rural Health Center (RHC) led by a physician assistant, a board certified pediatrician, a nurse practitioner, a certified nurse midwife, or a dentist. OHCA will determine eligibility based on the provider type, specialty associated with the provider in the Medicaid Management Information System, and documentation.

(A) Eligible professionals may not be hospital-based, unless they practice predominantly at an FQHC or RHC as defined by the CMS final rule. A "hospital-based" professional furnishes ninety percent (90%) or more of their SoonerCare-covered professional services during the relevant EHR reporting period in a hospital setting, whether inpatient or Emergency Room, through the use of the facilities and equipment of the hospital. Specific exclusions to the "hospital-based" definition may be allowed by federal law and are detailed in the Oklahoma EHR Incentive Program provider manual.

(B) Eligible professionals may not participate in both the Medicaid and Medicare EHR incentive payment program during the same payment year.

(2) **Eligible hospitals.** Eligible hospitals are children's hospitals or acute care hospitals, including critical access hospitals and cancer hospitals. An acute care hospital is defined as a health care facility where the average length of patient stay is twenty-

five (25) days or fewer and that has a CMS certification number that has the last four (4) digits in the series 0001-0879 and 1300-1399. A children's hospital is defined as a separately certified children's hospital, either freestanding or hospital-within-hospital, that predominantly treats individuals under twenty-one (21) years of age and has a CMS certification number with the last four (4) digits in the series 3300-3399 or, if it does not have a CMS certification number, has been provided an alternative number by CMS for purposes of enrollment in the Medicaid EHR Incentive Program. Hospitals that do not meet either of the preceding definitions are not eligible for incentive payments.

(c) **Patient volume.** Eligible professionals and eligible hospitals must meet SoonerCare patient volume criteria to qualify for incentive payments. Patient volume criteria compliance will be verified by the OHCA through claims data and provider audits. When calculating SoonerCare patient volume, all SoonerCare populations may be counted. To calculate patient volume, the provider's total SoonerCare patient encounters in the specified reporting period must be divided by the provider's total patient encounters in the same reporting period.

(1) **Eligible professionals.** Eligible professionals must meet a thirty percent (30%) SoonerCare patient volume threshold over a continuous ninety-day (90-day) period in the preceding calendar year or the preceding twelve-month (12-month) period from the date of attestation. The only exception is for pediatricians, as discussed in Oklahoma Administrative Code (OAC) 317:30-3-28(c) (5).

(2) **Eligible hospitals.** With the exception of children's hospitals, which have no patient volume requirement, eligible hospitals must meet a ten percent (10%) SoonerCare patient volume threshold over a continuous ninety-day (90-day) period in the preceding federal fiscal year or over the preceding twelve-month (12-month) period from the date of attestation for which data are available prior to the payment year.

(3) **FQHC or RHC patient volume.** Eligible professionals practicing predominantly in a FQHC or RHC may be evaluated according to their "needy individual" patient volume. To qualify as a "needy individual," patients must meet one (1) of the following criteria:

- (A) Received medical assistance from SoonerCare;
- (B) Were furnished uncompensated care by the provider;
- or
- (C) Were furnished services at either no cost or reduced cost based on a sliding scale determined by the individual's ability to pay.

(4) **Clinics and group practices.** Clinics or group practices may calculate patient volume using the clinic's or group's SoonerCare patient volume under the following conditions:

- (A) The clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the eligible professional;

- (B) There is an auditable data source to support the patient volume determination;
- (C) All eligible professionals in the clinic or group practice use the same methodology for the payment year;
- (D) The clinic or group practice uses the entire practice's patient volume and does not limit patient volume in any way; and
- (E) If an eligible professional works inside and outside of the clinic or practice, the patient volume calculation includes only those encounters associated with the clinic or group practice, and not the eligible professional's outside encounters.

(5) **Pediatricians.** Pediatricians may qualify for 2/3 incentive payments if their SoonerCare patient volume is twenty to twenty-nine percent (20-29%). A pediatrician is defined as a medical doctor who diagnoses, treats, examines, and prevents diseases and injuries in children and possesses a valid, unrestricted medical license and board certification in Pediatrics through either the American Board of Pediatrics (ABP) or the American Osteopathic Board of Pediatrics (AOBP). To qualify as a pediatrician for the purpose of receiving a 2/3 payment under the incentive program, the provider must provide OHCA with a copy of their pediatric licenses and board certification.

(6) **Out-of-state patients.** For eligible professionals and eligible hospitals using out-of-state Medicaid recipients for patient volume requirement purposes, the provider must retain proof of the encounter for the out-of-state patient.

(d) **Attestation.** Eligible professionals and eligible hospitals must execute an amendment to their SoonerCare Provider Agreement to attest to meeting program criteria through the Electronic Provider Enrollment (EPE) system in order to qualify for incentive payments. Registration in the CMS EHR Incentive Payment Registration and Attestation system is a pre-requisite to EPE attestation. All required/supporting documentation, additional documentation requests, and/or attestation corrections must be submitted or completed within thirty (30) days of notification to avoid denial of the EHR attestation.

(e) **Adoption/ Implementation/ Upgrade (A/I/U).** Eligible professionals or eligible hospitals in their first participation year under the Oklahoma EHR Incentive Program may choose to attest to adopting, implementing, or upgrading certified EHR technology. Proof of A/I/U must be submitted to OHCA in order to receive payment.

(f) **Meaningful use.** Eligible professionals in their second through sixth participation year and eligible hospitals in their second through third participation year must attest to meaningful use of certified EHR technology. Eligible hospitals must attest to meaningful use if they are participating in both the Medicare and Oklahoma EHR Incentive Programs in their first participation year. The definition of "meaningful use" is outlined in, and determined by, the Electronic Health Records Program Final Rule CMS-0033-F.

(g) **Payment.** Eligible professionals may receive a maximum of \$63,750 in incentive payments over six (6) years. Providers must begin their

participation by 2016 to be eligible for payments. Payments will be made one (1) time per year per provider and will be available through 2021. Eligible hospitals cannot initiate payments after 2016 and payment years must be consecutive after 2016.

(1) Eligible professionals and eligible hospitals must use a Taxpayer Identification Number (TIN) to assign a valid entity as the incentive payments recipient. Valid entities may be the individual provider or a group with which the provider is associated. The assigned payee must have a current Provider Agreement with OHCA.

(2) The provider is responsible for repayment of any identified overpayment. In the event OHCA determines monies have been paid inappropriately, OHCA will recoup the funds by reducing any future payments owed to the provider.

(h) **Administrative appeals.** Administrative appeals of decisions related to the Oklahoma EHR Incentive Program will be handled under the procedures described in OAC 317:2-1-2(c). The only exception to this section is when CMS conducts meaningful use audits. Results of any adverse CMS audits are subject to the CMS administrative appeals process and not the state appeal process.

[Source: Added at 28 Ok Reg 264, eff 11-15-10 (emergency); Added at 28 Ok Reg 1407, eff 6-25-11 ; Amended at 30 Ok Reg 1127, eff 7-1-13 ; Amended at 36 Ok Reg 870, eff 9-1-19]

317:30-3-29. Revisions of provider fee schedules

(a) The Oklahoma Health Care Authority (OHCA) reserves the right to review and/or update and adjust provider fee schedules. Provider fee schedules will be reviewed annually and adjustments to the fee schedules may be made at any time based on efficiency, budget considerations, economy, and quality of care. The OHCA assures that all payments will be sufficient to enlist enough providers so that care and services are available under the State Plan at least to the extent that such care and services are available to the general population in the geographic area. The OHCA may issue revisions to provider fee schedules during the year that they are effective. Providers will be notified of any revisions to the fee schedule and the revision effective dates. Provider fee schedules, when reviewed and changed, are posted to the OHCA's website in relation to the current State Fiscal Year. The OHCA will adjust provider fee schedules to:

- (1) comply with changes in state or federal requirements;
- (2) comply with changes in nationally recognized coding systems, such as Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT);
- (3) establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year; and
- (4) adjust the allowable amount when the OHCA determines that the current allowable amount is:
 - (A) not appropriate for the service provided; or
 - (B) based on errors in data or calculation.

(b) The OHCA will provide public notice, unless specified below, of any significant proposed change in its methods and standards for setting provider payment rates for services. The OHCA will not provide notice if:

- (1) the change is being made to conform to Medicare methods or levels of reimbursement;
- (2) the change is required by a court order; or
- (3) the change is based on changes in wholesalers' or manufacturers' prices of drugs or materials.

[Source: Added at 28 Ok Reg 1399, eff 6-25-11]

317:30-3-30. Signature requirements

(a) For medical review purposes, the Oklahoma Health Care Authority (OHCA) requires that all services provided and/or ordered be authenticated by the author. The method used shall be a handwritten signature, electronic signature, or signature attestation statement. Stamped signatures are not acceptable. Pursuant to federal and/or state law, there are some circumstances for which an order does not need to be signed.

- (1) Facsimile of original written or electronic signatures are acceptable for the certifications of terminal illness for hospice.
- (2) Orders for clinical diagnostic tests are not required to be signed. If the order for the clinical diagnostic test is unsigned, there must be medical documentation by the treating physician that he/she intended the clinical diagnostic test be performed. This documentation showing the intent that the test be performed must be authenticated by the author via a handwritten or electronic signature.
- (3) Orders for outpatient prescription drugs are not required to be signed. If the order for a prescription drug is unsigned, there must be medical documentation by the treating physician that he/she intended that the prescription drug be ordered. This documentation showing the intent that the prescription drug be ordered must be authenticated by the author via a handwritten or electronic signature.

(b) A handwritten signature is a mark or sign by an individual on a document to signify knowledge, approval, acceptance, or obligation. The authentication of a medical record (signature and date entry) is expected on the day the record is completed. If the medical record is transcribed by someone other than the provider, the signature of the rendering provider and date entry is expected within three (3) business days from the day the record is completed. Before any claim is submitted to the OHCA for payment of a provided service, the provider must authenticate the medical records relating to that service.

- (1) If a signature is illegible, the OHCA will consider evidence in a signature log or attestation statement to determine the identity of the author of a medical record entry.
- (2) If the signature is missing from an order, the OHCA will disregard the order during the review of the claim.

- (3) If the signature is missing from any other medical documentation, the OHCA will accept a signature attestation from the author of the medical record entry.
- (c) Providers may include in the documentation they submit a signature log that lists the typed or printed name of the author associated with initials or an illegible signature.
- (1) The signature log may be included on the actual page where the initials or illegible signature are used or may be a separate document.
- (2) The OHCA will not deny a claim for a signature log that is missing credentials.
- (3) The OHCA will consider all submitted signature logs regardless of the date they were created.
- (d) Providers may include in the documentation they submit a signature attestation statement. In order to be considered valid for medical review purposes, an attestation statement must be signed and dated by the author of the medical record entry and must contain sufficient information to identify the member.
- (1) The OHCA will not consider signature attestation statements where there is no associated medical record entry.
- (2) The OHCA will not consider signature attestation statements from someone other than the author of the medical record entry in question.
- (3) The OHCA will consider all signature attestation statements that meet the above requirements regardless of the date the attestation was created, except in those cases where the regulations or rules indicate that a signature must be in place prior to a given event or a given date.
- (e) Providers may use electronic signatures as an alternate signature method.
- (1) Providers must use a system and software products which are protected against modification and must apply administrative procedures which are adequate and correspond to recognized standards and laws.
- (2) Providers utilizing electronic signatures bear the responsibility for the authenticity of the information being attested to.
- (3) Providers utilizing electronic signatures must comply with OAC 317:30-3-4.1.
- (f) Nothing in this section is intended to absolve the provider of their obligations in accordance with the conditions set forth in their SoonerCare contract and the rules delineated in OAC 317:30.

[Source: Added at 28 Ok Reg 1400, eff 6-25-11 ; Amended at 33 Ok Reg 797, eff 9-1-16 ; Amended at 34 Ok Reg 622, eff 9-1-17 ; Amended at 35 Ok Reg 113, eff 10-6-17 (emergency); Amended at 35 Ok Reg 1385, eff 9-14-18]

317:30-3-31. Prior authorization for health care-related goods and services

- (a) Under the SoonerCare program, there are health care-related goods and services that require prior authorization (PA) by the Oklahoma

Health Care Authority (OHCA). PA is a process to determine if a prescribed good or service is medically necessary; it is not, however, a guarantee of member eligibility or of SoonerCare payment. All goods or services requiring PA will be authorized on the basis of information submitted to OHCA, including:

(1) The relevant code, as is appropriate for the good or service requested (for example, Current Procedural Terminology (CPT) codes for services; Healthcare Common Procedure Coding System (HCPCS) codes, for durable medical equipment; or National Drug Codes (NDC), for drugs); and/or

(2) Any other information required by OHCA, in the format as prescribed. The OHCA authorization file will reflect the codes that have been authorized.

(b) The OHCA staff will issue a determination for each requested good or service requiring a PA. The provider will be advised of that determination, either through the provider portal, or for requests made for out-of-state services, meals, mileage, transportation and lodging, by letter or other written communication. The member will be advised by letter. Policy regarding member appeal of a denied PA is available at Oklahoma Administrative Code (OAC) 317:2-1-2.

(c) The following is an inexhaustive list of the goods and services that may require a PA, for at least some SoonerCare member populations, under some circumstances. This list is subject to change, with OHCA expressly reserving the right to add a PA requirement to a covered good or service or to remove a PA requirement from a covered good or service.

(1) Physical therapy for children;

(2) Speech therapy for children;

(3) Occupational therapy for children;

(4) High Tech Imaging (for ex. CT, MRA, MRI, PET);

(5) Some dental procedures, including, but not limited to orthodontics (orthodontics are covered for children only);

(6) Inpatient psychiatric services;

(7) Some prescription drugs, physician administered, and/or high-investment drugs;

(8) Ventilators;

(9) Hearing aids (covered for children only);

(10) Prosthetics;

(11) High risk obstetrical (OB) services;

(12) Drug testing;

(13) Enteral therapy (covered for children only);

(14) Hyperalimentation;

(15) Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, supplies, or equipment that are determined to be medically necessary for a child or adolescent, and which are included within the categories of mandatory and optional services in Section 1905(a) of Title XIX, regardless of whether such services, supplies, or equipment are listed as covered in the Oklahoma Medicaid State Plan;

(16) Adaptive equipment for persons residing in private intermediate care facilities for individuals with intellectual disabilities (ICF/IID);

- (17) Some ancillary services provided in a long-term care hospital or in a long term care facility;
- (18) Rental of hospital beds, support surfaces, oxygen and oxygen related products, continuous positive airway pressure devices (CPAP and BiPAP), pneumatic compression devices, and lifts;
- (19) Allergy testing and immunotherapy;
- (20) Bariatric surgery;
- (21) Genetic testing;
- (22) Out-of-state services; and
- (23) Meals, travel, and lodging.

(d) Providers should refer to the provider-specific Part for PA requirements. For additional PA information and submission requests, providers may refer to the OHCA Provider Billing and Procedure Manual and the SoonerCare Medical Necessity Criteria for Inpatient Behavioral Health Services Manual available at <https://okhca.org>.

[Source: Added at 35 Ok Reg 1383, eff 9-14-18 ; Amended at 36 Ok Reg 872, eff 9-1-19 ; Amended at 37 Ok Reg 761, eff 5-14-20 (emergency); Amended at 38 Ok Reg 965, eff 9-1-21]

317:30-3-32. Retrospective review for payment for services to certain aliens

Certain aliens are only eligible for emergency medical services (Refer to OAC 317:35-5-25). Requests for alien services should be submitted to the local county Oklahoma Department of Human Services (OKDHS) office on Form 08MA005E (MS-MA-5), Notification of Needed Medical Services. OKDHS forwards the appropriate paperwork to the Oklahoma Health Care Authority where the case undergoes retrospective review for payment by medical staff. Retrospective review is a process in which a claim and medical records are reviewed after care is provided to validate that the services provided meet the definition of emergency before payment is made. Once a decision to approve or deny the requested services is made then the county OKDHS office is notified and the county OKDHS office is responsible for notifying the applicant and the provider of the decision.

[Source: Added at 35 Ok Reg 1383, eff 9-14-18]

317:30-3-33. Suspended claims review and/or prepayment review

Suspended claims review and/or prepayment review occurs after a healthcare good or service has been furnished and a claim for payment has been filed with the Oklahoma Health Care Authority (OHCA) by the provider, but before the claim has been paid. Suspended claims review and/or prepayment review may be performed by the OHCA or its contractor or designee, and may take the form of different types of reviews, including, but not limited to:

- (1) Any claims review process(es) required by federal and/or state law, including Section 447.45(f) of Title 42 of the Code of Federal Regulations (C.F.R.);
- (2) The suspended claims review process to confirm, prior to payment, the medical necessity of the healthcare good or service provided and use of the appropriate modifier, based on, among

other things, the claim's diagnosis, code, and/or modifier, as well as any attached medical record(s) or other supporting documentation; and

(3) Any provider-specific prepayment review, in which a provider's claims are temporarily held in the payment system, pending review of medical records and/or other supporting documentation, in order to confirm that the submitted claims were billed appropriately and relate to healthcare goods or services that are covered and medically necessary. OHCA shall notify the provider in writing within ten (10) business days before the effective start date of any provider-specific prepayment review, informing the provider as to the:

- (A) Implementation date, scope, and nature of the review;
- (B) Process for submitting claims and supporting documentation; and
- (C) Any accuracy goals that must be met before removal from the provider-specific prepayment review status can occur.

(4) Suspended claims review and/or prepayment review is not a sanction and cannot be appealed, nor is it subject to an informal hearing. However, any claim that is denied for payment by OHCA as a result of suspended claims review and/or prepayment review may be resubmitted to OHCA for reconsideration, in accordance with Oklahoma Administrative Code 317:30-3-11.1 and/or 317:30-3-20.

[Source: Added at 36 Ok Reg 879, eff 9-1-19]

317:30-3-34. Electronic visit verification (EVV) system

An EVV system is a telephone-based, computer-based, or other electronic-based system that verifies and documents the time and location of services requiring an in-home visit, including, but not limited to, self-directed services, in accordance with an approved prior authorization or individual plan of care, and pursuant to Title 42 of the United States Code, Section (§) 1396b(l).

(1) **Verification requirements.** An EVV system must verify the following for in-home or community services:

- (A) Type of service performed (service code and any applicable modifier);
- (B) Date of service;
- (C) SoonerCare member identification number of the individual receiving the service;
- (D) Unique vendor identification number for the individual providing the service (service provider);
- (E) Location where service starts and ends; and
- (F) Time the service starts and ends.

(2) **Services requiring EVV system use.** An EVV system must be used for personal care services, as defined by Oklahoma Administrative Code (OAC) 317:35-15-2.

(3) **Services not requiring EVV system use.** When services are provided through home and community-based waivers, EVV is not required if those services are provided in:

- (A) Combination with community residential supports, per Oklahoma Administrative Code (OAC) 340:100-5-22.1;
- (B) Combination with group home services, per OAC 340:100-6;
- (C) Congregate settings where twenty-four (24) hour service is available; or
- (D) Settings where the member and service provider live in the same residence.

(4) **Provider requirements.** Providers are required to use an OHCA authorized and approved EVV system or aggregator. Providers may use the designated statewide EVV system, or their own EVV compliant system. A provider of personal care services using an EVV system must:

- (A) Comply with all applicable federal and state laws and regulations, including, but not limited to, HIPAA privacy and security law, as defined in Section 3009 of the Public Health Service Act; required reporting of abused and/or neglected children, adolescents, and vulnerable adults [Section (§) 1-2-101 of Title 10A of the Oklahoma Statutes (O.S.) and 43A O.S. § 10-104]; and OAC 317:30-3-4.1, Uniform Electronic Transaction Act;
- (B) Adopt internal policies and procedures regarding the EVV system;
- (C) Ensure that employees are adequately trained on the EVV system's proper use, and make available to them real-time technical resources and support, such as a help desk or call center information;
- (D) Ensure employees are adequately trained to properly engage the personal care agency's backup system when the EVV system is not available; and
- (E) Ensure that the system:
 - (i) Accommodates members and service providers with hearing, physical, or visual impairments;
 - (ii) Accommodates multiple members and/or service providers in the same home or at the same phone number, as well as multiple work shifts per member per day;
 - (iii) Supports the addition or deletion of members, service providers, and health care services, at any time during the month, as authorized by the OHCA and/or the Oklahoma Department of Human Services (OKDHS);
 - (iv) Notifies supervisory staff at the personal care agency of any untimely or missed shifts, or any other deviation in scheduled care;
 - (v) Documents the existence of and justification for all manual modifications, adjustments, or exceptions after the service provider has entered

or failed to enter the information in paragraph (1), above; and

(vi) Has the ability to respond to requests for records or documentation in the timeframe and format requested by OHCA.

(F) Be capable of retrieving current and archived data to produce summary reports of the information verified in Paragraph (1), above, as well as the information documented in (3)(E)(vi), above;

(G) Maintain reliable backup and recovery processes that ensure all data is preserved in the event of a system malfunction or disaster situation;

(H) Retain all data regarding the delivery of health care services for a minimum of six (6) years; and

(I) Establish a process to deactivate an employee's access to the EVV or designated system records upon termination of the designated employee's employment.

(5) **Claims reimbursement.** SoonerCare will not pay a claim for reimbursement unless the data is from an OHCA authorized and approved EVV system or aggregator; and includes all of the EVV verification requirements [refer to (1)(A through F)] of this section:

(A) Corresponds with the health care services for which reimbursement is claimed; and

(B) Is consistent with any approved prior authorization or individual plan of care.

(6) **Program integrity.** Paid claims may be subject to retrospective review and recoupment, as appropriate, in accordance with OAC 317:30-3-2.1.

(7) **Procedures for EVV system failure or EVV system unavailability.** The EVV system provides alternate backup solutions if the automated system is unavailable; however, in the event of the EVV system failure, the provider documents the specified data in paragraph (1), above, in accordance with internal backup policies and procedures. This documentation is sufficient to account for in-home services. The personal care agency's backup procedures are only permitted when the EVV system is unavailable. For complete EVV system outages, providers would need to enter the specified data in paragraph (1), above, via web claim once the system is back online.

[Source: Added at 38 Ok Reg 404, eff 1-1-21 (emergency); Added at 38 Ok Reg 968, eff 9-1-21]

317:30-3-35. Oklahoma State Health Information Network and Exchange (OKSHINE)

(a) **Authority.** This rule is promulgated under the authority granted in Title 63 of the Oklahoma Statutes Section 1-133 (63 O.S. § 1-133). This Section is intended to be read in conjunction with applicable Oklahoma statutes and federal law.

(b) **Applicability and purpose.**

(1) **Applicability.** This section shall apply to and govern the establishment and operation of the statewide health information exchange (HIE), herein referred to as OKSHINE.

(2) **Purpose.** OKSHINE is the state-designated organization that facilitates the exchange of health information to and from authorized individuals and health care organizations in the state for the purpose of improving health outcomes, as per 63 O.S. § 1-133.

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

(1) **OKSHINE** means an organization that oversees, governs, and facilitates health information exchange among health care providers that are not related health care organizations as defined in the Oklahoma Statutes, to improve the security of patient information, coordination of patient care, and the efficiency of health care delivery.

(2) **Participant** means an organization, health care practitioner or institution, health plan, or health care clearinghouse who has executed a written participation agreement (PA) and business associate agreement (BAA) with OKSHINE.

(3) **Participant agreement** means the agreement between OKSHINE and a participant which authorizes the participant to have access to OKSHINE and outlines the policies and procedures for access, protection, and use of the electronic protected health information.

(4) **Oklahoma Statewide Health Information Exchange (OKHIE)** means a certified HIE as referenced in 63 O.S. § 1-133 whose primary business activity is health information exchange.

(d) **OKHIE Certification.** Per 63 O.S. § 1-133, an initial certification and an annual recertification will be required for health information exchanges to qualify as an OKHIE. In order to receive certification, the applying HIE must submit an application to the Oklahoma Health Care Authority (OHCA) and provide all requested documentation. The application and standards for certification shall be posted on the OHCA OKSHINE public website.

(1) The OHCA shall establish a health information exchange certification with input from stakeholders.

(2) Until such time as the health information exchange certification is established by the OHCA, an OKSHINE or an HIE organization that was previously certified by the Oklahoma Health Information Exchange Trust (OHIET) shall be deemed an OKHIE.

(3) An HIE must provide documentation of certification from OHIET to OHCA in order to receive initial OKHIE certification.

(e) **Fees.**

(1) **Certification fees.** Each health information exchange which applies for certification, will be required to pay annual certification/recertification fees. The OHCA will develop the certification criteria and will publish the criteria and associated fees, when available, on the OHCA OKSHINE public website.

(2) **Participant fees.** Each participant, as defined in this section, will be required to pay an annual participation fee as outlined in the participant agreement. The OHCA will develop the criteria for the fees and will publish the criteria when available. The participant agreement and fee schedule will be posted on the OHCA OKSHINE public website.

[Source: Added at 39 Ok Reg 1454, eff 9-12-22]

PART 3. GENERAL MEDICAL PROGRAM INFORMATION

317:30-3-39. Home and Community Based Services Waivers

The Oklahoma Health Care Authority operates or oversees the operation of several Home and Community Based Services waivers. The waivers allow individuals with physical or intellectual disabilities, requiring institutional level of care, the opportunity to reside at home or in a community based setting, while receiving institutional level of care services. Brief summaries of the Waivers are set forth in OAC 317:30-3-40 and OAC 317:30-3-41. Detailed information about each Waiver is available per the following citations:

- (1) Home and Community Based Services Waivers for People with Intellectual Disabilities and Related Conditions can be found at OAC 317:40-1-1 et seq.
- (2) Home and Community Based Services Waivers for People with Physical Disabilities:
 - (A) ADvantage Waiver information is available per OAC 317:30-5-760 et seq.
 - (B) Medically Fragile Waiver information is available per OAC 317:50-1-1 et seq.

[Source: Added at 28 Ok Reg 1401, eff 6-25-11 ; Amended at 32 Ok Reg 1030, eff 8-27-15]

317:30-3-40. Home and community-based services (HCBS) waivers for persons with intellectual disabilities or certain persons with related conditions

(a) **Introduction to HCBS waivers for persons with intellectual disabilities.** The Medicaid HCBS waiver programs are authorized per Section 1915(c) of the Social Security Act.

(1) The Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDS) operates HCBS waiver programs for persons with intellectual disabilities and certain persons with related conditions. The Oklahoma Health Care Authority (OHCA), the State's Medicaid agency, retains and exercises administrative authority over all HCBS waiver programs.

(2) Each waiver allows for the provision of specific SoonerCare-compensable services that assist members to reside in the community and avoid institutionalization.

- (3) HCBS waiver services:
 - (A) Complement and supplement services available to members through the Medicaid State Plan or other federal, state, or local public programs, as well as informal supports provided by families and communities;
 - (B) Are only provided to persons who are Medicaid eligible, outside of a nursing facility, hospital, or institution;
 - (C) Are not intended to replace other services and supports available to members; and
 - (D) Are authorized based solely on current need.

- (4) HCBS waiver services must be:
 - (A) Appropriate to the member's needs; and
 - (B) Included in the member's individual plan (IP).

- (i) The IP:

- (I) Is developed annually by the member's personal support team, per Oklahoma Administrative Code (OAC) 340:100-5-52; and

- (II) Contains detailed descriptions of services provided, documentation of amount and frequency of services, and types of providers to provide services.

- (ii) Services are authorized, per OAC 340:100-3-33 and 340:100-3-33.1.

- (5) DDS furnishes case management, targeted case management, and services to members as Medicaid State Plan services, per Section 1915(g)(1) of the Social Security Act and per OAC 317:30-5-1010 through 317:30-5-1012.

(b) **Eligible providers.** All providers must have entered into contractual agreements with OHCA to provide HCBS for persons with an intellectual disability or related conditions.

- (1) All providers, except pharmacy and durable medical equipment (DME) providers must be reviewed by OKDHS DDS.

The review process verifies that:

- (A) The provider meets the licensure, certification or other standards specified in the approved HCBS waiver documents; and

- (B) Organizations that do not require licensure wanting to provide HCBS services meet program standards, are financially stable and use sound business management practices.

- (2) Providers who do not meet program standards in the review process are not approved for a provider agreement.

- (3) Provider agreements with providers that fail to meet programmatic or financial requirements may not be renewed.

(c) **Coverage.** All services must be included in the member's IP and arranged by the member's case manager.

05 ; Amended at 24 Ok Reg 879, eff 5-11-07 ; Amended at 27 Ok Reg 1429, eff 6-11-10 ; Amended at 28 Ok Reg 1401, eff 6-25-11 ; Amended at 29 Ok Reg 1076, eff 6-25-12 ; Amended at 36 Ok Reg 879, eff 9-1-19 ; Amended at 39 Ok Reg 394, eff 12-21-21 (emergency); Amended at 39 Ok Reg 1430, eff 9-12-22]

317:30-3-41. Home and Community Based Services Waivers for persons with physical disabilities

(a) **ADvantage Waiver.** The ADvantage Waiver Program is a Medicaid Home and Community Based Services (HCBS) Waiver used to finance non-institutional long-term care services through Oklahoma's SoonerCare program for elderly and disabled individuals in specific waiver areas. To receive ADvantage Program services, individuals must meet the nursing facility level of care criteria, be age 65 years or older, or age 21 or older if disabled. ADvantage Program members must be SoonerCare eligible and reside in the designated service area. The number of members in the ADvantage Waiver is limited.

(b) **Medically Fragile Waiver.** The Medically Fragile Waiver Program is a Medicaid Home and Community Based Services (HCBS) Waiver used to finance non-institutional long-term care services through Oklahoma's SoonerCare program for medically fragile individuals. To receive Medically Fragile Program services, individuals must be at least 19 years of age, be SoonerCare eligible, and meet the OHCA skilled nursing facility (SNF) or hospital level of care (LOC) criteria. Eligibility does not guarantee placement in the program as Waiver membership is limited.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 28 Ok Reg 1401, eff 6-25-11 ; Amended at 32 Ok Reg 1030, eff 8-27-15 ; Amended at 41 Ok Reg, Number 12, effective 1-30-24 (emergency)]

317:30-3-42. Services in a Nursing Facility (NF)

Nursing facility services are those services furnished pursuant to a physician's orders which require the skills of technical or professional personnel, e.g., registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists or audiologists. This care is provided by nursing facilities licensed under State law to provide, on a regular basis, health related care and services to individuals who do not require hospitalization but whose physical or mental condition requires care and services above the level of room and board which can be made available to them only through a nursing facility.

- (1) To be eligible for nursing facility services the individual must:
 - (A) Require a treatment plan involving the planning and administration of services which require skills of licensed technical or professional personnel that are provided directly or under the supervision of such personnel and are prescribed by the physician;
 - (B) Have a physical impairment or combination of physical and mental impairments;
 - (C) Require professional nursing supervision (medication, hygiene and dietary assistance);
 - (D) Lack the ability to care for self or communicate needs to others; and

(E) Require medical care and treatment in a nursing facility to minimize physical health regression and deterioration. A physician's order and results from a standardized assessment which evaluates type and degree of disability and need for treatment must support the individual's need for NF level of care. Only standardized assessments approved by the OHCA and administered in accordance with Medicaid approved procedures shall be used to make the NF level of care determination.

(2) If the individual experiences mental illness or an intellectual disability or a related condition, payment cannot be made for services in a nursing facility unless the individual has been assessed through the Preadmission Screening and Resident Review (PASRR) process and the appropriate MR or MI authority has determined that nursing facility services are required. If it is determined that the patient also requires specialized services, the state must provide or arrange for the provision of such services. These determinations must be made prior to the patient's admission to the nursing facility.

(3) Payment cannot be made for an individual who is actively psychotic or capable of imminent harm to self or others (i.e., suicidal or homicidal).

(4) Payment is made to licensed nursing facilities that have agreements with the Authority.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 18 Ok Reg 2557, eff 6-25-01 ; Amended at 29 Ok Reg 1076, eff 6-25-12]

317:30-3-43. Services in an Intermediate Care Facility for Individuals with Intellectual Disabilities(ICF/IID)

Services in an ICF/IID facility are provided to individuals per OAC 317:30-5-122 and OAC 317:35-9-45.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 28 Ok Reg 1409, eff 6-25-11 ; Amended at 34 Ok Reg 626, eff 9-1-17]

317:30-3-44. Personal care

Personal care is a service provided in a member's home. To receive the service, the member must have met the appropriate level of care in accordance with procedures found in OAC 317:35-9. In geographic areas designated as ADvantage Program phase in areas, personal care services may be provided by agency providers who contract with the Medicaid agency for the provision of services. The service may be provided by individual personal care providers in geographic areas where there is insufficient agency providers to adequately serve the population.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 34 Ok Reg 612, eff 9-1-17]

317:30-3-45. Services for persons age 65 or older in mental health hospitals

Services for persons age 65 years or older in mental health hospitals are mental health services provided in an inpatient hospital setting to eligible categorically needy individuals whose condition cannot adequately be treated on an outpatient basis.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95]

317:30-3-46. Services for persons infected with tuberculosis

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

(1) Prescribed medications:

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

(2) Physician services:

(A) Physician services include:

- (i) ambulatory physician services;
- (ii) office visits; and
- (iii) ambulatory surgery and such, but not including inpatient services.

(B) Office visits are not limited for TB infected persons. However, prior authorization is required when the limit under Medicaid is exceeded;

(3) Outpatient hospital services;

(4) Rural Health Clinic services;

(5) Federally Qualified Health Clinic services;

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

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

(8) Targeted Case Management services.

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

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

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 16 Ok Reg 3413, eff 7-1-99 (emergency); Amended at 17 Ok Reg 1204, eff 5-11-

00 ; Amended at 21 Ok Reg 398, eff 1-1-04 (emergency); Amended at 21 Ok Reg 2176, eff 6-25-04 ; Amended at 31 Ok Reg 1629, eff 9-12-14]

317:30-3-46.1. Poison control services [REVOKED]

[Source: Added at 12 Ok Reg 3636, eff 6-21-95 (emergency); Added at 13 Ok Reg 1645, eff 5-27-96 ; Revoked at 15 Ok Reg 3815, eff 7-1-98 (emergency); Revoked at 16 Ok Reg 1429, eff 5-27-99]

317:30-3-47. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 13 Ok Reg 1519, eff 3-27-96 (emergency); Amended at 14 Ok Reg 1780, eff 5-27-97 ; Amended at 17 Ok Reg 2368, eff 6-26-00 ; Revoked at 23 Ok Reg 2463, eff 6-25-06]

317:30-3-48. Periodicity schedule [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 23 Ok Reg 2463, eff 6-25-06]

317:30-3-49. Initial screening examination [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 23 Ok Reg 2463, eff 6-25-06]

317:30-3-50. Screening components [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 16 Ok Reg 48, eff 9-11-98 (emergency); Amended at 16 Ok Reg 1429, eff 5-27-99 ; Revoked at 23 Ok Reg 2463, eff 6-25-06]

317:30-3-51. Diagnosis and treatment [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 23 Ok Reg 2463, eff 6-25-06]

317:30-3-52. Vision services [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 23 Ok Reg 2463, eff 6-25-06]

317:30-3-53. Dental services [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 21 Ok Reg 2201, eff 6-25-04 ; Revoked at 23 Ok Reg 2463, eff 6-25-06]

317:30-3-54. Hearing services [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 14 Ok Reg 524, eff 12-24-96 (emergency); Amended at 14 Ok Reg 1785, eff 5-27-97 ; Amended at 16 Ok Reg 1927, eff 6-11-99 ; Revoked at 23 Ok Reg 2463, eff 6-25-06]

**317:30-3-55. Periodic and interperiodic screening examinations
[REVOKED]**

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 23 Ok Reg 2463, eff 6-25-06]

317:30-3-56. Partial screening examination [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 23 Ok Reg 2463, eff 6-25-06]

317:30-3-57. General SoonerCare coverage - categorically needy

The following are general SoonerCare coverage guidelines for the categorically needy:

- (1) Inpatient hospital services.
 - (A) Adult coverage for inpatient hospital stays as described at Oklahoma Administrative Code (OAC) 317:30-5-41.
 - (B) Coverage for members under twenty-one (21) years of age is not limited. All admissions must be medically necessary. All psychiatric admissions require prior authorization for an approved length of stay.
- (2) Emergency department services.
- (3) Dialysis in an outpatient hospital or freestanding dialysis facility.
- (4) Outpatient therapeutic radiology or chemotherapy for proven malignancies or opportunistic infections.
- (5) Outpatient surgical services - facility payment for selected outpatient surgical procedures to hospitals which have a contract with the Oklahoma Health Care Authority (OHCA).
- (6) Outpatient mental health services for medical and remedial care including services provided on an outpatient basis by certified hospital-based facilities that are also qualified mental health clinics.
- (7) Rural health clinic services and other ambulatory services furnished by rural health clinic.
- (8) Optometrists' services - only as listed in Subchapter 5, Part 45, Optometrist specific rules of this Chapter.
- (9) Maternity clinic services.
- (10) Outpatient diagnostic x-rays and lab services. Other outpatient services provided to adults, not specifically addressed, are covered only when prior authorized by the Agency's Medical Authorization Unit.
- (11) Medically necessary screening mammography. Additional follow-up mammograms are covered when medically necessary.
- (12) Long-term care facility services (other than services in an institution for tuberculosis or mental diseases).
- (13) Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) are available for members under twenty-one (21) years of age to provide access to regularly scheduled

examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth. Federal regulations also require that diagnosis and treatment be provided for conditions identified during a screening whether or not they are covered under the State Plan, as long as federal funds are available for these services. These services must be necessary to ameliorate or correct defects and physical or mental illnesses or conditions and require prior authorization. EPSDT/OHCA child-health services are outlined in OAC 317:30-3-65.2 through 317:30-3-65.12.

(A) EPSDT screening examinations for eligible children by a medical or osteopathic physician, physician assistant, or advanced practice nurse practitioner.

(B) Diagnostic x-rays, lab, and/or injections when prescribed by a provider.

(C) Immunizations.

(D) Outpatient care.

(E) Dental services as outlined in OAC 317:30-3-65.8.

(F) Optometrists' services. The EPSDT periodicity schedule provides for at least one (1) visual screening and glasses each twelve (12) months. In addition, payment is made for glasses for children with congenital aphakia or following cataract removal. Interperiodic screenings and glasses at intervals outside the periodicity schedule for optometrists are allowed when a visual condition is suspected. Payment is limited to two (2) glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.

(G) Hearing services as outlined in OAC 317:30-3-65.9.

(H) Prescribed drugs.

(I) Outpatient psychological services as outlined in OAC 317:30-5-275 through 317:30-5-278.

(J) Inpatient psychiatric services as outlined in OAC 317:30-5-94 through 317:30-5-97.

(K) Transportation. Provided when necessary in connection with examination or treatment when not otherwise available.

(L) Inpatient hospital services.

(M) Medical supplies, equipment, appliances, orthotics and prosthetics.

(N) EPSDT services furnished in a qualified child health center.

(14) Family planning services and supplies for members of child-bearing age, including counseling, insertion of intrauterine device, implantation of subdermal contraceptive device, and sterilization for members twenty-one (21) years of age and older who are legally competent, not institutionalized and have signed the "Consent Form" at least thirty (30) days prior to procedure. Reversal of sterilization procedures for the purposes of conception is not covered. Reversal of sterilization procedures are covered when medically indicated and substantiating

documentation is attached to the claim.

(15) Physicians' services whether furnished in the office, the member's home, a hospital, a long-term care facility, intermediate care facilities for individuals with intellectual disabilities (ICF/IID), or elsewhere. For adults, payment is made for compensable hospital days described at OAC 317:30-5-41. Office visits for adults are limited to four (4) per month except when in connection with conditions as specified in OAC 317:30-5-9(b).

(16) Medical care and any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law. See applicable provider section for limitations to covered services for:

- (A) Podiatrists' services;
- (B) Optometrists' services;
- (C) Psychologists' services;
- (D) Certified registered nurse anesthetists;
- (E) Certified nurse midwives;
- (F) Advanced practice registered nurses; and
- (G) Anesthesiologist assistants.

(17) Freestanding ambulatory surgery centers.

(18) Prescribed drugs not to exceed a total of six (6) prescriptions with a limit of two (2) brand name prescriptions per month.

Exceptions to the six (6) prescription limit are:

(A) Unlimited medically necessary monthly prescriptions for:

(i) Members under the age of twenty-one (21) years; and

(ii) Residents of long-term care facilities or ICF/IID.

(B) Seven (7) medically necessary generic prescriptions per month in addition to the six (6) covered under the State Plan (including three (3) brand name prescriptions) are allowed for adults receiving services under the 1915(c) home and community-based services (HCBS) waivers.

These additional medically necessary prescriptions beyond the three (3) brand name or thirteen (13) total prescriptions are covered with prior authorization.

(19) Rental and/or purchase of medical supplies, equipment, and appliances.

(20) Adaptive equipment, when prior authorized, for members residing in private ICF/IID's.

(21) Dental services for members residing in private ICF/IID's in accordance with the scope of dental services for members under age twenty-one (21).

(22) For non-expansion adults, prosthetic devices are limited to catheters and catheter accessories, colostomy and urostomy bags and accessories, tracheostomy accessories, nerve stimulators, hyperalimentation and accessories, home dialysis equipment and supplies, external breast prostheses and support accessories, oxygen/oxygen concentrator equipment and supplies, respirator or ventilator equipment and supplies, and those devices inserted during the course of a surgical procedure. There is no coverage

for orthotic devices for adults.

(23) Orthotics and prosthetics are covered for expansion adult members, above the limitations within (22) of this Section, when prescribed by the treating provider (physician, physician assistant, or an advanced practice registered nurse) and medical necessity is documented in accordance with OAC 317:30-5-211.13.

(24) Standard medical supplies.

(25) Eyeglasses under EPSDT for members under age twenty-one (21). Payment is also made for glasses for children with congenital aphakia or following cataract removal. Payment is limited to two (2) glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.

(26) Blood and blood fractions for members when administered on an outpatient basis.

(27) Inpatient services for members age sixty-five (65) or older in institutions for mental diseases, limited to those members whose Medicare, Part A benefits are exhausted for this particular service and/or those members who are not eligible for Medicare services.

(28) Long-term care facility services, limited to members preauthorized and approved by OHCA for such care.

(29) Inpatient psychiatric facility admissions for members are limited to an approved length of stay with provision for requests for extensions.

(30) Transportation and subsistence (room and board) to and from providers of medical services to meet member's needs (ambulance or bus, etc.), to obtain medical treatment.

(31) Extended services for pregnant women including all pregnancy-related and postpartum services to continue to be provided, as though the women were pregnant, for twelve (12) months after the pregnancy ends regardless of the reason, beginning on the last date of pregnancy.

(32) Long-term care facility services for members under twenty-one (21) years of age.

(33) Personal care in a member's home, prescribed in accordance with a plan of treatment and rendered by a qualified person under supervision of a registered nurse (RN).

(34) Medicare Part A, Part B, and Part C deductibles, coinsurance, and copays.

(35) HCBS for the intellectually disabled.

(36) Home health services can be provided without a PA for the first thirty-six (36) visits. A PA will be required beyond the 36th visit. The visits are limited to any combination of RN and nurse aide visits.

(37) Medically necessary solid organ and bone marrow/stem cell transplantation services for children and adults are covered services based upon the conditions listed in (A)-(D) of this paragraph:

- (A) All transplantation services, except kidney and cornea, must be prior authorized;
 - (B) All transplant procedures are reviewed and prior authorization is based upon appropriate medical criteria;
 - (C) All organ transplants must be performed at a Medicare approved transplantation center;
 - (D) Procedures considered experimental or investigational are not covered. For more information regarding experimental or investigational including clinical trials, see OAC 317:30-3-57.1; and
 - (E) Donor search and procurement services are covered for transplants consistent with the methods used by the Medicare program for organ acquisition costs.
- (38) HCBS for intellectually disabled members who were determined to be inappropriately placed in a long-term care facility (Alternative Disposition Plan - ADP).
- (39) Case management services for the chronically and/or seriously mentally ill.
- (40) Emergency medical services, including emergency labor and delivery for undocumented or ineligible aliens.
- (41) Services delivered in Federally Qualified Health Centers (FQHCs). Payment is made on an encounter basis.
- (42) Early intervention services for children ages zero (0) to three (3).
- (43) Residential behavior management in therapeutic foster care setting.
- (44) Case management services through the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS).
- (45) HCBS for aged or physically disabled members.
- (46) Outpatient ambulatory services for members infected with tuberculosis.
- (47) Smoking and tobacco use cessation counseling for children and adults.
- (48) Services delivered to American Indians/Alaskan Natives (AI/AN) in Indian Health Services, Tribal Programs, and Urban Indian Clinics (I/T/Us). Payment is made on an encounter basis.
- (49) OHCA contracts with designated agents to provide disease state management for individuals diagnosed with certain chronic conditions. Disease state management treatments are based on protocols developed using evidence-based guidelines.
- (50) Residential substance use disorder (SUD) services.
- (51) Medication-assisted treatment (MAT) services.
- (52) Diabetes self-management education and support (DSMES).

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 13 Ok Reg 899, eff 8-1-95 (emergency); Amended at 13 Ok Reg 1645, eff 5-27-96 ; Amended at 13 Ok Reg 3607, eff 6-18-96 (emergency); Amended at 14 Ok Reg 524, eff 12-24-96 (emergency); Amended at 14 Ok Reg 3077, eff 7-1-97 (emergency); Amended at 15 Ok Reg 1083, eff 12-15-97 (emergency); Amended at 15 Ok Reg 1096, eff 1-6-98 (emergency); Amended at 15 Ok Reg 1535, eff 5-11-98 ; Amended at 15 Ok Reg 4182, eff 8-5-98 (emergency); Amended at 16 Ok Reg 141, eff 10-14-98 (emergency); Amended at 16 Ok Reg 1429, eff 5-27-99 ; Amended at 16 Ok Reg 3413, eff 7-1-99 (emergency); Amended at 17 Ok Reg 805, eff 7-16-99 (emergency); Amended at 17 Ok Reg 1204, eff 5-

11-00 ; Amended at 18 Ok Reg 245, eff 10-7-00 (emergency); Amended at 18 Ok Reg 477, eff 1-1-01 (emergency); Amended at 18 Ok Reg 761, eff 1-23-01 (emergency); Amended at 18 Ok Reg 1130, eff 5-11-01 ; Amended at 20 Ok Reg 2881, eff 7-1-03 (emergency); Amended at 21 Ok Reg 398, eff 1-1-04 (emergency); Amended at 21 Ok Reg 501, eff 1-1-04 (emergency); Amended at 21 Ok Reg 2176, eff 6-25-04 ; Amended at 23 Ok Reg 2477, eff 6-25-06 ; Amended at 24 Ok Reg 303, eff 12-1-06 (emergency); Amended at 24 Ok Reg 655, eff 2-1-07 (emergency); Amended at 24 Ok Reg 2060, eff 6-25-07 ; Amended at 24 Ok Reg 2877, eff 7-1-07 (emergency); Amended at 25 Ok Reg 1161, eff 5-25-08 ; Amended at 27 Ok Reg 614, eff 1-14-10 (emergency); Amended at 27 Ok Reg 1435, eff 6-11-10 ; Amended at 29 Ok Reg 1076, eff 6-25-12 ; Amended at 31 Ok Reg 648, eff 7-1-14 (emergency); Amended at 32 Ok Reg 1031, eff 8-27-15 ; Amended at 35 Ok Reg 19, eff 10-1-17 (emergency); Amended at 35 Ok Reg 1388, eff 9-14-18 ; Amended at 39 Ok Reg 394, eff 12-21-21 (emergency); Amended at 39 Ok Reg 769, eff 8-2-22 (emergency); Amended at 39 Ok Reg 1430, eff 9-12-22 ; Amended at 40 Ok Reg 652, eff 2-21-23 (emergency); Amended at 40 Ok Reg 2175, eff 9-11-23]

317:30-3-57.1. Coverage of routine services in relation to clinical trials

(a) **Coverage.** The Oklahoma Health Care Authority (OHCA) will cover routine patient costs provided under a qualifying clinical trial to an eligible member. The OHCA does not:

- (1) Determine eligibility for participation in any research study; or
- (2) Reimburse for any costs associated in the research study, other than for routine patient costs for clinical studies, as defined in this Section and in the Oklahoma Medicaid State Plan.

(b) **Qualifying clinical trials criteria.**

(1) Clinical trial, as adopted from the National Institute of Health (NIH) definition, means a research study in which one (1) or more human subjects are prospectively assigned to one (1) or more interventions, which may include placebo or other control, to evaluate the effects of those interventions on health-related biomedical or behavioral outcomes.

(2) Pursuant to Section 1905(a)(30) and 1905(gg) of the Act, as amended and added by Division CC, Title II, Section 210 of the Consolidated Appropriations Act, 2021 (Public Law 116-260, Section 210), qualifying clinical trial means a clinical trial, in any clinical phase of development, that is conducted in relation to the prevention, detection, or treatment of any serious or life-threatening disease or condition and is described in any of the following clauses:

(A) The clinical trial is approved, conducted, or supported (which may include funding through in-kind contributions) by one (1) or more of the following:

- (i) The National Institutes of Health (NIH);
- (ii) The Centers for Disease Control and Prevention (CDC);
- (iii) The Agency for Healthcare Research and Quality (AHRC);
- (iv) The Centers for Medicare and Medicaid Services (CMS);
- (v) A cooperative group or center of any of the entities described above or of the Department of Defense or the Department of Veteran Affairs;
- (vi) A qualified non-governmental research entity identified in guidelines issued by the National Institutes of Health for center support grants,

including guidelines issued after the date of these rules; or

(vii) Any of the following if the clinical trial has been reviewed and approved through a system of peer review that the Secretary determines to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health and assures unbiased review of the highest scientific standards by qualified individuals with no interest in the outcome of the review:

(I) The Department of Veterans Affairs;

(II) The Department of Defense; or

(III) The Department of Energy.

(B) The clinical trial is conducted pursuant to an investigational new drug exemption under section 505(i) of the Federal Food, Drug, and Cosmetic Act or an exemption for a biological product undergoing investigation under section 351(a)(3) of the Public Health Service Act.

(C) The clinical trial is a drug trial that is exempt from being required to have an investigational new drug exemption or an exemption for a biological product undergoing investigation.

(3) Serious disease or condition, as adopted from 21 C.F.R. § 312.300, means a disease or condition associated with morbidity that has substantial impact on day-to-day functioning. Short-lived and self-limiting morbidity will usually not be sufficient, but the morbidity need not be irreversible, provided it is persistent or recurrent. Whether a disease or condition is serious is a matter of clinical judgment, based on its impact on such factors as survival, day-to-day functioning, or the likelihood that the disease, if left untreated, will progress from a less severe condition to a more serious one.

(4) Life-threatening disease or condition, as adopted from 21 C.F.R. § 312.300, means a stage of disease in which there is reasonable likelihood that death will occur within a matter of months or in which premature death is likely without early treatment.

(c) **Clinical trials determination standards.** Pursuant to Section 1905(a)(30) and 1905(gg) of the Act, as amended and added by Division CC, Title II, Section 210 of the Consolidated Appropriations Act, 2021 (Public Law 116-260, Section 210, the OHCA will expedite and complete a coverage determination for routine services under this Section within seventy-two (72) hours of receiving the required attestation as described below. The OHCA will maintain the following standards in any coverage determination under this section:

(1) **Attestation.** The health care provider and principal investigator for the qualifying clinical trial must submit a standardized form attestation to the OHCA regarding the appropriateness of the qualifying clinical trial for the individual member.

(2) **Expedited determination.** Upon receiving the completed required attestation, the OHCA will expedite and complete a coverage determination under this Section within seventy-two (72) hours. All documentation submitted to request services must demonstrate, through adequate objective medical records, evidence sufficient to meet at least one (1) definition in subsection (b)(3)-(4) above for the terms "serious disease or condition" or "life-threatening disease or condition".

(3) **Geographic and network allowance.** The OHCA will determine coverage under this Section without limitation on the geographic location or network affiliation of the health care provider treating the individual member or the principal investigator of the qualifying clinical trial.

(4) **Protocols and proprietary documentation.** The OHCA will determine coverage under this Section without requiring the submission of the protocols of the qualifying clinical trial or any other documentation that may be proprietary or determined by the Secretary to be burdensome to provide.

(5) **Documentation of serious or life-threatening disease or condition.** In determining coverage under this Section, the OHCA will consider existing or newly offered documentation that the individual member has been diagnosed with or is suffering from one (1) or more serious or life-threatening diseases or conditions that are the subject of the qualifying clinical trial as shown in the attestation.

(d) **Routine patient costs.**

(1) **Included items and services.** Routine patient costs include any item or service provided to Medicaid-eligible members under the qualifying clinical trial, including:

- (A) Any item or service provided to prevent, diagnose, monitor, or treat complications resulting from participation in the qualifying clinical trial, to the extent that the provision of such items or services to the member would otherwise be covered outside the course of participation in the qualifying clinical trial under the Oklahoma Medicaid State Plan or waiver, including a demonstration project under section 1115 of the Act; and
- (B) Any item or service required solely for the provision of the investigational item or services that is the subject of the qualifying clinical trial, including the administration of the investigational item or service.

(2) **Excluded items and services.** The following items and services are excluded from routine patient costs in qualifying clinical trials:

- (A) Any investigational item or service that is:
 - (i) The subject of the qualifying clinical trial; and
 - (ii) Not otherwise covered outside of the clinical trial under the Oklahoma Medicaid State Plan or waiver, including a demonstration project under section 1115 of the Act; and
- (B) Any item or service that is:

- (i) Provided to the member solely to satisfy data collection and analysis for the qualifying clinical trial and is not used in the direct clinical management of the member; and
- (ii) Not otherwise covered under the Oklahoma Medicaid State Plan or waiver, including a demonstration project under section 1115 of the Act.

[Source: Added at 38 Ok Reg 970, eff 9-1-21 ; Amended at 40 Ok Reg 2179, eff 9-11-23]

317:30-3-58. General Medicaid coverages - medically needy [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 14 Ok Reg 749, eff 12-24-96 (emergency); Amended at 14 Ok Reg 1785, eff 5-27-97 ; Revoked at 20 Ok Reg 2762, eff 7-1-03 (emergency); Revoked at 21 Ok Reg 2176, eff 6-25-04]

317:30-3-59. General program exclusions - adults

The following are excluded from SoonerCare coverage for adults:

- (1) Inpatient admission for diagnostic studies that could be performed on an outpatient basis.
- (2) Services or any expense incurred for cosmetic surgery.
- (3) Services of two (2) physicians for the same type of service to the same member on the same day, except when supplemental skills are required and different specialties are involved.
- (4) Refractions and visual aids.
- (5) Pre-operative care within twenty-four (24) hours of the day of admission for surgery and routine post-operative care as defined under the global surgery guidelines promulgated by Current Procedural Terminology (CPT) and the Centers for Medicare and Medicaid Services (CMS).
- (6) Sterilization of members who are under twenty-one (21) years of age, mentally incompetent, or institutionalized or reversal of sterilization procedures for the purposes of conception.
- (7) Non-therapeutic hysterectomies.
- (8) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or that the pregnancy is the result of an act of rape or incest.
- (9) Medical services considered experimental or investigational. For more information regarding coverage of clinical trials, see Oklahoma Administrative Code (OAC) 317:30-3-57.1.
- (10) Services of a certified surgical assistant.
- (11) Services of a chiropractor. Payment is made for chiropractor services on crossover claims for coinsurance and/or deductible only.

- (12) Services of an independent licensed physical therapist and/or licensed physical therapist assistant. Per OAC 317:30-5-291.
- (13) Services of an independent licensed occupational therapist and/or occupational therapist assistant. Per OAC 317:30-5-296.
- (14) Services of a psychologist.
- (15) Services of an independent licensed speech-language pathologist, speech-language pathology assistant (SLPA), and/or speech-language clinical fellow. Per OAC 317:30-5-675.
- (16) Payment for more than four (4) outpatient visits per month (home or office) per member, except those visits in connection with family planning or related to emergency medical conditions.
- (17) Payment for more than two (2) long-term care facility visits per month.
- (18) More than one (1) inpatient visit per day per physician.
- (19) Payment for removal of benign skin lesions.
- (20) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing, tumor board review or multidisciplinary opinion, dictation, and similar functions.
- (21) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.
- (22) Payment for the services of social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in the Oklahoma Health Care Authority (OHCA) rules.
- (23) Mileage.
- (24) A routine hospital visit on the date of discharge unless the member expired.
- (25) Direct payment to perfusionist as this is considered part of the hospital reimbursement.
- (26) Fertility treatment.
- (27) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 14 Ok Reg 3077, eff 7-1-97 (emergency); Amended at 15 Ok Reg 1528, eff 5-11-98 ; Amended at 15 Ok Reg 4194, eff 7-20-98 (emergency); Amended at 16 Ok Reg 1429, eff 5-27-99 ; Amended at 16 Ok Reg 3413, eff 7-1-99 (emergency); Amended at 17 Ok Reg 2373, eff 6-26-00 ; Amended at 17 Ok Reg 3469, eff 8-1-00 (emergency); Amended at 18 Ok Reg 2566, eff 6-25-01 ; Amended at 20 Ok Reg 1924, eff 6-26-03 ; Amended at 21 Ok Reg 501, eff 1-1-04 (emergency); Amended at 21 Ok Reg 2176, eff 6-25-04 ; Amended at 23 Ok Reg 239, eff 10-3-05 (emergency); Amended at 23 Ok Reg 2487, eff 6-25-06 ; Amended at 24 Ok Reg 141, eff 10-8-16 (emergency); Amended at 24 Ok Reg 890, eff 5-11-07 ; Amended at 25 Ok Reg 112, eff 10-1-07 (emergency); Amended at 25 Ok Reg 1192, eff 5-25-08 ; Amended at 27 Ok Reg 294, eff 11-3-09 (emergency); Amended at 27 Ok Reg 1439, eff 6-11-10 ; Amended at 28 Ok Reg 1412, eff 6-25-11 ; Amended at 32 Ok Reg 721, eff 7-1-15 (emergency); Amended at 33 Ok Reg 801, eff 9-1-16 ; Amended at 39 Ok Reg 394, eff 12-21-21 (emergency); Amended at 39 Ok Reg 1430, eff 9-12-22]

317:30-3-60. General program exclusions - children

- (a) The following are excluded from SoonerCare coverage for children:
 - (1) Inpatient admission for diagnostic studies that could be performed on an outpatient basis.

- (2) Services or any expense incurred for cosmetic surgery unless the physician certifies the procedure emotionally necessary.
- (3) Services of two (2) physicians for the same type of service to the same member on the same day, except when supplemental skills are required and different specialties are involved.
- (4) Pre-operative care within twenty-four (24) hours of the day of admission for surgery and routine post-operative care as defined under the global surgery guidelines promulgated by Current Procedural Terminology (CPT) and the Centers for Medicare and Medicaid Services (CMS).
- (5) Sterilization of members who are under twenty-one (21) years of age, mentally incompetent, or institutionalized or reversal of sterilization procedures for the purposes of conception.
- (6) Non-therapeutic hysterectomies.
- (7) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or that the pregnancy is the result of an act of rape or incest. [See Oklahoma Administrative Code (OAC) 317:30-5-6 or 317:30-5-50].
- (8) Medical services considered experimental or investigational. For more information regarding experimental or investigational including clinical trials, see OAC 317:30-3-57.1.
- (9) Services of a Certified Surgical Assistant.
- (10) Services of a Chiropractor.
- (11) More than one (1) inpatient visit per day per physician.
- (12) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.
- (13) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing, tumor board review or multidisciplinary opinion, dictation, and similar functions.
- (14) Payment for the services of social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in Oklahoma Health Care Authority (OHCA) rules.
- (15) Direct payment to perfusionist as this is considered part of the hospital reimbursement.
- (16) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.
- (17) Mileage.
- (18) A routine hospital visit on date of discharge unless the member expired.

(b) Notwithstanding the exclusions listed in (1)-(18) of subsection (a), the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) provides for coverage of needed medical services normally outside the scope of the medical program when performed in connection with an EPSDT screening and prior authorized.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 15 Ok Reg 4194, eff 7-20-98 (emergency); Amended at 15 Ok Reg 4182, eff 8-5-98 (emergency); Amended at 16 Ok Reg 1429, eff 5-27-99 ; Amended at 17 Ok Reg 2373, eff 6-26-00 ; Amended at 27 Ok Reg 294, eff 11-3-09 (emergency); Amended at 27 Ok Reg 1439, eff 6-11-10 ; Amended at 28 Ok Reg 1412, eff 6-25-11 ; Amended at 38 Ok Reg 970, eff 9-1-21]

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

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

(b) **Definitions.**

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

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

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

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

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

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

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

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

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

(B) utilization of a Financial Management Service (FMS) for purposes of payroll and payment to vendors. The FMS may also provide other services as determined by the individual program;

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

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

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

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

- (1) training appropriate to each level of service to be provided;
- (2) credentialing or licensure by a recognized state agency, if applicable to the provider type and duties;
- (3) establish and specify an appropriate provider type and specialty code to apply to approved providers for the program. This provider type and specialty code must meet requirements for data integrity and auditing purposes.
- (4) specify the minimum and maximum allowed rates for providers by provider type. Rates will be governed by guidelines determined by the program within approved limits and budget allowances. The program will also establish an appropriate methodology for fees paid to the FMS for administration of payroll, accounting and any other contracted duties;
- (5) provider contracts with the OHCA or with a contracted agency operating as an Organized Health Care Delivery System (OHCDS);
- (6) establish a provider enrollment process. At a minimum, the process shall include the following:
 - (A) all rendering providers will be entered into the OHCA provider tracking system and given a unique rendering provider ID number. In instances of an Organized Health Care Delivery System, the OHCDS will be considered the rendering provider for purposes of enrollment.
 - (B) the FMS will be entered into the OHCA provider tracking system and given a unique provider ID number as the billing or group provider;
 - (C) all rendering providers must pass a background investigation prior to employment.

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

- (1) The program will identify methods for assisting members in provider selection.
- (2) The program will determine processes for informing and recruiting providers.
- (3) The program will develop processes for provider communication to inform providers of procedures, concerns and general information.

(f) **Claims filing process.**

- (1) The program will ensure claims are billed to the OHCA from the FMS and processed through the OHCA claims tracking system.
- (2) The program will have appropriate procedure codes with necessary modifiers for each benefit in the program.
- (3) Procedure codes must provide sufficient detail to allow for claims identification in the OHCA claims tracking system (all claims must have at a minimum a billing, rendering and pay to).

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

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

- (1) identify appropriate procedure codes with necessary modifiers to allow claims to be processed and identified in the OHCA claims tracking system;
- (2) prior authorization for alternative goods and services and payment made directly to the vendor. No payment for good or services will be made to the member.

[Source: Added at 27 Ok Reg 449, eff 12-3-09 (emergency); Added at 27 Ok Reg 934, eff 5-13-10]

317:30-3-62. Serious reportable events - never events

(a) **Definitions.** The following words and terms, when used in this Section, have the following meaning, unless the context clearly indicates otherwise.

- (1) **"Surgical and other invasive procedures"** are defined as operative procedures in which skin or mucous membranes and connective tissues are incised or an instrument is introduced through a natural body orifice. Invasive procedures include a range of procedures from minimally invasive dermatological procedures (biopsy, excision, and deep cryotherapy for malignant lesions) to extensive multi-organ transplantation. They include all procedures described by the codes in the surgery section of the Current Procedural Terminology (CPT) and other invasive procedures such as percutaneous transluminal angioplasty and cardiac catheterization. They include minimally invasive procedures involving biopsies or placement of probes or catheters requiring the entry into a body cavity through a needle or trocar. They do not include use of instruments such as otoscopes for examinations or very minor procedures such as drawing blood.
- (2) A surgical or other invasive procedure is considered to be the wrong procedure if it is not consistent with the correctly documented informed consent for that member.
- (3) A surgical or other invasive procedure is considered to have been performed on the wrong body part if it is not consistent with the correctly documented informed consent for that member including surgery on the right body part, but on the wrong location on the body; for example, left versus right (appendages and/or organs), or at the wrong level (spine).
- (4) A surgical or other invasive procedure is considered to have been performed on the wrong member if that procedure is not consistent with the correctly documented informed consent for that member.

(b) **Coverage.** The Oklahoma Health Care Authority (OHCA) will no longer cover a particular surgical or other invasive procedure to treat a particular medical condition when the practitioner erroneously performs (1) a different procedure altogether; (2) the correct procedure but on the wrong body part; or (3) the correct procedure but on the wrong member. SoonerCare will not cover hospitalizations or any services related to these non-covered procedures. All services provided in the operating room when an error occurs are considered related and therefore not covered. All providers in the operating room when the error occurs, who could bill individually for their services, are also not eligible for payment. All related services provided during the same hospitalization in which the error occurred are not covered. A provider cannot shift financial liability or responsibility for the non-covered services to the member if the OHCA has determined that the service is related to one of the above erroneous surgical procedures.

(c) **Billing.** For inpatient claims, hospitals are required to bill two claims when the erroneous surgery is reported, one claim with covered services or procedures unrelated to the erroneous surgery, the other claim with the non-covered services or procedures as a no-payment claim. For outpatient and practitioner claims, providers are required to append the applicable HCPCS modifiers to all lines related to the erroneous surgery. Claim lines submitted with one of the applicable HCPCS modifiers will be line-item denied.

(d) **Related claims.** Once a claim for the erroneous surgery(s) has been received, OHCA may review member history for related claims as appropriate. Incoming claims for the identified member may be reviewed for an 18-month period from the date of the surgical error. If such claims are identified to be related to the erroneous surgical procedure(s), OHCA may take appropriate action to deny such claims and recover any overpayments on claims already processed.

(e) **Dually eligible members.** SoonerCare will not act as a secondary payer for Medicare non-payment of the aforementioned erroneous surgery(s).

(f) **Hospital acquired conditions.** SoonerCare will not reimburse the extra cost of treating certain categories of conditions that occur while a member is in the hospital. See OAC 317:30-3-63 for specific information regarding hospital acquired conditions.

[Source: Added at 27 Ok Reg 617, eff 1-14-10 (emergency); Added at 27 Ok Reg 806, eff 4-1-10 (emergency); Added at 27 Ok Reg 1447, eff 6-11-10 ; Amended at 41 Ok Reg, Number 14, effective 3-8-24 (emergency)]

317:30-3-63. Hospital acquired conditions

(a) **Coverage.** The Oklahoma Health Care Authority (OHCA) will no longer reimburse the extra cost of treating certain categories of conditions that occur while a member is in the hospital. For discharges, hospitals will not receive additional payment for cases in which one of the selected conditions was not present on admission. The claim will be grouped to a DRG as if the diagnosis was not present on the claim. The selected conditions that OHCA recognizes are those conditions identified as non-payable by Medicare. OHCA may revise through addition or

deletion the selected conditions at any time during the fiscal year. The following is a complete list of the hospital acquired conditions (HACs) currently recognized by OHCA:

- (1) Foreign Object Retained After Surgery
- (2) Air Embolism
- (3) Blood Incompatibility
- (4) Pressure Ulcer Stages III & IV
- (5) Falls and Trauma
 - (A) Fracture
 - (B) Dislocation
 - (C) Intracranial Injury
 - (D) Crushing Injury
 - (E) Burn
 - (F) Electric Shock
- (6) Catheter-Associated Urinary Tract Infection
- (7) Vascular Catheter-Associated Infection
- (8) Manifestations of Poor Glycemic Control
 - (A) Diabetic Ketoacidosis
 - (B) Nonketotic Hyperosmolar Coma
 - (C) Hypoglycemic Coma
 - (D) Secondary Diabetes with Ketoacidosis
 - (E) Secondary Diabetes with Hyperosmolarity
- (9) Surgical Site Infection Following:
 - (A) Coronary Artery Bypass Graft- Mediastinitis
 - (B) Bariatric Surgery
 - (i) Laparoscopic Gastric Bypass
 - (ii) Gastroenterostomy
 - (iii) Laparoscopic Gastric Restrictive Surgery
 - (C) Orthopedic Procedures
 - (i) Spine
 - (ii) Neck
 - (iii) Shoulder
 - (iv) Elbow
- (10) Deep Vein Thrombosis and Pulmonary Embolism
 - (A) Total Knee Replacement
 - (B) Hip Replacement

(b) **Billing.** Hospitals paid under the diagnosis related grouping (DRG) methodology are required to submit a present on admission (POA) indicator for the principal diagnosis code and every secondary diagnosis code for all discharges. A valid POA indicator is required on all inpatient hospital claims. Claims with no valid POA indicator will be denied. For all claims involving inpatient admissions, OHCA will group diagnoses into the proper DRG using the POA indicator.

(c) **Dually eligible members.** SoonerCare will not act as a secondary payer for Medicare non-payment of the aforementioned hospital acquired conditions.

[Source: Added at 27 Ok Reg 806, eff 4-1-10 (emergency); Added at 27 Ok Reg 1447, eff 6-11-10 ; Revoked at 41 Ok Reg, Number 14, effective 3-8-24 (emergency)]

317:30-3-64. Payment for lodging and meals [AMENDED AND RENUMBERED TO 317:30-3-92]

[Source: Added at 30 Ok Reg 1129, eff 7-1-13 ; Amended at 32 Ok Reg 1035, eff 8-27-15 ; Amended and renumbered to 317:30-3-92 at 36 Ok Reg 872, eff 9-1-19]

**PART 4. EARLY AND PERIODIC SCREENING,
DIAGNOSTIC AND TREATMENT (EPSDT)
PROGRAM/CHILD-HEALTH SERVICES**

317:30-3-65. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program/Child-health Services

Payment is made to eligible providers for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services on behalf of eligible individuals under the age of twenty-one (21).

(1) The EPSDT program is a comprehensive child-health program, designed to ensure the availability of, and access to, required health care resources and help parents and guardians of Medicaid-eligible children and adolescents use these resources. An effective EPSDT program assures that health problems are diagnosed and treated early before they become more complex and their treatment more costly. The physician plays a significant role in educating parents and guardians about all services available through the EPSDT program. The receipt of an identified EPSDT screening makes the member eligible for all necessary follow-up care that is within the scope of the SoonerCare program. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) covers services, supplies, or equipment that are determined to be medically necessary for a child or adolescent, and which are included within the categories of mandatory and optional services in Section 1905(a) of Title XIX, regardless of whether such services, supplies, or equipment are listed as covered in Oklahoma's Medicaid State Plan.

(2) Federal regulations also require that the State set standards and protocols for each component of EPSDT services. The standards must provide for services at intervals which meet reasonable standards of medical and dental practice. The standards must also provide for EPSDT services at other intervals as medically necessary to determine the existence of certain physical or behavioral health illnesses or conditions.

(3) SoonerCare providers who perform EPSDT screenings must assure that the screenings they provide meet the minimum standards established by the Oklahoma Health Care Authority in order to be reimbursed at the level established for EPSDT services.

(4) An EPSDT screening is considered a comprehensive examination.

(A) If a member is receiving an EPSDT screening and an additional focused complaint arises that requires evaluation and management to address the complaint, the provider may deliver all medically necessary care and submit a claim for both the EPSDT screening and the appropriate level of focused service if the following requirements are met:

- (i) The medical issue is significant enough to require additional work to address the issue;
- (ii) The visit is documented on a separate note;
- (iii) Appropriate documentation that clearly lists the condition being managed at the time of the encounter and supports the billing of both services; and

(iv) Modifier 25 is added to the appropriate code that indicates that a separate evaluation and management service was provided by the same physician on the same day as the EPSDT screening. All claims submitted with Modifier 25 will be reviewed prior to payment, per Oklahoma Administrative Code (OAC) 317:30-3-33. The following items will be reviewed prior to any payment:

- (I) Medical necessity;
- (II) Appropriate utilization of Modifier 25; and
- (III) All documentation to support both the EPSDT screening and the additional evaluation and management for a focused complaint must be submitted for review.

(v) All claims are subject to a post payment review by the OHCA's Program Integrity Unit.

(B) When providing evaluation and management of a focused complaint, during an EPSDT screening, the provider may claim only the additional time that is required above and beyond the completion of the EPSDT screening.

(C) An insignificant or trivial problem that is encountered in the process of performing the preventive evaluation and management service and does not require additional work is included in the EPSDT visit and should not be billed/reported.

(5) There may be other additional diagnostic procedures or treatments not normally considered part of a comprehensive examination, including diagnostic tests and administration of immunizations, required at the time of screening. Additional diagnostic procedures or treatments may be billed independently from the screening. Some services as set out in this section may require prior authorization.

(6) For an EPSDT screening to be considered a completed reimbursable service, providers must perform, and document, all

required components of the screening examination. Documentation of screening services performed must be retained for future review.

(7) All comprehensive screenings provided to individuals under age twenty-one (21) must be filed on HCFA-1500 using the appropriate preventive medicine procedure code or an appropriate Evaluation and Management code from the Current Procedural Terminology Manual (CPT) accompanied by the appropriate well-child exam diagnosis code.

(8) For EPSDT services in a school-based setting that are provided pursuant to an IEP, please refer to Part 103, Qualified Schools As Providers Of Health-Related Services, in OAC 317:30-5-1020 through 317:30-5-1028.

[Source: Added at 23 Ok Reg 2463, eff 6-25-06 ; Amended at 35 Ok Reg 1394, eff 10-1-18 ; Amended at 37 Ok Reg 1486, eff 9-14-20 ; Amended at 40 Ok Reg 655, eff 3-1-23 (emergency); Amended at 40 Ok Reg 2183, eff 9-11-23]

317:30-3-65.1. Minimum required screenings [REVOKED]

[Source: Added at 23 Ok Reg 2463, eff 6-25-06 ; Revoked at 35 Ok Reg 1394, eff 10-1-18]

317:30-3-65.10. Periodic and interperiodic screening examinations

(a) **Periodic screening examination.** Periodic screenings must be provided in accordance with the recommended American Academy of Pediatrics' Bright Futures' periodicity schedule following the initial screening.

(b) **Interperiodic screening examination.** Interperiodic screenings must be provided when medically necessary to determine the existence of suspected physical or mental illnesses or conditions. This may include, but is not limited to, physical, mental or dental conditions. The screening components must include health and physical history, physical examination, assessment and administration of necessary immunizations, check of nutritional status, appropriate lab and x-ray and anticipatory guidance. The determination of whether an interperiodic screen is medically necessary may be made by a health, developmental or educational professional who comes into contact with the member outside of the formal health care system. Claims for interperiodic screenings must be billed under the appropriate Current Procedural Terminology codes on form HCFA-1500 for services that are determined medically necessary.

[Source: Added at 23 Ok Reg 2463, eff 6-25-06 ; Amended at 35 Ok Reg 1394, eff 10-1-18]

317:30-3-65.11. Partial screening examination

A partial screening may be paid if the provider cannot provide all of the minimum components of the screening.

[Source: Added at 23 Ok Reg 2463, eff 6-25-06]

317:30-3-65.12. Applied behavior analysis (ABA) services

ABA services are provided under the EPSDT benefit. Refer to OAC 317:30-5-310 through 317:30-5-316 for coverage, provider and program requirements, and reimbursement methodology.

[Source: Added at 36 Ok Reg 1099, eff 7-1-19 (emergency); Added at 37 Ok Reg 514, eff 1-6-20 (emergency); Added at 37 Ok Reg 1492, eff 9-14-20 ; Amended at 38 Ok Reg 981, eff 9-1-21 ; Amended at 39 Ok Reg 1455, eff 9-12-22]

317:30-3-65.2. Periodicity schedule

The Oklahoma Health Care Authority (OHCA) requires that physicians providing reimbursable Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screens adopt and utilize the guidelines established by the American Academy of Pediatrics' Bright Futures' periodicity schedule.

[Source: Added at 23 Ok Reg 2463, eff 6-25-06 ; Amended at 35 Ok Reg 1394, eff 10-1-18]

317:30-3-65.3. Initial screening examination

An initial EPSDT screening may be requested by an eligible individual at any time and must be provided without regard to whether the individual's age coincides with the established periodicity schedule.

[Source: Added at 23 Ok Reg 2463, eff 6-25-06]

317:30-3-65.4. Screening components

Comprehensive Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screenings are performed by, or under the supervision of, a SoonerCare physician or other SoonerCare practitioner. SoonerCare physicians are defined as all licensed allopathic and osteopathic physicians in accordance with the rules and regulations covering the Oklahoma Health Care Authority's (OHCA) SoonerCare program. Other SoonerCare practitioners are defined as all contracted physician assistants and advanced practice registered nurses in accordance with the rules and regulations covering the OHCA's SoonerCare program. At a minimum, screening examinations must include, but not be limited to, the following components:

(1) **Comprehensive health and developmental history.** Health and developmental history information may be obtained from the parent or other responsible adult who is familiar with the member's history and include an assessment of both physical and mental health development. Coupled with the physical examination, this includes:

(A) **Developmental assessment.** Developmental assessment includes a range of activities to determine whether an individual's developmental processes fall within a normal range of achievement according to age group and cultural background. Screening for development assessment is a part of every routine, initial and periodic screening examination. Acquire information

on the member's usual functioning as reported by the member, teacher, health professional or other familiar person. Review developmental progress as a component of overall health and well-being given the member's age and culture. As appropriate, assess the following elements:

- (i) Gross and fine motor development;
- (ii) Communication skills, language and speech development;
- (iii) Self-help, self-care skills;
- (iv) Social-emotional development;
- (v) Cognitive skills;
- (vi) Visual-motor skills;
- (vii) Learning disabilities;
- (viii) Psychological/psychiatric problems;
- (ix) Peer relations; and
- (x) Vocational skills.

(B) **Assessment of nutritional status.** Nutritional assessment may include preventive treatment and follow-up services including dietary counseling and nutrition education if appropriate. This is accomplished in the basic examination through:

- (i) Questions about dietary practices;
- (ii) Complete physical examination, including an oral dental examination;
- (iii) Height and weight measurements;
- (iv) Laboratory test for iron deficiency; and
- (v) Serum cholesterol screening, if feasible and appropriate.

(2) **Comprehensive unclothed physical examination.**

Comprehensive unclothed physical examination includes the following:

(A) **Physical growth.** Record and compare height and weight with those considered normal for that age. Record head circumference for children under one year of age. Report height and weight over time on a graphic recording sheet.

(B) **Unclothed physical inspection.** Check the general appearance of the member to determine overall health status and detect obvious physical defects. Physical inspection includes an examination of all organ systems such as pulmonary, cardiac, and gastrointestinal.

(3) **Immunizations.** Legislation created the Vaccine for Children Program effective October 1, 1994. Vaccines are provided free of charge to all enrolled providers for SoonerCare eligible children and adolescents. Participating providers may bill for an administration fee set by the Centers for Medicare and Medicaid Services (CMS) on a regional basis. They may not refuse to immunize based on inability to pay the administration fee.

(4) **Appropriate laboratory tests.** A blood lead screening test (by either finger stick or venipuncture) must be performed between the ages of nine and 12 months and at 24 months. A

blood lead test is required for any child up to age 72 months who had not been previously screened. A blood lead test equal to or greater than 10 micrograms per deciliter (ug/dL) obtained by capillary specimen (fingerstick) must be confirmed using a venous blood sample. If a child is found to have blood lead levels equal to or greater than 10 ug/dL, the Oklahoma Childhood Lead Poison Prevention Program (OCLPPP) must be notified according to rules set forth by the Oklahoma State Board of Health defined in Oklahoma Administrative Code (OAC) 310:512-3-5.

(A) The OCLPPP schedules an environmental inspection to identify the source of the lead for children who have a persistent blood lead level 15 ug/dL or greater.

Environmental inspections are provided through the Oklahoma State Department of Health (OSDH) upon notification from laboratories or providers and reimbursed through the OSDH cost allocation plan approved by OHCA.

(B) Medical judgment is used in determining the applicability of all other laboratory tests or analyses to be performed unless otherwise indicated on the periodicity schedule. If any laboratory tests or analyses are medically contraindicated at the time of the screening, they are provided when no longer medically contraindicated.

Laboratory tests should only be given when medical judgment determines they are appropriate. However, laboratory tests should not be routinely administered.

(5) **Health education.** Health education is a required component of screening services and includes anticipatory guidance. At the outset, the physical and dental assessment, or screening, gives the initial context for providing health education. Health education and counseling to parents, guardians or members is required. It is designed to assist in understanding expectations of the member's development and provide information about the benefits of healthy lifestyles and practices as well as accident and disease prevention.

(6) **Vision and hearing screens.** Vision and hearing services are subject to their own periodicity schedules. However, age-appropriate vision and hearing assessments may be performed as a part of the screening as outlined at OAC 317:30-3-65.7 and 317:30-3-65.9.

(7) **Dental screening services.** An oral screening may be included in the EPSDT screening and as a part of the nutritional status assessment. Federal regulations require a direct dental referral for every member in accordance with the American Academy of Pediatric Dentistry periodicity schedule and at other intervals as medically necessary. Therefore, when an oral screening is done at the time of the EPSDT screening, the member may be referred directly to a dentist for further screening and/or treatment. Specific dental services are outlined in OAC 317:30-3-65.8.

(8) **Maternal depression screens.** A maternal depression screening may be provided to the child's mother during the child's EPSDT screening as per the established guidelines in the American Academy of Pediatrics Bright Futures' periodicity schedule.

(9) **Reporting suspected abuse and/or neglect.** Instances of child abuse and/or neglect are to be reported in accordance with state law, including, but not limited to, 10A Oklahoma Statute (O.S.) § 1-2-101 and 43A O.S. § 10-104. Any person suspecting child abuse or neglect shall immediately report it to the Oklahoma Department of Human Services (DHS) hotline, at 1-800-522-3511; any person suspecting abuse, neglect, or exploitation of a vulnerable adult shall immediately report it to the local DHS County Office, municipal or county law enforcement authorities, or, if the report occurs after normal business hours, the DHS hotline. Health care professionals who are requested to report incidents of domestic abuse by adult victims with legal capacity shall promptly make a report to the nearest law enforcement agency, per 22 O.S. § 58.

[Source: Added at 23 Ok Reg 2463, eff 6-25-06 ; Amended at 24 Ok Reg 76, eff 8-2-06 (emergency); Amended at 24 Ok Reg 892, eff 5-11-07 ; Amended at 26 Ok Reg 2081, eff 6-25-09 ; Amended at 35 Ok Reg 1394, eff 10-1-18 ; Amended at 36 Ok Reg 880, eff 9-1-19]

317:30-3-65.5. Diagnosis and treatment

When a screening indicates the need for further evaluation of an individual's health, a referral for appropriate diagnostic studies or treatment services must be provided without delay. Diagnostic services are defined as those services necessary to fully evaluate defects, physical or behavioral health illnesses or conditions discovered by the screening.

(1) Health care, treatment, or other measures to correct or ameliorate defects, physical or mental illnesses or conditions must also be provided and will be covered by the EPSDT/OHCA Child Health Program as medically necessary. The defects, illnesses and conditions must have been discovered during the screening or shown to have increased in severity.

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

(3) 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. For more information regarding experimental or investigational including clinical trials, see Oklahoma Administrative Code 317:30-3-57.1.

[Source: Added at 23 Ok Reg 2463, eff 6-25-06 ; Amended at 38 Ok Reg 970, eff 9-1-21]

317:30-3-65.6. Documentation of Services

Records for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screens must contain adequate documentation of services rendered. Such documentation must include the physicians' signature or identifiable initials for every prescription or treatment. Documentation of records may be completed manually or electronically in accordance with guidelines found at OAC 317:30-3-15. Each required element of the age specific screening must be documented with a description of any noted problem, anomaly or concern. In addition, a plan for following necessary diagnostic evaluations, procedures and treatments, must be documented.

[Source: Added at 23 Ok Reg 2463, eff 6-25-06 ; Amended at 35 Ok Reg 1394, eff 10-1-18]

317:30-3-65.7. Vision services

Children and adolescents should receive periodic eye and vision examinations to diagnose and treat any eye disease in its early stages in order to prevent or minimize vision loss and maximize visual abilities.

(1) At a minimum, vision services include diagnosis and treatment for defects in vision, including eyeglasses once each twelve (12) months. In addition, payment is made for glasses for members with congenital aphakia or following cataract removal (refer to OAC 317:30-5-2(b)(5) for amount, duration, and scope). Payment is limited to only two (2) glasses per year for a member. Any glasses beyond the two (2) glasses limit must be prior authorized and determined to be medically necessary (refer to 317:30-5-432.1 for more information on corrective lenses and optical supplies).

(2) The OHCA recommends that physicians adopt and utilize the American Optometric Association standards for vision screenings and examinations.

[Source: Added at 23 Ok Reg 2463, eff 6-25-06 ; Amended at 31 Ok Reg 648, eff 7-1-14 (emergency); Amended at 32 Ok Reg 1031, eff 8-27-15 ; Amended at 35 Ok Reg 1394, eff 10-1-18]

317:30-3-65.8. Dental services

(a) At a minimum, dental services include relief of pain and infection; limited restoration of teeth and maintenance of dental health; and oral prophylaxis every six (6) months. Dental care includes emergency and preventive services and therapeutic services for dental disease which, if left untreated, may become acute dental problems or may cause irreversible damage to the teeth or supporting structures. Other dental services include inpatient services in an eligible participating hospital, and amalgam and composite restorations, pulpotomies, chrome steel crowns, anterior root canals, pulpectomies, band and loop space maintainers, acrylic partial and lingual arch bars; other restoration, repair and/or replacement of dental defects after the treatment plan submitted by a dentist has been authorized [refer to Oklahoma Administrative Code 317:30-5-696(2) for amount, duration and scope].

(b) Dental screenings should begin at the first sign of tooth eruption by the primary care provider and with each subsequent visit to determine if

the member needs a referral to a dental provider. Dental examinations by a qualified dental provider should begin by age one (1)(unless otherwise indicated) and every six (6) months to one (1) year thereafter.

Additionally, members should be seen for prophylaxis once every six (6) months, if indicated by risk assessment. All other dental services for relief of pain and infection, restoration of teeth and maintenance of dental health should occur as the provider deems necessary.

(c) Separate payment will be made to the member's primary care provider for the application of fluoride varnish during the course of a child-health screening for members ages six (6) months to sixty (60) months. Reimbursement is limited to two applications per year.

[Source: Added at 23 Ok Reg 2463, eff 6-25-06 ; Amended at 28 Ok Reg 1419, eff 6-25-11 ; Amended at 31 Ok Reg 1630, eff 9-12-14 ; Amended at 35 Ok Reg 1394, eff 10-1-18 ; Amended at 39 Ok Reg 1464, eff 9-12-22]

317:30-3-65.9. Hearing services

(a) At a minimum, hearing services include hearing evaluation once every twelve (12) months, hearing aid evaluation if indicated and purchase of a hearing aid when prescribed by a state licensed audiologist who:

- (1) holds a certificate of clinical competence from the American Speech and Hearing Association of the American Academy of Audiologists; or
- (2) has completed the equivalent educational requirements and work experience necessary for the certificate; or
- (3) has completed the academic program and is acquiring supervised work experience necessary for the certificate; and
- (4) holds a contract with Oklahoma Health Care Authority (OHCA) to perform such an evaluation and obtains prior authorization for the evaluation.

(b) Interperiodic hearing examinations are allowed at intervals outside the periodicity schedule when a hearing condition is suspected (refer to OAC 317:30-5-676 for amount, duration and scope). The following schedule outlines the services required in the EPSDT/OHCA child-health screening program for hearing services adopted by the OHCA.

- (1) Birth. Physiologic screen utilizing automated brainstem response testing or otoacoustic emissions testing.
- (2) Two (2) to five (5) months. Subjective screens. Question if passed physiologic newborn hearing screen months in both ears in addition to caregiver concerns regarding hearing sensitivity.
- (3) Six (6) to twelve (12) months. Infants with Joint Committee on Infant Hearing (JCIH) risk factors are screened/assessed with physiologic or behavioral measures which can include visual reinforcement audiometry, acoustic immittance/reflexes testing, auditory brainstem response testing and/or otoacoustic emissions testing. Infants without risk factors are screened subjectively with auditory behavior development checklist.
- (4) Eighteen (18) months. Subjective screen. To include brief questionnaire regarding appropriate speech and language development.

- (5) Twenty-four (24) months. Members with JCIH risk factors screened/assessed with physiologic or behavioral measures including visual reinforcement audiometry, immittance/reflex testing and/or otoacoustic emissions, or acoustic. Subjective screen for all others to include concerns of caregivers and brief questionnaire regarding speech and language development.
- (6) Three (3) years. Behavioral or physiologic screen/assessment which can include either conditioned play audiometry, acoustic immittance testing (including reflexes), pneumatic otoscopy, or otoacoustic emissions.
- (7) Four (4) years. Behavioral or physiologic screen/assessment which can include either conditioned play audiometry, acoustic immittance testing (including reflexes), or otoacoustic emissions.
- (8) Five (4) to six (6) years. Behavioral screen if not completed in school including conventional behavioral pure tone screening.
- (9) Eight (8), ten (10) and twelve (12) years. Behavioral screen if not completed in school including conventional behavioral pure tone screening.
- (10) Fifteen (15) and eighteen (18) years. Subjective screening to include concerns regarding school and home communicative performance.

[Source: Added at 23 Ok Reg 2463, eff 6-25-06 ; Amended at 35 Ok Reg 1394, eff 10-1-18]

PART 5. ELIGIBILITY [REVOKED]

317:30-3-70. Categorical relationship [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 18 Ok Reg 2557, eff 6-25-01 ; Amended at 20 Ok Reg 2762, eff 7-1-03 (emergency); Amended at 21 Ok Reg 2176, eff 6-25-04 ; Revoked at 30 Ok Reg 1131, eff 7-1-13]

317:30-3-71. Financial need [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 16 Ok Reg 685, eff 12-28-98 (emergency); Amended at 16 Ok Reg 1429, eff 5-27-99 ; Amended at 20 Ok Reg 2762, eff 7-1-03 (emergency); Amended at 21 Ok Reg 2176, eff 6-25-04 ; Revoked at 30 Ok Reg 1131, eff 7-1-13]

317:30-3-72. Spenddown [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 20 Ok Reg 2762, eff 7-1-03 (emergency); Revoked at 21 Ok Reg 2176, eff 6-25-04]

317:30-3-73. Persons eligible for medical assistance [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 16 Ok Reg 685, eff 12-28-98 (emergency); Amended at 16 Ok Reg 1429, eff 5-27-99 ; Amended at 19 Ok Reg 63, eff 9-1-01 ; Amended at 19 Ok Reg 2127, eff 6-27-02 ; Revoked at 21 Ok Reg 2201, eff 6-25-04]

**317:30-3-74. Persons not eligible for medical assistance
[REVOKED]**

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 23 Ok Reg 263, eff 9-1-05 (emergency); Revoked at 23 Ok Reg 1352, eff 5-25-06]

317:30-3-75. Person codes [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 18 Ok Reg 2557, eff 6-25-01 ; Revoked at 30 Ok Reg 1131, eff 7-1-13]

317:30-3-76. Retroactive eligibility [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 21 Ok Reg 2201, eff 6-25-04]

317:30-3-77. Notification of needed medical services [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 21 Ok Reg 2201, eff 6-25-04 ; Revoked at 30 Ok Reg 1131, eff 7-1-13]

**317:30-3-78. Request for prior authorization for dental services
[REVOKED]**

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 20 Ok Reg 1924, eff 6-26-03 ; Amended at 23 Ok Reg 2489, eff 6-25-06 ; Revoked at 35 Ok Reg 1383, eff 9-14-18]

**317:30-3-79. Hearing appliance prescription and supplier request
for prior authorization [REVOKED]**

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 14 Ok Reg 524, eff 12-24-96 (emergency); Amended at 14 Ok Reg 1785, eff 5-27-97 ; Amended at 16 Ok Reg 1927, eff 6-11-99 ; Revoked at 35 Ok Reg 1383, eff 9-14-18]

**317:30-3-80. Physician's prescription for appliances, prostheses,
and/or medical equipment and medical suppliers request for prior
authorization [REVOKED]**

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 18 Ok Reg 477, eff 1-1-01 (emergency); Amended at 18 Ok Reg 1130, eff 5-11-01 ; Revoked at 26 Ok Reg 3028, eff 9-1-09 (emergency); Amended at 27 Ok Reg 936, eff 5-13-10]

**317:30-3-81. Notification of eligibility status for assistance
(adults) [REVOKED]**

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 30 Ok Reg 1131, eff 7-1-13]

**317:30-3-82. Prior authorization for services to individuals under
21 years of age [REVOKED]**

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 15 Ok Reg 4182, eff 8-5-98 (emergency); Amended at 16 Ok Reg 1429, eff 5-27-99 ; Amended at 17 Ok Reg 805, eff 7-16-99 (emergency); Amended at 17 Ok Reg 1204, eff 5-11-00 ; Amended at 18 Ok Reg 477, eff 1-1-01 (emergency); Amended at 18 Ok Reg 1130, eff 5-11-01 ; Amended at 20 Ok Reg 1924, eff 6-26-03 ; Revoked at 35 Ok Reg 1383, eff 9-14-18]

317:30-3-83. Prior authorization for services to adults [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 15 Ok Reg 4182, eff 8-5-98 (emergency); Amended at 16 Ok Reg 1429, eff 5-27-99 ; Revoked at 35 Ok Reg 1383, eff 9-14-18]

317:30-3-84. Catastrophic illness [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 14 Ok Reg 749, eff 12-24-96 (emergency); Amended at 14 Ok Reg 1785, eff 5-27-97 ; Revoked at 20 Ok Reg 2762, eff 7-1-03 (emergency); Revoked at 21 Ok Reg 2176, eff 6-25-04]

317:30-3-85. Citizenship and alienage [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 24 Ok Reg 2068, eff 6-25-07 ; Revoked at 30 Ok Reg 1131, eff 7-1-13]

317:30-3-86. Residency [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 30 Ok Reg 1131, eff 7-1-13]

317:30-3-87. Presumptive eligibility [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 30 Ok Reg 1131, eff 7-1-13]

317:30-3-88. Medical identification card [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 16 Ok Reg 685, eff 12-28-98 (emergency); Amended at 16 Ok Reg 2733, eff 3-15-99 (emergency); Amended at 16 Ok Reg 1429, eff 5-27-99 ; Amended at 35 Ok Reg 10, eff 8-10-17 (emergency); Revoked at 35 Ok Reg 1500, eff 9-14-18]

PART 6. OUT-OF-STATE SERVICES

317:30-3-89. Definitions

The following words or terms used in this Part shall have the following meaning, unless the context clearly indicates otherwise:

"Emergency" means a serious situation or occurrence that happens unexpectedly and demands immediate action such as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected, by a reasonable and prudent layperson, to result in placing the member's health in serious jeopardy,

serious impairment to bodily function, or serious dysfunction of any bodily organ or part.

"Out-of-state provider" means a provider contracted with SoonerCare in accordance with Oklahoma Administrative Code (OAC) 317:30-3-2, if:

- (A) The physical address where services are or will be rendered is located outside the Oklahoma border and within the United States; or
- (B) The physical address where services are or will be rendered is located within the Oklahoma border, but:
 - (i) The out-of-state provider maintains all member and/or billing records outside the Oklahoma border; and
 - (ii) The out-of-state provider is unable to produce the originals or exact copies of the member and/or billing records from the location in Oklahoma where services are rendered.

"Temporary" means lasting for a limited period of time, such as when a member is on vacation, but does not include situations in which a SoonerCare member leaves Oklahoma for the purpose of receiving medical care and treatment.

[Source: Added at 36 Ok Reg 872, eff 9-1-19]

317:30-3-90. Out-of-state services

(a) Consistent with Section 431.52 of Title 42 of the Code of Federal Regulations (C.F.R.), an eligible SoonerCare member who is a resident of Oklahoma but who is temporarily out of state, may receive services from an out-of-state provider to the same extent that he or she would receive such services in Oklahoma, if:

- (1) Medical services are needed for a medical emergency, as determined by the attending physician or other provider (M.D., D.O., P.A., or AP.R.N), or a dentist [Doctor of Dental Surgery (DDS), or Doctor of Medicine in Dentistry (DMD)]. For any provider, who is not contracted at the time the services are provided, documentation as requested from the Oklahoma Health Care Authority (OHCA) of the emergency must be submitted, including, but not limited to, emergency room reports, medical histories, discharge summaries, and all other relevant medical reports.
- (2) Medical services are needed and the member's health would be endangered if he or she were required to return to Oklahoma for medical care and treatment, as determined by the attending physician or other provider (M.D., D.O., P.A., or AP.R.N), or a dentist [Doctor of Dental Surgery (DDS), or Doctor of Medicine in Dentistry (DMD)]. For any provider, who is not contracted at the time the services are provided, documentation of the nature and possible extent of the endangerment must be submitted as requested from the OHCA.

(3) The Oklahoma Health Care Authority's (OHCA) Chief Medical Officer (CMO), or his or her designee, determines, on the basis of medical advice, that the needed medical services, or necessary supplemental resources, are more readily available in the state where the member is located at the time of needing medical treatment. Prior authorization must be obtained from the OHCA's CMO, or his or her designee, before the services are rendered.

(b) Per 42 C.F.R. § 431.52, if it is the customary or general practice for SoonerCare members who are residing in a particular locality within Oklahoma to use medical or dental resources in another state, reimbursement is available for services furnished in another State to the same extent that reimbursement for services is furnished within Oklahoma boundaries. The services being rendered must be provided by a provider who is contracted with the OHCA and must be appropriately licensed and in good standing with the state in which they practice.

(1) Except for out-of-state inpatient psychiatric services, no prior authorization is necessary for services provided in accordance with paragraph (b), above, if the member obtains them from an out-of-state provider that is:

(A) Located in a border state (Arkansas, Colorado, Kansas, Missouri, New Mexico, or Texas) within fifty (50) miles of the Oklahoma border, with exceptions for dental services. The OHCA will allow the member to travel up to one hundred (100) miles of the Oklahoma border to receive dental services; and

(B) Provided, however, that nothing in this paragraph shall be interpreted to eliminate or otherwise affect a prior authorization requirement established by any other OHCA rule, including, but not limited to, Oklahoma Administrative Code (OAC) 317:30-3-31, that would have to be met if the health care-related good and/or service were provided in Oklahoma.

(2) In all other instances, prior authorization must be obtained from the OHCA's CMO, or his or her designee, before the services are rendered.

(c) Clinical trials, either in-state or out-of-state, will need to adhere to any federal regulations which provides for certain exceptions to OHCA's out-of-state policy. For the full clinical trials policy, please refer to OAC 317:30-3-57.1.

(d) Except as provided in subsections (a)(1),(a)(2) ,(b)(1) and (c), above, SoonerCare will not pay for any services furnished by an out-of-state provider unless prior authorization has been obtained from the OHCA's CMO, or his or her designee, before the services are rendered. Prior authorization for out of state services must be obtained in all instances in which the member is located in Oklahoma at the time the services are determined to be medically necessary.

(1) As part of this authorization process, the following documents must be submitted to the OHCA's CMO, or his or her designee:

(A) Documents sufficient to establish the "medical necessity" of the services requested, as that term is defined by OAC 317:30-3-1(f). See also OAC 317:30-3-31,

Prior authorization for health care-related goods and services. Examples of such documents may include, but are not limited to, Histories of Present Illnesses (HPIs), physical exams, laboratory reports, imaging reports, progress notes, hospital charts, and/or other relevant medical records; and

(B) Documents sufficient to establish that the health care needs of the member cannot be met in Oklahoma. Such documents shall include, but not be limited to, a letter from the referring provider that contains:

- (i) A clear presentation of the member's medical condition and diagnosis for which out-of-state treatment is requested, including a summary of treatment to date that is supported by the documents in paragraph (c)(1)(A), above;
- (ii) Names of physicians and/or facilities in Oklahoma that the member has previously been referred to for diagnosis and/or treatment;
- (iii) Physicians consulted by the attending physician relative to diagnosis and/or availability of recommended treatment in Oklahoma;
- (iv) Recommended treatment or further diagnostic work; and
- (v) Reasons why medical care cannot be provided in Oklahoma or the next closest location outside Oklahoma.

(C) Except for emergency medical, behavioral health cases, and as provided in subsections (a)(1),(a)(2) and (b) (1), above, prior authorization requests for out-of-state services must be made in writing with all the necessary documents that show medical necessity and details of the services provided, including but not limited to, relevant medical history, description of services and procedures to be performed, Histories of Present Illnesses (HPIs), physical exams, laboratory reports, imaging reports, and received by the OHCA at least ten (10) calendar days prior to the date services are to be provided in another state or at the discretion of the CMO or his/her designee.

- (i) Emergency medical, behavioral health, and dental cases must be identified as such by the physician or provider in the prior authorization request.
- (ii) Any telephone request for prior authorization of out-of-state services will only be accepted in emergency situations, and must be promptly followed by a written request.

(2) Prior authorization requirements for medically necessary lodging, transportation, and/or meals assistance associated with out-of-state services are established in other OHCA rules, including, but not limited to, OAC 317:30-3-92 and 317:30-5-327.1. In accordance with federal regulations, exceptions to prior

authorization requirements will be made for members who are participating in a clinical trial that require out-of-state medically necessary services. For the full clinical trials policy, please refer to OAC 317:30-3-57.1.

(e) The limitations established in subsections (a) through (c), above, shall not apply to children who reside outside of Oklahoma and for whom the Oklahoma Human Services (OKDHS) makes Title IV-E adoption assistance payments or Title IV-E foster care maintenance payments.

(f) Denials of requests for prior authorization may be appealed in accordance with OAC 317:2-1-2(d)(1)(C).

(g) Out-of-state providers shall, upon request by authorized OHCA representatives, make available fiscal and medical records as required by applicable federal regulations, OHCA rules, and the Provider Agreement. Such records shall be made available for review by authorized OHCA representatives at the OHCA's address in Oklahoma City, Oklahoma.

[Source: Added at 36 Ok Reg 872, eff 9-1-19 ; Amended at 38 Ok Reg 985, eff 9-1-21 ; Amended at 40 Ok Reg 2179, eff 9-11-23]

317:30-3-91. Reimbursement of services rendered by out-of-state providers

(a) Before an out-of-state provider can receive reimbursement, it shall contract with SoonerCare and be subject to enrollment, including, but not limited to, providing information requested by the Oklahoma Health Care Authority (OHCA) such as name, address, Social Security Number or Tax Identification Number, and verification of licensure and insurance. Out-of-state providers are also subject to the same screening rules, policies, and procedures as in-state providers, including, but not limited to Oklahoma Administrative Code (OAC) 317:30-3-2, and 317:30-3-19.3 through 317:30-3-19.4. Once the OHCA approves enrollment, the provider will receive a SoonerCare provider number that will allow claims to be processed.

(b) While the member's physician may suggest where the member be sent, the OHCA's Chief Medical Officer (CMO), or his or her designee, is responsible for making the final determination based on the most cost effective institution and treatment consistent with the recognized standards of care. Reimbursement for services rendered by out-of-state providers shall be as follows:

(1) Reimbursement for inpatient hospital services shall be made in accordance with OAC 317:30-5-47.

(2) Reimbursement for outpatient hospital services shall be made in accordance with OAC 317:30-5-42.14 and 317:30-5-566.

(3) Reimbursement for physician services shall be the lower of the SoonerCare maximum allowable fee as of the date the service was rendered, available at www.okhca.org (SoonerCare Fee Schedules), or the provider's actual charge. Exceptions to the above reimbursement method are payments for outpatient clinical diagnostic laboratory tests performed by a physician or independent laboratory. These tests will be reimbursed at the lower of the provider's actual charge or a rate of reimbursement equal to the rate paid by Medicare.

- (4) Unless authorized by the Oklahoma State Plan, any reimbursement shall not exceed the rate paid by Medicare.
- (c) The OHCA may negotiate a higher reimbursement rate for an out-of-state service that is prior authorized, provided that:
- (1) The service is not available in Oklahoma; and
 - (2) The negotiated reimbursement does not exceed the rate paid by Medicare, unless as authorized by the Oklahoma State Plan.
- Services not covered by Medicare but covered by SoonerCare may be reimbursed as determined by the OHCA.
- (d) Individual cases which are adversely affected by these reimbursement procedures may be presented to the OHCA's CMO, or his or her designee, for consideration as an exception to this rule on a case-by-case basis. The CMO's decision, or that of his or her designee, shall be the agency's final decision and is not otherwise appealable under these rules.
- (e) Reimbursement of medically necessary lodging, transportation, and/or meals assistance associated with out-of-state services is governed by other OHCA rules, including, but not limited to, OAC 317:30-3-92 and 317:30-5-327.1, as well as Part 31 of OAC 317:30-5.

[Source: Added at 36 Ok Reg 872, eff 9-1-19 ; Amended at 38 Ok Reg 985, eff 9-1-21]

317:30-3-92. Lodging and meals services

(a) Requests for lodging and meals services.

(1) Requests for lodging and meals services shall derive from the treating facility or the member. All requests shall be submitted at least three (3) business days prior to check-in, with exceptions made only in emergency situations. Requests will include, but are not limited to, the following information:

(A) SoonerCare member information:

- (i) Name;
- (ii) SoonerCare ID number;
- (iii) Address;
- (iv) Member diagnosis;

(B) Visit information:

- (i) Inpatient/outpatient visit;
- (ii) Facility name;
- (iii) Provider name and number;
- (iv) Appointment date and time:
 - (I) Check-in time;
 - (II) Duration of stay if inpatient;
 - (III) Admission date and time;

(C) Services requested:

- (i) Lodging;
- (ii) Meals; or
- (iii) Both lodging and meals;

(D) Medical escort information:

- (i) Name;
 - (ii) Relationship to member;
 - (iii) Medical necessity for the need of an escort;
- and

- (E) Any special accommodations that need to be met.
- (2) Any additional documentation, including medical records, that may be needed to determine the need for lodging and meals services.

(b) Meal requirements.

- (1) At least two (2) meals shall be provided/served to receive the per diem payment.
- (2) Meals provided shall strive to meet the nutritional guidance outlined in the current United States Department of Agriculture and Health and Human Services Dietary Guidelines.
- (3) Meals may be hot, cold, frozen, dried, or canned (with a satisfactory storage life).

(c) Reimbursement for lodging and meals services.

(1) Payment is made for lodging and/or meals assistance for an eligible member and one (1) approved medical escort, if needed, only when medically necessary and in connection with SoonerCare compensable services. For medically necessary criteria, please refer to Oklahoma Administrative Code 317:30-3-1 (f) (1) through (6). The Oklahoma Health Care Authority (OHCA) has discretion and final authority to approve or deny any lodging and/or meal services.

(A) Lodging and/or meals are reimbursable when prior approved. Payment for lodging and/or meals is limited to a period of up to twenty-four (24) hours prior to the start of member's medical service(s) and up to twenty-four (24) hours after the service(s) end. If travel arrangements cannot meet these timeframes, due to travel issues/restrictions and/or medically necessary services, then lodging and/or meals may be provided with approval from the OHCA.

(B) Lodging and/or meals will not be provided if a suitable alternative is available at a hospital or non-profit. Factors to be considered in determining availability include, but are not limited to:

- (i) Type of hospital room;
- (ii) Availability of "rooming-in";
- (iii) Shower facilities available for use by the medical escort; and
- (iv) Member's anticipated length of stay.

(C) The following conditions shall be met for lodging and/or meals to be reimbursed, unless the lodging and/or meals provision is determined to be the most cost-effective alternative:

- (i) Travel to obtain specialty care at the closest appropriate facility and be fifty (50) miles or greater from the member's home;
- (ii) The trip cannot be completed during SoonerRide operating hours or the member's medical treatment/condition requires an overnight stay; and

(iii) Medical necessity is confirmed and the medical escort will be actively engaged and participative in compensable care.

(D) Meals will be reimbursed if lodging criteria is met. Duration of the trip must be eighteen (18) hours or greater.

(E) Reimbursement for meals is based on a daily per diem and may be used for breakfast, lunch, or dinner, or all three (3) meals, as required.

(i) If meals or meal vouchers are provided by either the hospital or the lodging provider, additional reimbursement will not be provided to the member.

(ii) If meals or meal vouchers are not provided by either the hospital or lodging provider, the member may be reimbursed for getting meals outside of the hospital or lodging provider. In lieu of meals out, groceries may be reimbursed up to the daily per diem limit.

(iii) If meals or meal vouchers are provided by the lodging provider, but the member has a medically indicated dietary need that the lodging provider would not meet on a normal basis, the member may provide their own meals and be reimbursed.

(I) Members will be reimbursed based on the daily per diem rate. In lieu of meals out, groceries may be reimbursed up to the daily per diem limit.

(II) Medical documentation showing medically necessary dietary needs will need to be provided upon request for these circumstances.

(III) If varying dietary preferences need to be accommodated, that will be at the member's own expense.

(F) During the first fourteen (14) days of a member's inpatient stay, lodging and meals can be approved per a hospital social worker/provider without prior approval. Additional lodging and/or meals beyond the fourteen (14) days must be prior approved by the OHCA.

(G) A member may not receive reimbursement for lodging and/or meals services for days the member is inpatient in a hospital or medical facility since that will be provided at the location that the member is receiving inpatient services.

(2) Criteria for lodging and/or meals reimbursement is as follows:

(A) If lodging and/or meals assistance with contracted room and board providers is not available, the member and the medical escort may request reimbursement assistance by submitting the appropriate travel reimbursement forms. The travel reimbursement forms may be obtained by contacting the SoonerCare Population

Care Management division.

(B) Any lodging and/or meal expenses claimed on the travel reimbursement forms shall be documented with the required receipts. If the compensable service related to lodging/meals is not verifiable, reimbursement will be denied.

(C) Reimbursement for lodging will not exceed maximum State allowable amounts.

(D) In order for lodging to be reimbursed for a medical escort of a hospitalized member, the medical escort is required to actively assist the member during the escort and be of an age of legal majority recognized under State law. In cases where the lodging facility has additional requirements, the medical escort shall comply with them. This includes, but is not limited to, being compliant with the lodging facility's required age to check in.

(E) The lodging provider is not eligible for reimbursement if the member and/or approved medical escort do not stay overnight. If the member and/or escort do not remove personal belongings, the lodging provider may charge the member and/or medical escort for the room that is occupied.

(d) Authorizations and verification of services.

(1) The member and/or medical escort shall review and sign an appropriate attestation, from the lodging provider, verifying the correct dates are listed in the length of stay.

(2) The member and/or medical escort are responsible for notifying the lodging provider, and the OHCA, if they do not stay overnight or if they leave earlier than the days that have been allotted on the authorization. If the member and/or medical escort do not stay overnight, or leave early, the appropriate attestation shall still need to be reviewed, verified, and signed.

(3) The member and/or approved medical escort may be required to sign in/out at the lodging provider's front desk on a daily basis.

(e) Incidental charges, damages, and complaints.

(1) Incidental charges and damages.

(A) Any incidental charges, including costs and services that are not covered under the lodging and meals benefit, will not be paid. If the member and/or medical escort makes any charges outside the scope of the lodging and meals benefit, then the member and/or medical escort shall be responsible for the charges incurred.

(B) The member, and/or approved medical escort, shall be responsible for the payment of any damages that are made to the lodging facility.

(2) Complaints on members/medical escorts.

(A) If a complaint is received from the lodging provider on a member and/or approved medical escort, the OHCA will reassign the member and/or approved medical escort to another lodging facility.

(B) If the OHCA receives more than two (2) complaints on the member and/or medical escort, then the member and/or medical escort will be moved to a probationary period. During the probationary period, the member and/or medical escort will be required to provide his, her, or their own lodging which will be eligible for reimbursement up to the daily per diem rate.

(3) Complaints on providers/lodging facilities.

(A) Any complaints on lodging facilities should be directed to the SoonerCare Population Care Management division. The member should provide as much information as possible, including but not limited to, the time, facility, names, and the exact nature of the complaint.

(B) If the complaint is a safety issue, then the OHCA will assist the member into getting placed with another lodging provider, if available, or make arrangements for lodging reimbursement.

(C) The OHCA will gather all pertinent information and document it into the system to see if there are any ongoing trends with the lodging providers who have had complaints filed on them. The OHCA will use this information to attempt to decrease the likelihood of issue reoccurrences.

(D) If complaints/issues continue to persist, the OHCA will work with the lodging facility and the Oklahoma State Department of Health (OSDH) to create an appropriate solution.

(f) Temporary guardians.

(1) If the Oklahoma Department of Human Services (DHS) removes a child from his/her/their home, a court must appoint a temporary guardian. During this time, the temporary guardian is eligible for medical escort-related lodging and/or meals services. If the minor is in need of medical services and a temporary guardian has not been appointed, then the DHS case worker accompanying the minor is eligible for lodging and/or meal services.

(2) It is the responsibility of the OHCA to determine this necessity. The decision will be based on the following circumstances:

(A) When the individual's health or disability does not permit traveling alone; and

(B) When the individual seeking medical services is a minor child.

(g) Clinical trials. In accordance with federal regulations and OAC 317:30-3-57.1 and 317:30-3-90 (d)(2), exceptions to the lodging and meals prior authorization requirements will be made for members who are participating in a clinical trial that requires the member to go out-of-state.

(h) Final authority. The OHCA has discretion and the final authority in determining the need for lodging and meals, as well as who will be providing the lodging and meals services. This includes the mode of provision for the services, whether it be through a SoonerCare

contracted provider or direct reimbursement to a member or a medical escort.

[Source: Amended and renumbered from 317:30-6-64 at 36 Ok Reg 872, eff 9-1-19 ; Amended at 39 Ok Reg 1475, eff 9-12-22]

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 1. PHYSICIANS

317:30-5-1. Eligible providers

To allow patients free choice of physicians, the Oklahoma Health Care Authority (OHCA) recognizes all licensed medical and osteopathic physicians as being eligible to receive payment for compensable medical services rendered in behalf of a person eligible for such care in accordance with the rules and regulations covering the Authority's medical care programs. Payment will be made to fully licensed physicians who are participating in medical training programs as students, interns, residents, or fellows, or in any other capacity in training for services outside the training setting and are not in a duplicative billing situation. In addition, payment will be made to the employing facility for services provided by physicians who meet all requirements for employment by the Federal Government as a physician and are employed by the Federal Government in an IHS facility or who provide services in a 638 Tribal Facility. Payment will not be made to a provider who has been suspended or terminated from participation in the program.

(1) Payment to physicians under SoonerCare is made for services clearly identifiable as personally rendered services performed on behalf of a specific patient. There are no exceptions to personally rendered services unless specifically set out in coverage guidelines.

(2) Payment is made to the attending physician in a teaching medical facility for compensable services when he/she signs as claimant, and renders personal and identifiable services to the patient in conformity with Federal regulations.

(3) Payment is made to a physician for medically directing the services of a Certified Registered Nurse Anesthetist (CRNA) at a rate of 50% of the physician allowable for anesthesia services.

(4) Payment is made to a physician for the direct supervision of an Anesthesiologist Assistant (AA) at a rate of 50% of the physician allowable for anesthesia services. Direct supervision means the on-site, personal supervision by an anesthesiologist who is present in the office, or is present in the surgical or obstetrical suite when the procedure is being performed and who is in all instances immediately available to provide assistance and direction to the AA while anesthesia services are being performed.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 15 Ok Reg 1083, eff 12-15-97 (emergency); Amended at 15 Ok Reg 1528, eff 5-11-98 ; Amended at 26 Ok Reg 1759, eff 7-1-09 (emergency); Amended at 27 Ok Reg 937, eff 5-13-10]

317:30-5-2. General coverage by category

317:30-5-2.¹ General coverage by category

(a) **Adults.** Payment for adults is made to physicians for medical and surgical services within the scope of the Oklahoma Health Care Authority's (OHCA) SoonerCare program, provided the services are reasonable and necessary for the diagnosis and treatment of illness or injury, or to improve the functioning of a malformed body member. Coverage of certain services must be based on a determination made by the OHCA's medical consultant in individual circumstances.

(1) Coverage includes, but is not limited to, the following medically necessary services:

- (A) Inpatient hospital visits for all SoonerCare covered stays. All inpatient services are subject to post-payment review by the OHCA, or its designated agent.
- (B) Inpatient psychotherapy by a physician.
- (C) Inpatient psychological testing by a physician.
- (D) One (1) inpatient visit per day, per physician.
- (E) Certain surgical procedures performed in a Medicare certified free-standing ambulatory surgery center (ASC) or a Medicare certified hospital that offers outpatient surgical services.
- (F) Therapeutic radiology or chemotherapy on an outpatient basis without limitation to the number of treatments per month for members with proven malignancies.
- (G) Physician services on an outpatient basis include:
 - (i) A maximum of four (4) visits per member per month, including primary care or specialty, with the exception of SoonerCare Choice members.
 - (ii) Additional visits are allowed per month for treatment related to emergency medical conditions and family planning services.
- (H) Direct physician services in a nursing facility.
 - (i) A maximum of two (2) nursing facility visits per month are allowed; and if the visit (s) is for psychiatric services, it must be provided by a psychiatrist or a physician with appropriate behavioral health training.
 - (ii) To receive payment for a second nursing facility visit in a month denied by Medicare for a Medicare/SoonerCare member, attach the explanation of Medicare benefits (EOMB) showing denial and mark "carrier denied coverage."
- (I) Diagnostic x-ray and laboratory services.
- (J) Mammography screening and additional follow-up mammograms as per current guidelines.

(K) Obstetrical care.

(L) Pacemakers and prostheses inserted during the course of a surgical procedure.

(M) Prior authorized examinations for the purpose of determining medical eligibility for programs administered by OHCA. A copy of the authorization, Oklahoma Department of Human Services (OKDHS) form 08MA016E, Authorization for Examination and Billing, must accompany the claim.

(N) If a physician renders direct care to a member on the same day as a dialysis treatment, payment is allowed for a separately identifiable service unrelated to the dialysis.

(O) Family planning includes sterilization procedures for legally competent members twenty-one (21) years of age and over who voluntarily request such a procedure and execute the federally mandated consent form with his/her physician. A copy of the consent form must be attached to the claim form. Separate payment is allowed for the insertion and/or implantation of contraceptive devices during an office visit. Certain family planning products may be obtained through the Vendor Drug Program. Reversal of sterilization procedures for the purposes of conception is not allowed. Reversal of sterilization procedures are allowed when medically indicated and substantiating documentation is attached to the claim.

(P) Genetic counseling.

(Q) Laboratory testing.

(R) Payment for ultrasounds for pregnant women as specified in Oklahoma Administrative Code (OAC) 317:30-5-22.

(S) Payment to the attending physician in a teaching medical facility for compensable services when the physician signs as claimant and renders personal and identifiable services to the member in conformity with federal regulations.

(T) Payment to the attending physician for the services of a currently Oklahoma licensed physician in training when the following conditions are met:

- (i) Attending physician performs chart review and signs off on the billed encounter;
- (ii) Attending physician is present in the clinic/or hospital setting and available for consultation; and
- (iii) Documentation of written policy and applicable training of physicians in the training program regarding when to seek the consultation of the attending physician.

(U) Payment for services rendered by medical residents in an outpatient academic setting when the following conditions are met:

- (i) The resident has obtained a medical license or a special license for training from the appropriate

regulatory state medical board; and

(ii) Has the appropriate contract on file with the OHCA to render services within the scope of their licensure.

(V) The payment to a physician for medically directing the services of a certified registered nurse anesthetist (CRNA) or for the direct supervision of the services of an anesthesiologist assistant (AA) is limited. The maximum allowable fee for the services of both providers combined is limited to the maximum allowable had the service been performed solely by the anesthesiologist.

(W) Screening and follow up pap smears as per current guidelines.

(X) Medically necessary organ and tissue transplantation services for children and adults are covered services based upon the conditions listed in (i)-(v) of this subparagraph:

(i) All transplantation services, except kidney and cornea, must be prior authorized;

(ii) All transplant procedures are reviewed and prior authorization is based upon appropriate medical criteria;

(iii) All organ transplants must be performed at a Medicare-approved transplantation center;

(iv) Procedures considered experimental or investigational are not covered. For more information regarding experimental or investigational including clinical trials, see OAC 317:30-3-57.1; and

(v) Donor search and procurement services are covered for transplants consistent with the methods used by the Medicare program for organ acquisition costs.

(Y) Donor expenses incurred for complications are covered only if they are directly and immediately attributable to the donation procedure. Donor expenses that occur after the ninety (90) day global reimbursement period must be submitted to the OHCA for review.

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

(AA) Ventilator equipment.

(BB) Home dialysis equipment and supplies.

(CC) Ambulatory services for treatment of members with tuberculosis (TB). This includes, but is not limited to, physician visits, outpatient hospital services, rural health clinic visits and prescriptions. Drugs prescribed for the treatment of TB beyond the prescriptions covered under SoonerCare require prior authorization by the University of Oklahoma College of Pharmacy Help Desk using form "Petition for TB Related Therapy." Ambulatory services to members infected with TB are not limited to the scope of

the SoonerCare program, but require prior authorization when the scope is exceeded.

(DD) Smoking and tobacco use cessation counseling for treatment of members using tobacco.

(i) Smoking and tobacco use cessation counseling consists of the 5As:

(I) Asking the member to describe their smoking use;

(II) Advising the member to quit;

(III) Assessing the willingness of the member to quit;

(IV) Assisting the member with referrals and plans to quit; and

(V) Arranging for follow-up.

(ii) Up to eight (8) sessions are covered per year per individual.

(iii) Smoking and tobacco use cessation counseling is a covered service when performed by physicians, physician assistants (PA), advanced registered nurse practitioners (ARNP), certified nurse midwives (CNM), dentists, Oklahoma State Health Department (OSDH) and Federally Qualified Health Center (FQHC) nursing staff, and maternal/child health licensed clinical social worker trained as a certified tobacco treatment specialist (CTTS). It is reimbursed in addition to any other appropriate global payments for obstetrical care, primary care provider (PCP) care coordination payments, evaluation and management codes, or other appropriate services rendered. It must be a significant, separately identifiable service, unique from any other service provided on the same day.

(iv) Chart documentation must include a separate note that addresses the 5A's and office note signature along with the member specific information addressed in the five (5) steps and the time spent by the practitioner performing the counseling. Anything under three (3) minutes is considered part of a routine visit and not separately billable.

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

(FF) Genetic testing and other molecular pathology services are covered when medically necessary. Genetic testing may be considered medically necessary when the following conditions are met:

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

identification of specific genetic changes will impact treatment or management; and

- (ii) Clinical studies published in peer-reviewed literature have established strong evidence that the result of the test will positively impact the clinical decision-making or clinical outcome for the member; and
- (iii) The testing method is proven to be scientifically valid for the identification of a specific genetically-linked inheritable disease or clinically important molecular marker; and
- (iv) A medical geneticist, physician, or licensed genetic counselor provides documentation that supports the recommendation for testing based on a review of risk factors, clinical scenario, and family history.

(2) General coverage exclusions include, but is not limited to, the following:

- (A) Inpatient admission for diagnostic studies that could be performed on an outpatient basis.
- (B) Services or any expense incurred for cosmetic surgery.
- (C) Services of two (2) physicians for the same type of service to the same member on the same day, except when supplemental skills are required and different specialties are involved.
- (D) Routine eye examinations for the sole purpose of prescribing glasses or visual aids, determination of refractive state, treatment of refractive errors or purchase of lenses, frames or visual aids.
- (E) Pre-operative care within twenty-four (24) hours of the day of admission for surgery and routine post-operative care as defined under the global surgery guidelines promulgated by Current Procedural Terminology (CPT) and the Centers for Medicare and Medicaid Services (CMS).
- (F) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.
- (G) Sterilization of members who are under twenty-one (21) years of age, mentally incompetent, or institutionalized or reversal of sterilization procedures for the purposes of conception.
- (H) Non-therapeutic hysterectomies.
- (I) Medical services considered experimental or investigational. For more information regarding experimental or investigational including clinical trials, see OAC 317:30-3-57.1.
- (J) Payment for more than four (4) outpatient visits per member (home or office) per month, except visits in connection with family planning, services related to emergency medical conditions, or primary care services provided to SoonerCare Choice members.

- (K) Payment for more than two (2) nursing facility visits per month.
- (L) More than one (1) inpatient visit per day per physician.
- (M) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing, tumor board review or multidisciplinary opinion, dictation, and similar functions.
- (N) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.
- (O) Payment for the services of social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in OHCA rules.
- (P) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or that the pregnancy is the result of an act of rape or incest. (Refer to OAC 317:30-5-6 or 317:30-5-50).
- (Q) Speech and hearing services.
- (R) Mileage.
- (S) A routine hospital visit on the date of discharge unless the member expired.
- (T) Direct payment to perfusionist as this is considered part of the hospital reimbursement.
- (U) Inpatient chemical dependency treatment.
- (V) Fertility treatment.
- (W) Payment for removal of benign skin lesions.

(b) **Children.** Payment is made to physicians for medical and surgical services for members under the age of twenty-one (21) within the scope of the SoonerCare program, provided the services are medically necessary for the diagnosis and treatment of illness or injury, or to improve the functioning of a malformed body member. Medical and surgical services for children are comparable to those listed for adults. For services rendered to a minor child, the child's parent or court-appointed legal guardian must provide written authorization prior to the service being rendered, unless there is an explicit state or federal exception to this requirement. In addition to those services listed for adults, the following services are covered for children.

(1) **Pre-authorization of inpatient psychiatric services.** All inpatient psychiatric services for members under twenty-one (21) years of age must be prior authorized by an agency designated by the OHCA. All psychiatric services are prior authorized for an approved length of stay. Non-authorized inpatient psychiatric services are not SoonerCare compensable.

(A) All inpatient psychiatric services are authorized based on the medical necessity criteria as described in OAC 317:30-5-95.25, 317:30-5-95.27 and 317:30-5-95.29.

(B) For out of state placements, refer to OAC 317:30-3-89 through 317:30-3-92.

(2) **General Acute inpatient service limitations.** All general Acute inpatient hospital services for members under the age of twenty-one (21) are not limited. All inpatient care must be medically necessary.

(3) **Procedures for requesting extensions for inpatient services.** The physician and/or facility must provide necessary justification to enable OHCA, or its designated agent, to make a determination of medical necessity and appropriateness of treatment options. Extension requests for psychiatric admissions must be submitted to the OHCA or its designated agent. Extension requests must contain the appropriate documentation validating the need for continued treatment in accordance with the medical necessity criteria described in OAC 317:30-5-95.26, 317:30-5-95.28 and 317:30-5-95.30. Requests must be made prior to the expiration of the approved inpatient stay. All decisions of OHCA or its designated agent are final.

(4) **Utilization control requirements for psychiatric beds.** Utilization control requirements for inpatient psychiatric services for members under twenty-one (21) years of age apply to all hospitals and residential psychiatric treatment facilities.

(5) **Early and periodic screening diagnosis and treatment (EPSDT) program.** Payment is made to eligible providers for EPDST of members under age twenty-one (21). These services include medical, dental, vision, hearing and other necessary health care. Refer to OAC 317:30-3-65.2 through 317:30-3-65.12 for specific guidelines.

(6) **Reporting suspected abuse and/or neglect.** Instances of child abuse and/or neglect are to be reported in accordance with state law, including, but not limited to, Section 1-2-101 of Title 10A of the Oklahoma Statutes and 43A O.S. § 10-104. Any person suspecting child abuse or neglect shall immediately report it to the Oklahoma Department of Human Services (OKDHS) hotline, at 1-800-522-3511; any person suspecting abuse, neglect, or exploitation of a vulnerable adult shall immediately report it to the local OKDHS county office, municipal or county law enforcement authorities, or, if the report occurs after normal business hours, the OKDHS hotline. Health care professionals who are requested to report incidents of domestic abuse by adult victims with legal capacity shall promptly make a report to the nearest law enforcement agency, per 22 O.S. § 58.

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

(A) Inpatient admission for diagnostic studies that could be performed on an outpatient basis.

(B) Services or any expense incurred for cosmetic surgery unless the physician certifies the procedure emotionally necessary.

(C) Services of two (2) physicians for the same type of service to the same member on the same day, except when

supplemental skills are required and different specialties are involved.

(D) Pre-operative care within twenty-four (24) hours of the day of admission for surgery and routine post-operative care as defined under the global surgery guidelines promulgated by CPT and CMS.

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

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

(G) Non-therapeutic hysterectomies.

(H) Medical services considered experimental or investigational. For more information regarding experimental or investigational including clinical trials, see OAC 317:30-3-57.1.

(I) More than one (1) inpatient visit per day per physician.

(J) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or that the pregnancy is the result of an act of rape or incest. (Refer to OAC 317:30-5-6 or 317:30-5-50).

(K) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing, tumor board review or multidisciplinary opinion, dictation, and similar functions.

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

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

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

(O) Mileage.

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

(c) Individuals eligible for Part B of Medicare. Payment is made utilizing the OHCA allowable for comparable services. Claims filed with Medicare Part B should automatically cross over to OHCA. The EOMB reflects a message that the claim was referred to SoonerCare. If such a message is not present, a claim for coinsurance and deductible must be filed with the OHCA within ninety (90) days of the date of Medicare payment and within one (1) year of the date of service in order to be considered timely filed.

(1) In certain circumstances, some claims do not automatically "cross over." Providers must file a claim for coinsurance and/or

deductible to SoonerCare within ninety (90) days of the Medicare payment and within one (1) year from the date of service.

(2) If payment was denied by Medicare Part B and the service is a SoonerCare covered service, mark the claim "denied by Medicare" and attach the EOMB showing the reason for the denial.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 13 Ok Reg 899, eff 8-1-95 (emergency); Amended at 13 Ok Reg 1645, eff 5-27-96 ; Amended at 13 Ok Reg 3607, eff 6-18-96 (emergency); Amended at 13 Ok Reg 3585, eff 7-16-96 (emergency); Amended at 14 Ok Reg 151, eff 10-24-96 (emergency); Amended at 14 Ok Reg 524, eff 12-24-96 (emergency); Amended at 14 Ok Reg 750, eff 1-24-97 (emergency); Amended at 14 Ok Reg 3077, eff 7-1-97 (emergency); Amended at 15 Ok Reg 1083, eff 12-15-97 (emergency); Amended at 15 Ok Reg 1528, eff 5-11-98 ; Amended at 15 Ok Reg 4194, eff 7-20-98 (emergency); Amended at 15 Ok Reg 4182, eff 8-5-98 (emergency); Amended at 16 Ok Reg 1429, eff 5-27-99 ; Amended at 16 Ok Reg 3413, eff 7-1-99 (emergency); Amended at 17 Ok Reg 805, eff 7-16-99 (emergency); Amended at 17 Ok Reg 2373, eff 6-26-00 ; Amended at 17 Ok Reg 3469, eff 8-1-00 (emergency); Amended at 18 Ok Reg 245, eff 10-7-00 (emergency); Amended at 18 Ok Reg 761, eff 1-23-01 (emergency); Amended at 18 Ok Reg 1130, eff 5-11-01 ; Amended at 19 Ok Reg 63, eff 9-1-01 (emergency); Amended at 19 Ok Reg 2127, eff 6-27-02 ; Amended at 19 Ok Reg 2922, eff 7-1-02 (emergency); Amended at 20 Ok Reg 1193, eff 5-27-03 ; Amended at 21 Ok Reg 398, eff 1-1-04 (emergency); Amended at 21 Ok Reg 501, eff 1-1-04 (emergency); Amended at 21 Ok Reg 2176, eff 6-25-04 ; Amended at 23 Ok Reg 239, eff 10-3-05 (emergency); Amended at 23 Ok Reg 2477, eff 6-25-06 ; Amended at 24 Ok Reg 143, eff 10-8-06 (emergency); Amended at 24 Ok Reg 311, eff 12-1-06 (emergency); Amended at 24 Ok Reg 660, eff 2-1-07 (emergency); Amended at 24 Ok Reg 2060, eff 6-25-07 ; Amended at 25 Ok Reg 114, eff 9-1-07 (emergency); Amended at 24 Ok Reg 648, eff 1-1-08 (emergency); Amended at 25 Ok Reg 1161, eff 5-25-08 ; Amended at 26 Ok Reg 2081, eff 6-25-09 ; Amended at 26 Ok Reg 1759, eff 7-1-09 (emergency); Amended at 27 Ok Reg 294, eff 11-3-09 (emergency); Amended at 27 Ok Reg 1439, eff 6-11-10 ; Amended at 28 Ok Reg 1412, eff 6-25-11 ; Amended at 30 Ok Reg 327, eff 1-14-13 (emergency); Amended at 30 Ok Reg 1133, eff 7-1-13 ; Amended at 31 Ok Reg 1631, eff 9-12-14 ¹; Amended at 31 Ok Reg 1637, eff 9-12-14 ¹; Amended at 32 Ok Reg 721, eff 7-1-15 (emergency); Amended at 33 Ok Reg 801, eff 9-1-16 ²; Amended at 34 Ok Reg 188, eff 11-22-16 (emergency); Amended at 34 Ok Reg 645, eff 9-1-17 ; Amended at 36 Ok Reg 882, eff 9-1-19 ; Amended at 37 Ok Reg 1492, eff 9-14-20 ; Amended at 38 Ok Reg 970, eff 9-1-21]

Editor's Note: ¹*The agency promulgated two permanent amended versions of this Section (317:30-5-2) with the same effective date (9-12-14). Both versions were published in the 2014 and 2015 OAC Supplements.*

Editor's Note: ²*The agency reconciled the two 2014 versions of this Section through permanent rulemaking on 9-1-16.*

317:30-5-3. Documentation of services

(a) Records in a physician's office or a medical institution (hospital, nursing home or other medical facility), must contain adequate documentation of services rendered. Such documentation must include the physician's signature or identifiable initials in relation to every patient visit, every prescription, or treatment. In verifying the accuracy of claims for procedures which are reimbursed on a time frame basis, it will be necessary that documentation be placed in the patient's chart as to the beginning and ending times for the service claimed.

(b) Providers must adhere to signature requirements found at OAC 317:30-3-30.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 33 Ok Reg 797, eff 9-1-16]

317:30-5-4. Procedure and diagnosis coding

(a) The Authority uses the Health Care Financing Administration Common Procedure Coding System (HCPCS). This system is a five digit coding system using numbers and letters. Modifiers are used to further identify services. There are two sets of codes in the HCPCS system which are maintained by different organizations. First are the CPT codes, established and maintained by the American Medical Association. Second, are the second level HCPCS codes assigned and maintained by the Federal Health Care Financing Administration, the American Dental Association, etc. These codes are common to all Medicare Carriers.

(b) The coding process in the CPT includes a description of the various levels of services and a guide to selecting the codes which appropriately describe the level of services provided. Normally a physician will perform office, hospital, nursing home and emergency room visits which include the complete range of levels of service from brief to comprehensive. Physicians who routinely bill only for higher levels of care may appear on utilization reports and will be reviewed and/or investigated to determine if the service rendered matches the level of service claimed.

(c) The Authority accepts the International Classification of Diseases diagnosis coding currently used by the Centers for Medicare and Medicaid Services.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 13 Ok Reg 3627, eff 7-16-96 (emergency); Amended at 14 Ok Reg 1780, eff 5-27-97 ; Amended at 16 Ok Reg 151, eff 10-14-98 (emergency); Amended at 16 Ok Reg 1429, eff 5-27-99 ; Amended at 17 Ok Reg 706, eff 1-10-00 (emergency); Amended at 17 Ok Reg 2368, eff 6-26-00 ; Amended at 18 Ok Reg 109, eff 10-7-00 (emergency); Amended at 18 Ok Reg 2557, eff 6-25-01 ; Amended at 19 Ok Reg 2134, eff 6-27-02 ; Amended at 30 Ok Reg 1169, eff 7-1-13]

317:30-5-5. Diagnosis Codes [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 19 Ok Reg 2134, eff 6-27-02]

317:30-5-6. Abortions

(a) Payment is made only for abortions in those instances where the abortion is necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed, or where the pregnancy is the result of an act of rape or incest. Medicaid coverage for abortions to terminate pregnancies that are the result of rape or incest will only be provided as long as Congress considers abortions in cases of rape or incest to be medically necessary services and federal financial participation is available specifically for these services.

(1) For abortions necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, the physician must complete the Certification for Medicaid Funded Abortion and certify in writing that the abortion is being performed due to

a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed. The patient's name and address must be included in the certification and the certification must be signed and dated by the physician. The certification must be attached to the claim.

(2) For abortions in cases of rape or incest, there are two requirements for the payment of a claim. First, the physician must fully complete the Certification for Medicaid Funded Abortion. Second, the patient must have made a police report or counselor's report of the rape or incest. In cases where an official report of the rape or incest is not available, the physician must certify in writing and provide documentation that in his or her professional opinion, the patient was unable, for physical or psychological reasons, to comply with the requirement. The statement explains the reason the rape or incest was not reported. The patient's name and address must be included in the certification and the certification must be signed and dated by the physician and the patient. In cases where a physician provides certification and documentation of a patient's inability to file a report, the Authority will perform a prepayment review of all records to ensure there is sufficient documentation to support the physician's certification.

(b) The Oklahoma Health Care Authority performs a "look-behind" procedure for abortion claims paid from Medicaid funds. This procedure will require that this Agency obtain the complete medical records for abortions paid under Medicaid. On a post-payment basis, this Authority will obtain the complete medical records on all claims paid for abortions.

(c) Claims for spontaneous abortions, including dilation and curettage do not require certification. The following situations also do not require certification:

(1) If the physician has not induced the abortion, counseled or otherwise collaborated in inducing the abortion; and

(2) If the process has irreversibly commenced at the point of the physician's medical intervention.

(d) Claims for the diagnosis "incomplete abortion" require medical review.

(e) The appropriate diagnosis codes should be used indicating spontaneous abortion, etc., otherwise the procedure will be denied.

[Source: Amended at 16 eff 5-27-99 ; Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 13 Ok Reg 2521, eff 6-27-96 ; Amended at 15 Ok Reg 4194, eff 7-20-98 (emergency); Amended at 16 Ok Reg 1429, eff 5-27-99 ; Amended at 38 Ok Reg 1000, eff 9-1-21]

317:30-5-7. Anesthesia

(a) **Procedure codes.** Anesthesia codes from the Physicians' Current Procedural Terminology should be used. Payment is made only for the major procedure during an operative session.

(b) **Modifiers.** All anesthesia procedure codes must have a modifier. Without the modifier, the claim will be denied.

(c) **Qualifying circumstances.** Certain codes in the Medicine section of the CPT are used to identify extraordinary anesthesia services. The appropriate modifiers should be added to these codes. Additional payment can be made for extremes of age, total body hypothermia, and controlled hypertension.

(d) **Hypothermia.** Hypothermia total body or regional is not covered unless medical necessity is documented and approved through review by the Authority's Medical Consultants.

(e) **Anesthesia with Blood Gas Analysis.** Blood gas analysis is part of anesthesia service. Payment for anesthesia includes payment for blood gas analysis.

(f) **Steroid injections.** Steroid injections administered by an anesthesiologist are covered as nerve block. The appropriate CPT procedure code is used to bill services.

(g) **Local anesthesia.** If local anesthesia is administered by attending surgeon, payment is included in the global surgery fee, except for spinal or epidural anesthesia in conjunction with childbirth.

(h) **Stand by anesthesia.** This is not covered unless the physician is actually in the operating room administering medication, etc. If this is indicated, claim will be processed as if anesthesia was given. Use appropriate anesthesia code.

(i) **Other qualifying circumstances.** All other qualifying circumstances, i.e., physical status, emergency, etc. have been structured into the total allowable for the procedure.

(j) **Central venous catheter and anesthesia.** Payment for placement of central venous catheter, injection of anesthesia substance or similar procedures will be made only when the procedure is distinctly separate from the anesthesia procedure.

(k) **Pain management.** Pain management procedures performed during the anesthesia session will be covered when medically necessary to adequately control anticipated post-operative pain.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 17 Ok Reg 708, eff 1-10-00 (emergency); Amended at 17 Ok Reg 1204, eff 5-11-00 ; Amended at 19 Ok Reg 2134, eff 6-27-02 ; Amended at 20 Ok Reg 1924, eff 6-26-03 ; Amended at 29 Ok Reg 1084, eff 6-25-12]

317:30-5-8. Surgery

(a) The OHCA uses certain nationally recognized coding and editing guidelines for determination of reimbursement logic related to situations including, but not limited to, multiple, bilateral, assistant surgery, incidental, and mutually exclusive procedure codes. When a procedure is performed for which specific procedure codes exist, the specific procedure code must be used. A claim submitted with an "unlisted" procedure code is subject to medical review and requires the submission of all pertinent medical records for determination of payment.

(b) The Physicians' Current Procedural Terminology (CPT) provides for 2-digit modifiers to further describe surgical services. These modifiers must be used on OHCA claims when applicable.

(c) Reduction mammoplasty is covered only when the procedure has been determined medically necessary; prior authorization is required.

(d) Intradermal introduction of pigments or tattooing is compensable when related to breast reconstruction; prior authorization is required.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 13 Ok Reg 3185, eff 6-18-96 (emergency); Amended at 14 Ok Reg 1780, eff 5-27-97 ; Amended at 14 Ok Reg 3103, eff 6-17-97 (emergency); Amended at 15 Ok Reg 1528, eff 5-11-98 ; Amended at 18 Ok Reg 2952, eff 5-17-01 (emergency); Amended at 19 Ok Reg 1067, eff 5-13-02 ; Amended at 21 Ok Reg 2201, eff 6-25-04 ; Amended at 24 Ok Reg 143, eff 10-8-06 (emergency); Amended at 24 Ok Reg 671, eff 2-1-07 (emergency)¹; Amended at 24 Ok Reg 2824, eff 5-1-07 through 7-14-08 (emergency)²; Amended at 25 Ok Reg 2655, eff 7-25-08]

Editor's Note: ¹*Pursuant to 75 O.S., Section 253, the 2-1-07 emergency amendments to this section 317:30-5-8 were scheduled to expire on 7-15-07, if not already superseded by a permanent action or by another emergency action(s) that retained the same 7-15-07 expiration date. If the emergency action expired, the text of the section would then revert back to the permanent text that became effective prior to the 2-1-07 emergency action . As of 7-15-07, the agency had not superseded the 2-1-07 emergency amendments with a permanent action or with another emergency action that retained the 7-15-07 expiration date. However, on 5-1-07, the agency did issue another emergency action amending the section, but citing a later expiration date of 7-15-08.*

Editor's Note: ²*This emergency action expired before being superseded by a permanent action. Upon expiration of an emergency amendatory action, the last effective permanent text is reinstated. Therefore, on 7-15-08 (after the 7-14-08 expiration of the emergency action), the text of 317:30-5-8 reverted back to the permanent text that became effective 6-25-04, as was last published in the 2006 Edition of the OAC, and remained as such until amended again by permanent action on 7-25-08.*

317:30-5-9. Medical services

(a) **Use of medical modifiers.** The physicians' Current Procedural Terminology (CPT) and the second level Healthcare Common Procedure Coding System (HCPCS) provide for 2-digit medical modifiers to further describe medical services. Modifiers are used when appropriate.

(b) **Covered office services.**

(1) Payment is made for four (4) office visits (or home) per month per member, for adults [over age twenty-one (21)], regardless of the number of physicians involved. Additional visits per month are allowed for services related to emergency medical conditions.

(2) Visits for the purpose of family planning are excluded from the four (4) per month limitation.

(3) Payment is allowed for the insertion and/or implantation of contraceptive devices in addition to the office visit.

(4) Separate payment will be made for the following supplies when furnished during a physician's office visit.

- (A) Casting materials;
- (B) Dressing for burns;
- (C) Contraceptive devices; and
- (D) IV fluids.

- (5) Medically necessary office lab and X-rays are covered.
- (6) Hearing exams by physician for members between the ages of twenty one (21) and sixty five (65) are covered only as a diagnostic exam to determine type, nature and extent of hearing loss.
- (7) Hearing aid evaluations are covered for members under twenty one (21) years of age.
- (8) IPPB (Intermittent Positive Pressure Breathing) is covered when performed in physician's office.
- (9) Payment is made for an office visit in addition to allergy testing.
- (10) Separate payment is made for antigen.
- (11) Eye exams are covered for members between ages twenty one (21) and sixty five (65) for medical diagnosis only.
- (12) If a physician personally sees a member on the same day as a dialysis treatment, payment can be made for a separately identifiable service unrelated to the dialysis.
- (13) Separate payment is made for the following specimen collections:
 - (A) Catheterization for collection of specimen; and
 - (B) Routine venipuncture.
- (14) The Professional Component for electrocardiograms, electroencephalograms, electromyograms, and similar procedures are covered on an inpatient basis as long as the interpretation is not performed by the attending physician.
- (15) Cast removal is covered only when the cast is removed by a physician other than the one who applied the cast.
- (16) Payment may be made for medication-assisted treatment (MAT) medications prescribed and/or administered by a physician.

(c) Non-covered office services.

- (1) Payment is not made separately for an office visit and rectal exam, pelvic exam or breast exam. Office visits including one of these types of exams should be coded with the appropriate office visit code.
- (2) Payment cannot be made for prescriptions or medication dispensed by a physician in his office.
- (3) Payment will not be made for completion of forms, abstracts, narrative reports or other reports, separate charge for use of office or telephone calls.
- (4) Additional payment will not be made for mileage.
- (5) Payment is not made for an office visit where the member did not keep appointment.
- (6) Refractive services are not covered for persons between the ages of twenty-one (21) and sixty-five (65).
- (7) Removal of stitches is considered part of post-operative care.
- (8) Payment is not made for a consultation in the office when the physician also bills for surgery.
- (9) Separate payment is not made for oxygen administered during an office visit.

(d) Covered inpatient medical services.

(1) Payment is allowed for inpatient hospital visits for all SoonerCare covered admissions. Psychiatric admissions must be prior authorized.

(2) Payment is allowed for the services of two physicians when supplemental skills are required and different specialties are involved.

(3) Certain medical procedures are allowed in addition to office visits.

(4) Payment for critical care is all-inclusive and includes payment for all services that day. Payment for critical care, first hour is limited to one unit per day.

(e) Non-covered inpatient medical services.

(1) For inpatient services, all visits to a member on a single day are considered one service except where specified. Payment is made for only one (1) visit per day.

(2) A hospital admittance or visit and surgery on the same day would not be covered if post-operative days are included in the surgical procedure. If there are no post-operative days, a physician can be paid for visits.

(3) Drugs administered to inpatients are included in the hospital payment.

(4) Payment will not be made to a physician for an admission or new patient work-up when the member receives surgery in out-patient surgery or ambulatory surgery center.

(5) Payment is not made to the attending physician for interpretation of tests on his own patient.

(f) Other medical services.

(1) Payment will be made to physicians providing Emergency Department services.

(2) Payment is made for two (2) nursing facility visits per month. The appropriate CPT code is used.

(3) When payment is made for evaluation of arrhythmias or evaluation of sinus node, the stress study of the arrhythmia includes inducing the arrhythmia and evaluating the effects of drugs, exercise, etc. upon the arrhythmia.

(4) When the physician bills twice for the same procedure on the same day, it must be supported by a written report.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 13 Ok Reg 3607, eff 6-18-96 (emergency); Amended at 14 Ok Reg 1780, eff 5-27-97 ; Amended at 16 Ok Reg 155, eff 10-14-98 (emergency); Amended at 16 Ok Reg 1429, eff 5-27-99 ; Amended at 16 Ok Reg 3413, eff 7-1-99 (emergency); Amended at 17 Ok Reg 2373, eff 6-26-00 ; Amended at 17 Ok Reg 3469, eff 8-1-00 (emergency); Amended at 18 Ok Reg 761, eff 1-23-01 (emergency); Amended at 18 Ok Reg 1130, eff 5-11-01 ; Amended at 19 Ok Reg 2134, eff 6-27-02 ; Amended at 21 Ok Reg 501, eff 1-1-04 (emergency); Amended at 21 Ok Reg 2176, eff 6-25-04 ; Amended at 23 Ok Reg 239, eff 10-3-05 through 7-14-06 (emergency)¹; Amended at 25 Ok Reg 121, eff 8-1-07 (emergency); Amended at 25 Ok Reg 1192, eff 5-25-08 ; Amended at 26 Ok Reg 2088, eff 6-25-09 ; Amended at 27 Ok Reg 294, eff 11-3-09 (emergency); Amended at 27 Ok Reg 1439, eff 6-11-10 ; Amended at 28 Ok Reg 1412, eff 6-25-11 ; Amended at 33 Ok Reg 858, eff 9-1-16 ; Amended at 38 Ok Reg 424, eff 1-1-21 (emergency); Amended at 38 Ok Reg 1020, eff 9-1-21]

Editor's Note: ¹*This emergency action expired without being superseded by a permanent action. Upon expiration of an emergency*

amendatory action, the last effective permanent text is reinstated. Therefore, on 7-15-06 (after the 7-14-06 expiration of the emergency action), the text of 317:30-5-9 reverted back to the permanent text that became effective 6-25-04, as was last published in the 2005 OAC Supplement, and remained as such until amended again by emergency action on 8-1-07.

317:30-5-10. Ophthalmology services

(a) Covered services for adults.

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

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

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

(b) Covered services for children.

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

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

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

(d) Procedure codes.

(1) The appropriate procedure codes used for billing eye care services are found in the Current Procedural Terminology (CPT) and HCPCS Coding Manuals.

(2) Vision screening is a component of all eye exams performed by ophthalmologists or optometrists and is not billed separately.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 17 Ok Reg 3354, eff 8-1-00 (emergency); Amended at 18 Ok Reg 1130, eff 5-11-01 ; Amended at 19 Ok Reg 2134, eff 6-27-02 ; Amended at 24 Ok Reg 2824, eff 5-1-07 (emergency); Amended at 25 Ok Reg 653, eff 2-1-08 through 7-14-08 (emergency)¹; Amended at 25 Ok Reg 2634, eff 7-25-08]

Editor's Note: ¹*This emergency action expired on 7-14-08 before being superseded by a permanent action. Upon expiration of an emergency amendatory action, the last effective permanent text is reinstated. Therefore, on 7-15-08 (after the 7-14-08 expiration of the emergency action), the text of 317:30-5-10 reverted back to the permanent text that*

became effective 6-27-02, as was last published in the 2006 Edition of the OAC, and remained as such until amended again by permanent action on 7-25-08.

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 (CPT) 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 at least one (1) diagnosis from the most recent version of the Diagnosis and Statistical Manual of Mental Disorders (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.

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

(e) With the exception of the two (2) allowable direct physician services in a nursing facility (refer to OAC 317:30-5-2), reimbursement for psychiatric services to members residing in a nursing facility is not allowed. Provision of these services is the responsibility of the nursing facility and reimbursement is included within the all-inclusive per diem payment that nursing facilities receive for the member's care.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 14 Ok Reg 537, eff 12-24-96 (emergency); Amended at 14 Ok Reg 1785, eff 5-27-97 ; Amended at 15 Ok Reg 1083, eff 12-15-97 (emergency); Amended at 15 Ok Reg 1528, eff 5-11-98 ; Amended at 17 Ok Reg 805, eff 7-16-99 (emergency); Amended at 17 Ok Reg 1204, eff 5-11-00 ; Amended at 19 Ok Reg 2134, eff 6-27-02 ; Amended at 21 Ok Reg 501, eff 1-1-04 (emergency); Amended at 21 Ok Reg 2176, eff 6-25-04 ; Amended at 25 Ok Reg 2637, eff 7-25-08 ; Amended at 26 Ok Reg 249, eff 1-1-09 (emergency); Amended at 26 Ok Reg 1053, eff 5-11-09 ; Amended at 34 Ok Reg 649, eff 9-1-17 ; Amended at 36 Ok Reg 882, eff 9-1-19]

317:30-5-12. Family planning

(a) **Adults.** Payment is made for the following family planning services:

- (1) physical examination to determine the general health of the member and most suitable method of contraception;

- (2) complete general history of the member and pertinent history of immediate family members;
- (3) laboratory services for the determination of pregnancy, detection of certain sexually transmitted infections and detection of cancerous or pre-cancerous conditions of the reproductive anatomy;
- (4) education and counseling regarding issues related to reproduction and contraception;
- (5) annual supply of chosen contraceptive;
- (6) insertion and removal of contraceptive devices;
- (7) vasectomy and Tubal Ligation procedures; and
- (8) additional visits for members experiencing difficulty with a particular contraceptive method or having concerns related to their reproductive health.

(b) **Children.** Payment is made for children as set forth in this Section for adults. However payment cannot be made for the sterilization of persons under the age of 21.

(c) **SoonerPlan Members.** Non-pregnant women and men ages 19 and older not enrolled in SoonerCare may apply for the SoonerPlan program. Eligible members receive family planning services set forth in this Section as well as family planning related services (vaccinations for the prevention of certain sexually transmitted infections and male exams). SoonerPlan eligibility requirements are found at OAC 317:35-7-48.

(d) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services. Claims for services which are not covered by Medicare should be filed directly with the Fiscal Agent for payment within the scope of the program.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 24 Ok Reg 303, eff 12-1-06 (emergency); Amended at 24 Ok Reg 895, eff 5-11-07 ; Amended at 29 Ok Reg 1085, eff 6-25-12]

317:30-5-13. Rape and abuse exams

When a rape/abuse exam is performed on a child with SoonerCare benefits, a claim is filed with the fiscal agent. Payment is made for the rape/abuse exam and medically necessary procedures as per recognized coding guidelines.

- (1) Supplies used during an exam for rape or abuse may be billed. Appropriate HCPCS and diagnosis codes are used.
- (2) If the child is in custody as reported by the Oklahoma Department of Human Services but does not have SoonerCare benefits, or the child is not in custody and the parents are unable or unwilling to assume payment responsibility, the social worker obtains from the physician a completed OKDHS form 10AD012, Claim Form. The 10AD012 form is routed according to procedures established by the Oklahoma Department of Human Services, Division of Children and Family Services.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 19 Ok Reg 2134, eff 6-27-02 ; Amended at 24 Ok Reg 78, eff 8-2-06 (emergency); Amended at 24 Ok Reg 902, eff 5-11-07]

317:30-5-14. Injections

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

(1) **Immunizations for children.** An administration fee will be paid for vaccines administered by providers participating in the Vaccines for Children Program. For vaccines administered as part of the Vaccines for Children Program, only one administration fee is permitted per vaccine, regardless of the number of vaccine/toxoid components in the vaccine. Payment will not be made for vaccines covered by the Vaccines for Children Program. When the vaccine is not included in the program, the administration fee is separately payable.

(2) **Immunizations for adults.** Coverage for adults is provided as per the Advisory Committee on Immunization Practices (ACIP) guidelines. A separate payment will be made for the administration of a vaccine. Only one administration fee per vaccine is permitted, regardless of the number of vaccine/toxoid components in the vaccine.

(b) Providers must use the appropriate HCPCS code and National Drug Code (NDC). In addition to the NDC and HCPCS code, claims must contain the drug name, strength, and dosage amount.

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

(d) Human Papillomavirus (HPV) vaccine is approved and covered under guidelines established by the ACIP for children and adults. Payment can be made separately to the physician for administration and the vaccine product.

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

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

aspirations.

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

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

(i) In the event a pandemic virus is declared by the Centers for Disease Control (CDC) and/or the Department of Health & Human Services, an administration fee will be paid to providers for administering the pandemic virus vaccine to adults and children as authorized by the Centers for Medicare and Medicaid Services (CMS).

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 13 Ok Reg 3627, eff 7-16-96 (emergency); Amended at 14 Ok Reg 1780, eff 5-27-97 ; Amended at 16 Ok Reg 158, eff 10-14-98 (emergency); Amended at 16 Ok Reg 691, eff 12-31-98 (emergency); Amended at 16 Ok Reg 1429, eff 5-27-99 ; Amended at 18 Ok Reg 109, eff 10-7-00 (emergency); Amended at 18 Ok Reg 1130, eff 5-11-01 ; Amended at 20 Ok Reg 1931, eff 6-26-03 ; Amended at 23 Ok Reg 28, eff 8-1-05 (emergency); Amended at 23 Ok Reg 1353, eff 5-25-06 ; Amended at 24 Ok Reg 311, eff 12-1-06 (emergency); Amended at 24 Ok Reg 904, eff 5-11-07 ; Amended at 25 Ok Reg 656, eff 1-18-08 through 7-14-08 (emergency)¹; Amended at 25 Ok Reg 2660, eff 7-25-08 ; Amended at 26 Ok Reg 994, eff 5-1-09 (emergency); Amended at 27 Ok Reg 618, eff 1-14-10 (emergency); Amended at 27 Ok Reg 1449, eff 6-11-10 ; Amended at 30 Ok Reg 1138, eff 7-1-13 ; Amended at 32 Ok Reg 1037, eff 8-27-15]

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317:30-5-14.1. Allergy services

(a) **Allergy testing.** Allergy testing is the process of identifying allergen(s) that may cause an allergic or anaphylactic reaction and the degree of the reaction. By identifying the allergen(s), the member can avoid exposures and the allergic reaction can be managed appropriately. Treatment options for allergies are avoidance of the allergen(s), pharmacological therapy, and/or immunotherapy. Oklahoma Health Care Authority (OHCA) may consider allergy testing medically necessary when a complete medical, immunological history, and physical examination is performed and indicates symptoms are suggestive of a chronic allergy. Allergy testing may also be determined medically necessary if diagnosis indicates an allergy and simple medical treatment and avoidance of the allergen(s) were tried and showed inadequate response.

(1) **Coverage.** OHCA will provide reimbursement for allergy testing when the following conditions are met:

- (A) Testing is done in a hospital or providers office under direct supervision of an eligible provider;
- (B) The diagnostic testing is based on the member's immunologic history and physical examination, which document that the antigen(s) being used for testing have a reasonable probability of exposure in the members

environment;

(C) The member has significant life-threatening symptomatology or a chronic allergic state (e.g., asthma) which has not responded to conservative measures;

(D) The member's records document the need for allergy testing and the justification for the number of tests performed;

(E) The complete report of the test results, as well as controls, will be kept as part of the medical record; and

(F) The member is observed for a minimum of twenty (20) minutes following allergy testing to monitor for signs of allergic or anaphylactic reactions.

(2) **Provider requirements.** Only contracted providers (a physician (MD or DO), physician's assistant, or advanced practice nurse) who are board certified or board eligible in allergy and immunology or have received training in allergy and immunology in an accredited academic institution for a minimum of one (1) month clinical rotation (authenticated by supporting letter from institution or mentor).

(A) Follow-up administration of medically indicated allergy immunotherapy can be done by a practitioner other than an allergist.

(B) Allergy testing and/or immunotherapy for SoonerCare members younger than five (5) years of age preferably should be performed by an allergy specialist.

(3) **Description of services.** There are a variety of tests to identify the allergen(s) that may be responsible for the member's allergic response. OHCA covers the following allergy test(s) for SoonerCare members:

(A) Direct skin tests:

(i) Percutaneous (i.e., scratch, prick, or puncture) tests are performed for inhalant allergies, suspected food allergies, hymenoptera allergies, or specific drug allergies.

(ii) Intra-cutaneous (i.e., intradermal) tests are performed commonly when a significant allergic history is obtained and results of the percutaneous test are negative or equivocal.

(B) Patch or application tests;

(C) Photo or photo patch skin tests;

(D) Inhalant bronchial challenge testing (not including necessary pulmonary function tests);

(E) Ingestion challenge tests (this test is used to confirm an allergy to a food or food additives); and

(F) Double-blind food challenge testing.

(G) Ophthalmic mucous membrane or direct nasal membrane tests, serum allergy tests, serial dilution endpoint tests, or any unlisted allergy procedure not stated above will require prior authorization.

(4) **Reimbursement.** Reimbursement for allergy testing is limited to a total of 60 tests every three years. Repeat allergy testing for

the same allergen(s) within three years will require prior authorization. Any service related to allergy testing beyond predetermined limits must be submitted with the appropriate documentation to OHCA for prior authorization consideration.

(5) **Non-covered services.** OHCA does not cover allergy testing determined to be investigational or experimental in nature. For more information regarding experimental or investigational including clinical trials, see OAC 317:30-3-57.1.

(b) **Allergy immunotherapy.** Allergy immunotherapy involves administration of allergenic extracts at periodic intervals, with the goal of reducing symptoms, including titrating to a dosage that is maintained as maintenance therapy. Allergy immunotherapy is initiated once the offending allergen(s) has been identified through exposure and/or allergy testing. The documented allergy should correspond to the allergen planned for immunotherapy. OHCA may consider allergy immunotherapy medically necessary for members who have significant life-threatening symptomology or a chronic allergic state that cannot be managed by medication, avoidance, or environmental control measures. Before beginning allergy immunotherapy, consideration must be given to other common medical conditions that could make allergy immunotherapy more risky.

(1) **Coverage requirements.** Allergy immunotherapy is covered when the following criteria are met and documented in the medical record:

- (A) The member has allergic asthma, or
- (B) Allergic rhinitis and/or conjunctivitis, or
- (C) Life-threatening allergy to hymenoptera (stinging insect allergy), or
- (D) There is clinical evidence of an inhalant allergen(s) sensitivity; and
- (E) Documentation supports that the member's symptoms are not controlled with medications and avoidance of the allergen(s) are impractical.

(2) **Provider qualifications.** See OAC 317:30-5-14.1 (a)(2) for provider qualifications.

(3) **Administering sites.** Allergy immunotherapy should be administered in a medical facility with trained staff and proper medical equipment available in the case of significant reaction. Should home administration be necessary, the following requirements must be met:

- (A) Adequate documentation must be present in the member's record indicating why home administration is medically necessary;
- (B) Documentation must indicate the member and/or family member have been properly trained in recognizing and treating anaphylactic and/or allergic reactions to allergy immunotherapy administration;
- (C) Epinephrine kits must be available to the member and the family and the member and/or family have been instructed in its use;

- (D) Documentation of member and/or family member having been properly trained in antigen(s) dosing plan, withdrawing of correct amount of antigen(s) from the vial and administration of allergy immunotherapy;
- (E) The signed consent by the member or family member to administer allergy immunotherapy at home;
- (F) The provider initiated allergy immunotherapy in their office and is planning to continue therapy at the member's home; and
- (G) Signed acknowledgement by the member or family member of receiving antigen vial(s) as per treatment protocol.

(4) **Treatment period.** A "treatment period" is generally 90 days, and adequate documentation must be available for continuation of therapy after each treatment period. The length of allergy immunotherapy treatment depends on the demonstrated clinical efficacy of the treatment.

(5) **Reimbursement.** Payment is made for the administration of allergy injections as well as supervision and provision of antigen(s) for adults and children, with the following considerations:

- (A) When a contracted provider actually administers or supervises administration of the allergy injections, the administration fee is compensable;
- (B) Reimbursement for the administration only codes is limited to one per member, per day;
- (C) No reimbursement is made for administration of allergy injections when the allergy injection is self-administered by the member; and
- (D) For antigens purchased by the provider for supervision, preparation and provision for allergy immunotherapy, an invoice reflecting the purchase should be made available upon request for post-payment review.

(6) **Limitations.** The following limitations and restrictions apply to immunotherapy:

- (A) A presumption of failure can be assumed if, after twelve (12) months of allergy immunotherapy, the member does not experience any signs of improvement, and all other reasonable factors have been ruled out.
- (B) Documented success of allergy immunotherapy treatment is evidenced by:
 - (i) A noticeable decrease of hypersensitivity symptoms, or
 - (ii) An increase in tolerance to the offending allergen(s), or
 - (iii) A reduction in medication usage.
- (C) Very low dose immunotherapy or continued submaximal dose has not been shown to be effective and will be denied as not medically necessary.
- (D) Liquid antigen(s) prepared for sublingual administration are not covered as they have not been

proven to be safe and effective.

(E) Food and Drug Administration (FDA) approved oral desensitization therapies may be covered as part of the member's pharmacy benefits and requires prior authorization.

(F) If a provider is preparing single dose vials of antigens to be administered by a different provider, member or family member, only thirty (30) units per treatment period of ninety (90) days with a limit of one hundred and twenty (120) units per year is allowed. Additional units above the stated limits will require prior authorization.

(G) If using multi-dose vials, there is a limitation of 10 units per vial, with a maximum of twenty (20) units allowed per ninety (90) day treatment period. There is a limit of 80 units allowed per year. Additional units above the stated limits will require prior authorization.

(7) **Non-covered services.** Allergy immunotherapy determined by OHCA to be investigational or experimental will not be covered. For more information regarding experimental or investigational including clinical trials, see OAC 317:30-3-57.1.

[Source: Added at 32 Ok Reg 1037, eff 8-27-15 ; Amended at 38 Ok Reg 970, eff 9-1-21]

317:30-5-15. Chemotherapy injections

(a) Outpatient.

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

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

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

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

(b) Inpatient.

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

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

connection with chemotherapy.

(3) The following are not compensable:

- (A) Chemotherapy for Multiple Sclerosis;
- (B) Efudex;
- (C) Oral Chemotherapy;
- (D) Photochemotherapy;
- (E) Scalp Hypothermia during Chemotherapy; and
- (F) Strep Staph Chemotherapy.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 18 Ok Reg 109, eff 10-7-00 (emergency); Amended at 18 Ok Reg 1130, eff 5-11-01 ; Amended at 21 Ok Reg 501, eff 1-1-04 (emergency); Amended at 21 Ok Reg 2176, eff 6-25-04 ; Amended at 25 Ok Reg 656, eff 1-18-08 through 7-14-08 (emergency)¹; Amended at 25 Ok Reg 2660, eff 7-25-08]

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317:30-5-16. Miscellaneous injections [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 13 Ok Reg 2315, eff 4-10-96 (emergency); Amended at 13 Ok Reg 3627, eff 7-16-96 (emergency); Amended at 14 Ok Reg 1780, eff 5-27-97 ; Revoked at 18 Ok Reg 109, eff 6-1-00 (emergency); Revoked at 18 Ok Reg 1130, eff 5-11-01]

317:30-5-17. Authorized examinations - eligibility determinations

When an examination is to be made for the purpose of determining original or continuing eligibility, it is necessary that DHS Form ABCDM-16, Authorization for Examination and Billing, be secured from the county office of the Department of Human Services. Report of such examination must be submitted on DHS Form ABCDM-80. DHS Form ABCDM-16 must be attached to the claim. If a UA is indicated, payment will be made separately at the current allowable rate.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 19 Ok Reg 2134, eff 6-27-02]

317:30-5-18. Elective sterilizations

(a) Payment is made for elective sterilizations performed in behalf of eligible individuals if all of the following circumstances are met:

- (1) The patient must be at least 21 years of age at the time the consent form is signed;
- (2) The patient must be mentally competent, and not presently institutionalized;
- (3) A properly completed federally mandated consent for sterilization form is attached to the claim; and

(4) The form is signed and dated at least 30 days, but not more than 180 days prior to surgery.

(b) When a sterilization procedure is performed in conjunction with a C-Section, the appropriate HCPC coding is used to report the procedures performed. A consent form is required when the sterilization procedure is performed.

(c) Reversal of sterilization procedures for the purpose of conception are not covered. Reversal of sterilization procedures may be covered when medically indicated and substantiating documentation is attached to the claim.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 17 Ok Reg 708, eff 1-10-00 (emergency); Amended at 17 Ok Reg 1204, eff 5-11-00 ; Amended at 21 Ok Reg 2201, eff 6-25-04 ; Amended at 25 Ok Reg 114, eff 9-1-07 (emergency); Amended at 25 Ok Reg 1161, eff 5-25-08]

317:30-5-19. Hysterectomies

(a) A hysterectomy performed for purposes of sterilization or family planning is not compensable. The 30 day waiting period which applies to elective sterilizations does not apply to therapeutic hysterectomies. Payment is made for therapeutic hysterectomies only when one of the following circumstances is met:

(1) A properly completed hysterectomy acknowledgement is attached to the claim form. The acknowledgement must clearly state that the patient or her representative was informed, orally and in writing, prior to the surgery that she would be rendered permanently incapable of reproduction.

(2) The surgeon must certify in writing that the patient was sterile prior to the surgery. The reason for the sterility, i.e., post-menopausal, previous tubal ligation, etc. must be given.

(3) The surgeon must certify that the surgery was performed in an emergency, life endangering situation. The life endangering circumstances must be given.

(b) A hysterectomy acknowledgement form may be signed by the patient and dated after the surgery as long as the acknowledgement meets all other requirements. the patient must acknowledge in the form that prior to surgery she was advised orally and in writing that she would be rendered sterile as a result of the surgery.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95]

317:30-5-20. Laboratory services

For laboratory policies please refer to Part 7, Laboratories (Independent, Physician, And Hospital), of this Chapter.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 14 Ok Reg 757, eff 1-24-97 (emergency); Amended at 14 Ok Reg 1792, eff 5-27-97 ; Amended at 14 Ok Reg 2394, eff 5-28-97 (emergency); Amended at 15 Ok Reg 1528, eff 5-11-98 ; Amended at 16 Ok Reg 3413, eff 7-1-99 (emergency); Amended at 17 Ok Reg 1204, eff 5-11-00 ; Amended at 19 Ok Reg 2134, eff 6-27-02 ; Amended at 25 Ok Reg 121, eff 8-1-07 (emergency); Amended at 25 Ok Reg 1192, eff 5-25-08 ; Amended at 27 Ok Reg 294, eff 11-3-09 (emergency); Amended at 27 Ok Reg 704, eff 2-4-10 (emergency); Amended at 27 Ok Reg 1450, eff 6-11-10 ; Amended at 31 Ok Reg 1641, eff 9-12-14 ; Amended at 32 Ok Reg 726, eff 7-1-15 (emergency); Amended at 33 Ok Reg 854, eff 9-1-16 ;

Amended at 34 Ok Reg 656, eff 9-1-17 ; Amended at 36 Ok Reg 127, eff 11-16-18 (emergency); Amended at 36 Ok Reg 887, eff 9-1-19 ; Amended at 37 Ok Reg 1504, eff 9-14-20 ; Amended at 38 Ok Reg 970, eff 9-1-21 ; Amended at 39 Ok Reg 1479, eff 9-12-22 ; Amended at 40 Ok Reg 2197, eff 9-11-23]

317:30-5-20.1. Drug screening and testing

For policy regarding drug screening and testing, please refer to Oklahoma Administrative Code (OAC) 317:30-5-101.

[Source: Added at 32 Ok Reg 726, eff 7-1-15 (emergency); Added at 33 Ok Reg 854, eff 9-1-16 ; Amended at 37 Ok Reg 1504, eff 9-14-20 ; Amended at 39 Ok Reg 1479, eff 9-12-22 ; Amended at 40 Ok Reg 2197, eff 9-11-23]

317:30-5-20.2. Molecular diagnostic testing utilizing polymerase chain reaction for infectious diseases

For policy regarding molecular diagnostic testing utilizing polymerase chain reaction for infectious diseases, please refer to Oklahoma Administrative Code (OAC) 317:30-5-102.

[Source: Added at 37 Ok Reg 1510, eff 9-14-20 ; Amended at 40 Ok Reg 2197, eff 9-11-23]

317:30-5-21. Unusual procedures

A service that is rarely provided, unusual, variable, new or unlisted requires a special report to determine the medical appropriateness or reimbursement rate. Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure, i.e., operative report. This information should be submitted to OHCA Provider Relations.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95]

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 OB care. Inclusive dates of care should be indicated on the claim form as part of the description. Payment for total OB 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 (1) 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 antepartum visits. The antepartum 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 OB care are listed in (1) - (8) of this subsection.

(1) The completion of an American College of Obstetricians and Gynecologist (ACOG) assessment form or form covering same elements as ACOG, and the most recent version of the Oklahoma Health Care Authority's (OHCA) Prenatal Psychosocial

Assessments are reimbursable when both documents are included in the prenatal record. SoonerCare allows one (1) assessment per provider and no more than two (2) per pregnancy.

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

(A) One (1) ultrasound will be covered in the first trimester of an uncomplicated pregnancy. Both an abdominal and vaginal ultrasound may be allowed when clinically appropriate and medically necessary. The ultrasound must be performed by a board eligible/board certified obstetrician-gynecologist (OB-GYN), radiologist, or a board eligible/board certified maternal-fetal medicine specialist. In addition, this ultrasound may be performed by a certified nurse midwife (CNM), family practice physician or advanced practice nurse practitioner (APRN) in obstetrics with a certification in OB ultrasonography.

(B) One (1) ultrasound after the first trimester will be covered. This ultrasound must be performed by a board eligible/board certified OB-GYN, radiologist, or a board eligible/board certified maternal-fetal medicine specialist. In addition, this ultrasound may be performed by a CNM, family practice physician, or APRN with certification in OB ultrasonography.

(C) One (1) additional detailed ultrasound is allowed by a board eligible/board certified maternal fetal specialist or general obstetrician with documented specialty training in performing detailed ultrasounds. This additional ultrasound is allowed to identify or confirm a suspected fetal/maternal anomaly. This additional ultrasound does not require prior authorization. Any subsequent ultrasounds will require prior authorization.

(3) Standby attendance at cesarean section (C-section), for the purpose of attending the baby, is compensable when billed by a physician or qualified health care provider not participating in the delivery.

(4) Anesthesia administered by the attending physician is a compensable service and may be billed separately from the delivery.

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

(6) Additional payment is not made for the delivery of multiple gestations. If one (1) fetus is delivered vaginally and additional fetus(es) are delivered by C-section by the same physician, the

higher-level procedure is paid. If one (1) fetus is delivered vaginally and additional fetus(es) are 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) Reimbursement is allowed for nutritional counseling in a group setting for members with gestational diabetes. Refer to OAC 317:30-5-1076(5).

(8) Limited OB ultrasounds are covered in an emergency room (ER) setting when medically necessary.

(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 (6) weeks postpartum office visit.

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

(1) Non stress test 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 OB procedures that include prenatal or postpartum 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) OB coverage for children is the same as for adults. Additional procedures may be covered under Early and Periodic Screening, Diagnostic and Treatment (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 OHCA 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. For more information regarding experimental or investigational and clinical trials see OAC 317:30-3-57.1.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 14 Ok Reg 2394, eff 5-28-97 (emergency); Amended at 15 Ok Reg 1528, eff 5-11-98 ; Amended at 16 Ok Reg 3413, eff 7-1-99 (emergency); Amended at 17 Ok Reg 708, eff 1-10-00 (emergency); Amended at 17 Ok Reg 1204, eff 5-11-00 ; Amended at 19 Ok Reg 2134, eff 6-27-02 ; Amended at 21 Ok Reg 2176, eff 6-25-04 ; Amended at 24 Ok Reg 207, eff 11-1-06 (emergency); Amended at 24 Ok Reg 895, eff 5-11-07 ; Amended at 25 Ok Reg 426, eff 11-1-07 (emergency); Amended at 25 Ok Reg 658, eff 1-1-08 (emergency); Amended at 25 Ok Reg 1161, eff 5-25-08 ; Amended at 26 Ok Reg 100, eff 8-1-08 (emergency); Amended at 26 Ok Reg 254, eff 12-1-08 (emergency); Amended at 26

Ok Reg 1059, eff 5-11-09 ; Amended at 26 Ok Reg 1766, eff 7-1-09 (emergency); Amended at 27 Ok Reg 108, eff 10-2-09 (emergency); Amended at 27 Ok Reg 946, eff 5-13-10 ; Amended at 32 Ok Reg 729, eff 7-1-15 (emergency); Amended at 32 Ok Reg 1050, eff 8-27-15 ; Amended at 32 Ok Reg 731, eff 8-27-15 (emergency); Amended at 33 Ok Reg 801, eff 9-1-16 ; Amended at 34 Ok Reg 192, eff 11-22-16 (emergency); Amended at 34 Ok Reg 657, eff 9-1-17 ; Amended at 38 Ok Reg 1002, eff 9-1-21 ; Amended at 39 Ok Reg 1481, eff 9-12-22]

317:30-5-22.1. Enhanced services for medically high risk pregnancies

(a) **Enhanced services.** Enhanced services are available for pregnant women eligible for SoonerCare and are in addition to services for uncomplicated maternity cases. Women deemed high risk based on criteria established by the Oklahoma Health Care Authority (OHCA) must receive prior authorization for medically necessary enhanced benefits which include:

- (1) Prenatal at risk antepartum management;
- (2) A combined maximum of five (5) fetal non stress test(s) and biophysical profiles (additional units can be prior authorized for multiple fetuses)with one (1) test per week beginning at thirty-two (32) weeks gestation and continuing to thirty-eight (38) weeks; and
- (3) A maximum of three (3) follow-up ultrasounds not covered under Oklahoma Administrative Code (OAC) 317:30-5-22(b)(2).

(b) **Prior authorization.** To receive enhanced services, the following documentation must be received by the OHCA Medical Authorization Unit for review and approval:

- (1) A comprehensive prenatal assessment from the American College of Obstetricians and Gynecologist (ACOG) or other comparable comprehensive prenatal assessment; and
- (2) Appropriate documentation supporting medical necessity from a board eligible/board certified Maternal Fetal Medicine (MFM) specialist, a board eligible/board certified Obstetrician-Gynecologist (OB-GYN), or a board eligible/board certified Family Practice Physician who has completed an Accreditation Council for Graduate Medical Education (ACGME) approved residency. The medical residency program must include appropriate obstetric training, and the physician must be credentialed by the hospital at which they provide obstetrical services in order to perform such services. The documentation must include information identifying and detailing the qualifying high risk condition. Non-MFM obstetrical providers requesting enhanced services are limited to a specific set of diagnoses as outlined on the OHCA website (www.okhca.org).

(c) **Reimbursement.** When prior authorized, enhanced benefits will be reimbursed as follows:

- (1) Antepartum management for high risk is reimbursed to the primary obstetrical provider. If the primary provider of obstetrical care is not the MFM and wishes to request authorization of the antepartum management fee, the treatment plan must be signed by the primary provider of OB care. Additionally, reimbursement for enhanced at risk antepartum management is not made during an in-patient hospital stay.

(2) Non stress tests, biophysical profiles and ultrasounds [in addition to those covered under OAC 317:30-5-22 (b)(2) (A) through (C)] are reimbursed when prior authorized.

(3) Reimbursement for enhanced at risk antepartum management is not available to physicians who already qualify for enhanced reimbursement as state employed physicians.

[Source: Added at 25 Ok Reg 426, eff 11-1-07 (emergency); Added at 25 Ok Reg 1161, eff 5-25-08 ; Amended at 26 Ok Reg 100, eff 8-1-08 (emergency); Amended at 26 Ok Reg 1063, eff 5-11-09 ; Amended at 32 Ok Reg 729, eff 7-1-15 (emergency); Amended at 32 Ok Reg 1050, eff 8-27-15 ; Amended at 32 Ok Reg 731, eff 8-27-15 (emergency); Amended at 33 Ok Reg 801, eff 9-1-16 ; Amended at 34 Ok Reg 657, eff 9-1-17 ; Amended at 37 Ok Reg 100, eff 10-2-19 (emergency); Amended at 37 Ok Reg 1511, eff 9-14-20 ; Amended at 38 Ok Reg 985, eff 9-1-21]

317:30-5-23. Newborn care

Claims for newborn care and circumcision are filed under the newborn's SoonerCare member ID number.

(1) When there is a newborn child and the mother is receiving SoonerCare benefits, an OKDHS form 08MA015E (FSS-NB-1) or other notification must be submitted to the county OKDHS office. If the mother is not already receiving SoonerCare benefits, an application will need to be completed. Services are billed using the appropriate codes contained in the Physician's Current Procedural Terminology (CPT).

(2) Neonatal intensive care codes (contained in the CPT) are used to report neonatal intensive care services. Certain procedures are bundled into the relevant inpatient neonatal critical care evaluation and management codes and are not reimbursed separately. All other medically-necessary procedures provided are considered for reimbursement using recognized coding and/or editing logic. Additional payment is allowed for standby at Cesarean Section, attendance at delivery or newborn resuscitation.

(3) Payment may be made for an evaluation and management service and newborn circumcision provided by the same provider on the same date of service.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 14 Ok Reg 2397, eff 2-5-97 (emergency); Amended at 14 Ok Reg 2928, eff 7-11-97 ; Amended at 16 Ok Reg 151, eff 10-14-98 (emergency); Amended at 16 Ok Reg 1429, eff 5-27-99 ; Amended at 17 Ok Reg 3199, eff 1-23-01 (emergency); Amended at 18 Ok Reg 1130, eff 5-11-01 ; Amended at 24 Ok Reg 2069, eff 6-25-07]

317:30-5-24. Radiology

(a) Outpatient and emergency department.

(1) The technical component of outpatient radiological services performed during an emergency department visit is covered.

(2) The professional component of x-rays performed during an emergency department visit is covered.

(3) Ultrasounds for obstetrical care are paid in accordance with provisions found at OAC 317:30-5-22(b)(2)(A-C).

(4) Payment is made for charges incurred for the administration of chemotherapy for the treatment of medically necessary and

medically approved procedures. Payment for radiation therapy is limited to the treatment of proven malignancies and benign conditions appropriate for stereotactic radiosurgery (e.g., gamma knife).

(5) Medically necessary screening mammography is a covered benefit. Additional follow-up mammograms are covered when medically necessary.

(b) **Inpatient procedures.** Inpatient radiological procedures are compensable if done on a referral basis. Claims for inpatient interpretations by the attending physician are not compensable unless the attending physician reads interpretations for the hospital on all patients.

(c) **Inpatient radiology performed outside of hospital.** When a member is an inpatient but has to be taken elsewhere for an x-ray, such as to an office or another hospital because the admitting hospital did not have proper equipment, the place of service must still be inpatient hospital, since the member is considered to be in the hospital at the time of service.

(d) **Radiology therapy management.** Weekly clinical management is based on five fractions delivered comprising one week regardless of the time interval separating the delivery of treatments. Weekly clinical management must be billed as one unit of service rather than five.

(e) **Miscellaneous.**

(1) **Arteriograms, angiograms and aortograms.** When arteriograms, angiograms or aortograms are performed by a radiologist, they are considered radiology, not surgery.

(2) **Injection procedure for arteriograms, angiograms and aortograms.** The "interpretation only" code and the "complete procedure" code are not both allowed for one of these procedures.

(3) **Evac-U-Kit or Evac-O-Kit.** Evac-U-Kit and Evac-O-Kit are included in the charge for the Barium Enema.

(4) **Examination.** Examination at bedside or in operating room allows an additional charge to be made. Examination outside regular hours is not a covered charge.

(5) **Supplies.** Separate payment is not made for supplies such as "administration set" used in provision of office chemotherapy.

(6) **Fluoroscopy or Esophagus study.** Separate charge for fluoroscopy or esophagus study in addition to a routine gastrointestinal tract examination is not covered unless a report is submitted indicating an esophagram was done as a separate procedure.

(f) **Magnetic Resonance Imaging, Positron Emission Tomography, and Computed Tomography.** MRI/MRA, PET, and CT/CTA scans are covered when medically necessary. Documentation in the progress notes must reflect the medical necessity. The diagnosis code must be shown on the claim.

(g) **Placement of radium or other radioactive material.**

(1) For Radium Application use the appropriate HCPCS code.

(2) When a physician supplies the therapeutic radionuclides (implant grains or Gold Seeds) and provides a copy of the invoice, payment is made at 100% of the invoice charges. Fee must

include cost of radium, container, and shipping and handling.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 13 Ok Reg 3607, eff 6-18-96 (emergency); Amended at 14 Ok Reg 3077, eff 7-1-97 (emergency); Amended at 15 Ok Reg 1528, eff 5-11-98 ; Amended at 17 Ok Reg 708, eff 1-10-00 (emergency); Amended at 17 Ok Reg 1204, eff 5-11-00 ; Amended at 18 Ok Reg 761, eff 1-23-01 (emergency); Amended at 18 Ok Reg 1130, eff 5-11-01 ; Amended at 18 Ok Reg 2957, eff 5-17-01 (emergency); Amended at 19 Ok Reg 1067, eff 5-13-02 ; Amended at 19 Ok Reg 2134, eff 6-27-02 ; Amended at 21 Ok Reg 2176, eff 6-25-04 ; Amended at 24 Ok Reg 207, eff 11-1-06 (emergency); Amended at 24 Ok Reg 303, eff 12-1-06 (emergency); Amended at 24 Ok Reg 895, eff 5-11-07 ; Amended at 27 Ok Reg 619, eff 1-14-10 (emergency); Amended at 27 Ok Reg 1453, eff 6-11-10 ; Amended at 28 Ok Reg 1479, eff 6-25-11]

317:30-5-25. Oklahoma Health Care Authority's Quality Improvement Organization (QIO)

All inpatient stays and outpatient observation services are subject to post-payment utilization review by the OHCA's designated Quality Improvement Organization (QIO). These reviews are based on severity of illness and intensity of treatment.

(1) It is the policy and intent of OHCA to allow hospitals and physicians the opportunity to present any and all documentation available to support the medical necessity of an admission and/or extended stay or outpatient observation of a SoonerCare member. If the QIO, upon their initial review determines the admission or outpatient observation services should be denied, a notice is issued to the facility and the attending physician advising them of the decision. This notice also advises that a reconsideration request may be submitted within the specified timeframe on the notice and consistent with the Medicare guidelines. Additional information submitted with the reconsideration request is reviewed by the QIO that utilizes an independent physician advisor. If the denial decision is upheld through this review of additional information, the QIO sends written notification of the denial decision to the hospital, attending physician and the OHCA. Once the OHCA has been notified, the overpayment is processed as per the final denial determination.

(2) If the hospital or attending physician did not request reconsideration from the QIO, the QIO informs OHCA there has been no request for reconsideration and as a result their initial denial decision is final. OHCA, in turn, processes the overpayment as per the denial notice sent to the OHCA by the QIO.

(3) If the QIO's review results in denial and the denial is upheld throughout the review process and refund from the hospital and physician is required, the SoonerCare member cannot be billed for the denied services.

(4) If a hospital or physician believes a hospital admission, continued stay, or outpatient observation service is not medically necessary and thus not SoonerCare compensable but the member insists on treatment, the member is informed that he/she will be personally responsible for all charges.

(A) If a SoonerCare claim is filed and paid and the service is later denied after medical necessity review, the member is not responsible.

(B) If a SoonerCare claim is not filed, the member can be billed.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 13 Ok Reg 3585, eff 7-16-96 (emergency); Amended at 14 Ok Reg 1780, eff 5-27-97 ; Amended at 17 Ok Reg 1204, eff 5-11-00 ; Amended at 18 Ok Reg 2568, eff 6-25-01 ; Amended at 23 Ok Reg 771, eff 3-9-06 (emergency); Amended at 23 Ok Reg 2440, eff 6-25-06 ; Amended at 24 Ok Reg 78, eff 8-2-06 (emergency); Amended at 24 Ok Reg 892, eff 5-11-07]

PART 2. PHYSICIAN ASSISTANTS

317:30-5-30. Eligible providers

Eligible providers shall:

- (1) Have and maintain current license by the Oklahoma State Board of Medical Licensure and Supervision as specified in Section 519.6 of Title 59 of the Oklahoma Statutes;
- (2) Have a current contract with the Oklahoma Health Care Authority (OHCA); and
- (3) Have a practice agreement with a SoonerCare contracted delegating physician(s) (who is licensed and in good standing with the State Board of Medical Licensure and Supervision or the State Board of Osteopathic Examiners) concerning the scope of practice of the physician assistant (PA). If at any time the delegating physician(s) change, an updated copy of the practice agreement must be submitted within ten (10) business days to OHCA, Provider Enrollment.

[Source: Added at 14 Ok Reg 760, eff 1-24-97 (emergency); Added at 14 Ok Reg 1792, eff 5-27-97 ; Amended at 22 Ok Reg 103, eff 7-1-04 (emergency); Amended at 21 Ok Reg 2470, eff 7-11-05 ; Amended at 40 Ok Reg 2214, eff 9-11-23]

317:30-5-31. Coverage

The OHCA covers medical services (as described in OAC 317:30-5, Part 1, Physicians) by a physician assistant (PA) when rendered within the licensure and scope of practice of the PA. Services must be in compliance with the state-specific statutes including Title 59 O.S. § 519.2, rules and regulations of the applicable practice act.

[Source: Added at 14 Ok Reg 760, eff 1-24-97 (emergency); Added at 14 Ok Reg 1792, eff 5-27-97 ; Amended at 22 Ok Reg 103, eff 7-1-04 (emergency); Amended at 21 Ok Reg 2470, eff 7-11-05 ; Amended at 40 Ok Reg 2214, eff 9-11-23]

317:30-5-32. Reimbursement

- (a) Payment for services within the physician assistant's scope of practice shall be made when ordered or performed by the eligible physician assistant if the same service would have been covered if ordered or performed by a physician.
- (b) Payment is not made to physician assistant when a service(s) is (are) performed simultaneously with the delegating physician and billed by the physician on the same day.

(c) Payment is made per the methodology established in the Oklahoma Medicaid State Plan.

[Source: Added at 14 Ok Reg 760, eff 1-24-97 (emergency); Added at 14 Ok Reg 1792, eff 5-27-97 ; Amended at 40 Ok Reg 2214, eff 9-11-23]

317:30-5-33. Post payment utilization review [REVOKED]

[Source: Added at 14 Ok Reg 760, eff 1-24-97 (emergency); Added at 14 Ok Reg 1792, eff 5-27-97 ; Revoked at 40 Ok Reg 2214, eff 9-11-23]

317:30-5-34. Payment rates [REVOKED]

[Source: Added at 14 Ok Reg 760, eff 1-24-97 (emergency); Added at 14 Ok Reg 1792, eff 5-27-97 ; Amended at 19 Ok Reg 2134, eff 6-27-02 ; Revoked at 22 Ok Reg 103, eff 7-1-04 (emergency); Revoked at 21 Ok Reg 2470, eff 7-11-05]

PART 3. HOSPITALS

317:30-5-40. Eligible providers

(a) All general medical/surgical hospitals and critical access hospitals eligible for reimbursement under this Part must be licensed by the appropriate state survey agency, meet Medicare conditions of participation, and have a current contract on file with the Oklahoma Health Care Authority (OHCA).

(b) Children specialty hospitals must be appropriately licensed and certified and have a current contract with the OHCA.

(c) Eligibility requirements for specialized rehabilitation hospitals are covered in OAC 317:30-5-110; inpatient psychiatric hospitals are covered in OAC 317:30-5-95; and long term care hospitals are covered in OAC 317:30-5-60.

(d) Certain providers who provide professional and other services within an inpatient or outpatient hospital require separate contracts with the OHCA.

(e) Reimbursement for laboratory services is made in accordance with the Clinical Laboratory Improvement Amendment of 1988 (CLIA). These regulations provide that payment may be made only for services furnished by a laboratory that meets CLIA conditions. Eligible providers must be certified under the CLIA program and have obtained a CLIA ID number from the Center for Medicare and Medicaid Services (CMS) and have a current contract on file with this Authority.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 17 Ok Reg 3469, eff 8-1-00 (emergency); Amended at 18 Ok Reg 1130, eff 5-11-01 ; Amended at 24 Ok Reg 317, eff 12-1-06 (emergency); Amended at 24 Ok Reg 905, eff 5-11-07 ; Amended at 34 Ok Reg 664, eff 9-1-17]

317:30-5-40.1. General information

(a) This Chapter applies to coverage in an inpatient and/or outpatient setting. Coverage is the same for adults and children unless otherwise indicated.

(b) **Professional Services.** Payment is made to a participating hospital group or corporation for hospital based physician's services. The hospital must have a Hospital Group Physician's Contract with OHCA for this method of billing.

(c) **Prior Authorization.** OHCA requires prior authorization for certain procedures to validate the medical need for the service.

(d) **Medical necessity.** Medical necessity requirements are listed at OAC 317:30-3-1(f) and 317:30-5-20.

[Source: Added at 24 Ok Reg 317, eff 12-1-06 (emergency); Added at 24 Ok Reg 905, eff 5-11-07 ; Amended at 36 Ok Reg 127, eff 11-16-18 (emergency); Amended at 36 Ok Reg 887, eff 9-1-19]

317:30-5-40.2. Definitions [REVOKED]

[Source: Added at 24 Ok Reg 317, eff 12-1-06 (emergency); Added at 24 Ok Reg 905, eff 5-11-07 ; Revoked at 39 Ok Reg 1425, eff 9-12-22]

317:30-5-41. Inpatient hospital coverage/limitations

(a) Covered hospital inpatient services are those medically necessary services which require an inpatient stay ordinarily furnished by a hospital for the care and treatment of inpatients and which are provided under the direction of a physician or dentist in an institution approved under OAC:317:30-5-40.1(a) or (b). Claims for inpatient admissions in acute care or critical access hospitals are reimbursed the lesser of the billed charges or the Diagnosis Related Groups (DRG) amount.

(b) **Inpatient status.** OHCA considers a member an inpatient when the member is admitted to the hospital and is counted in the midnight census. In situations when a member inpatient admission occurs and the member dies, is discharged following an obstetrical stay, or is transferred to another facility on the day of admission, the member is also considered an inpatient of the hospital.

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

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

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

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

- (A) The patient is formally released from the hospital; or
- (B) The patient dies in the hospital; or

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

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 13 Ok Reg 3607, eff 6-18-96 (emergency); Amended at 13 Ok Reg 3585, eff 7-16-96 through 7-16-96 (emergency); Amended at 14 Ok Reg 1208, eff 8-7-96 (emergency); Amended at 14 Ok Reg 3077, eff 7-1-97 (emergency); Amended at 15 Ok Reg 1528, eff 5-11-98 ; Amended at 15 Ok Reg 3784, eff 7-1-98 (emergency); Amended at 16 Ok Reg 1429, eff 5-27-99 ; Amended at 16 Ok Reg 3413, eff 7-1-99 (emergency); Amended at 17 Ok Reg 708, eff 1-10-00 (emergency); Amended at 17 Ok Reg 1204, eff 5-11-00 ; Amended at 17 Ok Reg 3469, eff 8-1-00 (emergency); Amended at 18 Ok Reg 477, eff 1-1-01 (emergency); Amended at 18 Ok Reg 761, eff 1-23-01 (emergency); Amended at 18 Ok Reg 1130, eff 5-11-01 ; Amended at 19 Ok Reg 2134, eff 6-27-2 ; Amended at 20 Ok Reg 2762, eff 7-1-03 (emergency); Amended at 21 Ok Reg 2176, eff 6-25-04 ; Amended at 23 Ok Reg 239, eff 10-3-05 (emergency); Amended at 23 Ok Reg 771, eff 3-9-06 (emergency); Amended at 23 Ok Reg 2440, eff 6-25-06 ; Amended at 24 Ok Reg 317, eff 12-1-06 (emergency); Amended at 24 Ok Reg 905, eff 5-11-07 ; Amended at 31 Ok Reg 1643, eff 9-12-14 ; Amended at 32 Ok Reg 733, eff 7-1-15 (emergency); Amended at 33 Ok Reg 860, eff 9-1-16]

317:30-5-41.1. Acute inpatient psychiatric services

(a) Inpatient stays in a psychiatric unit of a general medical/ surgical hospital are covered for members of any age. See OAC 317:30-5-95 for coverage in a freestanding psychiatric hospital or psychiatric residential treatment facility.

(b) **Utilization Control.** All psychiatric admissions must be prior authorized. SoonerCare utilization control requirements applicable to inpatient psychiatric services in freestanding psychiatric hospitals apply to acute care hospitals. Acute care hospitals are required to maintain the same level of documentation on individuals receiving psychiatric services as the freestanding psychiatric facilities (refer to OAC 317:30-5-95.12).

[Source: Added at 24 Ok Reg 317, eff 12-1-06 (emergency); Added at 24 Ok Reg 905, eff 5-11-07]

317:30-5-41.2. Organ transplants

Solid organ and bone marrow/stem cell transplants are covered when appropriate and medically necessary.

(1) Transplant procedures, except kidney and cornea, must be prior authorized to be compensable.

(2) To be prior authorized all procedures are reviewed based on appropriate medical criteria.

(3) To be compensable under the SoonerCare program all transplants must be performed at a facility which meets the requirements contained in Section 1138 of the Social Security Act.

(4) Procedures considered experimental or investigational are not covered. For more information regarding experimental or investigational including clinical trials, see OAC 317:30-3-57.1.

(5) Donor search and procurement services are covered for transplants consistent with the methods used by the Medicare program for organ acquisition costs.

[Source: Added at 24 Ok Reg 317, eff 12-1-06 (emergency); Added at 24 Ok Reg 2060, eff 6-25-07 ; Amended at 38 Ok Reg 970, eff 9-1-21]

317:30-5-42. Coverage for children [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 13 Ok Reg 3607, eff 6-18-96 (emergency); Amended at 13 Ok Reg 3585, eff 7-16-96 (emergency); Amended at 14 Ok Reg 1215, eff 8-7-96 (emergency); Amended at 14 Ok Reg 252, eff 10-24-96 (emergency); Amended at 14 Ok Reg 1780, eff 5-27-97 ; Amended at 14 Ok Reg 3077, eff 7-1-97 (emergency); Amended at 15 Ok Reg 1528, eff 5-11-98 ; Amended at 16 Ok Reg 3413, eff 7-1-99 (emergency); Amended at 17 Ok Reg 805, eff 7-16-99 (emergency); Amended at 17 Ok Reg 1204, eff 5-11-00 ; Amended at 17 Ok Reg 3469, eff 8-1-00 (emergency); Amended at 18 Ok Reg 1130, eff 5-11-01 ; Amended at 19 Ok Reg 2134, eff 6-27-02 ; Amended at 8 Ok Reg 59, eff 5-1-05 (emergency); Amended at 23 Ok Reg 1354, eff 5-25-06 ; Revoked at 24 Ok Reg 317, eff 12-1-06 (emergency); Revoked at 24 Ok Reg 905, eff 5-11-07]

317:30-5-42.1. Outpatient hospital services

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

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

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

(2) The care is medically necessary.

(3) The member is not an inpatient [refer to Oklahoma Administrative Code (OAC) 317:30-5-41].

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

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

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

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

(f) Physical, occupational, and speech therapy services are covered when performed in an outpatient hospital-based setting. Coverage is limited to one (1) evaluation/re-evaluation visit (unit) per discipline per calendar year and fifteen (15) visits (units) per discipline per date of service per calendar year. Claims for these services must include the appropriate revenue code(s).

(g) Diabetes self-management education and support (DSMES) services are provided to members diagnosed with diabetes. DSMES services are comprised of one (1) hour of individual instruction (face-to-face

encounters between the diabetes educator and the member) and nine (9) hours of group instruction on diabetes self-management. Members shall receive up to ten (10) hours of services during the first twelve (12) month period beginning with the initial training date. After the first twelve (12) month period has ended, members shall only be eligible for two (2) hours of individual instruction on DSMES per calendar year. Refer to OAC 317:30-5-1080 through 317:30-5-1084 for specific provider and program requirements, and reimbursement methodology.

(h) For high-investment drugs, refer to OAC 317:30-5-42.20.

(i) For partial hospitalization program services for adults and children, refer to OAC 317:30-5-241.2.2 and 317:30-5-241.2.3.

[Source: Added at 24 Ok Reg 317, eff 12-1-06 (emergency); Added at 24 Ok Reg 905, eff 5-11-07 ; Amended at 31 Ok Reg 1643, eff 9-12-14 ; Amended at 37 Ok Reg 521, eff 1-6-20 (emergency); Amended at 37 Ok Reg 1543, eff 9-14-20 ; Amended at 38 Ok Reg 965, eff 9-1-21 ; Amended at 39 Ok Reg 1506, eff 9-12-22]

317:30-5-42.10. Laboratory

For laboratory policies please refer to Part 7, Laboratories (Independent, Physician, And Hospital), of this Chapter.

[Source: Added at 24 Ok Reg 317, eff 12-1-06 (emergency); Added at 24 Ok Reg 905, eff 5-11-07 ; Amended at 36 Ok Reg 127, eff 11-16-18 (emergency); Amended at 36 Ok Reg 887, eff 9-1-19 ; Amended at 40 Ok Reg 2197, eff 9-11-23]

317:30-5-42.11. Observation/treatment

(a) Payment is made for the use of a treatment room associated with outpatient observation services. Observation services must be ordered by a physician or other individual authorized by state law. Observation services are furnished by the hospital on the hospital's premises and include use of the bed and periodic monitoring by hospital staff. Observation services must include a minimum of eight (8) hours of continuous care. Outpatient observation services are not covered when they are provided:

- (1) On the same day as an emergency department visit.
- (2) Prior to an inpatient admission, as those observation services are considered part of the inpatient DRG.
- (3) For the convenience of the member, member's family or provider.
- (4) When specific diagnoses are not present on the claim.
- (5) As part of another service, i.e. for post operative monitoring; recovery after diagnostic testing or concurrently with therapeutic services such as chemotherapy.

(b) Payment is made for observation services in a labor or delivery room. Observation services must include a minimum of eight (8) hours of continuous care. Specific pregnancy-related diagnoses are required.

[Source: Added at 24 Ok Reg 317, eff 12-1-06 (emergency); Added at 24 Ok Reg 905, eff 5-11-07 ; Amended at 27 Ok Reg 110, eff 10-2-09 (emergency); Amended at 27 Ok Reg 948, eff 5-13-10 ; Amended at 37 Ok Reg 100, eff 10-2-19 (emergency); Amended at 37 Ok Reg 1511, eff 9-14-20]

317:30-5-42.12. Physical therapy

Payment is made for preauthorized outpatient physical therapy, including evaluations, for children.

[Source: Added at 24 Ok Reg 317, eff 12-1-06 (emergency); Added at 24 Ok Reg 905, eff 5-11-07]

317:30-5-42.13. Radiology

Payment is made for the technical component of outpatient radiation therapy and compensable x-ray procedures.

- (1) **Mammograms.** Medically necessary screening mammography is a covered benefit. Additional follow-up mammograms are covered when medically necessary.
- (2) **Ultrasounds.** Ultrasounds for obstetrical care are paid in accordance with provisions found at OAC 317:30-5-22(b)(2)(A)-(C).

[Source: Added at 24 Ok Reg 317, eff 12-1-06 (emergency); Added at 24 Ok Reg 905, eff 5-11-07]

317:30-5-42.14. Surgery and diagnostic services

(a) **Ambulatory Patient Classification (APC) Groups.** All outpatient hospital services paid under the Medicare Outpatient Prospective Payment System (OPPS) are classified into groups called Ambulatory Payment Classifications or APCs. Group services identified by Health Care Procedure Coding System (HCPCS) codes and descriptors within APC groups are the basis for setting payment rates under OPPS. Services in each APC are similar clinically and in terms of the resources they require. The payment rate calculated for an APC applies to all of the services assigned to the APC. Depending on the services provided, a hospital may receive a number of APC payments for the services furnished to a member on a single day.

(b) **Reimbursement.** Reimbursement is made for selected services performed in an outpatient hospital. Hospital outpatient services are paid on a rate-per-service basis that varies according to the Ambulatory Payment Classification (APC) group to which the services are assigned.

(c) **Multiple Surgeries.** Multiple procedures furnished during the same visit are discounted. The full amount is paid for the procedure with the highest payment group. Fifty percent is paid for any other surgical procedure(s) performed at the same time if the procedure is subject to discounting based on the status indicator established by Medicare.

(d) **Status indicators.** Status indicators identify whether the service described by a HCPCS code is paid under the OPPS and if so, whether payment is made separately or packaged and if payment is subject to discounting. SoonerCare follows Medicare's guidelines for packaged/bundled service costs.

(e) **Minor procedures.** Minor procedures that are normally performed in a physician's office are not covered in the outpatient hospital unless medically necessary.

(f) **Ambulatory Surgery.** When an ambulatory surgery is performed in the inpatient hospital setting, the physician must provide exception rationale justifying the need for an inpatient setting to OHCA medical staff for review.

(g) **Dental Procedures.** Routine dental procedures that are normally performed in a dentist's office are not covered in an outpatient hospital setting unless medically necessary as determined by OHCA. For OHCA payment purposes, the APC list has been expanded to cover dental services for adults in an ICF/MR and all children.

(1) Non-emergency routine dental that is provided in an outpatient hospital setting is covered under the following circumstances:

(A) The child has a medical history of uncontrolled bleeding or other medical condition which renders in-office treatment impossible.

(B) The child has uncontrollable behavior in the dental office even with premedication.

(C) The child needs extensive dental procedures or oral surgery procedures.

(2) Non-emergency routine dental that is provided in an outpatient hospital setting is covered for children and/or adults who are residents in ICFs/MR only under the following circumstances:

(A) A concurrent hazardous medical condition exists;

(B) The nature of the procedure requires hospitalization or;

(C) Other factors (e.g. behavioral problems due to mental impairment) necessitate hospitalization.

[Source: Added at 24 Ok Reg 317, eff 12-1-06 (emergency); Added at 24 Ok Reg 905, eff 5-11-07 ; Amended at 25 Ok Reg 2653, eff 7-25-08 ; Amended at 26 Ok Reg 527, eff 1-2-09 (emergency); Amended at 26 Ok Reg 2117, eff 6-25-09]

317:30-5-42.15. Outpatient hospital services for members infected with tuberculosis

Outpatient hospital services are covered for members infected with tuberculosis. Coverage includes, but may not be limited to, outpatient hospital visits, laboratory work and x-rays.

(1) Services to members infected with TB are not limited to the scope of the SoonerCare program; however, prior authorization is required for services that exceed the scope of coverage under SoonerCare.

(2) Drugs prescribed for the treatment of TB not in accordance with OAC 317:30-3-46 require prior authorization by the OHCA Pharmacy Helpdesk using form "Petition for TB Related Therapy."

[Source: Added at 24 Ok Reg 317, eff 12-1-06 (emergency); Added at 24 Ok Reg 905, eff 5-11-07]

317:30-5-42.16. Related services

(a) **Ambulance.** Ambulance services furnished by the facility are covered separately if otherwise compensable under the SoonerCare program.

(b) **Home health care.** Hospital-based home health providers must be Medicare certified and have a current Home Health Agency contract with the Oklahoma Health Care Authority (OHCA). For home health services, a qualified provider must conduct and document a face-to-face encounter

with the member in accordance with provisions of 42 Code of Federal Regulations (C.F.R.) § 440.70. Refer to Oklahoma Administrative Code (OAC) 317:30-5-546 and OAC 317:30-5-547 for additional policy related to coverage and reimbursement for home health care services.

[Source: Added at 24 Ok Reg 317, eff 12-1-06 (emergency); Added at 24 Ok Reg 905, eff 5-11-07 ; Amended at 28 Ok Reg 511, eff 1-6-11 (emergency); Amended at 28 Ok Reg 1489, eff 6-25-11 ; Amended at 34 Ok Reg 672, eff 9-1-17 ; Amended at 39 Ok Reg 394, eff 12-21-21 (emergency); Amended at 39 Ok Reg 1430, eff 9-12-22]

317:30-5-42.17. Non-covered services

In addition to the general program exclusions [Oklahoma Administrative Code (OAC) 317:30-5-2(a)(2)] the following are excluded from coverage:

- (1) Inpatient admission for diagnostic studies that could be performed on an outpatient basis.
- (2) Procedures that result in sterilization which do not meet the guidelines set forth in this Chapter.
- (3) Reversal of sterilization procedures for the purposes of conception are not covered.
- (4) Medical services considered experimental or investigational. For more information regarding coverage of clinical trials, see OAC 317:30-3-57.1.
- (5) Payment for removal of benign skin lesions for adults.
- (6) Visual aids.
- (7) Charges incurred while the member is in a skilled nursing or swing bed.

[Source: Added at 24 Ok Reg 317, eff 12-1-06 (emergency); Added at 24 Ok Reg 905, eff 5-11-07 ; Amended at 27 Ok Reg 294, eff 11-3-09 (emergency); Amended at 27 Ok Reg 1439, eff 6-11-10 ; Amended at 32 Ok Reg 721, eff 7-1-15 (emergency); Amended at 33 Ok Reg 801, eff 9-1-16 ; Amended at 34 Ok Reg 56, eff 9-22-16 (emergency); Amended at 34 Ok Reg 698, eff 9-1-17 ; Amended at 39 Ok Reg 394, eff 12-21-21 (emergency); Amended at 39 Ok Reg 1430, eff 9-12-22]

317:30-5-42.18. Coverage for children

(a) Services, deemed medically necessary and allowable under federal Medicaid regulations, may be covered under 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.

(b) 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. For more information regarding experimental or investigational including clinical trials, see Oklahoma Administrative Code 317:30-3-57.1.

[Source: Added at 24 Ok Reg 317, eff 12-1-06 (emergency); Added at 24 Ok Reg 905, eff 5-11-07 ; Amended at 38 Ok Reg 970, eff 9-1-21]

317:30-5-42.19. 340B Drug Discount Program

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

[Source: Added at 31 Ok Reg 1662, eff 9-12-14]

317:30-5-42.2. Blood and blood fractions

Payment is made for blood and blood fractions and the administration of blood and blood fractions when these products are required for the treatment of a congenital or acquired disease of the blood and not available from another source.

[Source: Added at 24 Ok Reg 317, eff 12-1-06 (emergency); Added at 24 Ok Reg 905, eff 5-11-07]

317:30-5-42.20. High-investment drugs - outpatient hospitals

(a) The Oklahoma Health Care Authority (OHCA) designates certain high-investment drugs to be reimbursed separately pursuant to the Oklahoma Medicaid State Plan for members receiving services at an outpatient hospital.

(b) The list of OHCA-designated high-investment drugs is set forth on the Pharmacy page of the OHCA website, which is available at <https://okhca.org>. This list may be updated as deemed necessary.

(c) All high-investment drugs require prior authorization [refer to Oklahoma Administrative Code (OAC) 317:30-3-31], and the outpatient hospital stay continues to be subject to applicable medical necessity criteria requirements [refer to OAC 317:30-3-1(f)].

(d) OHCA-designated high-investment drugs provided to eligible members, when treated in out-of-state outpatient hospitals, may be reimbursed in the same manner as in-state hospitals. Out-of-state outpatient hospitals must meet applicable out-of-state conditions of payment set forth in OAC 317:30-3-89 through 317:30-3-92, and in the Oklahoma Medicaid State Plan.

[Source: Added at 37 Ok Reg 761, eff 5-14-20 (emergency); Added at 38 Ok Reg 965, eff 9-1-21]

317:30-5-42.3. Chemotherapy and radiation therapy

Payment is made for charges incurred for the administration of chemotherapy for the treatment of medically necessary and medically approved procedures. Payment for radiation therapy is limited to the treatment of proven malignancies and benign conditions appropriate for stereotactic radiosurgery (e.g., gamma knife).

[Source: Added at 24 Ok Reg 317, eff 12-1-06 (emergency); Added at 24 Ok Reg 905, eff 5-11-07]

317:30-5-42.4. Clinic/treatment room services; urgent care

(a) An outpatient hospital clinic is a non-emergency service providing diagnostic, preventive, curative and rehabilitative services on a scheduled basis.

(b) Urgent care payment is made for services provided in non-emergency clinics operated by a hospital. This payment does not include the professional charges of the treating physician, nurse practitioner,

physician assistant or charges for diagnostic testing. A facility charge is also allowed when drug and/or blood are administered outpatient.
(c) Urgent Care services will not require a referral for SoonerCare Choice members however other claims will deny without a referral.
(d) Adults are limited to four clinic visits per month.

[Source: Added at 24 Ok Reg 317, eff 12-1-06 (emergency); Added at 24 Ok Reg 905, eff 5-11-07]

317:30-5-42.5. Diagnostic testing therapeutic services

(a) Reimbursement is made for diagnostic testing to diagnose a disease or medical condition.
(b) Separate payment may be made for ancillary services that are not covered as an integral part of a facility fee.

[Source: Added at 24 Ok Reg 317, eff 12-1-06 (emergency); Added at 24 Ok Reg 905, eff 5-11-07]

317:30-5-42.6. Dialysis

Payment for dialysis is made at the Medicare prospective payment system wage adjusted base rate. This rate includes all services which Medicare has established as an integral part of the dialysis procedure. The physician is reimbursed separately.

[Source: Added at 24 Ok Reg 317, eff 12-1-06 (emergency); Added at 24 Ok Reg 905, eff 5-11-07 ; Amended at 28 Ok Reg 2329, eff 7-13-11 (emergency); Amended at 29 Ok Reg 1106, eff 6-25-12]

317:30-5-42.7. Emergency department (ED) care/services

Emergency department care must:

- (1) Be provided in a hospital with a designated emergency department; and
- (2) Provide direct patient care, including patient assessment, monitoring, and treatment by hospital medical personnel such as physicians, nurses, or lab and x-ray technicians.
 - (A) Medical records must document the emergency diagnosis and the extent of direct patient care.
 - (B) Emergency department care does not include unattended waiting time.
 - (C) Emergency services are covered for a medical emergency. This means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:
 - (i) Placing the physical or mental health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or continuation of severe pain;
 - (ii) serious impairment to bodily functions; serious dysfunction of any bodily organ or part; or death.

(D) Labor and delivery is a medical emergency, if it meets this definition.

(3) Prescheduled services are not considered an emergency.

(4) Services provided as follow-up to initial emergency care are not considered emergency services.

[Source: Added at 24 Ok Reg 317, eff 12-1-06 (emergency); Added at 24 Ok Reg 905, eff 5-11-07]

317:30-5-42.8. Hearing and speech therapy

Payment is covered for hearing and speech services, including evaluations, for children when prior authorized.

[Source: Added at 24 Ok Reg 317, eff 12-1-06 (emergency); Added at 24 Ok Reg 905, eff 5-11-07]

317:30-5-42.9. Infusions/injections

Intramuscular, subcutaneous or intravenous injections and intravenous (IV) infusions are covered when medically necessary and not considered a compensable part of the procedure.

[Source: Added at 24 Ok Reg 317, eff 12-1-06 (emergency); Added at 24 Ok Reg 905, eff 5-11-07]

317:30-5-43. Vocational Rehabilitation coverage [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 17 Ok Reg 3469, eff 8-1-00 (emergency); Revoked at 18 Ok Reg 1130, eff 5-11-01]

317:30-5-44. Medicare eligible individuals

Payment is made to hospitals for services to Medicare eligible individuals as set forth in this section.

(1) Claims filed with Medicare automatically cross over to OHCA. The explanation of Medicare Benefits (EOMB) reflects a message that the claim was referred to SoonerCare. If such a message is not present, a claim for coinsurance and deductible must be filed with the OHCA within 90 days of the date of Medicare payment and within one year of the date of service in order to be considered timely filed.

(2) If payment is denied by Medicare and the service is a SoonerCare covered service, mark the claim "denied by Medicare" and attach the Medicare EOMB showing the reason for denial.

(3) In certain circumstances, some claims do not automatically "cross over". Providers must file a claim for coinsurance and/or deductible to SoonerCare within 90 days of the Medicare payment and within one year from the date of service.

(4) For individuals who have exhausted Medicare Part A benefits, claims must be accompanied by a statement from the Medicare Part A intermediary showing the date benefits were exhausted.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 18 Ok Reg 107, eff 11-1-00 (emergency); Amended at 18 Ok Reg 1130, eff 5-11-

01 ; Amended at 19 Ok Reg 2134, eff 6-27-02 ; Amended at 19 Ok Reg 2938, eff 7-1-02 (emergency); Amended at 20 Ok Reg 1193, eff 5-27-03 ; Amended at 25 Ok Reg 648, eff 1-1-08 (emergency); Amended at 25 Ok Reg 1161, eff 5-25-08 ; Amended at 32 Ok Reg 719, eff 7-1-15 (emergency); Amended at 33 Ok Reg 791, eff 9-1-16]

317:30-5-45. Psychiatric hospitals - inpatient services for persons age 65 and over [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 13 Ok Reg 593, eff 11-21-95 (emergency); Amended at 13 Ok Reg 1645, eff 5-27-96 ; Amended at 17 Ok Reg 805, eff 7-16-99 (emergency); Amended at 17 Ok Reg 1204, eff 5-11-00 ; Revoked at 17 Ok Reg 3469, eff 8-1-00 (emergency); Revoked at 18 Ok Reg 1130, eff 5-11-01]

317:30-5-46. Psychiatric hospitals and residential psychiatric treatment facilities - inpatient services for persons under age 21 [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 13 Ok Reg 593, eff 11-21-95 (emergency); Amended at 13 Ok Reg 1645, eff 5-27-96 ; Amended at 14 Ok Reg 258, eff 8-5-96 (emergency); Amended at 14 Ok Reg 1780, eff 5-27-97 ; Amended at 15 Ok Reg 3784, eff 7-1-98 (emergency); Amended at 16 Ok Reg 1429, eff 5-27-99 ; Amended at 17 Ok Reg 805, eff 7-1-99 (emergency); Amended at 17 Ok Reg 1204, eff 5-11-00 ; Revoked at 17 Ok Reg 3469, eff 8-1-00 (emergency); Revoked at 18 Ok Reg 1130, eff 5-11-01]

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

Reimbursement will be made for inpatient hospital services 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 the lesser of the billed charges or the Diagnosis Related Group (DRG) amount. In addition to the billed charges or DRG payment, whichever is less, an outlier payment may be made to the hospital for very high cost stays. Additional outlier payment is applicable if either the amount billed by the hospital or DRG payment, whichever applies, 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 lesser of the billed charges or DRG amount 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 seventy-two (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 SoonerCare program, when treated in out-of-state hospitals will be reimbursed in the same manner as in-state hospitals. Refer to OAC 317:30-3-90 and 317:30-3-91.
- (5) Cases which indicate transfer from one (1) 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) The transferring hospital will be paid the lesser of the calculated transfer fee or the DRG base payment amount for a non-transfer.
- (7) 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.
- (8) Covered inpatient services provided in out-of-state specialty hospitals may be reimbursed at a negotiated rate not to exceed one-hundred percent (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.
- (9) 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.
- (10) All inpatient services are reimbursed per the methodology described in this Section and/or as approved under the Oklahoma Medicaid State Plan.
- (11) For high-investment drugs, refer to OAC 317:30-5-47.6.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 13 Ok Reg 825, eff 12-21-95 (emergency); Amended at 13 Ok Reg 2523, eff 6-27-96 ; Amended at 15 Ok Reg 1100, eff 1-6-98 (emergency); Amended at 15 Ok Reg 1535, eff 5-11-98 ; Amended at 15 Ok Reg 3784, eff 7-1-98 (emergency); Amended at 16 Ok Reg 2733, eff 3-15-99 (emergency); Amended at 16 Ok Reg 1429, eff 5-27-99 ; Amended at 16 Ok Reg 3275, eff 5-28-99 (emergency); Amended at 17 Ok Reg 1204, eff 5-11-00 ; Amended at 17 Ok Reg 3469, eff 8-1-00 (emergency); Amended at 18 Ok Reg 1130, eff 5-11-01 ; Added at 19 Ok Reg 327, eff 11-6-01 (emergency); Amended at 19 Ok Reg 2762, eff 4-30-02 (emergency); Amended at 19 Ok Reg 1067, eff 5-13-02 ; Amended at 19 Ok Reg 2939, eff 7-1-02 (emergency); Amended at 20 Ok Reg 1933, eff 6-26-03 ; Amended at 21 Ok Reg 2166, eff 6-25-04 ; Amended at 23 Ok Reg 239, eff 10-3-05 (emergency); Amended at 23 Ok Reg 807, eff 2-1-06 (emergency); Amended at 23 Ok Reg 2500, eff 6-25-06 ; Amended at 24 Ok Reg 317, eff 12-1-06 (emergency); Amended at 24 Ok Reg 905, eff 5-11-07 ; Amended at 26 Ok Reg 249, eff 1-1-09 (emergency); Amended at 26 Ok Reg 1053, eff 5-11-09 ; Amended at 31 Ok Reg 1663, eff 9-12-14 ; Amended at 32 Ok Reg 733, eff 7-1-15 (emergency); Amended at 33 Ok Reg 860, eff 9-1-16 ; Amended at 34 Ok Reg 641, eff 9-1-17 ; Amended at 37 Ok Reg 761, eff 5-14-20 (emergency); Amended at 38 Ok Reg 965, eff 9-1-21]

317:30-5-47.1. Reimbursement for newborn screening services provided by the OSDH

Newborn screening performed by the Oklahoma State Department of Health in accordance with State Law is excluded from the inpatient

DRG payment.

[Source: Added at 20 Ok Reg 1863, eff 4-30-03 (emergency); Added at 21 Ok Reg 1324, eff 5-27-04 ; Amended at 24 Ok Reg 317, eff 12-1-06 (emergency); Amended at 24 Ok Reg 905, eff 5-11-07]

317:30-5-47.2. Disproportionate share hospitals (DSH)

Payment will be made to hospitals qualifying for Disproportionate Share Hospital adjustments pursuant to the methodology described in the Oklahoma Title XIX Inpatient Hospital State Plan.

[Source: Added at 23 Ok Reg 239, eff 10-3-05 (emergency); Added at 23 Ok Reg 1346, eff 5-25-06 ; Amended at 24 Ok Reg 317, eff 12-1-06 (emergency); Amended at 24 Ok Reg 905, eff 5-11-07]

317:30-5-47.3. Indirect medical education (IME) adjustment

Payment will be made to hospitals qualifying for Indirect Medical Education payment adjustments pursuant to the methodology described in the Oklahoma Title XIX Inpatient Hospital State Plan.

[Source: Added at 23 Ok Reg 239, eff 10-3-05 (emergency); Added at 23 Ok Reg 1346, eff 5-25-06 ; Amended at 24 Ok Reg 317, eff 12-1-06 (emergency); Amended at 24 Ok Reg 905, eff 5-11-07]

317:30-5-47.4. Direct medical education payment adjustment

Payment will be made to hospitals qualifying for Direct Medical Education payment adjustments pursuant to the methodology described in the Oklahoma Title XIX Inpatient Hospital State Plan.

[Source: Added at 23 Ok Reg 239, eff 10-3-05 (emergency); Added at 23 Ok Reg 1346, eff 5-25-06 ; Amended at 24 Ok Reg 317, eff 12-1-06 (emergency); Amended at 24 Ok Reg 905, eff 5-11-07]

317:30-5-47.5. Critical Access Hospitals

Critical Access Hospitals (CAHs) are rural public or non-profit hospitals which have been certified by Medicare as a Critical Access Hospital. The facility must provide documentation to be determined eligible for the CAH peer group.

[Source: Added at 23 Ok Reg 239, eff 10-3-05 (emergency); Added at 23 Ok Reg 1346, eff 5-25-06]

317:30-5-47.6. High-investment drugs - inpatient hospitals

(a) The Oklahoma Health Care Authority (OHCA) designates certain high-investment drugs to be reimbursed separately pursuant to the Oklahoma Medicaid State Plan for members receiving services at an inpatient hospital.

(b) The list of OHCA-designated high-investment drugs is set forth on the Pharmacy page of the OHCA website, which is available at <https://okhca.org>. This list may be updated as deemed necessary.

(c) All high-investment drugs require prior authorization [refer to Oklahoma Administrative Code (OAC) 317:30-3-31], and the inpatient hospital stay continues to be subject to applicable medical necessity criteria requirements [refer to OAC 317:30-3-1(f)].

(d) OHCA-designated high-investment drugs provided to eligible members, when treated in out-of-state inpatient hospitals, may be

reimbursed in the same manner as in-state hospitals. Out-of-state inpatient hospitals must meet applicable out-of-state conditions of payment set forth in OAC 317:30-3-89 through 317:30-3-92, and in the Oklahoma Medicaid State Plan.

[Source: Added at 37 Ok Reg 761, eff 5-14-20 (emergency); Added at 38 Ok Reg 965, eff 9-1-21]

317:30-5-48. Cost reports [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 15 Ok Reg 3784, eff 7-1-98 (emergency); Amended at 16 Ok Reg 1429, eff 5-27-99 ; Revoked at 23 Ok Reg 239, eff 10-3-05 (emergency); Revoked at 23 Ok Reg 1346, eff 5-25-06]

317:30-5-49. Reporting suspected abuse

Instances of child abuse and/or neglect are to be reported in accordance with State law. Any person suspecting child abuse or neglect shall immediately report it to the Oklahoma Department of Human Services (OKDHS) hotline, at 1-800-522-3511. Any person suspecting abuse, neglect, or exploitation of a vulnerable adult shall immediately report it to the local OKDHS County Office, municipal or county law enforcement authorities, or, if the report occurs after normal business hours, the OKDHS hotline. 10A O.S. § 1-2-101; 43A O.S. § 10-104. Health care professionals who are requested to report incidents of domestic abuse by adult victims with legal capacity shall promptly make a report to the nearest law enforcement agency, per 22 O.S. § 58.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 26 Ok Reg 2081, eff 6-25-09 ; Amended at 34 Ok Reg 664, eff 9-1-17]

317:30-5-50. Abortions

(a) Payment is made only for abortions in those instances where the abortion is necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed, or where the pregnancy is the result of an act of rape or incest. SoonerCare coverage for abortions to terminate pregnancies that are the result of rape or incest are considered to be medically necessary services and federal financial participation is available specifically for these services.

(1) For abortions necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, the physician must complete the Certification for Medicaid Funded Abortion and certify in writing that the abortion is being performed due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed. The patient's name and address must be included in the certification and the certification must be signed and dated by the physician. The certification must be attached to the claim.

(2) For abortions in cases of rape or incest, there are two requirements for the payment of a claim. First, the physician must fully complete the Certification for Medicaid Funded Abortion. Second, the patient must have made a police report or counselor's report of the rape or incest. In cases where an official report of the rape or incest is not available, the physician must certify in writing and provide documentation that in his or her professional opinion, the patient was unable, for physical or psychological reasons, to comply with the requirement. The statement explains the reason the rape or incest was not reported. The patient's name and address must be included in the certification and the certification must be signed and dated by the physician and the patient. In cases where a physician provides certification and documentation of a patient's inability to file a report, the Oklahoma Health Care Authority (OHCA) will perform a prepayment review of all records to ensure there is sufficient documentation to support the physician's certification.

(b) The OHCA performs a look-behind procedure for abortion claims paid from SoonerCare funds. This procedure will require that this Agency obtain the complete medical records for abortions paid under SoonerCare. On a post payment basis, this Authority will obtain the complete medical records on all claims paid for abortions.

(c) Claims for spontaneous abortions, including Dilation and Curettage do not require certification. The following situations also do not require certification:

- (1) If the physician has not induced the abortion, counseled or otherwise collaborated in inducing the abortion, and
- (2) If the process has irreversibly commenced at the point of the physician's medical intervention.

(d) Claims for the diagnosis incomplete abortion require medical review. The appropriate diagnosis codes should be used indicating spontaneous abortion, etc.; otherwise the procedure will be denied.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 13 Ok Reg 2521, eff 6-27-96 ; Amended at 15 Ok Reg 4194, eff 7-20-98 (emergency); Amended at 16 Ok Reg 1429, eff 5-27-99 ; Amended at 24 Ok Reg 317, eff 12-1-06 (emergency); Amended at 24 Ok Reg 905, eff 5-11-07 ; Amended at 38 Ok Reg 1000, eff 9-1-21]

317:30-5-51. Elective sterilizations

(a) Payment is made to hospitals for elective sterilizations performed in behalf of eligible individuals if all of the following circumstances are met:

- (1) The patient must be at least 21 years of age at the time the consent form is signed,
- (2) The patient must be mentally competent,
- (3) A properly completed Federally mandated consent for sterilization form is attached to the claim, and
- (4) The form is signed by the patient at least 30 days, but not more than 180 days prior to the surgery.

(b) When a sterilization procedure is performed in conjunction with a C-section, it is considered multiple surgery and a consent form for the sterilization is required.

(c) Reversal of sterilization procedures for the purposes of conception are not covered. Reversal of sterilization procedures may be covered when medically necessary and substantiating documentation is attached to the claim.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95]

317:30-5-52. Hysterectomies

A hysterectomy performed for purposes of sterilization or family planning is not compensable. Payment is made to hospitals for therapeutic hysterectomies only when one of the following circumstances is met.

(1) A properly completed hysterectomy acknowledgement is attached to the claim form. The acknowledgement must clearly state that the patient or her representative was informed, orally and in writing, prior to the surgery that she would be rendered permanently incapable of reproduction. The 30 day waiting period which applies to elective sterilizations does not apply to therapeutic hysterectomies.

(2) The surgeon must certify in writing that the patient was sterile prior to the surgery. The reason for the sterility, i.e., post-menopausal, previous tubal ligation, etc. must be given.

(3) The surgeon must certify that the surgery was performed in an emergency, life endangering situation. The circumstances must be given. A hysterectomy acknowledgement form may be signed by the patient and dated after the surgery as long as the acknowledgement meets all other requirements. The patient must acknowledge in the form that prior to surgery she was advised orally and in writing that she would be rendered sterile as a result of the surgery.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95]

317:30-5-53. Newborn care

The county Department of Human Services office where the mother resides must be notified in writing within five days of the child's birth in order for an individual person code to be assigned to the newborn. A claim may then be filed for nursery charges for the baby under the case number and the baby's name and assigned person code. Nursery charges billed on the mother's person code will be denied. Providers must use Form FSS-NB-1 to notify the county DHS office of the child's birth. Copies of the form may be obtained at the county DHS office.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95]

317:30-5-54. Hospital rate appeals [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 13 Ok Reg 3585, eff 7-16-96 (emergency); Amended at 14 Ok Reg 1780, eff 5-27-97 ; Revoked at 15 Ok Reg 3784, eff 7-1-98 (emergency); Revoked at 16 Ok Reg 1424, eff 5-27-99]

317:30-5-55. Residential psychiatric treatment facility rate appeals [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 13 Ok Reg 3585, eff 7-16-96 (emergency); Amended at 14 Ok Reg 1780, eff 5-27-97 ; Revoked at 15 Ok Reg 3784, eff 7-1-98 (emergency); Revoked at 16 Ok Reg 1424, eff 5-27-99]

317:30-5-56. Utilization review

All inpatient services are subject to post-payment utilization review by the Oklahoma Health Care Authority, or its designated agent. These reviews will be based on OHCA's, or its designated agent's, admission criteria on severity of illness and intensity of treatment. In addition to the random sample of all admissions, retrospective review policy includes the following:

(1) Hospital stays less than three days in length will be reviewed for medical necessity and appropriateness of care. (Discharges involving healthy mother and healthy newborns may be excluded from this review requirement.) If it is determined that the inpatient stay was unnecessary or inappropriate, the prospective payment for the inpatient stay will be denied.

(2) Cases which indicate transfer from one acute care hospital to another will be monitored to help ensure that payment is not made for inappropriate transfers.

(3) Readmissions occurring within 30 days of prior acute care admission for a related condition will be reviewed to determine medical necessity and appropriateness of care or whether the readmission was potentially preventable. If it is determined that either or both admissions were unnecessary or inappropriate or potentially preventable, payment for either or both admissions may be denied. Such review may be focused to exempt certain cases at the sole discretion of the OHCA.

[Source: Added at 24 Ok Reg 317, eff 12-1-06 (emergency); Added at 24 Ok Reg 905, eff 5-11-07 ; Amended at 31 Ok Reg 662, eff 10-1-14 (emergency); Amended at 32 Ok Reg 1040, eff 8-27-15]

317:30-5-57. Notice of denial

(a) **General.** It is the policy and intent to allow hospitals and physicians the opportunity to present any and all documentation available to support the medical necessity of an admission and/or extended stay of a SoonerCare member. If the OHCA, or its designated agent, upon their initial review determines the admission should be denied, a notice is sent to the facility and the attending physician(s) advising them of the decision. This notice also advises that a reconsideration request may be submitted within 60 days.

(b) **Reconsideration request.** All inpatient stays and outpatient observation services are subject to post-payment utilization review by the OHCA's designated Quality Improvement Organization (QIO). These

reviews are based on severity of illness and intensity of treatment. It is the policy and intent of OHCA to allow hospitals and physicians the opportunity to present any and all documentation available to support the medical necessity of an admission and/or extended stay or outpatient observation of a SoonerCare member. If the QIO, upon their initial review determines the admission or outpatient observation services should be denied, a notice is issued to the facility and the attending physician advising them of the decision. This notice also advises that a reconsideration request may be submitted within the specified time frame on the notice and consistent with the Medicare guidelines. Additional information submitted with the reconsideration request is reviewed by the QIO that utilizes an independent physician advisor. If the denial decision is upheld through this review of additional information, the QIO sends written notification of the denial decision to the hospital, attending physician and the OHCA. Once the OHCA has been notified, the overpayment is processed as per the final denial determination.

(c) **Reconsideration request not made.** If the hospital or attending physician did not request reconsideration from the QIO, the QIO informs OHCA there has been no request for reconsideration and as a result their initial denial decision is final. OHCA, in turn, processes the overpayment as per the denial notice sent to the OHCA by the QIO.

(d) **Patient liability.** If an OHCA, or its designated agent, review results of a denial and the denial is upheld throughout the appeal process and refund from the hospital and physician is required, the member cannot be billed for the denied services.

(1) If a hospital or physician believes that an acute care hospital admission or continued stay is not medically necessary and thus not compensable but the member insists on treatment, the member should be informed in writing that he/she will be personally responsible for all charges.

(2) If a claim is filed and paid and the service is later denied the member is not responsible.

[Source: Added at 24 Ok Reg 317, eff 12-1-06 (emergency); Added at 24 Ok Reg 905, eff 5-11-07]

317:30-5-58. Supplemental Hospital Offset Payment Program

(a) **Purpose.** The Supplemental Hospital Offset Payment Program (SHOPP) is a hospital assessment fee that is eligible for federal matching funds when used to reimburse SoonerCare services in accordance with Section 3241.1 of Title 63 of the Oklahoma Statutes (O.S.).

(b) **Definitions.** The following words and terms, when used in this Section have the following meaning, unless the context clearly indicates otherwise:

(1) **"Base Year"** means a hospital's fiscal year ending in 2009, as reported in the Medicare Cost Report or as determined by the Oklahoma Health Care Authority (OHCA) if the hospital's data is not included in a Medicare Cost Report.

(2) **"Directed payments"** means payment arrangements allowed under 42 Code of Federal Regulations (C.F.R.) Section (§) 438.6(c) that permit states to direct specific payments made by managed

care plans to providers under certain circumstances and can assist states in furthering the goals and priorities of their Medicaid programs.

(3) "**Fee**" means supplemental hospital offset assessment pursuant to Section (§) 3241.1 of Title 63 of the O.S.

(4) "**Hospital**" means an institution licensed by the State Department of Health as a hospital pursuant to § 1-701.1 of Title 63 of the O.S. maintained primarily for the diagnosis, treatment, or care of patients.

(5) "**Hospital Advisory Committee**" means the Committee established for the purposes of advising the OHCA and recommending provisions within and approval of any state plan amendment or waiver affecting the Supplemental Hospital Offset Payment Program.

(6) "**NET hospital patient revenue**" means the gross hospital revenue as reported on Worksheet G-2 (Columns 1 and 2, Lines "Total inpatient routine care services", "Ancillary services", "Outpatient services") of the Medicare cost report, multiplied by hospital's ratio of total net to gross revenue, as reported on Worksheet G-3(Column 1, Line 3)"Net patient revenues"and Worksheet G-2 (Part I, Column 3, Line "Total patient revenues").

(7) "**Medicare cost report**" means the hospital cost report, Form CMS-2552-96 or subsequent versions.

(8) "**Upper payment limit (UPL)**" means the maximum ceiling imposed by 42 C.F.R. §§ 447.272 and 447.321 on hospital Medicaid reimbursement for inpatient and outpatient services, other than to hospitals owned or operated by state government.

(9) "**Upper payment limit gap**" means the difference between the upper payment limit and SoonerCare payments not financed using hospital assessments.

(c) **Supplemental Hospital Offset Payment Program.**

(1) Pursuant to 63 O.S. §§ 3241.1 through 3241.6 the OHCA is mandated to assess hospitals licensed in Oklahoma, unless exempted under (c) (2) of this Section, a supplemental hospital offset payment fee.

(2) The following hospitals are exempt from the SHOPP fee:

- (A) A hospital that is owned or operated by the state or a state agency, or the federal government, as determined by OHCA, using most recent Medicare cost report worksheet S-2, column 1, line 18 or other line that indicates ownership, or by a federally recognized Indian tribe or Indian Health Services, as determined by OHCA, using the most recent IHS/Tribal facility list for Oklahoma as updated by the Indian Health Service Office of Resource Access and Partnerships in Partnership with the Centers for Medicare and Medicaid Services and state operations.
- (B) A hospital that provides more than fifty percent (50%) of its inpatient days under a contract with a state agency other than the OHCA, as determined by OHCA, using data provided by the hospital;

(C) A hospital for which the majority of its inpatient days are for any one of the following services, as determined by OHCA, using the Inpatient Discharge Data File published by the Oklahoma State Department of Health, or in the case of a hospital not included in the Inpatient Discharge Data File, using substantially equivalent data provided by the hospital:

- (i) Treatment of a neurological injury;
- (ii) Treatment of cancer;
- (iii) Treatment of cardiovascular disease;
- (iv) Obstetrical or childbirth services; or
- (v) Surgical care except that this exemption will not apply to any hospital located in a city of less than five hundred thousand (500,000) population and for which the majority of inpatient days are for back, neck, or spine surgery.

(D) A hospital that is certified by the Centers for Medicare and Medicaid Services (CMS) as a long term acute hospital, according to the most recent list of LTCH's published on the CMS

<http://www.cms.gov/LongTermCareHospitalPPS/08download.asp> or as a children's hospital; and

(E) A hospital that is certified by CMS as a critical access hospital, according to the most recent list published by Flex Monitoring Team for Critical Access Hospital (CAH) Information at

<http://www.flexmonitoring.org/cahlistRA.cgi>, which is based on CMS quarterly reports, augmented by information provided by state Flex Coordinators.

(d) The SHOPP Assessment.

(1) The SHOPP assessment is imposed on each hospital, except those exempted under (c) (2) of this Section, for each calendar year in an amount calculated as a percentage of each hospital's net hospital patient revenue. The SHOPP assessment is imposed on each hospital, except those exempted under (c) (2) of this Section, in an amount calculated as a percentage of each hospital's net hospital patient revenue. At no time will the assessment rate exceed four percent (4%). For the calendar year ending December 31, 2022, the assessment rate shall be fixed at three percent (3%). For the calendar year ending December 31, 2023, the assessment rate shall be fixed at three and one-half percent (3.5%). For the calendar year ending December 31, 2024 and for all subsequent calendar years shall, the assessment rate exceed shall be fixed at four percent (4%).

(2) A hospital may not charge any patient for any portion of the SHOPP assessment.

(3) The method of collection is as follows:

(A) The OHCA will send a notice of assessment to each hospital informing the hospital of the assessment rate, the hospital's net hospital patient revenue calculation, and the assessment amount owed by the hospital for the applicable

year.

(B) The hospital has thirty (30) days from the date of its receipt of a notice of assessment to review and verify the hospital's net patient revenue calculation, and the assessment amount.

(C) New hospitals will only be added at the beginning of each calendar year.

(D) The annual assessment imposed is due and payable on a quarterly basis. Each quarterly installment payment is due and payable by the fifteenth day of the first month of the applicable quarter (i.e. January 15th, April 15th, etc.)

(E) Failure to pay the amount by the 15th or failure to have the payment mailing postmarked by the 13th may result in a debt to the State of Oklahoma and is subject to penalties of five percent (5%) of the amount.

(F) If a hospital fails to timely pay the full amount of a quarterly assessment, OHCA may add to the assessment:

(i) A penalty assessment equal to five percent (5%) of the quarterly amount not paid on or before the due date, and

(ii) On the last day of each quarter after the due date until the assessed amount and the penalty imposed under section (i) of this paragraph are paid in full, an additional five percent (5%) penalty assessment on any unpaid quarterly and unpaid penalty assessment amounts.

(iii) The quarterly assessment including applicable penalties and interest must be paid regardless of any appeals action requested by the facility. If a provider fails to pay the OHCA the assessment within the time frames noted on the invoice to the provider, the assessment and applicable penalty will be deducted from the facility's payment. Any change in payment amount resulting from an appeals decision in which a recoupment or additional allocation is necessary will be adjusted in future payments in accordance with Oklahoma Administrative Code (OAC) 317:2-1-15 SHOPP appeals.

(iv) If additional allocation or recoupment resulting from an appeal is for the current calendar year and another SHOPP payment is scheduled for the calendar year, an adjustment to the next payment will be calculated. If additional allocation or recoupment is for a prior calendar year, a separate payment/account receivable (AR) will be issued.

(G) The SHOPP assessments excluding penalties and interest are an allowable cost for cost reporting purposes.

(e) SHOPP Cost Reports.

(1) The report referenced in paragraph (b)(6) must be signed by the preparer and by the Owner, authorized Corporate Officer or

Administrator of the facility for verification and attestation that the reports were compiled in accordance with this section.

(2) The Owner or authorized Corporate Officer of the facility must retain full accountability for the report's accuracy and completeness regardless of report submission method.

(3) Penalties for false statements or misrepresentation made by or on behalf of the provider are provided at 42 United States Code (U.S.C.) Section 1320a-7b which states, in part, "Whoever...(2) at any time knowingly and willfully makes or causes to be made any false statement of a material fact for use in determining rights to such benefits or payment...shall (i) in the case of such statement, representation, failure, or conversion by any person in connection with furnishing (by the person) of items or services for which payment is or may be under this title (42 U.S.C. § 1320 et seq.), be guilty of a felony and upon conviction thereof fined not more than twenty-five thousand dollars (\$25,000) or imprisoned for not more than five (5) years or both, or (ii) in the case of such a statement, representation, concealment, failure or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than ten thousand dollars (\$10,000) or imprisoned for not more than one year, or both."

(4) Net hospital patient revenue is determined using the data from each hospital's applicable Medicare cost report contained in the Centers for Medicare and Medicaid Services' Healthcare Cost Report Information System (HCRIS) file. The base year for assessment shall be the hospital's fiscal year that ended two years prior (e.g. calendar year 2022 will use 2020 fiscal year cost reports), as contained in the HCRIS file dated June 30 of each year.

(5) If a hospital's applicable Medicare cost report is not contained in the Centers for Medicare and Medicaid Services' HCRIS file, the hospital will submit a copy of the hospital's applicable Medicare cost report to the OHCA in order to allow the OHCA to determine the hospital's net hospital patient revenue for the base year.

(6) If a hospital commenced operations after the due date for a Medicare cost report, the hospital will submit its initial Medicare cost report to OHCA in order to allow the OHCA to determine the hospital's net patient revenue for the base year.

(7) Partial year reports may be prorated for an annual basis. Hospitals whose assessments were based on partial year cost reports will be reassessed the following year using a cost report that contains a full year of operational data.

(8) In the event that a hospital does not file a uniform cost report under 42 U.S.C., Section 1396a(a)(40), the OHCA will provide a data collection sheet for such facility.

(f) Closure, merger and new hospitals.

(1) If a hospital ceases to operate as a hospital or for any reason ceases to be subject to the fee, the assessment for the year in which the cessation occurs is adjusted by multiplying the annual assessment by a fraction, the numerator of which is the number of

days in the year during which the hospital is subject to the assessment and denominator of which is 365. Within thirty (30) days of ceasing to operate as a hospital, or otherwise ceasing to be subject to the assessment, the hospital will pay the assessment for the year as so adjusted, to the extent not previously paid.

(2) Cost reports required under (e)(5),(e)(6),or (e)(8) of this subsection for assessment calculation must be submitted to OHCA by September 30 of each year.

(g) Disbursement of payment to hospitals.

(1) All in-state inpatient hospitals are eligible for hospital access payments each year as set forth in this subsection except for those listed in OAC 317:30-5-58 (c) (2):

(A) In addition to any other funds paid to inpatient critical access hospital for services provided to SoonerCare members, each critical access hospital will receive hospital access payments equal to the amount by which the payment for these services was less than one hundred one percent (101%) of the hospital's cost of providing these services.

(B) In addition to any other funds paid to hospitals for inpatient hospital services to SoonerCare members, each eligible hospital will receive inpatient hospital access payments each year equal to the hospital's pro rata share of the inpatient supplemental payment pool as reduced by payments distributed in paragraph (1) (A) of this Section. The pro rata share will be based upon the hospital's SoonerCare payment for inpatient services divided by the total SoonerCare payments for inpatient services of all eligible hospitals within each class of hospital and cannot exceed the UPL for the class.

(C) Directed payments paid through a managed care organization (MCO) as approved in the CMS-approved 438.6(c) directed payment pre-prints.

(2) All in-state outpatient hospitals are eligible for hospital access payments each year as set forth in this subsection except for those listed in OAC 317:30-5-58 (c) (2):

(A) In addition to any other funds paid to outpatient critical access hospital for services provided to SoonerCare members, each critical access hospital will receive hospital access payments equal to the amount by which the payment for these services was less than one hundred one percent (101%) of the hospital's cost of providing these services.

(B) In addition to any other funds paid to hospitals for outpatient hospital services to SoonerCare members, each eligible hospital will receive outpatient hospital access payments each year equal to the hospital's pro rata share of the outpatient supplemental payment pool as reduced by payments distributed in paragraph (2) (A) of this Section. The pro rata share will be based upon the hospital's SoonerCare payment for outpatient services

divided by the total SoonerCare payments for outpatient services of all eligible hospitals within each class of hospital and cannot exceed the UPL for the class.

(C) Directed payments paid through a managed care organization (MCO) as approved in the CMS-approved 438.6(c) directed payment pre-prints.

(3) Medicaid payments to a group of facilities within approved categories may not exceed the upper payment limit in accordance with 42 C.F.R. 447.272 (b) (2) and 42 C.F.R 447.321 (b) (2). If any audit determines that a class of hospitals has exceeded the inpatient and/or outpatient UPL the overpayment will be recouped and redistributed based on the following methods:

(A) If it is determined prior to issuance of hospital access payments that the pool of hospitals would exceed the upper payment limit estimate of that pool, the amount above the UPL estimate will be allocated to another pool of hospitals that does not exceed the upper payment limit estimate of that pool. The reallocation can be applied to multiple pools if necessary.

(B) If the overpayment cannot be redistributed due to all classes being paid at their UPL, the overpayment will be deposited in to the SHOPP fund.

(4) Effective for all subsequent calendar years the OHCA will distribute payments in the following quarterly percentages: 23.6%, 25%, 25%, 25%. A fifth (5th) payment of 1.4% in the fourth (4th) quarter of each calendar year will also be made as soon as all assessments are received.

[Source: Added at 29 Ok Reg 189, eff 11-22-11 (emergency); Added at 29 Ok Reg 474, eff 5-11-12 ; Amended at 30 Ok Reg 1139, eff 7-1-13 ; Amended at 38 Ok Reg 1596, eff 7-19-21 (emergency); Amended at 39 Ok Reg 1483, eff 9-12-22]

PART 4. LONG TERM CARE HOSPITALS

317:30-5-60. Subacute level of care

Subacute (SA) level of care is skilled care provided by a long term care hospital to patients with medically complex needs. The patients who are treated include those with complex pulmonary problems, children requiring long-term care to improve or maintain their physical condition or prevent deterioration to children who are terminally ill, children who are experiencing severe developmental disabilities and multi-handicaps.

[Source: Added at 15 Ok Reg 1100, eff 1-6-98 (emergency); Added at 15 Ok Reg 1535, eff 5-11-98]

317:30-5-61. Eligible providers

To be eligible for reimbursement hospitals must be Medicare certified and have a current contract on file with the Oklahoma Health Care Authority. The facility must also be designated as a long term care facility by the Social Security Administration and be appropriately

licensed as a Children's Specialty Hospital. Payment will be made to licensed Children's hospitals specializing in subacute nursing and rehabilitative services.

[Source: Added at 15 Ok Reg 1100, eff 1-6-98 (emergency); Added at 15 Ok Reg 1535, eff 5-11-98]

317:30-5-62. Coverage by category

(a) **Adults.** There is no coverage for adults.

(b) **Children.** Payment is made to long term care hospitals for subacute medical and rehabilitative services for persons under the age of 21 within the scope of the Authority's Medical Programs, provided the services are reasonable for the diagnosis and treatment of illness or injury, or to improve the functioning of a malformed body member.

(1) **Inpatient services.**

(A) All inpatient services are subject to post-payment utilization review by the Oklahoma Health Care Authority, or its designated agent. These reviews will be based on OHCA's, or its designated agent's, admission criteria on severity of illness and intensity of treatment.

(i) It is the policy and intent of the Oklahoma Health Care Authority to allow hospitals and physicians the opportunity to present any and all documentation available to support the medical necessity of an admission and/or extended stay of a Medicaid recipient. If the OHCA, or its designated agent, upon their initial review determines the admission should be denied, a notice is sent to the facility and the attending physician(s) advising them of the decision. This notice also advises that a reconsideration request may be submitted within 60 days. Additional information submitted with the reconsideration request will be reviewed by the OHCA, or its designated agent, who utilizes an independent physician advisor. If the denial decision is upheld through this review of additional information, OHCA is informed. At that point, OHCA sends a letter to the hospital and physician requesting refund of the Title XIX payment previously made on the denied admission.

(ii) If the hospital or attending physician did not request reconsideration by the OHCA, or its designated agent, the OHCA, or its designated agent, informs OHCA that there has been no request for reconsideration and as a result their initial denial decision is final. OHCA, in turn, sends a letter to the hospital and physician requesting refund of the amount of Title XIX payment previously made on the denied admission.

(iii) If an OHCA, or its designated agent, review results in denial and the denial is upheld

throughout the review process and refund from the hospital and physician is required, the Medicaid recipient cannot be billed for the denied services. The reconsideration process outlined in (A) of this paragraph will end on July 1, 2006.

(B) If a hospital or physician believes that a long term care facility admission or continued stay is not medically necessary and thus not Medicaid compensable but the patient insists on treatment, the patient must be informed that he/she will be personally responsible for all charges. If a Medicaid claim is filed and paid and the service is later denied the patient is not responsible. If a Medicaid claim is not filed and paid the patient can be billed.

(2) Utilization control requirements.

(A) **Certification and recertification of need for inpatient care.** The certification and recertification of need for inpatient care must be in writing and must be signed and dated by the physician who has knowledge of the case that continued inpatient care is required. The certification and recertification documents for all Medicaid patients must be maintained in the patient's medical records or in a central file at the facility where the patient is or was a resident.

(i) **Certification.** A physician must certify for each applicant or recipient that inpatient services in a long term care hospital were needed. The certification must be made at the time of admission or, if an individual applies for assistance while in a hospital, before the Medicaid agency authorizes payment.

(ii) **Recertification.** A physician must recertify for each applicant or recipient that inpatient services in the long term care hospital are needed. Recertification must be made at least every 60 days after certification.

(B) Individual written plan of care.

(i) Before admission to a long term care hospital, an interdisciplinary team including the attending physician or staff physician must establish a written plan of care for each applicant or recipient. The plan of care must include:

- (I) Diagnoses, symptoms, complaints, and complications indicating the need for admission,
- (II) the acuity level of the individual,
- (III) Objectives,
- (IV) Any order for medication, treatments, restorative and rehabilitative services, activities, therapies, social services, diet and special procedures recommended for the health and safety of the patient,

(V) Plans for continuing care, including review and modification to the plan of care, and

(VI) Plans for discharge.

(ii) The attending or staff physician and other personnel involved in the recipient's care must review each plan of care at least every 90 days.

(iii) All plans of care and plan of care reviews must be clearly identified as such in the patient's medical records. All must be signed and dated by the physician and other treatment team members in the required review interval.

(iv) The plan of care must document appropriate patient and/or family participation in the development and implementation of the treatment plan.

(C) **Continued stay review.** The facility must complete a continued stay review at least every 90 days.

(i) The methods and criteria for the continued stay review must be contained in the facility utilization review plan.

(ii) Documentation of the continued stay review must be clearly identified as such, signed and dated by the committee chairperson, and must clearly state the continued stay dates and time period approved.

[Source: Added at 15 Ok Reg 1100, eff 1-6-98 (emergency); Added at 15 Ok Reg 1535, eff 5-11-98 ; Amended at 23 Ok Reg 771, eff 3-9-06 (emergency); Amended at 23 Ok Reg 2440, eff 6-25-06]

317:30-5-63. Trust funds

When a new member is admitted to a long term care hospital, the administrator will complete and send to the county office the Management of Recipient's Funds form to indicate whether or not the member has requested the administrator to handle personal funds. If the administrator agrees to handle the member's funds, the Management of Recipient's Funds form will be completed each time funds or other items of value, other than monthly income, are received.

(1) The facility may use electronic ledgers and bank statements as the source documentation for each member for whom they are holding funds or other items of value. This information must be available at all times for inspection and audit purposes. The facility must have written policies that ensure complete accounting of the member's personal funds. All member's funds which are handled by the facility must be clearly identified and maintained separately from funds belonging to the facility or to private patients. When the total sum of all funds for all members is \$250.00 or more, they must be deposited by the facility in a local bank account designated as "Recipient's Trust Funds". The funds are not to be commingled with the operating funds of the facility. Each resident in an intermediate care facility for

individuals with intellectual disabilities (ICF/IID) must be allowed to possess and use money in normal ways or be learning to do so.

(2) The facility is responsible for notifying the county office at any time a member's account reaches or exceeds the maximum reserve by use of the Accounting-Recipient's Personal Funds and Property form. This form is also prepared by the facility when the member dies or is transferred or discharged, and at the time of the county eligibility review of the member.

(3) The Management of Recipient's Funds form, the Accounting-Recipient's Personal Funds and Property form, and the Ledger Sheets for Recipient's Account are available online at www.okdhs.org.

(4) When the ownership or operation of the facility is discontinued or where the facility is sold and the members' trust funds are to be transferred to a successor facility, the status of all member's trust funds must be verified by the OHCA and/or the buyer must be provided with written verification by an independent public accountant of all residents' monies and properties being transferred, and a signed receipt obtained from the owner. All transfers of a member's trust funds must be acknowledged, in writing, by the transferring facility and proper receipts given by the receiving facility.

(5) Unclaimed funds or other property of deceased member's, with no known heirs, must be reported to the Oklahoma Tax Commission.

(6) It is permissible to use an individual trust fund account to defray the cost of last illness, outstanding personal debts and burial expenses of a deceased member of the OHCA; however, any remaining balance of unclaimed funds must be reported to the Oklahoma Tax Commission. The Unclaimed Property Division, Oklahoma Tax Commission, State Capitol Complex, Oklahoma City, Oklahoma, is to be notified for disposition instructions on any unclaimed funds or property. No money is to be sent to the Oklahoma Tax Commission until so instructed by the Unclaimed Property Division.

(7) Books, records, ledgers, charge slips and receipts must be on file in the facility for a period of six (6) years and available at all times in the facility for inspection and audit purposes.

[Source: Added at 15 Ok Reg 1100, eff 1-6-98 (emergency); Added at 15 Ok Reg 1535, eff 5-11-98 ; Amended at 34 Ok Reg 626, eff 9-1-17]

317:30-5-64. Inpatient and routine services

(a) Long Term Care Hospital services includes routine items and services that must be provided directly or through appropriate arrangement by the facility when required by Medicaid residents. Charges for routine services may not be made to resident's personal funds or to resident family members, guardians or other parties who have responsibility for the resident. If reimbursement is available from Medicare or another public or private insurance or benefit program, those programs are billed by the facility. In the absence of other available reimbursement, the

facility must provide routine services from the funds received from the regular Medicaid vendor payment and Medicaid resident's applied income, or spenddown amount.

(b) An ad hoc committee composed of recognized nursing facility representatives and Oklahoma Health Care Authority staff will review the listing at least annually for additions or deletions, as indicated. Routine services should be patient specific and in accordance with standard medical care. Routine Services include, but are not limited to:

- (1) Regular room;
- (2) Dietary Services:
 - (A) regular diets,
 - (B) special diets,
 - (C) salt and sugar substitutes,
 - (D) supplemental feedings,
 - (E) special dietary preparations,
 - (F) equipment required for preparing and dispensing tube and oral feedings, and
 - (G) special feeding devices (furnished or arranged for);
- (3) Medically related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, nursing care, and activities programs (costs for a private duty nurse or sitter are not allowed);
- (4) Personal services - personal laundry services for residents (does not include dry cleaning);
- (5) Personal hygiene items (personal care items required to be provided does not include electrical appliances such as shavers and hair dryers, or individual personal batteries) include:
 - (A) shampoo, comb and brush;
 - (B) bath soap;
 - (C) disinfecting soaps or specialized cleansing agents when indicated to treat or prevent special skin problems or to fight infection;
 - (D) razor and/or shaving cream;
 - (E) nail hygiene services; and
 - (F) sanitary napkins, douche supplies, perineal irrigation equipment, solutions and disposable douches;
- (6) Routine oral hygiene items including:
 - (A) toothbrushes,
 - (B) toothpaste,
 - (C) dental floss,
 - (D) lemon glycerin swabs or equivalent products,
- (7) Necessary items furnished routinely as needed to all patients, e.g., water pitcher, cup and tray, towels, wash cloths, hospital gowns, emesis basin, bedpan, and urinal.
- (8) The facility will furnish as needed items such as alcohol, applicators, cotton balls, tongue depressors. Also, first aid supplies including small bandages, ointments and preparations for minor cuts and abrasions, enema supplies, including disposable enemas, gauze, 4 × 4's ABD pads, surgical and micropore tape, telfa gauze, ace bandages, etc.

(9) Over the counter drugs (non-legend) not covered by the prescription drug program (PRN or routine). In general, long term care hospitals are not required to provide any particular brand of non-legend drugs, only those items necessary to ensure appropriate care.

(A) If the physician orders a brand specific non-legend drug with no generic equivalent, the facility must provide the drug at no cost to the patient. If the physician orders a brand specific non-legend drug that has a generic equivalent, the facility may choose a generic equivalent, upon approval of the ordering physician;

(B) If the physician does not order a specific type or brand of non-legend drug, the facility may choose the type or brand;

(C) If the recipient, family, or other responsible party (excluding long term care hospital) prefers a specific type or brand of non-legend drug rather than the ones furnished by the facility, the recipient, family or responsible party may be charged the difference between the cost of the brand the resident requests and the cost of the brand generally provided by the facility. (Facilities are not required to provide an unlimited variety of brands of these items and services. It is the required assessment of resident needs, not resident preferences, that will dictate the variety of products facilities need to provide);

(D) Before purchasing or charging for the preferred items, the facility must secure written authorization from the recipient, family member, or responsible party indicating his or her desired preference, the date and signature of the person requesting the preferred item. The signature may not be that of an employee of the facility. The authorization is valid until rescinded by the maker of the instrument;

(10) The facility will furnish or obtain any necessary equipment to meet the needs of the patient upon physician order. Examples include: trapeze bars and overhead frames, foot and arm boards, bed rails, cradles, wheelchairs, foot stools, adjustable crutches, canes, walkers, bedside commode chairs, hot water bottles or heating pad, ice bags, sand bags, traction equipment, I.V. stands, etc.;

(11) Physician prescribed lotions, ointments, powders, medications and special dressings for the prevention and treatment of decubitus ulcers, skin tears and related conditions, when medications are not covered under the Vendor Drug Program or other third party payor;

(12) Supplies required for dispensing medications, including needles, syringes including insulin syringes, tubing for IVs, paper cups, medicine containers, etc.;

(13) Equipment and supplies required for simple tests and examinations, including scales, sphygmomanometers, stethoscopes, clinitest, acetest, dextrostix, pulse oximeters, blood

- glucose meters and test strips, etc.;
- (14) Underpads and diapers, waterproof sheeting and pants, etc., as required for incontinence or other care.
- (A) If the assessment and care planning process determines that it is medically necessary for the resident to use diapers as part of a plan to achieve proper management of incontinence, and if the resident has a current physician order for adult diapers, then the facility must provide the diapers without charge;
- (B) If the resident or the family requests the use of disposable diapers and they are not prescribed or consistent with the facility's methods for incontinent care, the resident/family would be responsible for the expense;
- (15) Oxygen for emergency use, or intermittent use as prescribed by the physician for medical necessity;
- (16) Other physician ordered equipment to adequately care for the patient and in accordance with standard patient care, including infusion pumps and supplies, and nebulizers and supplies, etc.

[Source: Added at 15 Ok Reg 1100, eff 1-6-98 (emergency); Added at 15 Ok Reg 1535, eff 5-11-98]

317:30-5-65. Ancillary services

Ancillary services are those items which are not considered routine services. Ancillary services may be billed separately to the SoonerCare program, unless reimbursement is available from Medicare or other insurance or benefit programs. Coverage criteria, utilization controls and program limitations are specified in Part 17 of OAC 317:30-5. Ancillary services are limited to the following services:

- (1) Services requiring prior authorization:
- (A) Ventilators and supplies.
- (B) Total Parenteral Nutrition (TPN), and supplies.
- (C) Custom seating for wheelchairs.
- (D) Enteral feeding.
- (2) Services not requiring prior authorization:
- (A) Permanent indwelling or male external catheters and catheter accessories.
- (B) Colostomy and urostomy supplies.
- (C) Tracheostomy supplies.
- (D) Prescription drugs, laboratory procedures, and x-rays.

[Source: Added at 15 Ok Reg 1100, eff 1-6-98 (emergency); Added at 15 Ok Reg 1535, eff 5-11-98 ; Amended at 20 Ok Reg 1924, eff 6-26-03 ; Amended at 27 Ok Reg 303, eff 1-1-10 (emergency); Amended at 27 Ok Reg 1455, eff 6-11-10]

317:30-5-66. Reimbursement for inpatient hospital subacute services

Reimbursement for inpatient hospital subacute services is made based on cost reports submitted to the OHCA. The cost reports will be reviewed annually to ensure that the interim rate is appropriate for the current cost/case mix of care for these facilities and to make settlement

to the facility based on total allowable costs under Medicare/Medicaid cost principles.

[Source: Added at 15 Ok Reg 1100, eff 1-6-98 (emergency); Added at 15 Ok Reg 1535, eff 5-11-98 ; Amended at 30 Ok Reg 1170, eff 7-1-13]

317:30-5-67. Cost reports

Each long term care facility is required to submit, on uniform cost reports designed by the Authority, an annual cost report for the fiscal year just completed. The fiscal year is July 1 through June 30. The reports must be submitted to the Authority on or before the first day of September.

- (1) When there is a change of operation or ownership, the selling or closing ownership is required to file a cost report for that portion of the fiscal year it was in operation. The successor ownership is correspondingly required to file a cost report for that portion of the fiscal year it was in operation.
- (2) Cost report forms and instructions are mailed annually to each facility before the first of July. The completed forms are to be returned to the Authority, Attention: Reimbursement and Audit.
- (3) Normally, all ordinary and necessary expenses incurred in the conduct of an economical and efficiently operated business are recognized as allowable.
- (4) All reports are subject to on-site audits and are deemed public records.

(A) Only "allowable costs" may be included in the cost reports, (costs should be net of any offsets of credits). Allowable costs include all items of Medicaid-covered expense which pediatric long term care hospitals incur in the provision of routine services. "Routine services" include, but are not limited to:

- (i) regular room,
- (ii) dietary and nursing services,
- (iii) minor medical and surgical supplies,
- (iv) over-the-counter medications,
- (v) transportation, and
- (vi) the use and maintenance of equipment and facilities essential to the provision of routine care.

(B) Allowable costs must be considered reasonable, necessary and proper, and shall include only those costs that are considered allowable for Medicare purposes and that are consistent with federal Medicaid requirements.

(The guidelines for allowable costs in the Medicare program are set forth in the Medicare Provider Reimbursement Manual ("PRM"), HCFA-Pub. 15.)

(C) Ancillary items reimbursed outside the long term care hospital rate should not be included in the cost report and are not allowable costs.

(D) A supplemental addendum to the cost report, including all inpatient and outpatient charges by payor source, will be included with the annual cost report.

317:30-5-68. Rate Appeals [REVOKED]

[Source: Added at 15 Ok Reg 1100, eff 1-6-98 (emergency); Added at 15 Ok Reg 1535, eff 5-11-98 ; Revoked at 15 Ok Reg 3784, eff 7-1-98 (emergency); Revoked at 16 Ok Reg 1424, eff 5-27-99]

PART 5. PHARMACIES

317:30-5-70. Eligible providers

Eligible providers are entities licensed under applicable provisions of Oklahoma law as pharmacies, including non-resident pharmacies not located in Oklahoma that are transacting or doing business in Oklahoma by soliciting, receiving, dispensing, and/or delivering prescription medications and devices to Oklahoma residents.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 17 Ok Reg 2383, eff 6-26-00 ; Amended at 25 Ok Reg 2662, eff 7-25-08 ; Amended at 35 Ok Reg 1388, eff 9-14-18]

317:30-5-70.1. Pharmacist responsibility

Eligible providers in the SoonerCare program are expected to act in accordance with the rules of professional conduct as promulgated by the Oklahoma Board of Pharmacy, 59 Oklahoma Statutes, Sec. 353.7(12). A pharmacist may refuse to dispense any prescription which appears to be improperly executed or which, in their professional judgment, is unsafe as presented.

[Source: Added at 17 Ok Reg 2383, eff 6-26-00 ; Amended at 25 Ok Reg 2662, eff 7-25-08 ; Amended at 35 Ok Reg 1388, eff 9-14-18]

317:30-5-70.2. Record retention/post payment review

Post-payment audits of the SoonerCare program are performed routinely by state and federal agencies. This Section applies to any post-payment audit regardless of the agency performing the audit. Pharmacies may be selected at random, as a result of a peer comparison, or data analysis for audits. The pharmacy is required to provide original written prescriptions and signature logs as well as purchase invoices and other records necessary to document their compliance with program guidelines at the time of the audit. Written prescriptions must conform with the standards set forth in 42 United States Code, Sec. 1396b(i) and related federal regulations requiring the use of a tamper-resistant prescription pad. These standards do not apply to prescriptions transmitted via telephone, facsimile or electronic prescription systems. Original written prescriptions are defined as any order for drug or medical supplies written or signed, or transmitted by word of mouth, telephone or other means of communication by a practitioner licensed by law to prescribe such drugs and medical supplies intended to be filled, compounded, or dispensed by a pharmacist. Signature logs are defined as any document which verifies that the prescription was delivered to the member or their representative. This may include electronic forms of

tracking including but not limited to scanning a bar code of the filled prescription. The electronic tracking system must be able to produce a copy of the scan for audit purposes. Records must be available for seven (7) years. Failure to provide the requested information to the Reviewer may result in a recommendation ranging from a potential recoupment of SoonerCare payments for the service to contract termination.

[Source: Added at 17 Ok Reg 2383, eff 6-26-00 ; Amended at 19 Ok Reg 2773, eff 4-24-02 (emergency); Amended at 20 Ok Reg 1193, eff 5-27-03 ; Amended at 24 Ok Reg 902, eff 5-11-07 ; Amended at 25 Ok Reg 118, eff 8-1-07 (emergency); Amended at 25 Ok Reg 1192, eff 5-25-08 ; Amended at 35 Ok Reg 1388, eff 9-14-18]

317:30-5-70.3. Prescriber identification numbers

(a) Pharmacies must use the prescriber's National Provider Identification (NPI) number to identify the prescribing provider.

(b) To comply with Federal law, claims for covered over-the-counter products must be prescribed by a health care professional with prescriptive authority. The claim should be submitted using the prescriber name and NPI number.

[Source: Added at 17 Ok Reg 2383, eff 6-26-00 ; Amended at 19 Ok Reg 2773, eff 4-24-02 (emergency); Amended at 20 Ok Reg 1193, eff 5-27-03 ; Amended at 25 Ok Reg 2662, eff 7-25-08 ; Amended at 31 Ok Reg 1693, eff 9-12-14]

317:30-5-70.4. Federal/State cost share-optional program [REVOKED]

[Source: Added at 17 Ok Reg 2383, eff 6-26-00 ; Revoked at 40 Ok Reg 2172, eff 9-11-23]

317:30-5-71. Drug Utilization Review [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 17 Ok Reg 2383, eff 6-26-00]

317:30-5-72. Categories of service eligibility

(a) **Coverage for adults.** Prescription drugs for categorically needy adults are covered as set forth in this subsection.

(1) With the exception of (2) and (3) of this subsection, categorically needy adults are eligible for a maximum of six (6) covered prescriptions per month with a limit of two (2) brand name prescriptions. A prior authorization may be granted for a third brand name if determined to be medically necessary by OHCA and if the member has not already utilized their six (6) covered prescriptions for the month.

(2) Subject to the limitations set forth in Oklahoma Administrative Code (OAC) 317:30-5-72.1, 317:30-5-77.2, and 317:30-5-77.3, exceptions to the six (6) medically necessary prescriptions per month limit are:

(A) Unlimited monthly medically necessary prescriptions for categorically related individuals who are residents of nursing facilities (NF) or intermediate care facilities for individuals with an intellectual disability (ICF/IID); and

(B) Seven (7) additional medically necessary prescriptions which are generic products per month to the six (6) covered under the State Plan [including three (3) brand name prescriptions] are allowed for adults receiving services under the 1915(c) Home and Community-Based Services (HCBS) waivers. Medically necessary prescriptions beyond the three (3) brand name or thirteen (13) total prescriptions will be covered with prior authorization.

(3) For purposes of this Section, "exempt from the prescription limit" means claims filed for any of these prescriptions will not count toward the prescriptions allowed per month. Drugs exempt from the prescription limit include:

(A) Antineoplastics;

(B) Anti-retroviral agents for persons diagnosed with Acquired Immune Deficiency Syndrome (AIDS) or who have tested positive for the Human Immunodeficiency Virus (HIV);

(C) Frequently monitored prescription drugs. A complete list of the selected drugs considered as frequently monitored can be viewed on the agency's website at www.okhca.org.

(D) Medication-assisted treatment (MAT) drugs for opioid use disorder;

(E) Contraceptives;

(F) Hemophilia drugs;

(G) Compensable smoking and tobacco cessation products;

(H) Naloxone for use in opioid overdose;

(I) Certain carrier or diluent solutions used in compounds (i.e. sodium chloride, sterile water, etc.);

(J) Drugs used for the treatment of tuberculosis; and

(K) Prenatal vitamins.

(4) When a brand drug is preferred over its generic equivalent due to lower net cost, that drug shall not count toward the brand limit; however, it will count toward the monthly prescription limit.

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

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

(d) **Individuals eligible for a prescription drug benefit through a Prescription Drug Plan (PDP) or Medicare Advantage - Prescription Drug (MA-PD) plan as described in the Medicare Modernization Act (MMA) of 2003.** Individuals who qualify for enrollment in a PDP or MA-PD are specifically excluded from coverage under the SoonerCare pharmacy benefit. This exclusion applies to these

individuals in any situation which results in a loss of Federal Financial Participation for the SoonerCare program. This exclusion shall not apply to items covered at OAC 317:30-5-72.1(2) unless those items are required to be covered by the prescription drug provider in the MMA or subsequent federal action.

[**Source:** Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 14 Ok Reg 761, eff 12-24-96 (emergency); Amended at 14 Ok Reg 1785, eff 5-27-97 ; Amended at 15 Ok Reg 1114, eff 1-6-98 (emergency); Amended at 15 Ok Reg 1535, eff 5-11-98 ; Amended at 16 Ok Reg 54, eff 9-11-98 (emergency); Amended at 16 Ok Reg 685, eff 12-28-98 (emergency); Amended at 16 Ok Reg 1429, eff 5-27-99 ; Amended at 16 Ok Reg 3446, eff 7-1-99 (emergency)¹; Amended at 17 Ok Reg 2383, eff 6-26-00 ; Amended at 19 Ok Reg 2773, eff 4-24-02 (emergency); Amended at 20 Ok Reg 1193, eff 5-27-03 ; Amended at 20 Ok Reg 2762, eff 7-1-03 (emergency); Amended at 20 Ok Reg 2881, eff 7-1-03 (emergency); Amended at 21 Ok Reg 398, eff 1-1-04 (emergency); Amended at 21 Ok Reg 2176, eff 6-25-04 ; Amended at 21 Ok Reg 2465, eff 7-11-05 ; Amended at 27 Ok Reg 614, eff 1-14-10 (emergency); Amended at 27 Ok Reg 949, eff 5-13-10 (emergency); Amended at 27 Ok Reg 1427, eff 6-11-10 ; Amended at 27 Ok Reg 949, eff 5-13-10 (emergency); Amended at 28 Ok Reg 1448, eff 6-25-11 ; Amended at 31 Ok Reg 1693, eff 9-12-14 ; Amended at 35 Ok Reg 19, eff 10-1-17 (emergency); Amended at 35 Ok Reg 1388, eff 9-14-18 ; Amended at 37 Ok Reg 510, eff 1-6-20 (emergency); Amended at 37 Ok Reg 1479, eff 9-14-20 ; Amended at 41 Ok Reg, Number 14, effective 3-8-24 (emergency)]

Editor's Note: ¹*On October 15, 1999, the District Court of Oklahoma County issued a Temporary Injunction Order "prohibiting, barring, enjoining and restraining the Oklahoma Health Care Authority from relying upon, maintaining, employing or using t[his] emergency rule." [See Astrazeneca LP v. Oklahoma Health Care Authority, Case No. CJ-99-5898, 10-15-99, Judge Bryan C. Dixon, District Court of Oklahoma County] On 6-26-00, the emergency action was superseded by a permanent action, and on 10-10-00, the case was dismissed with prejudice.*

317:30-5-72.1. Drug benefit

The Oklahoma Health Care Authority (OHCA) administers and maintains an Open Formulary subject to the provisions of 42 U.S.C. § 1396r-8. The OHCA covers a drug that has been approved by the Food and Drug Administration (FDA) and whose manufacturers have entered into a drug rebate agreement with the Centers for Medicare and Medicaid Services (CMS), subject to the following exclusions and limitations.

- (1) The following drugs, classes of drugs, or their medical uses are excluded from coverage:
 - (A) Agents used to promote fertility.
 - (B) Agents primarily used to promote hair growth.
 - (C) Agents used for cosmetic purposes.
 - (D) Agents used primarily for the treatment of anorexia or weight gain. Drugs used primarily for the treatment of obesity, such as appetite suppressants are not covered. Drugs used primarily to increase weight are not covered unless otherwise specified.
 - (E) Agents that are investigational, experimental or whose side effects make usage controversial including agents that have been approved by the FDA but are being investigated for additional indications. For more

information regarding experimental or investigational including clinical trials see, OAC 317:30-3-57.1.

(F) Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or designee.

(G) Agents when used for the treatment of sexual or erectile dysfunction, unless such agents are used to treat a condition, other than sexual or erectile dysfunction, for which the agents have been approved by the FDA.

(H) Agents used for the symptomatic relief of cough and colds.

(2) The drug categories listed in (A) through (D) of this paragraph are covered at the option of the state and are subject to restrictions and limitations. An updated list of products in each of these drug categories is included on the OHCA's public website.

(A) Vitamins and Minerals. Vitamins and minerals are not covered except under the following conditions:

- (i) Prenatal vitamins are covered for pregnant women;
- (ii) Fluoride preparations are covered for persons under sixteen (16) years of age or pregnant;
- (iii) Vitamin D, metabolites, and analogs when used to treat chronic kidney disease or end stage renal disease are covered;
- (iv) Iron supplements may be covered for pregnant women if determined to be medically necessary;
- (v) Vitamin preparations may be covered for children less than twenty-one (21) years of age when medically necessary and furnished pursuant to EPSDT protocol; and
- (vi) Some vitamins are covered for a specific diagnosis when the FDA has approved the use of that vitamin for a specific indication.

(B) Coverage of non-prescription or over the counter drugs is limited to:

- (i) Insulin;
- (ii) Certain smoking cessation products;
- (iii) Family planning products;
- (iv) OTC products may be covered for children if the particular product is both cost-effective and clinically appropriate; and
- (v) Prescription and non-prescription products which do not meet the definition of outpatient covered drugs, but are determined to be medically necessary.

(C) Coverage of food supplements is limited to PKU formula and amino acid bars for members diagnosed with PKU, other certain nutritional formulas and bars for children diagnosed with certain rare metabolic conditions when medically necessary and prior authorized.

(3) All covered outpatient drugs are subject to prior authorization as provided in OAC 317:30-5-77.2 and 317:30-5-77.3.

(4) All covered drugs may be excluded or coverage limited if:

(A) The prescribed use is not for a medically accepted indication as provided under 42 U.S.C. § 1396r-8; or

(B) The drug is subject to such restriction pursuant to the rebate agreement between the manufacturer and CMS.

[Source: Added at 17 Ok Reg 2383, eff 6-26-00 ; Amended at 19 Ok Reg 2773, eff 4-24-02 (emergency); Amended at 20 Ok Reg 1193, eff 5-27-03 ; Amended at 20 Ok Reg 2771, eff 7-1-03 (emergency); Amended at 21 Ok Reg 419, eff 1-1-04 (emergency); Amended at 21 Ok Reg 2176, eff 6-25-04 ; Amended at 25 Ok Reg 119, eff 8-1-07 (emergency); Amended at 25 Ok Reg 1192, eff 5-25-08 ; Amended at 27 Ok Reg 306, eff 11-3-09 (emergency); Amended at 27 Ok Reg 949, eff 5-13-10 ; Amended at 28 Ok Reg 266, eff 11-15-10 (emergency); Amended at 28 Ok Reg 1448, eff 6-25-11 ; Amended at 33 Ok Reg 861, eff 9-1-16 ; Amended at 34 Ok Reg 346, eff 12-29-16 (emergency); Amended at 34 Ok Reg 706, eff 9-1-17 ; Amended at 35 Ok Reg 19, eff 10-1-17 (emergency); Amended at 35 Ok Reg 1388, eff 9-14-18 ; Amended at 38 Ok Reg 970, eff 9-1-21]

317:30-5-73. Coverage for children (categorically and medically needy) [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 14 Ok Reg 761, eff 12-24-96 (emergency); Amended at 14 Ok Reg 1785, eff 5-27-97 ; Amended at 15 Ok Reg 1114, eff 1-6-98 (emergency); Amended at 15 Ok Reg 1535, eff 5-11-98 ; Revoked at 17 Ok Reg 2383, eff 6-26-00]

317:30-5-74. Vocational rehabilitation [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 16 Ok Reg 685, eff 12-28-98 (emergency); Revoked at 16 Ok Reg 1429, eff 5-27-99]

317:30-5-75. Individuals eligible for Part B of Medicare [REVOKED]

[Source: Revoked at 17 Ok Reg 2383, eff 6-26-00]

317:30-5-76. Generic drugs

All eligible providers are required to substitute generic medications for prescription name brand medications with the exception of prescriptions in which a brand necessary certification as provided in OAC 317:30-5-77 is made by a prescribing provider or when the agency has notified pharmacy providers that the net cost of the brand name medication is lower than the net cost of the generic medication.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 16 Ok Reg 3446, eff 7-1-99 (emergency)¹; Amended at 17 Ok Reg 2383, eff 6-26-00 ; Amended at 35 Ok Reg 1388, eff 9-14-18]

Editor's Note: ¹On October 15, 1999, the District Court of Oklahoma County issued a Temporary Injunction Order "prohibiting, barring, enjoining and restraining the Oklahoma Health Care Authority from relying upon, maintaining, employing or using t[his] emergency rule." [See *Astrazeneca LP v. Oklahoma Health Care Authority*, Case No.

CJ-99-5898, 10-15-99, Judge Bryan C. Dixon, District Court of Oklahoma County] On 6-26-00, the emergency action was superseded by a permanent action, and on 10-10-00, the case was dismissed with prejudice.

317:30-5-77. Brand necessary certification

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

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

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

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

(4) It is unacceptable to use a printed box on the prescription blank that could be checked by the physician to indicate brand necessary, or to use a hand-written statement that is transferred to a rubber stamp and then stamped onto the prescription blank.

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

(b) The Brand Necessary Certification applies to State Maximum Allowable Cost (SMAC) products.

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

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

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 17 Ok Reg 2383, eff 6-26-00 ; Amended at 20 Ok Reg 2774, eff 7-1-03 (emergency); Amended at 21 Ok Reg 2176, eff 6-25-04 ; Amended at 28 Ok Reg 266, eff 11-15-10 (emergency); Amended at 28 Ok Reg 1448, eff 6-25-11 ; Amended at 31 Ok Reg 1693, eff 9-12-14]

317:30-5-77.1. Dispensing quantity

(a) Prescription quantities shall be limited to a thirty-four (34) day supply, except in the following situations:

(1) The Drug Utilization Review (DUR) Board has recommended a different day supply or quantity limit based on published medical data, including the manufacturer's package insert;

(2) The product is included on the Maintenance List of medications, which are exempted from this limit, and may be dispensed up to a ninety (90) day supply;

(3) The manufacturer of the drug recommends a dispensing quantity less than a thirty-four (34) day supply.

(b) Refills are to be provided only if authorized by the prescriber, allowed by law, and should be in accordance with the current medical and pharmacological practices. A provider may not generate automated refills unless the member has specifically requested such service.

Documentation of this request must be available for review by OHCA auditors.

(c) The DUR Board shall develop a Maintenance List of medications which are used in general practice on a continuing basis. These drugs shall be made available through the Vendor Drug Program in quantities up to a ninety (90) day supply when approved by the prescriber. The DUR Board shall review the Maintenance List at least annually. When approved by the prescriber, all maintenance medications must be filled at the maximum quantity allowed after a sufficient stabilization period when dispensed to SoonerCare members who do not reside in a long-term care facility. For members residing in a long-term care facility, chronic medications, including all products on the Maintenance List, must be dispensed in quantities of not less than a twenty-eight (28) day supply.

(d) For products covered by the Oklahoma Vendor Drug Program, the metric quantity shown on the claim form must be in agreement with the descriptive unit of measure applicable to the specific National Drug Code (NDC). Only numeric characters should be entered. Designations, such as the form of drug, i.e., tabs, caps, suppositories, etc., must not be used. Products should be billed in a manner consistent with quantity measurements.

[Source: Added at 17 Ok Reg 2383, eff 6-26-00 ; Amended at 21 Ok Reg 2175, eff 6-25-04 ; Amended at 37 Ok Reg 510, eff 1-6-20 (emergency); Amended at 37 Ok Reg 1479, eff 9-14-20]

317:30-5-77.2. Prior authorization

(a) **Definition.** The term prior authorization in pharmacy means an approval for payment by the Oklahoma Health Care Authority (OHCA) to the pharmacy before a prescription is dispensed by the pharmacy. An updated list of all products requiring prior authorization is available at the agency's website.

(b) **Process.** Because of the required interaction between a prescribing provider (such as a physician) and a pharmacist to receive a prior authorization, OHCA allows a pharmacist up to thirty (30) calendar days from the point of sale notification to provide the data necessary for OHCA to make a decision regarding prior authorization. Should a pharmacist fill a prescription prior to the actual authorization he/she takes a business risk that payment for filling the prescription will be denied. In the case that information regarding the prior authorization is not provided within the thirty (30) days, claims will be denied.

(c) **Documentation.** Prior authorization petitions with clinical exceptions must be mailed or faxed to the Medication Authorization Unit of OHCA's contracted prior authorization processor. Other authorization

petitions, claims processing questions and questions pertaining to Drug Utilization Review (DUR) alerts must be addressed by contacting the pharmacy help desk. Authorization petitions with complete information are reviewed and a response returned to the dispensing pharmacy within twenty-four (24) hours. Petitions and other claim forms are available on the OHCA public website.

(d) **Emergencies.** In an emergency situation, the OHCA will authorize a seventy-two (72) hour supply of medications to a member. The authorization for a seventy-two (72) hour emergency supply of medications does not count against the SoonerCare limit described in OAC 317:30-5-72(a)(1).

(e) **Utilization and scope.** There are three (3) reasons for the use of prior authorization: utilization controls, scope controls and product based controls. Product-based prior authorizations, including step therapy protocols as defined by Section 7310(A)(4) of Title 63 of the Oklahoma Statutes, are covered in OAC 317:30-5-77.3. The DUR Board recommends the approved clinical criteria and any restrictions or limitations.

(1) **Utilization controls.** Prior authorizations that fall under this category generally apply to the quantity of medication or duration of therapy approved.

(2) **Scope controls.** Scope controls are used to ensure a drug is used for an approved indication and is clinically appropriate, medically necessary and cost effective.

(A) Medications which have been approved by the Food and Drug Administration (FDA) for multiple indications may be subject to a scope-based prior authorization when at least one (1) of the approved indications places that drug into a therapeutic category or treatment class for which a prior authorization is required. Prior authorizations for these drugs may be structured as step therapy or a tiered approach as recommended by the DUR Board and approved by the OHCA.

(B) Prior authorization may be required to assure compliance with FDA approved and/or medically accepted indications, dosage, duration of therapy, quantity, or other appropriate use criteria including pharmacoeconomic consideration.

(C) Prior authorization may be required for certain non-standard dosage forms of medications when the drug is available in standard dosage forms.

(D) Prior authorization may be required for certain compounded prescriptions if the allowable cost exceeds a predetermined limit as published on the agency's website.

[Source: Added at 17 Ok Reg 2383, eff 6-26-00 ; Amended at 17 Ok Reg 3506, eff 8-31-00 (emergency); Amended at 18 Ok Reg 1130, eff 5-11-01 ; Amended at 18 Ok Reg 3457, eff 6-28-01 (emergency); Amended at 19 Ok Reg 2773, eff 4-24-02 (emergency); Amended at 19 Ok Reg 1067, eff 5-13-02 ; Amended at 19 Ok Reg 2773, eff 4-24-02 (emergency); Amended at 20 Ok Reg 1193, eff 5-27-03 ; Amended at 20 Ok Reg 2771, eff 7-1-03 (emergency); Amended at 20 Ok Reg 2897, eff 9-1-03 (emergency); Amended at 21 Ok Reg 419, eff 1-1-04 (emergency); Amended at 21 Ok Reg 2176, eff 6-25-04 ; Amended at 23 Ok Reg 2477, eff 6-25-06 ; Amended at 35 Ok Reg 19, eff 10-1-17 (emergency); Amended at 35 Ok Reg 1388, eff 9-14-18 ; Amended at 37 Ok Reg 523, eff 1-6-20 (emergency); Amended

317:30-5-77.3. Product-based prior authorization (PBPA)

The Oklahoma Health Care Authority (OHCA) utilizes a PBPA system pursuant to its authority under Section 1396r-8 of Title 42 of the United States Code and Section 5030.3(A) of Title 63 of the Oklahoma Statutes. The PBPA program, which includes step therapy protocols as defined in 63 O.S. § 7310(A)(4), is not a drug formulary, which is separately authorized in 42 U.S.C. § 1396r-8. In the PBPA system, drugs are placed into two (2) or more tiers based on similarities in clinical efficacy, side-effect profile, and cost-effectiveness, after recommendation by the Drug Utilization Review (DUR) Board and approval by the OHCA Board. Drugs placed in tier one (1) generally require no prior authorization; however, drugs placed in any tier may be subject to prior authorization.

(1) Exceptions to the requirement of prior authorization shall be granted based upon a properly-supported justification submitted by the prescribing provider demonstrating one (1) or more of the bases for exception identified in Oklahoma Administrative Code (OAC) 317:30-5-77.4(b)(3).

(2) The manufacturer or labeler of a product may opt to participate in the state supplemental drug rebate program to move a product from a higher tier to a lower tier which will remove or reduce the prior authorization requirement for that product. Supplemental rebate negotiations are done through Sovereign States Drug Consortium (SSDC); a multi-state purchasing pool.

(A) Supplemental rebate agreements shall be in effect for one (1) year and may be terminated at the option of either party with a sixty (60) day notice. Supplemental rebate agreements are subject to the approval of the Centers for Medicare and Medicaid Services (CMS). Termination of a supplemental rebate agreement will result in the specific product reverting to the previously assigned higher tier in the PBPA program.

(B) Drugs or drug categories which are not part of the PBPA program as outlined in 63 O.S. § 5030.5 may be eligible for supplemental rebate participation. The OHCA DUR Board may recommend supplemental rebate eligibility for drugs or drug categories after considering clinical efficacy, side effect profile, cost-effectiveness, and other applicable criteria.

[Source: Added at 17 Ok Reg 718, eff 11-30-99 (emergency); Added at 17 Ok Reg 2393, eff 6-26-00 ; Amended at 19 Ok Reg 2135, eff 6-27-02 ; Amended at 20 Ok Reg 2899, eff 9-1-03 (emergency); Amended at 21 Ok Reg 2176, eff 6-25-04 ; Amended at 28 Ok Reg 1448, eff 6-25-11 ; Amended at 31 Ok Reg 1693, eff 9-12-14 ; Amended at 37 Ok Reg 523, eff 1-6-20 (emergency); Amended at 37 Ok Reg 1570, eff 9-14-20]

317:30-5-77.4. Step therapy exception process

(a) Definitions.

(1) "**Exigent circumstances**" means circumstances in which a delay in receiving a prescription drug will jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.

(2) "**Step therapy**" or "**step therapy protocol**" means a protocol or program that establishes a specific sequence in which prescription drugs for a specified medical condition that are medically appropriate for a particular patient are covered by Medicaid. Step therapy protocols are based upon the recommendation of the Drug Utilization Review (DUR) Board, as approved by the Oklahoma Health Care Authority (OHCA) Board.

(3) A "**step therapy exception**" means the process by which a step therapy protocol is overridden in favor of immediate coverage of a SoonerCare provider's selected prescription drug.

(b) **Process.** The step therapy exception process shall be initiated by a SoonerCare provider on behalf of a SoonerCare member. An exception can be requested following a denial of a prior authorization request for the specified prescription drug(s), or can be requested at the outset. In either case, the provider shall:

(1) Submit the exception request using the step therapy exception request form, which is available on the OHCA website and/or provider portal; and

(2) Submit with the step therapy exception request form, documentation or other information adequate to support the medical necessity for overriding the otherwise-applicable step therapy protocol for the particular prescription drug.

(3) A properly-supported step therapy exception request will be granted if it demonstrates that any of the following circumstances exists:

(A) The required prescription drug is contraindicated or will likely cause an adverse reaction or physical or mental harm to the patient;

(B) The required prescription drug is expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug;

(C) The patient has tried the required prescription drug while under the patient's current or a previous health insurance plan and such prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event;

(D) The required prescription drug is not in the best interest of the patient, based on medical necessity; or

(E) The patient is stable on a prescription drug selected by the patient's healthcare provider for the medical condition under consideration while on the patient's current or a previous health insurance plan.

(4) The OHCA or its contractor or designee may request additional information that is reasonably necessary to determine whether a step therapy exception request should be granted, as provided by Oklahoma law.

(c) **Notification.**

(1) The OHCA or its contractor or designee shall respond to any step therapy exception request within seventy-two (72) hours of the submission of a completed and properly-supported request. For exigent circumstances, the OHCA shall respond to the exception request within twenty-four (24) hours of receipt. Provided, however, that if the timeframe for response ends on a weekend, or on any other day the OHCA is closed or closes early, including, but not limited to, legal holidays as defined by 25 O.S. § 82.1, the timeframe for response shall run until the close of the next full business day. Any exception request not responded to within this timeframe shall be deemed granted.

(2) The OHCA shall respond to a request for a step therapy exception by:

- (A) Notifying the provider that the request is approved;
- (B) Notifying the provider that the request is not approved based on medical necessity;
- (C) Notifying the provider that the medical necessity of the requested exception cannot be approved or denied as a result of missing or incomplete documentation or information necessary to approve or disapprove the request;
- (D) Notifying the provider that the member is no longer eligible for coverage; or
- (E) Notifying the provider that the step therapy exemption request cannot be processed because it was not properly submitted using the required form.

(3) The rejection of a step therapy exception request based upon missing or incomplete documentation or other information, or because it was not properly submitted using the required form is not a denial, and shall not be subject to further appeal. It must, instead, be resubmitted as a new request for exception pursuant to this rule before it will be considered for approval.

(d) **Appeal.** If a step therapy exception request is denied, an appeal may be initiated by the member within thirty (30) days of the denial pursuant to Oklahoma Administrative Code (OAC) 317:2-1-18.

[Source: Added at 37 Ok Reg 523, eff 1-6-20 (emergency); Added at 37 Ok Reg 1570, eff 9-14-20]

317:30-5-78. Reimbursement

(a) **Reimbursement.** Reimbursement for pharmacy claims is based on the sum of the ingredient cost plus a professional dispensing fee for brand and generic drugs dispensed by a retail community pharmacy or for a member residing in a long term care facility.

(b) **Ingredient cost.** Ingredient cost is determined by one of the following methods:

- (1) **Maximum Allowable Cost.** The State Maximum Allowable Cost (SMAC) is established for certain products which have a Food and Drug Administration (FDA) approved generic equivalent. The SMAC will be calculated using prices from

pharmaceutical wholesalers who supply these products to pharmacy providers in Oklahoma. Pharmacies may challenge a specific product's SMAC price by providing information from their wholesaler(s) to certify a net cost higher than the calculated SMAC price and that there is not another product available to them which is generically equivalent to the higher priced product.

(2) **Actual Acquisition Cost.** The Actual Acquisition Cost (AAC) means the cost of a particular drug product to the pharmacy based on a review of invoices or the Wholesale Acquisition Cost (WAC), whichever is lower. The National Average Drug Acquisition Cost (NADAC) is based on a review of invoices and published by Centers for Medicare and Medicaid Services (CMS) and will be used in the determination of AAC.

(3) **Specialty Pharmaceutical Allowable Cost.** Reimbursement for specialty drugs not typically dispensed by a retail community pharmacy and dispensed primarily by delivery, including clotting factor for hemophilia, shall be set as a Specialty Pharmaceutical Allowable Cost (SPAC). The Medicare Part B allowed charge, defined as Average Sales Price (ASP) plus 6%, WAC, and NADAC when available, will be considered in setting the SPAC rate. For the purpose of this section, a drug may be classified as a specialty drug when it has one or more of the following characteristics:

- (A) Covered by Medicare Part B;
- (B) "5i drug" - Injected, infused, instilled, inhaled, or implanted;
- (C) Cost greater than \$1,000.00 per claim;
- (D) Licensed by the FDA under a Biological License Application;
- (E) Special storage, shipping, or handling requirements;
- (F) Available only through a limited distribution network; and/or
- (G) Does not have a NADAC price from CMS.

(4) **Exceptions.**

(A) Physician administered drugs shall be priced based on a formula equivalent to the Medicare Part B allowed charge, defined as ASP plus 6%. If a price equivalent to the Medicare Part B allowed charge cannot be determined, a purchase invoice may be supplied by the provider and will be considered in setting the reimbursement.

(B) I/T/U pharmacies shall be reimbursed at the OMB encounter rate as a per member per facility per day fee regardless of the number of prescriptions filled on that day. I/T/U pharmacies should not split prescriptions into quantities less than a one month supply for maintenance medications. For this purpose a maintenance medication is one that the member uses consistently month to month.

(C) Pharmacies other than I/T/U facilities that acquire drugs via the Federal Supply Schedule (FSS) or at nominal price outside the 340B program or FSS shall notify OHCA and submit claims at their actual invoice price plus a

professional dispensing fee.

(c) **Professional dispensing fee.** The professional dispensing fee for prescribed medication is established by review of surveys. A recommendation is made by the State Plan Amendment Rate Committee and presented to the Oklahoma Health Care Authority Board for their approval. There may be more than one level or type of dispensing fee if approved by the OHCA Board and CMS. A contracted pharmacy agrees to participate in any survey conducted by the OHCA with regard to dispensing fees. The pharmacy shall furnish all necessary information to determine the cost of dispensing drug products. Failure to participate may result in administrative sanctions by the OHCA which may include but are not limited to a reduction in the dispensing fee.

(d) **Reimbursement for prescription claims.** Prescription claims will be reimbursed using the lower of the following calculation methods:

- (1) the lower of Actual Acquisition Cost (AAC), State Maximum Allowable Cost (SMAC), or Specialty Pharmaceutical Allowable Cost (SPAC) plus a professional dispensing fee, or
- (2) usual and customary charge to the general public. The pharmacy is responsible to determine its usual and customary charge to the general public and submit it to OHCA on each pharmacy claim. The OHCA may conduct periodic reviews within its audit guidelines to verify the pharmacy's usual and customary charge to the general public and the pharmacy agrees to make available to the OHCA's reviewers prescription and pricing records deemed necessary by the reviewers. The OHCA defines general public as the patient group accounting for the largest number of non-SoonerCare prescriptions from the individual pharmacy, but does not include patients who purchase or receive their prescriptions through other third-party payers. If a pharmacy offers discount prices to a portion of its customers (i.e. -10% discount to senior citizens), these lower prices would be excluded from the usual and customary calculations unless the patients receiving the favorable prices represent more than 50% of the pharmacy's prescription volume. The usual and customary charge will be a single price which includes both the product price and the dispensing fee. For routine usual and customary reviews, the pharmacy may provide prescription records for non-SoonerCare customers in a manner which does not identify the customer by name so long as the customer's identity may be determined later if a subsequent audit is initiated. The OHCA will provide the pharmacy notice of its intent to conduct a review of usual and customary charges at least ten days in advance of its planned date of review.

(e) **Payment of Claims.** In order for an eligible provider to be paid for filling a prescription drug, the pharmacy must complete all of the following:

- (1) have an existing provider agreement with OHCA,
- (2) submit the claim in a format acceptable to OHCA,
- (3) have a prior authorization before filling the prescription, if a prior authorization is necessary,

- (4) have a proper brand name certification for the drug, if necessary, and
- (5) include the usual and customary charges to the general public as well as the actual acquisition cost and professional dispensing fee.

(f) **Claims.** Prescription reimbursement may be made only for individuals who are eligible for coverage at the time a prescription is filled. Member eligibility information may be accessed by swiping a SoonerCare identification card through a commercial card swipe machine which is connected to the eligibility database or via the Point of Sale (POS) system when a prescription claim is submitted for payment. Persons who do not contract with commercial vendors can use the Member Eligibility Verification System (EVS) at no additional cost.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 12 Ok Reg 3638, eff 9-8-95 (emergency); Amended at 13 Ok Reg 1645, eff 5-27-96 ; Amended at 16 Ok Reg 3446, eff 7-1-99 (emergency)¹; Amended at 17 Ok Reg 719, eff 11-30-99 (emergency); Amended at 17 Ok Reg 1211, eff 5-11-00 ; Amended at 17 Ok Reg 2383, eff 6-26-00 ; Amended at 19 Ok Reg 2136, eff 6-27-02 ; Amended at 25 Ok Reg 2662, eff 7-25-08 ; Amended at 28 Ok Reg 266, eff 11-15-10 (emergency); Amended at 28 Ok Reg 1448, eff 6-25-11 ; Amended at 34 Ok Reg 346, eff 12-29-16 (emergency); Amended at 34 Ok Reg 706, eff 9-1-17 ; Amended at 41 Ok Reg, Number 14, effective 3-8-24 (emergency)]

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317:30-5-78.1. Special billing procedures

(a) **Antihemophilic Factor (AHF) Products.** AHF products are sold by the amount of drug (International Units of AHF) in the container. For their products, regardless of the container size, the package size is always "1". Therefore, pricing assumes that the "package size" actually dispensed is the actual number of units dispensed. Examples: If 250 AHF units are dispensed and multiplied by a unit cost of \$.25, the allowable cost would be \$62.50. Metric Quantity is shown as 250; if 500 AHF units are dispensed and multiplied by a unit cost of \$.25, the allowable would be \$125.00. Metric Quantity is shown as 500.

(b) **Compound and intravenous drugs.** Prescriptions claims for compound and Intravenous (IV) drugs are billed and reimbursed using the NDC number and quantity for each compensable ingredient in the compound or IV, up to 25 ingredients. Ingredients without an NDC number are not compensable. A dispensing fee as described in OAC 317:30-5-78(c) is added to the total ingredient cost.

(c) **Coordination of benefits.** Pharmacies must pursue all third party resources before filing a claim with the OHCA as set out in State Fiscal Administration, 42 Code of Federal Regulation, Sec. 433.139.

(d) **Over-the-counter drugs.** Payment for covered over-the-counter medication is made according to the reimbursement methodology in OAC 317:30-5-78(d).

(e) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the SoonerCare allowable for comparable services. The appropriate Durable Medical Equipment Regional Carrier must be billed prior to billing OHCA for all Medicare compensable drugs. Part B crossover claims cannot be submitted through the pharmacy point of sale system and must be submitted using the CMS 1500 form or electronic equivalent.

(f) **Claims for prescriptions which are not picked up.** A prescription for a member which has been submitted to and approved for payment by OHCA which has not been received by the member within fifteen (15) days of the date of service must be reversed no later than the 15th day after claim submission. An electronic reversal will cause a refund to be generated to the agency. Claims may also be reversed using a manual process if electronic reversal is not possible. For the purpose of this Section, the date of service means the date the prescription was filled.

(g) **Partially-filled prescriptions.** If a member has not picked up the remainder of any partially-filled prescription within fifteen (15) days of the date of service, the claim must be reversed on the 15th day and a new claim submitted for the quantity actually dispensed.

[Source: Added at 17 Ok Reg 2383, eff 6-26-00 ; Amended at 17 Ok Reg 3506, eff 8-31-00 (emergency); Amended at 18 Ok Reg 1130, eff 5-11-01 ; Amended at 19 Ok Reg 2773, eff 4-24-02 (emergency); Amended at 19 Ok Reg 2922, eff 7-1-02 (emergency); Amended at 20 Ok Reg 1193, eff 5-27-03 ; Amended at 20 Ok Reg 1941, eff 6-26-03 ; Amended at 25 Ok Reg 2662, eff 7-25-08 ; Amended at 28 Ok Reg 266, eff 11-15-10 (emergency); Amended at 28 Ok Reg 1448, eff 6-25-11 ; Amended at 35 Ok Reg 1388, eff 9-14-18]

317:30-5-78.2. Falsification of claims

No pharmacist shall knowingly present or cause to be presented a false or fraudulent claim for payment. No pharmacist shall knowingly make, use or caused to be made or used, a false record or statement to get a false or fraudulent claim paid or approved. The term knowingly shall mean that a person, with respect to information has actual knowledge of the information, acts in deliberate ignorance of the truth or falsity of the information or acts in reckless disregard of the truth or falsity of the information. Violation of this section may lead to actions from education of the provider, to recoupment of payment to criminal penalties as prescribed in OAC 317:30-3-18.

[Source: Added at 17 Ok Reg 2383, eff 6-26-00 ; Amended at 20 Ok Reg 1193, eff 5-27-03 ; Amended at 25 Ok Reg 2662, eff 7-25-08]

317:30-5-79. Quantity dispensed [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 14 Ok Reg 761, eff 12-24-96 (emergency); Amended at 14 Ok Reg 1785, eff 5-27-97 ; Revoked at 16 Ok Reg 3446, eff 7-1-99 (emergency)¹; Revoked at 17 Ok Reg 2383, eff 6-26-00]

Editor's Note: ¹On October 15, 1999, the District Court of Oklahoma County issued a Temporary Injunction Order "prohibiting, barring, enjoining and restraining the Oklahoma Health Care Authority from relying upon, maintaining, employing or using t[his] emergency rule." [See *Astrazeneca LP v. Oklahoma Health Care Authority*, Case No. CJ-99-5898, 10-15-99, Judge Bryan C. Dixon, District Court of Oklahoma County] On 6-26-00, the emergency action was superseded by a permanent action, and on 10-10-00, the case was dismissed with prejudice.

317:30-5-80. National drug code [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 19 Ok Reg 2773, eff 4-24-02 (emergency); Amended at 20 Ok Reg 1193, eff 5-27-03 ; Revoked at 40 Ok Reg 2172, eff 9-11-23]

317:30-5-81. Medical identification card [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 16 Ok Reg 685, eff 12-28-98 (emergency); Amended at 16 Ok Reg 1429, eff 5-27-99 ; Revoked at 17 Ok Reg 2383, eff 6-26-00]

317:30-5-82. Prescriber numbers [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 17 Ok Reg 2383, eff 6-26-00]

317:30-5-83. Pharmacist's responsibility [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 17 Ok Reg 2383, eff 6-26-00]

317:30-5-84. Record retention [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 17 Ok Reg 2383, eff 6-26-00]

317:30-5-85. Special billing procedures [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 17 Ok Reg 2383, eff 6-26-00]

317:30-5-86. Drug Utilization Review (DUR) program

(a) The Oklahoma Health Care Authority (OHCA) Drug Utilization Review (DUR) program is authorized by regulations contained in the Omnibus Budget Reconciliation Act of 1990 (OBRA 90) to conduct prospective and retrospective review of pharmacy claims to ensure that prescriptions are:

- (1) Appropriate;
- (2) Medically necessary; and
- (3) Not likely to result in adverse medical results.

(b) The OHCA is authorized to use this program to educate physicians, other prescribers, pharmacists, and patients and also to conserve program funds and personal expenditures and prevent fraud, abuse, and misuse of prescriptions.

(c) The OHCA utilizes a DUR Board managed by an outside contractor to review and analyze clinical and economic data available. The DUR Board reviews and makes recommendations based on predetermined standards submitted to it by the OHCA contractor(s) and, in concert with the retrospective review of claims data, makes recommendations for educational interventions, prospective DUR, and the prior authorization process.

(d) The DUR Board assesses data on drug use in accordance with predetermined standards, including, but not limited to:

- (1) Monitoring for therapeutic appropriateness;
- (2) Overutilization and underutilization;
- (3) Appropriate use of generic products;
- (4) Therapeutic duplication;
- (5) Drug-disease contraindications;
- (6) Drug-drug interaction;
- (7) Incorrect drug dosage or duration of drug treatment; and
- (8) Clinical abuse or misuse.

(e) The DUR Board is comprised of ten (10) members that are appointed according to 63 O.S. § 5030.1. DUR Board members with a conflict of interest with respect to OHCA, Medicaid members, and/or pharmaceutical manufacturers must recuse themselves/abstain from voting on any DUR actions related to the conflict of interest.

(f) The DUR program shall adhere to the provisions of Section 1396a(o) of Title 42 of the United States Code.

(1) The OHCA has implemented the following claims review requirements:

(A) Opioid safety edits at the point-of-sale, including, but not limited to, day supply, early refills, duplicate fills, quantity limitations, and maximum daily morphine milligram equivalent (MME) safety edits. MME safety edits will automatically decline reimbursement of prescription drugs that exceed an established daily MME limit.

(B) Claims review automated process that monitors concurrent use of opioid(s) with benzodiazepine(s) and/or antipsychotic(s).

(C) The prescriptions in (A) and (B) may be reimbursed upon a showing of medical necessity, as evidenced by a prior authorization approved by OHCA or its designee or contractor.

(2) The OHCA has implemented a program to monitor the appropriate use of antipsychotic prescribing for children. The OHCA, or its contractor or designee, regularly reviews a sample of all antipsychotics prescribed to members aged eighteen (18) and younger, including, but not limited to, foster children, that were reimbursed by Medicaid, for safety and appropriate utilization.

(3) The OHCA has implemented a process to identify potential fraud or abuse of controlled substances by members, pharmacies, and prescribing clinicians.

(g) All prescribing clinicians and/or pharmacists shall adhere to appropriate prescribing practices that are consistent with state and federal regulations or may be subject to agency review processes, audits, recoupment, and/or termination of Medicaid contracts [refer to the Oklahoma Administrative Code (OAC), including, but not limited to, 317:30-3-2.1, 317:30-3-19.5, 317:30-3-33, and 317:30-5-70.1].

[Source: Added at 16 Ok Reg 3446, eff 7-1-99 (emergency)¹; Added at 17 Ok Reg 2383, eff 6-26-00 ; Amended at 20 Ok Reg 1193, eff 5-27-03 ; Amended at 25 Ok Reg 2662, eff 7-25-08 ; Amended at 37 Ok Reg 526, eff 1-6-20 (emergency); Amended at 37 Ok Reg 1545, eff 9-14-20]

Editor's Note: ¹*On October 15, 1999, the District Court of Oklahoma County issued a Temporary Injunction Order "prohibiting, barring, enjoining and restraining the Oklahoma Health Care Authority from relying upon, maintaining, employing or using t[his] emergency rule." [See Astrazeneca LP v. Oklahoma Health Care Authority, Case No. CJ-99-5898, 10-15-99, Judge Bryan C. Dixon, District Court of Oklahoma County] On 6-26-00, the emergency action was superseded by a permanent action, and on 10-10-00, the case was dismissed with prejudice.*

317:30-5-86.1. Disease state management [REVOKED]

[Source: Added at 17 Ok Reg 2383, eff 6-26-00 ; Amended at 21 Ok Reg 2485, eff 7-11-05 ; Revoked at 24 Ok Reg 2877, eff 7-1-07 (emergency); Revoked at 25 Ok Reg 1161, eff 5-25-08]

317:30-5-86.2. Case management [REVOKED]

[Source: Added at 17 Ok Reg 2383, eff 6-26-00 ; Revoked at 40 Ok Reg 2172, eff 9-11-23]

317:30-5-87. 340B Drug Discount Program

(a) The 340B Drug Discount Program is a drug-pricing program established under section 256b of Title 42 of the United States Code (U.S.C) under which a manufacturer of covered outpatient drugs agrees that it will not charge a 340B covered entity more than the 340B price for a 340B covered outpatient drug.

(b) Covered entities participating in the 340B Drug Discount Program will adhere to the following provisions outlined in this Section and as defined in 42 U.S.C. §256b. Covered entities must:

- (1) Notify the OHCA Pharmacy Department in writing within thirty (30) days of any changes in 340B Program participation, as well as any changes in name, address, National Provider Identification (NPI), SoonerCare Provider Number, etc.
- (2) Maintain their status on the Health Resources & Services Administration (HRSA) Medicaid Exclusion File (MEF) and report any changes to the OHCA within thirty (30) days.

(3) Execute a contract addendum with the OHCA in addition to their provider contract.

(c) To prevent a duplicate discount, quarterly adjustments will be made to all pharmacy or medical claims for drugs submitted by covered entities when billed using the registered SoonerCare Provider Number on the MEF.

(1) All pharmacy claims submitted by covered entities shall be adjusted by the 340B ceiling price whether purchased through the 340B Program or otherwise.

(2) Medical claims submitted by covered entities with procedure code modifiers indicating the use of the 340B purchased drugs shall be adjusted by the 340B ceiling price. OHCA will adjust each claim by subtracting the 340B ceiling price from the amount reimbursed and multiplying the difference by the quantity submitted. OHCA will use the 340B ceiling price applicable to the quarter in which the claim is paid. Medical claims submitted by covered entities with a procedure code modifier indicating the use of non 340B purchased drugs will not be adjusted by the 340B ceiling price and will be submitted for federal rebates as required by CMS. Covered entities are required to use an appropriate procedure code modifier on all physician administered drug lines when submitting medical claims.

(d) Contract pharmacies for covered entities may be permitted to bill drug products purchased under the 340B Drug Discount Program to the Oklahoma Medicaid Program when certain conditions are met and an agreement is in place between the OHCA, the contract pharmacy, and the covered entity. These pharmacies will be subject to the recovery process stated in this Section.

[Source: Added at 31 Ok Reg 1662, eff 9-12-14 ; Amended at 34 Ok Reg 346, eff 12-29-16 (emergency); Amended at 34 Ok Reg 706, eff 9-1-17 ; Amended at 39 Ok Reg 1514, eff 9-12-22]

PART 6. INPATIENT PSYCHIATRIC AND SUBSTANCE USE DISORDER SERVICES

317:30-5-94. Definitions

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

"Adult" means an individual twenty-one (21) and over, unless otherwise specified. Refer to Oklahoma Administrative Code (OAC) 317:30-1-4.

"C.F.R." means Code of Federal Regulations.

"Child" means an individual under the age of twenty (21) in an inpatient psychiatric setting as per 42 C.F.R. § 441. 151(a)(3). If an individual is receiving services before he or she reaches twenty-one (21), then the individual can continue to receive services until the individual no longer requires the services or the date the individual turns twenty-two (22), whichever comes first. For services other than inpatient psychiatric services or otherwise specified by statute, regulation, and/or

policy adopted by the Oklahoma Health Care Authority (OHCA), refer to OAC 317:30-1-4.

"C.M.S" means Centers for Medicare and Medicaid Services.

"General hospital" means a general medical surgical hospital, as defined by Section 1-701 (2) of Title 63 of the Oklahoma Statutes.

"Institution for Mental Diseases (IMD)" means a hospital, nursing facility, or other institution of more than sixteen (16) beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services, as defined by 42 C.F.R. § 435.1010.

"Licensed behavioral health professional (LBHP)" means any of the following practitioners:

(A) An allopathic or osteopathic physician with a current license and board certification in psychiatry or board eligible in the state in which services are provided, or a current resident in psychiatry practicing as described in OAC 317:30-5-2.

(B) A practitioner with a current license to practice in the state in which services are provided, within one (1) of the areas of practice listed in (i) through (vi).

- (i) Psychology;
- (ii) Social work (clinical specialty only);
- (iii) Professional counselor;
- (iv) Marriage and family therapist;
- (v) Behavioral practitioner; or
- (vi) Alcohol and drug counselor.

(C) An advanced practice registered nurse certified in a psychiatric mental health specialty, and licensed as a registered nurse (RN) with a current certification of recognition from the board of nursing in the state in which services are provided.

(D) A physician assistant who is licensed and in good standing in the state and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or counseling functions.

"Licensure candidate" means a practitioner actively and regularly receiving board approved supervision, and extended supervision by a fully licensed clinician if board's supervision requirement is met but the individual is not yet licensed, to become licensed by one (1) of the areas of practice listed in (B)(i) through (vi) above. The supervising LBHP responsible for the member's care must:

- (A) Staff the member's case with the candidate;
- (B) Be personally available, or ensure the availability of an LBHP to the candidate for consultation while they are providing services;
- (C) Agree with the current plan for the member;
- (D) Confirm that the service provided by the candidate was appropriate; and
- (E) The member's medical record must show that the requirements for reimbursement were met and the LBHP responsible for the member's care has reviewed,

countersigned, and dated the service plan and any updates thereto so that it is documented that the licensed professional is responsible for the member's care.

"OHCA" means Oklahoma Health Care Authority.

"OAC" means Oklahoma Administrative Code.

"O.S." means Oklahoma Statutes.

"Psychiatric hospital" means an institution which is primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons, as defined by Section 1395x(f) of Title 42 of the United States Code.

"Psychiatric residential treatment facility (PRTF)" means a non-hospital facility contracted with the OHCA to provide inpatient psychiatric services to SoonerCare-eligible members under the age of twenty-one (21), as defined by 42 C.F.R. § 483.352.

"U.S.C." means United States Code.

[Source: Added at 37 Ok Reg 1573, eff 9-14-20]

317:30-5-95. General provisions and eligible providers

(a) **Eligible settings for inpatient psychiatric services.** The following individuals may receive SoonerCare-reimbursable inpatient psychiatric services in the following eligible settings:

(1) Individuals under twenty-one (21) years of age, in accordance with OAC 317:30-5-95.23, may receive SoonerCare-reimbursable inpatient psychiatric services in a psychiatric unit of a general hospital, a psychiatric hospital, or a PRTF; and may receive chemical dependency detoxification/withdrawal management services in a psychiatric unit of a general hospital or in a psychiatric hospital.

(2) Individuals ages twenty-one (21) and older may receive SoonerCare-reimbursable inpatient psychiatric and/or chemical dependency detoxification/withdrawal management services in a psychiatric unit of a general hospital or in a psychiatric hospital.

(b) **Psychiatric hospitals and psychiatric units of general hospitals.** To be eligible for payment under this Part, inpatient psychiatric programs must be provided to eligible SoonerCare members in a hospital that:

(1) Is a psychiatric hospital that:

(A) Successfully underwent a State survey to determine whether the hospital meets the requirements for participation in Medicare as a psychiatric hospital per 42 C.F.R. § 482.60; or

(B) Is accredited by a national organization whose psychiatric accrediting program has been approved by CMS; or

(2) Is a general hospital with a psychiatric unit that:

(A) Successfully underwent a State survey to determine whether the hospital meets the requirements for participation in Medicare as a hospital as specified in 42 C.F.R. Part 482; or

(B) Is accredited by a national accrediting organization whose accrediting program has been approved by CMS; and

(3) Meets all applicable federal regulations, including, but not limited to:

(A) Medicare Conditions of Participation for Hospitals (42 C.F.R. Part 482), including special provisions applying to psychiatric hospitals (42 C.F.R. § 482.60-.62);

(B) Medicaid for Individuals Age 65 or over in Institutions for Mental Diseases (42 C.F.R. Part 441, Subpart C);

(C) Inpatient Psychiatric Services for Individuals under Age 21 in Psychiatric Facilities or Programs (42 C.F.R. Part 441, Subpart D); and/or

(D) Utilization Control [42 C.F.R. Part 456, Subpart C (Utilization Control: Hospitals) or Subpart D (Utilization Control: Mental Hospitals)]; and

(4) Is contracted with the OHCA; and

(5) If located within Oklahoma and serving members under eighteen (18) years of age, is appropriately licensed by the Oklahoma Department of Human Services (OKDHS) as a residential child care facility (10 O.S. §§ 401 to 402) that is providing services as a residential treatment facility in accordance with OAC 340:110-3-168.

(6) If located out of state, services must be provided within the licensure for each facility and scope of practice for each provider and supervising or rendering practitioner for the state in which the facility/provider is located. Services must be in compliance with the state-specific statutes, rules and regulations of the applicable practice act.

(c) **PRTF.** Every PRTF must:

(1) Be individually contracted with OHCA as a PRTF;

(2) Meet all of the state and federal participation requirements for SoonerCare reimbursement, including, but not limited to, 42 C.F.R. § 483.354, as well as all requirements in 42 C.F.R. 483 Subpart G governing the use of restraint and seclusion;

(3) Be appropriately licensed and/or certified:

(A) If an in-state facility, by OKDHS as a residential child care facility (10 O.S. § 401 to 402) that is providing services as a residential treatment facility in accordance with OAC 340:110-3-168; or

(B) If an out-of-state facility, by the licensing or certifying authority of the state in which the facility does business and must provide an attestation to OHCA that the PRTF is in compliance with the condition of participation for restraint and seclusion, as is required by federal law.

(4) Be appropriately certified by the State Survey Agency, the Oklahoma State Department of Health (OSDH) as meeting Medicare Conditions of Participation; and

(5) Be accredited by TJC, the Council on Accreditation of Rehabilitation Facilities (CARF), or the Council on Accreditation (COA).

(d) Required documents. The required documents for enrollment for each participating provider can be downloaded from the OHCA's website.

[Source: Added at 17 Ok Reg 3469, eff 8-01-00 (emergency); Added at 18 Ok Reg 1130, eff 5-11-01 ; Amended at 19 Ok Reg 2138, eff 6-27-02 ; Amended at 23 Ok Reg 2508, eff 6-25-06 ; Amended at 24 Ok Reg 2880, eff 7-1-07 (emergency); Amended at 25 Ok Reg 1161, eff 5-25-08 ; Amended at 27 Ok Reg 111, eff 10-2-09 (emergency); Amended at 27 Ok Reg 964, eff 5-13-10 ; Amended at 27 Ok Reg 2737, eff 7-20-10 (emergency); Amended at 28 Ok Reg 1452, eff 6-25-11 ; Amended at 35 Ok Reg 516, eff 2-27-18 ; Amended at 35 Ok Reg 1428, eff 9-14-18 ; Amended at 37 Ok Reg 1573, eff 9-14-20 ; Amended at 38 Ok Reg 428, eff 12-18-20 (emergency); Amended at 38 Ok Reg 1023, eff 9-1-21 ; Amended at 40 Ok Reg 362, eff 11-4-22 (emergency); Amended at 40 Ok Reg 2204, eff 9-11-23]

317:30-5-95.1. Medical necessity criteria and coverage for adults aged twenty-one (21) to sixty-four (64)

(a) Coverage for adults. Coverage for adults aged twenty-one (21) to sixty-four (64) is limited to services in a psychiatric unit of a general hospital or in a psychiatric hospital (see OAC 317:30-5-95). Inpatient psychiatric services must be prior authorized in accordance with OAC 317:30-5-41.1. OHCA rules that apply to inpatient psychiatric coverage for adults aged twenty-one (21) to sixty-four (64) are found in Sections OAC 317:30-5-95.1 through 317:30-5-95.10.

(b) Medical necessity criteria for admission of adults aged twenty-one (21) to sixty-four (64) for psychiatric disorders. An inpatient admission of an adult aged twenty-one (21) to sixty-four (64) that is attributable to a psychiatric disorder must meet the terms or conditions contained in (1), (2), (3), (4), one of (5)(A) to (5)(D), and one of (6)(A) to (6)(C) of this subsection.

(1) A primary diagnosis from the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) with the exception of V-codes, adjustment disorders, and substance related disorders, accompanied by a detailed description of the symptoms supporting the diagnosis.

(2) Conditions are directly attributable to a psychiatric disorder as the primary need for professional attention (this does not include placement issues, criminal behavior, and/or status offenses). Adjustment or substance related disorder may be a secondary diagnosis.

(3) It has been determined by the OHCA designated agent that the current disabling symptoms could not have been managed or have not been manageable in a less intensive treatment program.

(4) Adult must be medically stable.

(5) Within the past forty-eight (48) hours, the behaviors present an imminent life-threatening emergency such as evidenced by:

(A) Specifically described suicide attempts, suicidal intent, or serious threat by the patient.

(B) Specifically described patterns of escalating incidents of self-mutilating behaviors.

(C) Specifically described episodes of unprovoked significant physical aggression and patterns of escalating physical aggression in intensity and duration.

(D) Specifically described episodes of incapacitating depression or psychosis that result in an inability to function or care for basic needs.

(6) Requires secure twenty-four (24) hour nursing/medical supervision as evidenced by:

- (A) Stabilization of acute psychiatric symptoms.
- (B) Needs extensive treatment under physician direction.
- (C) Physiological evidence or expectation of withdrawal symptoms which require twenty-four (24) hour medical supervision.

(c) Medical necessity criteria for admission of adults aged twenty-one (21) to sixty-four (64) for inpatient chemical dependency detoxification/withdrawal management.

An inpatient admission of an adult aged twenty-one (21) to sixty-four (64) for chemical dependency/ substance use/ detoxification must meet the terms and conditions contained in (1), (2), (3), and one of (4)(A) through (D) of this subsection.

(1) Any psychoactive substance dependency disorder described in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) with detailed symptoms supporting the diagnosis and need for medical detoxification, except for cannabis, nicotine, or caffeine dependencies.

(2) Conditions are directly attributable to a substance dependency disorder as the primary need for professional attention (this does not include placement issues, criminal behavior, and/or status offenses).

(3) It has been determined by the OHCA designated agent that the current disabling symptoms could not be managed or have not been manageable in a less intensive treatment program.

(4) Requires secure twenty-four (24) hour nursing/medical supervision as evidenced by:

- (A) Need for active and aggressive pharmacological interventions.
- (B) Need for stabilization of acute psychiatric symptoms.
- (C) Need extensive treatment under physician direction.
- (D) Physiological evidence or expectation of withdrawal symptoms which require twenty-four (24) hour medical supervision.

[Source: Added at 17 Ok Reg 3469, eff 8-01-00 (emergency); Added at 18 Ok Reg 1130, eff 5-11-01 ; Amended at 19 Ok Reg 2138, eff 6-27-02 ; Amended at 23 Ok Reg 2508, eff 6-25-06 ; Amended at 35 Ok Reg 1428, eff 9-14-18 ; Amended at 36 Ok Reg 914, eff 9-1-19 ; Amended at 38 Ok Reg 428, eff 12-18-20 (emergency); Amended at 38 Ok Reg 1023, eff 9-1-21]

317:30-5-95.10. Discharge plan for adults aged twenty-one (21) to sixty-four (64)

Each adult member aged twenty-one (21) to sixty-four (64) must have a discharge plan that includes a recapitulation of the member's hospitalization; recommendations for follow-up and aftercare, to include referral to medication management, outpatient behavioral health counseling, and/or case management, to include the specific appointment information (time, date, and name, address, and telephone number of provider and related community services); and a summary of the member's condition at discharge. All discharge and aftercare plans must be documented in the member's medical records.

[Source: Added at 23 Ok Reg 2508, eff 6-25-06 ; Amended at 27 Ok Reg 2737, eff 7-20-10 (emergency); Amended at 28 Ok Reg 1452, eff 6-25-11 ; Amended at 35 Ok Reg 1428, eff 9-14-18]

317:30-5-95.11. Inpatient acute psychiatric services for persons sixty-five (65) years of age or older

Payment is made for medically necessary inpatient acute psychiatric services for persons sixty-five (65) years of age or older. OHCA rules that apply to inpatient acute psychiatric coverage for persons sixty-five (65) years of age or older are found in Sections OAC 317:30-5-95.12 through 317:30-5-95.21.

[Source: Added at 23 Ok Reg 2508, eff 6-25-06 ; Amended at 35 Ok Reg 1428, eff 9-14-18]

317:30-5-95.12. Utilization control requirements for inpatient acute psychiatric services for persons sixty-five (65) years of age or older

As set forth in 42 C.F.R. §§ 456.50 and 456.150, general hospitals and psychiatric hospitals must maintain medical records and other documentation sufficient to show that all requirements concerning certification of need for care, plan of care, and utilization review plans have been met. Psychiatric hospitals must also maintain medical records and other documentation sufficient to show that all requirements concerning medical evaluation and admission review have been met, in accordance with 42 C.F.R. § 456.150.

[Source: Added at 23 Ok Reg 2508, eff 6-25-06 ; Amended at 35 Ok Reg 1428, eff 9-14-18]

317:30-5-95.13. Certification and recertification of need for inpatient care for inpatient acute psychiatric services for persons sixty-five (65) years of age or older

The certification and recertification of need for inpatient care for persons sixty-five (65) years of age or older must be in writing and must be signed and dated by the physician who has knowledge of the case and the need for continued inpatient psychiatric care. The certification and recertification documents for all SoonerCare members must be maintained in the member's medical records or in a central file at the facility where the member is or was a resident.

(1) **Certification.** A physician must certify for each applicant or member that inpatient services in an acute care setting are or were needed. The certification must be made at the time of admission or, if an individual applies for assistance while hospitalized, before OHCA, or its designated agent, authorizes payment.

(2) **Recertification.** A physician must recertify for each applicant or member that inpatient services in the acute care setting are needed. Recertification must be made at least every sixty (60) days after certification.

[Source: Added at 23 Ok Reg 2508, eff 6-25-06 ; Amended at 27 Ok Reg 2737, eff 7-20-10 (emergency); Amended at 28 Ok Reg 1452, eff 6-25-11 ; Amended at 35 Ok Reg 1428, eff 9-14-18]

317:30-5-95.14. Individual plan of care for persons sixty-five (65) years of age or older receiving inpatient acute psychiatric services

(a) Before admission to a psychiatric hospital or psychiatric unit of a general hospital or immediately after admission, the attending physician or staff physician must establish a written plan of care for each applicant or member. The plan of care must include:

- (1) Diagnoses, symptoms, complaints, and complications indicating the need for admission;
- (2) A description of the functional level of the individual;
- (3) Objectives;
- (4) Any order for medication, treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the member;
- (5) Plans for continuing care, including review and modification to the plan of care; and
- (6) Plans for discharge.

(b) The attending or staff physician and other treatment team personnel involved in the member's care must review each plan of care at least every seven (7) days.

(c) All plans of care and plan of care reviews must be clearly identified as such in the member's medical records. All must be signed and dated by the physician, RN, LBHP or licensure candidate, member, and other treatment team members that provide individual, family, and group therapy in the required review interval. Licensure candidate signatures must be co-signed. All plans of care and plan of care reviews must be signed by the member upon completion, except when a member is too physically ill or his or her acuity level precludes him or her from signing. If the member has designated an advocate, the advocate's signature is also required on all plans of care and plan of care reviews. If the member was too physically ill or his or her acuity level precluded him or her from signing the plan of care and/or the plan of care review at the time of completion, the member must sign the plan when his or her condition improves, but before discharge.

(d) The plan of care must document appropriate member participation in the development and implementation of the treatment plan.

[Source: Added at 23 Ok Reg 2508, eff 6-25-06 ; Amended at 27 Ok Reg 2737, eff 7-20-10 (emergency); Amended at 28 Ok Reg 1452, eff 6-25-11 ; Amended at 32 Ok Reg 1105, eff 8-27-15 ; Amended at 35 Ok Reg 1428, eff 9-14-18 ; Amended at 37 Ok Reg 1573, eff 9-14-20]

317:30-5-95.15. Physician review of prescribed medications for persons over 65 years of age receiving inpatient acute psychiatric services

All prescribed medications for persons over 65 years of age receiving inpatient acute psychiatric services must be reviewed by the physician at least every seven days; the review must be documented in the member's medical record by the physician signing his/her name and title and dating the orders.

[Source: Added at 23 Ok Reg 2508, eff 6-25-06 ; Amended at 27 Ok Reg 2737, eff 7-20-10 (emergency); Amended at 28 Ok Reg 1452, eff 6-25-11]

317:30-5-95.16. Medical psychiatric and social evaluations for persons sixty-five (65) years of age or older receiving inpatient acute psychiatric services

The record of a member sixty-five (65) years of age or older receiving inpatient acute psychiatric services must contain complete medical, psychiatric, and social evaluations.

(1) The evaluations must be completed as follows:

(A) History and physical must be completed within twenty-four (24) hours of admission by a licensed independent practitioner [Allopathic Doctor, Osteopathic Doctor, Advanced Practice Registered Nurse (APRN), or Physician Assistant (PA)].

(B) Psychiatric evaluation must be completed within sixty (60) hours of admission by an Allopathic or Osteopathic physician with a current license and a board certification/eligible in psychiatry, an APRN with a psychiatric certification or a PA.

(C) Psychosocial evaluation must be completed within seventy-two (72) hours of admission by a licensed independent practitioner (Allopathic Doctor, Osteopathic Doctor, APRN, or PA), an LBHP, or licensure candidate as defined in OAC 317:30-5-240.3.

(2) The evaluations must be clearly identified as such and must be signed and dated by the evaluator.

[Source: Added at 23 Ok Reg 2508, eff 6-25-06 ; Amended at 24 Ok Reg 2880, eff 7-1-07 (emergency); Amended at 25 Ok Reg 1161, eff 5-25-08 ; Amended at 27 Ok Reg 2737, eff 7-20-10 (emergency); Amended at 28 Ok Reg 1452, eff 6-25-11 ; Amended at 32 Ok Reg 1107, eff 8-27-15 ; Amended at 35 Ok Reg 1428, eff 9-14-18 ; Amended at 40 Ok Reg 373, eff 11-4-22 (emergency); Amended at 40 Ok Reg 2245, eff 9-11-23]

317:30-5-95.17. Active treatment for persons over 65 years of age receiving inpatient acute psychiatric services

Active treatment must be provided to each member over 65 years of age who is receiving inpatient acute psychiatric services. The active treatment program must be appropriate to the needs of the member and be directed toward restoring and maintaining optimal levels of physical and psychiatric-social functioning. The services and individual plan of care must be recovery focused, trauma informed, and specific to culture, age and gender.

[Source: Added at 23 Ok Reg 2508, eff 6-25-06 ; Amended at 25 Ok Reg 1161, eff 5-25-08]

317:30-5-95.18. Nursing services for persons over 65 years of age receiving inpatient acute psychiatric services

Each facility providing inpatient acute psychiatric services to adults over 65 must have a qualified Director of Psychiatric Nursing. In addition to the Director of Nursing, there must be adequate numbers of

registered nurses, licensed practical nurses, and mental health workers to provide nursing care necessary under the active treatment program and to maintain progress notes on each member. A registered nurse must document member progress at least weekly. The progress notes must contain recommendations for revisions in the treatment plan, as needed, as well as an assessment of the member's progress as it relates to the treatment plan goals and objectives.

[Source: Added at 23 Ok Reg 2508, eff 6-25-06 ; Amended at 27 Ok Reg 2737, eff 7-20-10 (emergency); Amended at 28 Ok Reg 1452, eff 6-25-11]

317:30-5-95.19. Therapeutic services for persons sixty-five (65) years of age or older receiving inpatient acute psychiatric services

An interdisciplinary team of a physician, licensed behavioral health professional(s) (LBHP), Registered Nurse, and other staff who provide services to members sixty-five (65) years of age or older who are receiving inpatient acute psychiatric services in the facility oversee all components of the active treatment and provide services appropriate to each team member's respective discipline. The team developing the individual plan of care must include, at a minimum, the following:

- (1) Allopathic or Osteopathic Physician with a current license and a board certification/eligible in psychiatry, or a current resident in psychiatry practicing as described in OAC 317:30-5-2(a)(1)(U); and
- (2) An LBHP licensed to practice by one of the boards in (A) through (F):
 - (A) Psychology (health service specialty only);
 - (B) Social Work (clinical specialty only);
 - (C) Licensed Professional Counselor;
 - (D) Licensed Behavioral Practitioner;
 - (E) Licensed Marital and Family Therapist;
 - (F) Licensed Alcohol and Drug Counselor; or
 - (G) Advanced Practice Registered Nurse (APRN) (certified in a psychiatric mental health specialty, licensed as a Registered Nurse with a current certification of recognition from the Board of Nursing in the state in which the services are provided);
- (3) Under the supervision of an LBHP, a licensure candidate actively and regularly receiving board approved supervision to become licensed by one of the boards in A through F above, and extended supervision if the board's supervision requirement is met but the individual is not yet licensed, may be a part of the team; and
- (4) A Registered Nurse with a minimum of two (2) years of experience in a mental health treatment setting.

[Source: Added at 23 Ok Reg 2508, eff 6-25-06 ; Amended at 24 Ok Reg 2880, eff 7-1-07 (emergency); Amended at 25 Ok Reg 1161, eff 5-25-08 ; Amended at 27 Ok Reg 2737, eff 7-20-10 (emergency); Amended at 28 Ok Reg 1452, eff 6-25-11 ; Amended at 32 Ok Reg 1109, eff 8-27-15 ; Amended at 35 Ok Reg 1428, eff 9-14-18]

317:30-5-95.2. Coverage for children [REVOKED]

[Source: Added at 17 Ok Reg 3469, eff 8-01-00 (emergency); Added at 18 Ok Reg 1130, eff 5-11-01 ; Amended at 19 Ok Reg 2138, eff 6-27-02 ; Amended at 23 Ok Reg 771, eff 3-9-06 (emergency); Revoked at 23 Ok Reg 2508, eff 6-25-06]

317:30-5-95.20. Discharge plan for persons sixty-five (65) years of age or older receiving inpatient acute psychiatric services

Each member sixty-five (65) years of age or older receiving inpatient acute psychiatric services must have a discharge plan that includes a recapitulation of the member's hospitalization; recommendations for follow-up and aftercare, to include referral to medication management, outpatient behavioral health counseling, and/or case management, to include the specific appointment information (time, date, and name, address, and telephone number of provider and related community services); and a summary of the member's condition at discharge. All discharge and aftercare plans must be documented in the member's medical records.

[Source: Added at 23 Ok Reg 2508, eff 6-25-06 ; Amended at 27 Ok Reg 2737, eff 7-20-10 (emergency); Amended at 28 Ok Reg 1452, eff 6-25-11 ; Amended at 35 Ok Reg 1428, eff 9-14-18]

317:30-5-95.21. Continued stay review for persons sixty-five (65) years of age or older receiving inpatient acute psychiatric services

The facility must complete a continued stay review at least every ninety (90) days each time the facility utilization review committee determines that the continued inpatient psychiatric hospital stay is required for persons sixty-five (65) years of age or older.

- (1) The methods and criteria for continued stay review must be contained in the facility utilization review plan.
- (2) Documentation of the continued stay review must be clearly identified as such, signed, and dated by the committee chairperson, and must clearly state the continued stay dates and time period approved.

[Source: Added at 23 Ok Reg 2508, eff 6-25-06 ; Amended at 35 Ok Reg 1428, eff 9-14-18]

317:30-5-95.22. Coverage for children

(a) In order for services to be covered, services in psychiatric units of general hospitals, psychiatric hospitals, and PRTF programs must meet the requirements in OAC 317:30-5-95.25 through 317:30-5-95.30. OHCA rules that apply to inpatient psychiatric coverage for individuals aged twenty-one (21) and under are found in Sections OAC 317:30-5-95.22 through 317:30-5-95.42.

(b) The following words and terms, when used in OAC 317:30-5-95.22 through 317:30-5-95.42, shall have the following meaning, unless the context clearly indicates otherwise:

- (1) **"Acute"** means care delivered in a psychiatric unit of a general hospital or psychiatric hospital that provides assessment, medical management and monitoring, and short-term intensive

treatment and stabilization to individuals experiencing acute episodes of behavioral health disorders.

(2) "**Acute II**" means care delivered in a psychiatric unit of a general hospital or psychiatric hospital; however, services at this level of care are designed to serve individuals under twenty-one (21) who need longer-term, more intensive treatment, and a more highly-structured environment than they can receive in family and other community-based alternatives to hospitalization. However, care delivered in this setting is less intense than the care provided in Acute.

(3) "**Border placement**" means placement in an inpatient psychiatric facility that is in one (1) of the states that borders Oklahoma (Arkansas, Colorado, Kansas, Missouri, New Mexico, and Texas).

(4) "**Border status**" means placement in a facility in a state that does not border Oklahoma, but which facility routinely provides inpatient psychiatric services to SoonerCare members.

(5) "**Chemical dependency/substance abuse services/detoxification**" means services offered to individuals with a substance-related disorder whose biomedical and emotional/behavioral problems are sufficiently severe to require inpatient care.

(6) "**Enhanced treatment unit or specialized treatment**" means an intensive residential treatment unit that provides a program of care to a population with special needs or issues requiring increased staffing requirements, co-morbidities, environmental accommodations, specialized treatment programs, and longer lengths of stay.

(7) "**Evidence-based practice (EBP)**" means programs or practices that are supported by research methodology and have produced consistently positive patterns of results in accordance with the Substance Abuse and Mental Health Services Administration (SAMHSA).

(8) "**Out-of-state placement**" means a placement for intensive or specialized services not available in Oklahoma requiring additional authorization procedures and approval by the OHCA Behavioral Health Unit.

(9) "**Public facilities**" means Oklahoma government owned or operated facilities.

(10) "**Trauma-informed**" means the recognition and responsiveness to the presence of the effects of past and current traumatic experiences in the lives of members.

[Source: Added at 23 Ok Reg 2508, eff 6-25-06 ; Amended at 24 Ok Reg 2880, eff 7-1-07 (emergency); Amended at 25 Ok Reg 1161, eff 5-25-08 ; Amended at 27 Ok Reg 2737, eff 7-20-10 (emergency); Amended at 28 Ok Reg 1452, eff 6-25-11 ; Amended at 37 Ok Reg 1573, eff 9-14-20 ; Amended at 39 Ok Reg 1526, eff 9-12-22]

317:30-5-95.23. Individuals age 21

Individuals eligible for SoonerCare may be covered for inpatient psychiatric services before the member reaches age 21 or, if the member

was receiving inpatient psychiatric services at the time he or she reached age 21. Services may continue until the member no longer requires the services or the member becomes 22 years of age, whichever comes first. Sections OAC 317:30-5-95.24 through 317:30-5-95.42 apply to coverage for inpatient services in acute care hospitals, freestanding psychiatric hospitals, and PRTFs.

[Source: Added at 23 Ok Reg 2508, eff 6-25-06 ; Amended at 27 Ok Reg 2737, eff 7-20-10 (emergency); Amended at 28 Ok Reg 1452, eff 6-25-11]

317:30-5-95.24. Prior authorization of inpatient psychiatric services for individuals under twenty-one (21)

(a) All inpatient psychiatric services for members under twenty-one (21) years of age must be prior authorized by the OHCA or its designated agent. All inpatient Acute, Acute II, and PRTF services will be prior authorized for an approved length of stay. Admission requirements for services must be provided in accordance with 42 C.F.R. Part 441 and 456. Additional information will be required for SoonerCare-compensable approval on enhanced treatment units or in special population programs.

(b) Unit staffing ratios shall always meet the requirements in OAC 317:30-5-95.24 (c), (d), (h) and (i). Out-of-state facilities may adhere to the staffing requirements of the state in which the services are provided if the staff ratio is sufficient to ensure patient safety and that patients have reasonable and prompt access to services. The facility cannot use staff that is also on duty in other units of the facility in order to meet the unit staffing ratios. Patients shall be grouped for accommodation by gender, age, and treatment needs. At a minimum, children, adolescent, and adult treatment programs shall be separate with distinct units for each population. A unit is determined by separate and distinct sleeping, living, and treatment areas often separated by walls and/or doors. A unit that does not allow clear line of sight due to the presence of walls or doors is considered a separate unit. Each individual unit shall have assigned staff to allow for appropriate and safe monitoring of patients and to provide active treatment.

(c) In Acute and Acute II settings, at least one (1) registered nurse (RN) must be on duty per unit at all times, with additional RNs to meet program needs. RNs must adhere to Oklahoma State Department of Health (OSDH) policy at OAC 310:667-15-3 and 310:667-33-2(a)(3).

(d) Acute, non-specialty Acute II, and non-specialty PRTF programs require a staffing ratio of one (1) staff: six (6) patients during routine waking hours and one (1) staff: eight (8) patients during time residents are asleep with twenty-four (24) hour nursing care supervised by an RN for management of behaviors and medical complications. For PRTF programs, at a minimum, a supervising RN must be available by phone and on-site within one (1) hour. If the supervising RN is off-site, then an RN or licensed practical nurse (LPN) must be on-site to adhere to a twenty-four (24) hour nursing care coverage ratio of one (1) staff: thirty (30) patients during routine waking hours and one (1) staff: forty (40) patients during time residents are asleep.

(e) Specialty treatment at Acute II or PRTF is a longer-term treatment that requires a higher staff-to-member ratio because of the need for

constant, intense, and immediate reinforcement of new behaviors to develop an understanding of the behaviors. The environment of specialized residential treatment centers requires special structure and configuration (e.g., sensory centers for autistic members) and specialized training for the staff in the area of the identified specialty. The physician, Advanced Practice Registered Nurse (APRN) with psychiatric certification or Physician Assistant (PA) will see the child at least one (1) time a week.

(f) An Acute II or PRTF will not be considered a specialty treatment program for SoonerCare without prior approval of the OHCA behavioral health unit.

(g) A treatment program that has been approved as a specialized treatment program must maintain medical records that document the degree and intensity of the psychiatric care delivered to the members and must meet active treatment requirements found at OAC 317:30-5-95.34.

(h) Criteria for classification as a specialty Acute II will require a staffing ratio of one (1) staff: four (4) patients at a minimum during routine waking hours and one (1) staff: six (6) patients during time residents are asleep with twenty-four (24) hour nursing care supervised by a RN for management of behaviors and medical complications. The specialty Acute II will be a secure unit, due to the complexity of needs and safety considerations. Admissions and authorization for continued stay for a specialty Acute II will be restricted to members who meet the medical necessity criteria at OAC 317:30-5-95.29 and OAC 317:30-5-95.30 for the respective level of care and meet the additional criteria found in the Behavioral Health Services Medical Necessity Criteria Manual, available on OHCA's website, www.oklahoma.gov/ohca.

(i) Criteria for classification as a specialty PRTF will require a staffing ratio of one (1) staff: four (4) patients at a minimum during routine waking hours and one (1) staff: six (6) patients during time residents are asleep with twenty-four (24) hour nursing care supervised by a RN for management of behaviors and medical complications. The specialty PRTF will be a secure unit, due to the complexity of needs and safety considerations. Admissions and authorization for continued stay in a specialty PRTF will be restricted to members who meet the medical necessity criteria at OAC 317:30-5-95.29 and OAC 317:30-5-95.30 for the respective level of care and meet the additional criteria found in the Behavioral Health Services Medical Necessity Criteria Manual, available on OHCA's website, www.oklahoma.gov/ohca.

(j) Non-authorized inpatient psychiatric services will not be SoonerCare compensable.

(k) For out-of-state placement policy, refer to OAC 317:30-3-89 through 317:30-3-92. A prime consideration for placements will be proximity to the family or guardian in order to involve the family or guardian in active treatment, including discharge and reintegration planning. Out-of-state facilities are responsible for insuring appropriate medical care, as needed under SoonerCare provisions, as part of the per-diem rate.

(l) Reimbursement for inpatient psychiatric services in all psychiatric units of general hospitals, psychiatric hospitals, and PRTFs are limited to the approved length of stay. OHCA, or its designated agent, will approve

lengths of stay using the current OHCA Behavioral Health medical necessity criteria as described in OAC 317:30-5-95.25 through OAC 317:30-5-95.30. The approved length of stay applies to both facility and physician services.

[Source: Added at 23 Ok Reg 2508, eff 6-25-06 ; Amended at 24 Ok Reg 2880, eff 7-1-07 (emergency); Amended at 25 Ok Reg 1161, eff 5-25-08 ; Amended at 27 Ok Reg 2737, eff 7-20-10 (emergency); Amended at 28 Ok Reg 1452, eff 6-25-11 ; Amended at 29 Ok Reg 413, eff 3-7-12 (emergency); Amended at 29 Ok Reg 1125, eff 6-25-12 ; Amended at 32 Ok Reg 1100, eff 8-27-15 ; Amended at 33 Ok Reg 883, eff 9-1-16 ; Amended at 34 Ok Reg 612, eff 9-1-17 ; Added at 36 Ok Reg 872, eff 9-1-19 ; Amended at 37 Ok Reg 1573, eff 9-14-20 ; Amended at 38 Ok Reg 442, eff 1-1-21 (emergency); Amended at 38 Ok Reg 1062, eff 9-1-21 ; Amended at 40 Ok Reg 362, eff 11-4-22 (emergency); Amended at 40 Ok Reg 2204, eff 9-11-23]

317:30-5-95.25. Medical necessity criteria for acute psychiatric admissions for children

Acute psychiatric admissions for children must meet the terms or conditions contained in (1), (2), (3), (4) and one of (5)(A) to (5)(D), and one of (6)(A) to (6)(C) of this subsection.

(1) A primary diagnosis from the most recent edition of "The Diagnostic and Statistical Manual of Mental Disorders" (DSM) with the exception of V-codes, adjustment disorders, and substance related disorders, accompanied by a detailed description of the symptoms supporting the diagnosis. In lieu of a qualifying diagnosis, children 18-21 years of age may have a diagnosis of any personality disorder.

(2) Conditions are directly attributable to a psychiatric disorder as the primary need for professional attention (this does not include placement issues, criminal behavior, status offenses). Adjustment or substance related disorder may be a secondary diagnosis.

(3) It has been determined by the OHCA designated agent that the current disabling symptoms could not have been managed or have not been manageable in a lesser intensive treatment program.

(4) Child must be medically stable.

(5) Within the past 48 hours, the behaviors present an imminent life threatening emergency such as evidenced by:

(A) Specifically described suicide attempts, suicide intent, or serious threat by the patient.

(B) Specifically described patterns of escalating incidents of self-mutilating behaviors.

(C) Specifically described episodes of unprovoked significant physical aggression and patterns of escalating physical aggression in intensity and duration.

(D) Specifically described episodes of incapacitating depression or psychosis that result in an inability to function or care for basic needs.

(6) Requires secure 24-hour nursing/medical supervision as evidenced by:

(A) Stabilization of acute psychiatric symptoms.

(B) Needs extensive treatment under physician direction.

(C) Physiological evidence or expectation of withdrawal symptoms which require 24-hour medical supervision.

[Source: Added at 23 Ok Reg 2508, eff 6-25-06 ; Amended at 27 Ok Reg 2737, eff 7-20-10 (emergency); Amended at 28 Ok Reg 1452, eff 6-25-11 ; Amended at 29 Ok Reg 413, eff 3-7-12 (emergency); Amended at 29 Ok Reg 1125, eff 6-25-12 ; Amended at 30 Ok Reg 1203, eff 7-1-13 ; Amended at 33 Ok Reg 885, eff 9-1-16]

317:30-5-95.26. Medical necessity criteria for continued stay - acute psychiatric admission for children

For continued stay acute psychiatric admissions for children must meet all of the conditions set forth in (1) to (5) of this subsection.

(1) A primary diagnosis from the most recent edition of "The Diagnostic and Statistical Manual of Mental Disorders" (DSM) with the exception of V-Codes, adjustment disorders, and substance abuse related disorders, accompanied by a detailed description of the symptoms supporting the diagnosis. In lieu of a qualifying diagnosis, children 18-20 years of age may have a diagnosis of any personality disorder. Adjustment or substance related disorders may be a secondary diagnosis.

(2) Patient continues to manifest a severity of illness that requires an acute level of care as defined in the admission criteria and which could not be provided in a less restrictive setting.

(A) Documentation of regression is measured in behavioral terms.

(B) If condition is unchanged, evidence of re-evaluation of treatment objectives and therapeutic interventions.

(3) Conditions are directly attributable to a mental disorder as the primary need for professional attention (this does not include placement issues, criminal behavior, status offenses).

(4) Documented efforts of working with the child's family, legal guardians and/or custodians and other human service agencies toward a tentative discharge date.

(5) Requires secure 24-hour nursing/medical supervision as evidenced by:

(A) Stabilization of acute psychiatric symptoms;

(B) Need for extensive treatment under the direction of a physician; and

(C) Physiological evidence or expectation of withdrawal symptoms which require 24-hour medical supervision.

[Source: Added at 23 Ok Reg 2508, eff 6-25-06 ; Amended at 27 Ok Reg 2737, eff 7-20-10 (emergency); Amended at 28 Ok Reg 1452, eff 6-25-11 ; Amended at 29 Ok Reg 413, eff 3-7-12 (emergency); Amended at 29 Ok Reg 1125, eff 6-25-12 ; Amended at 33 Ok Reg 885, eff 9-1-16 ; Amended at 34 Ok Reg 714, eff 9-1-17]

317:30-5-95.27. Medical necessity criteria for admission - inpatient chemical dependency detoxification for children

Inpatient chemical dependency detoxification admissions for children must meet the terms and conditions contained in (1), (2), (3), and one of (4)(A) through (D) of this subsection.

(1) Any psychoactive substance dependency disorder described in the most recent edition of "The Diagnostic and Statistical Manual of Mental Disorders" (DSM) with detailed symptoms supporting the diagnosis and need for medical detoxification, except for cannabis, nicotine, or caffeine dependencies.

(2) Conditions are directly attributable to a substance dependency disorder as the primary need for professional attention (this does not include placement issues, criminal behavior, or status offenses).

(3) It has been determined by the OHCA designated agent that the current disabling symptoms could not be managed or have not been manageable in a lesser intensive treatment program.

(4) Requires secure 24-hour nursing/medical supervision as evidenced by:

(A) Need for active and aggressive pharmacological interventions.

(B) Need for stabilization of acute psychiatric symptoms.

(C) Need extensive treatment under physician direction.

(D) Physiological evidence or expectation of withdrawal symptoms which require 24-hour medical supervision.

[Source: Added at 23 Ok Reg 2508, eff 6-25-06 ; Amended at 27 Ok Reg 2737, eff 7-20-10 (emergency); Amended at 28 Ok Reg 1452, eff 6-25-11 ; Amended at 29 Ok Reg 413, eff 3-7-12 (emergency); Amended at 29 Ok Reg 1125, eff 6-25-12]

317:30-5-95.28. Medical necessity criteria for continued stay - inpatient chemical dependency detoxification program for children

Authorization for admission to a chemical dependency detoxification program is limited to up to five days. Exceptions to this limit may be made up to eight days based on a case-by-case review, per medical necessity criteria as described in OAC 317:30-5-95.27.

[Source: Added at 23 Ok Reg 2508, eff 6-25-06 ; Amended at 27 Ok Reg 2737, eff 7-20-10 (emergency); Amended at 28 Ok Reg 1452, eff 6-25-11 ; Amended at 29 Ok Reg 413, eff 3-7-12 (emergency); Amended at 29 Ok Reg 1125, eff 6-25-12]

317:30-5-95.29. Medical necessity criteria Acute II and PRTF admissions for children

Acute II and PRTF admissions for individuals under twenty-one (21) must meet the terms and conditions in (1), (2), (3), (4), (5) and one (1) of the terms and conditions of (6)(A) through (D) of this subsection.

(1) A primary diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) with the exception of V-codes, adjustment disorders, and substance-related disorders, accompanied by detailed symptoms supporting the diagnosis. Members eighteen (18) to twenty (20) years of age may have a diagnosis of any personality disorder. Adjustment or substance-related disorders may be a secondary diagnosis.

(2) Conditions are directly attributed to a mental disorder as the primary reason for professional attention (this does not include

placement issues, criminal behavior, or status offenses).

(3) Patient has either received treatment in an acute setting or it has been determined by the OHCA, or its designated agent, that the current disabling symptoms could not or have not been manageable in a less-intensive treatment program.

(4) Member must be medically stable.

(5) Requires twenty-four (24) hour observation and treatment as evidenced by:

(A) Intensive behavioral management;

(B) Intensive treatment with the family/guardian and child in a structured milieu; and

(C) Intensive treatment in preparation for re-entry into community.

(6) Within the past fourteen (14) calendar days, the patient has demonstrated an escalating pattern of self-injurious or assaultive behaviors as evidenced by any of (A) through (D) below.

Exceptions to the fourteen (14) day requirement may be made in instances when evidence of the behavior could not have reasonably been discovered within fourteen (14) days (e.g., sexual offenses).

(A) Suicidal ideation and/or threat.

(B) History of/or current self-injurious behavior.

(C) Serious threats or evidence of physical aggression.

(D) Current incapacitating psychosis or depression.

[Source: Added at 23 Ok Reg 2508, eff 6-25-06 ; Amended at 27 Ok Reg 2737, eff 7-20-10 (emergency); Amended at 28 Ok Reg 1452, eff 6-25-11 ; Amended at 29 Ok Reg 413, eff 3-7-12 (emergency); Amended at 29 Ok Reg 1125, eff 6-25-12 ; Amended at 30 Ok Reg 1203, eff 7-1-13 ; Amended at 31 Ok Reg 1713, eff 9-12-14 ; Amended at 37 Ok Reg 1573, eff 9-14-20 ; Amended at 39 Ok Reg 1526, eff 9-12-22]

317:30-5-95.3. Medicare eligible individuals [REVOKED]

[Source: Added at 17 Ok Reg 3469, eff 8-01-00 (emergency); Added at 18 Ok Reg 1130, eff 5-11-01 ; Amended at 19 Ok Reg 2938, eff 7-1-02 (emergency); Amended at 20 Ok Reg 1193, eff 5-27-03 ; Amended at 21 Ok Reg 2485, eff 7-11-05 ; Revoked at 23 Ok Reg 2508, eff 6-25-06]

317:30-5-95.30. Medical necessity criteria for Acute II and PRTF continued stay for children

For continued stay in Acute II and PRTF programs, members must meet the terms and conditions contained in (1), (2), (3), (4), and either (5) or (6) of this subsection:

(1) A primary diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) with the exception of V codes, adjustment disorders, and substance abuse-related disorders, accompanied by detailed symptoms supporting the diagnosis. In lieu of a qualifying primary diagnosis, members eighteen (18) to twenty (20) years of age may have a secondary diagnosis of any personality disorder.

(2) Conditions are directly attributed to a psychiatric disorder as the primary reason for continued stay (this does not include placement issues, criminal behavior, or status offenses).

- (3) There is documented continuing need for twenty-four (24) hour observation and treatment as evidenced by:
 - (A) Intensive behavioral management.
 - (B) Intensive treatment with the family/guardian and child in a structured milieu.
 - (C) Intensive treatment in preparation for re-entry into community.
- (4) Documented efforts of working with child's family, legal guardian and/or custodian and other human service agencies toward a tentative discharge date.
- (5) Patient is making measurable progress toward the treatment objectives specified in the treatment plan.
 - (A) Progress is measured in behavioral terms and reflected in the patient's treatment and discharge plans.
 - (B) Patient has made gains toward social responsibility and independence.
 - (C) There is active, ongoing psychiatric treatment and documented progress toward the treatment objective and discharge.
 - (D) There are documented efforts and evidence of active involvement with the family, guardian, child welfare worker, extended family, etc.
- (6) Child's condition has remained unchanged or worsened.
 - (A) Documentation of regression is measured in behavioral terms and reflected in the patient's treatment and discharge plans.
 - (B) If condition is unchanged, there is evidence of re-evaluation of the treatment objectives and therapeutic interventions.

[Source: Added at 23 Ok Reg 2508, eff 6-25-06 ; Amended at 27 Ok Reg 2737, eff 7-20-10 (emergency); Amended at 28 Ok Reg 1452, eff 6-25-11 ; Amended at 29 Ok Reg 413, eff 3-7-12 (emergency); Amended at 29 Ok Reg 1125, eff 6-25-12 ; Amended at 31 Ok Reg 1713, eff 9-12-14 ; Amended at 37 Ok Reg 1573, eff 9-14-20 ; Amended at 39 Ok Reg 1526, eff 9-12-22]

317:30-5-95.31. Prior authorization and extension procedures for children

- (a) Prior authorization for inpatient psychiatric services for members must be requested from the OHCA or its designated agent. The OHCA or its designated agent will evaluate and render a decision within twenty-four (24) hours of receiving the request. A prior authorization will be issued by the OHCA or its designated agent, if the member meets medical necessity criteria. For the safety of SoonerCare members, additional approval from OHCA, or its designated agent, is required for placement on specialty units or in special population programs or for members with special needs such as very low intellectual functioning.
- (b) Extension requests (psychiatric) must be made through OHCA or its designated agent. All requests are made prior to the expiration of the approved extension. Requests for the continued stay of a member who has been in an Acute psychiatric program for a period of fifteen (15) days and an Acute II or PRTF program for three (3) months will require a

review of all treatment documentation completed by the OHCA, or its designated agent, to determine the efficiency of treatment.

(c) Providers seeking prior authorization will follow OHCA's, or its designated agent's, prior authorization process guidelines for submitting behavioral health case management requests on behalf of the SoonerCare member.

(d) In the event a member disagrees with the decision by OHCA, or its designated agent, the member may request an evidentiary hearing under OAC 317:2-1-2(b). The member's request for such an appeal must be received within thirty (30) calendar days of the date of the notice of the initial decision.

[Source: Added at 23 Ok Reg 2508, eff 6-25-06 ; Amended at 24 Ok Reg 2880, eff 7-1-07 (emergency); Amended at 25 Ok Reg 1161, eff 5-25-08 ; Amended at 27 Ok Reg 2737, eff 7-20-10 (emergency); Amended at 28 Ok Reg 1452, eff 6-25-11 ; Amended at 29 Ok Reg 413, eff 3-7-12 (emergency); Amended at 29 Ok Reg 1125, eff 6-25-12 ; Amended at 36 Ok Reg 864, eff 9-1-19 ; Amended at 37 Ok Reg 1573, eff 9-14-20]

317:30-5-95.32. Quality of care requirements for children

(a) At the time of admission of the child to an inpatient psychiatric program, the admitting facility will provide the member and their family or guardian with written explanation of the facility's policy regarding the following:

- (1) Member rights.
- (2) Behavior Management of members in the care of the facility.
- (3) Member Grievance procedures.
- (4) Information for contact with the Office of Client Advocacy.
- (5) Seclusion and Restraint policy.

(b) At the time of admission to an inpatient psychiatric program, the admitting facility will provide the member and their family or guardian with the guidelines for the conditions of family or guardian participation in the treatment of their child. The written Conditions of Participation are provided for the facility by the Oklahoma Health Care Authority. These guidelines specify the conditions of the family or guardian's participation in "Active Treatment". The signature of the family member or guardian acknowledges their understanding of the conditions of their participation in "Active Treatment" while the member remains in the care of the facility. The conditions include provisions of participation required for the continued SoonerCare compensable treatment. Members 18 and over are exempt from the family participation requirement. Families of members that have been placed out of state for behavioral health treatment may not be able to attend family therapy each week but should remain active in the member's treatment by telephone and attendance for family therapy at least once a month.

(c) Documented evidence must exist that the treatment program is trauma-informed.

[Source: Added at 23 Ok Reg 2508, eff 6-25-06 ; Amended at 27 Ok Reg 2737, eff 7-20-10 (emergency); Amended at 28 Ok Reg 1452, eff 6-25-11]

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

(a) An individual plan of care (IPC) is a written plan developed for each member within four (4) calendar days of admission to an Acute, Acute II, or a PRTF that directs the care and treatment of that member. The IPC must be recovery-focused, trauma-informed, and specific to culture, age, and gender and include:

- (1) A primary diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) with the exception of V-codes, adjustment disorders, and substance abuse-related disorders, accompanied by a detailed description of the symptoms supporting the diagnosis. Members eighteen (18) to twenty (20) years of age may have a diagnosis of any personality disorder. Adjustment or substance-related disorders may be a secondary diagnosis;
- (2) The current functional level of the individual;
- (3) Treatment goals and measurable, time-limited objectives;
- (4) 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 member;
- (5) Plans for continuing care, including review and modification to the IPC; and
- (6) Plan for discharge, all of which is developed to improve the member's condition to the extent that the inpatient care is no longer necessary.

(b) The IPC:

- (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 in consultation with the member, his or her parents or legal guardians [for members under the age of eighteen (18)], or others in whose care he or she will be released after discharge. This team must consist of professionals as specified below:
 - (A) For a member admitted to a psychiatric hospital or PRTF, by the "interdisciplinary team" as defined by OAC 317:30-5-95.35(b)(2), per 42 C.F.R. §§ 441.155 and 483.354; or
 - (B) For a member admitted to a psychiatric unit of a general hospital, by a team comprised of at least:
 - (i) An allopathic or osteopathic physician with a current license and a board certification/eligible in psychiatry, or a current resident in psychiatry practicing as described in OAC 317:30-5-2(a)(1)(U); and
 - (ii) A registered nurse (RN) with a minimum of two (2) years of experience in a mental health treatment setting; and
 - (iii) An LBHP.
- (3) Must establish treatment goals that are general outcome statements and reflective of informed choices of the member

served. Additionally, the treatment goals must be appropriate to the member'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 parents/legal guardians (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 IPC. The treatment objectives must be achievable and understandable to the member and the parents/legal guardians (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 aftercare plans that are appropriate to the member's needs and effective on the day of discharge. At the time of discharge, aftercare plans will include referral to medication management, outpatient 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 his or her family, school, and community;

(7) Must be reviewed, at a minimum, every nine (9) calendar days for members admitted to Acute; every fourteen (14) calendar days for members admitted to Acute II or non-specialty PRTF; every twenty-one (21) calendar days for members admitted to an OHCA-approved longer-term treatment program or specialty Acute II or PRTF. Review must be undertaken by the appropriate team specified in OAC 317:30-5-95.33(b)(2), above, to determine that services being provided are or were required on an inpatient basis, and to recommend changes in the IPC 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 recertification [42 C.F.R. §§ 456.60(b), 456.160(b), and 456.360(b)], and establishment and periodic review of the IPC (42 C.F.R. §§ 456.80, 456.180, and 456.380); and,

(9) Each IPC and IPC review must be clearly identified as such and be signed and dated individually by the member, parents/legal guardians [for members under the age of eighteen (18)], and required team members.

(A) All IPCs and IPC reviews must be signed by the member upon completion, except when a member is too physically ill or the member's acuity level precludes him or her from signing.

(i) If the member is too physically ill or the member's acuity level precludes him or her from signing the IPC and/or the IPC review at the time

of completion, the member must sign the plan when his or her condition improves, but before discharge.

(ii) The documentation should indicate the reason the member was unable to sign and when the next review will occur to obtain the signature.

(B) IPCs and IPC reviews are not valid until completed and appropriately signed and dated.

(i) All requirements for the IPCs and IPC reviews must be met; otherwise, a partial per diem recoupment will be merited.

(ii) If the member's parent/legal guardian is unable to sign the IPC or IPC review on the date it is completed, then within seventy-two (72) hours the provider must in good faith and with due diligence attempt to telephonically notify the parent/legal guardian of the document's completion and review it with them.

(iii) Documentation of reasonable efforts to make contact with the member's parent/legal guardian must be included in the clinical file.

(iv) In those instances where it is necessary to mail or fax an IPC or IPC review to a parent/legal guardian or Oklahoma Department of Human Services/Oklahoma Office of Juvenile Affairs (OKDHS/OJA) worker for review, the parent/legal guardian and/or OKDHS/OJA worker may fax back his or her signature. The provider must obtain the original signature for the clinical file within thirty (30) days. Stamped or photocopied signatures are not allowed for any parent/legal guardian or member of the treatment team.

(10) Medically necessary Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services shall be provided to members, under the age of twenty-one (21), who are residing in an inpatient psychiatric facility, regardless of whether such services are listed on the IPC. Reimbursement for the provision of medically necessary EPSDT services to individuals under age twenty-one (21), while the member is residing in an inpatient psychiatric facility, will be provided in accordance with the Oklahoma Medicaid State Plan.

[Source: Added at 23 Ok Reg 2508, eff 6-25-06 ; Amended at 24 Ok Reg 2880, eff 7-1-07 (emergency); Amended at 25 Ok Reg 1161, eff 5-25-08 ; Amended at 25 Ok Reg 2764, eff 7-1-08 (emergency); Amended at 26 Ok Reg 262, eff 12-1-08 (emergency); Amended at 26 Ok Reg 1072, eff 5-11-09 ; Amended at 27 Ok Reg 816, eff 3-3-10 (emergency); Amended at 27 Ok Reg 1469, eff 6-11-10 ; Amended at 27 Ok Reg 2737, eff 7-20-10 (emergency); Amended at 28 Ok Reg 1452, eff 6-25-11 ; Amended at 30 Ok Reg 1203, eff 7-1-13 ; Amended at 32 Ok Reg 1105, eff 8-27-15 ; Amended at 33 Ok Reg 885, eff 9-1-16 ; Amended at 34 Ok Reg 714, eff 9-1-17 ; Amended at 35 Ok Reg 1428, eff 9-14-18 ; Amended at 36 Ok Reg 918, eff 9-1-19 ; Amended at 37 Ok Reg 1573, eff 9-14-20 ; Amended at 39 Ok Reg 1526, eff 9-12-22]

317:30-5-95.34. Active treatment for children

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

(1) "**Active treatment**" means implementation of a professionally developed and supervised individual plan of care (IPC) that involves the member and his or her family or guardian from the time of an admission, and through the treatment and discharge process.

(2) "**Discharge/transition planning**" means a patient-centered, interdisciplinary process that begins with an initial assessment of the member's needs at the time of admission and continues throughout the member's stay. Active collaboration with the member, family, and all involved outpatient practitioners and agencies should be ongoing throughout treatment so that effective connections remain intact. Needed services may consist of the wraparound process through Systems of Care, counseling, case management, and other supports in the member's community. The linkages with these supports should be made prior to discharge to allow for a smooth transition.

(3) "**Expressive group therapy**" means art, music, dance, movement, poetry, drama, psychodrama, structured therapeutic physical activities, and experiential (e.g., ropes course), recreational, or occupational therapies that encourage the member to express themselves emotionally and psychologically.

(4) "**Family therapy**" means interaction between an LBHP or licensure candidate, member, and family member(s) to facilitate emotional, psychological, or behavioral changes and promote successful communication and understanding.

(5) "**Group rehabilitative treatment**" means behavioral health remedial services, as specified in the individual care plan, which are necessary for the treatment of the existing primary behavioral health disorders and/or any secondary alcohol and other drug (AOD) disorders in order to increase the skills necessary to perform activities of daily living (ADL).

(6) "**Individual rehabilitative treatment**" means a face-to-face, one-on-one interaction which is performed to assist a member who is experiencing significant functional impairment due to the existing primary behavioral health disorder and/or any secondary AOD disorder, in order to increase the skills necessary to perform ADL.

(7) "**Individual therapy**" means a method of treating existing primary behavioral health disorders and/or any secondary AOD disorders using face-to-face, one-on-one interaction between an LBHP or licensure candidate and a member to promote emotional or psychological change to alleviate disorders.

(8) "**Process group therapy**" means a method of treating existing primary behavioral health disorders and/or secondary AOD disorders using the interaction between an LBHP or licensure candidate, and two (2) or more members to promote positive emotional and/or behavioral change.

(b) Inpatient psychiatric programs must provide "active treatment". Families and/or guardians must be notified of the dates and times of

treatment team meetings and be welcomed to attend. Family members must attend family therapy weekly for continued SoonerCare reimbursement. Reasons for exceptions to this requirement must be well-documented in the member's treatment plan. Family therapy attendance by family members is not a requirement for individuals in the age range of eighteen (18) up to twenty-one (21). Active treatment also includes ongoing assessment, diagnosis, intervention, evaluation of care and treatment, and planning for discharge and aftercare under the direction of a physician.

(c) For individuals ages eighteen (18) up to twenty-one (21), the active treatment program must be appropriate to the needs of the member and be directed toward restoring and maintaining optimal levels of physical and psychiatric-social functioning. The services and the IPC must be recovery-focused, trauma-informed, specific to culture, age, and gender, and provided face to face. Services, including type and frequency, will be specified in the IPC.

(d) A treatment week consists of seven (7) calendar days. In an Acute setting, the treatment week begins the day of admission. In Acute II and PRTF, the treatment week starts on Sunday and ends on Saturday. Active treatment service components are provided as per item (e) below if the services are provided within a seven (7) day treatment week. A chart outlining active treatment component requirements and timelines may also be found at www.okhca.org. If a member has a length of stay of less than seven (7) days, the treatment week is considered a partial treatment week. Active treatment requirements, when provided during a partial treatment week, are delivered as per item (f) below. An hour of treatment must be sixty (60) minutes. When appropriate to meet the needs of the child, the sixty (60) minute timeframe may be split into sessions of no less than fifteen (15) minutes each, on the condition that the active treatment requirements are fully met by the end of the treatment week.

(e) For individuals under age eighteen (18), the components of active treatment consist of face-to-face integrated therapies that are provided on a regular basis and will remain consistent with the member's ongoing need for care. The services and IPC must be recovery-focused, trauma-informed, and specific to culture, age, and gender. Individuals receiving services in an Acute setting must receive seventeen (17) hours of documented active treatment services each week, with seven (7) of those hours dedicated to core services as described in (1) below. Individuals in Acute II and PRTFs must receive fourteen (14) hours of documented active treatment services each week, with four and a half (4.5) of those hours dedicated to core services as described in (1) below. Upon fulfilling the core service hours requirement, the member may receive either the elective services listed in (2) below or additional core services to complete the total required hours of active treatment. The following components meet the minimum standards required for active treatment, although an individual child's needs for treatment may exceed this minimum standard:

(1) Core services.

(A) Individual treatment provided by the physician, Advanced Practice Registered Nurse (APRN), or Physician Assistant (PA). Individual treatment provided

by the physician, APRN with psychiatric certification or PA is required three (3) times per week for Acute and one (1) time a week in Acute II and PRTFs. Individual treatment provided by the physician, APRN with psychiatric certification or PA will never exceed ten (10) calendar days between sessions in Acute II and PRTFs, and never exceed seven (7) calendar days in a specialty Acute II and specialty PRTF. Individual treatment provided by the physician, APRN with psychiatric certification or PA may consist of therapy or medication management intervention for Acute, Acute II, and PRTF programs.

(B) **Individual therapy.** LBHPs or licensure candidates performing this service must use and document an approach to treatment such as cognitive behavioral treatment, narrative therapy, solution-focused brief therapy, or another widely accepted theoretical framework for treatment. Ongoing assessment of the member's status and response to treatment, as well as psycho-educational intervention, are appropriate components of individual therapy. Individual therapy must be provided in a confidential setting. The therapy must be goal-directed, utilizing techniques appropriate to the member's plan of care and the member's developmental and cognitive abilities. Individual therapy must be provided two (2) hours per week in Acute and one (1) hour per week in Acute II and PRTFs by an LBHP or licensure candidate. One (1) hour of family therapy may be substituted for one (1) hour of individual therapy at the treatment team's discretion.

(C) **Family therapy.** The focus of family therapy must be directly related to the goals and objectives on the individual member's plan of care. Family therapy must be provided one (1) hour per week in Acute, Acute II, and PRTFs. One (1) hour of individual therapy addressing relevant family issues may be substituted for a family session in an instance in which the family is unable to attend a scheduled session by an LBHP or licensure candidate.

(D) **Process group therapy.** The focus of process group therapy must be directly related to goals and objectives on the individual member's plan of care. The individual member's behavior and the focus of the group must be included in each member's medical record. This service does not include social skills development or daily living skills activities and must take place in an appropriate confidential setting, limited to the therapist, appropriate hospital staff, and group members. Group therapy must be provided three (3) hours per week in Acute and two (2) hours per week in Acute II and PRTFs by an LBHP or licensure candidate. In lieu of one (1) hour of process group therapy, one (1) hour of expressive group therapy

provided by an LBHP, licensure candidate, or licensed therapeutic recreation specialist may be substituted.

(E) **Transition/discharge planning.** Transition/discharge planning must be provided one (1) hour per week in Acute and thirty (30) minutes per week in Acute II and PRTFs.

Transition/discharge planning can be provided by any level of inpatient staff.

(2) **Elective services.**

(A) **Expressive group therapy.** Through active expression, inner strengths are discovered that can help the member deal with past experiences and cope with present life situations in more beneficial ways. The focus of the group must be directly related to goals and objectives on the individual member's plan of care.

Documentation must include how the member is processing emotions/feelings. Expressive therapy must be a planned therapeutic activity, facilitated by staff with a relevant bachelor's degree and/or staff with relevant training, experience, or certification to facilitate the therapy.

(B) **Group rehabilitative treatment.** Examples of educational and supportive services, which may be covered under the definition of group rehabilitative treatment services, are basic living skills, social skills (re)development, interdependent living, self-care, lifestyle changes, and recovery principles. Each service provided under group rehabilitative treatment services must have goals and objectives directly related to the IPC.

(C) **Individual rehabilitative treatment.** Services are provided to reduce psychiatric and behavioral impairment and to restore functioning consistent with the requirements of independent living and enhanced self-sufficiency. This service includes educational and supportive services regarding independent living, self-care, social skills (re)development, lifestyle changes, and recovery principles and practices. Each individual rehabilitative treatment service provided must have goals and objectives directly related to the IPC and the member's diagnosis.

(D) **Recreation therapy.** Services are provided to reduce psychiatric and behavioral impairment and to restore, remediate, and rehabilitate an individual's level of functioning and independence in life activities. Services are provided to promote health and wellness, as well as reduce or eliminate barriers caused by illness or disabling conditions that limit or restrict a member from participating in life activities. Recreational therapy can be provided in an individual or group setting. If the only activities prescribed for the individual are primarily diversional in nature, (i.e., to provide some social or recreational outlet for the individual), it will not be

regarded as active treatment. If provided, recreational therapy must be a planned therapeutic activity, facilitated by a licensed therapeutic recreation specialist.

(E) **Occupational therapy.** Services are provided to address developmental and/or functional needs related to the performance of self-help skills, adaptive behavioral, and/or sensory, motor, and postural development. Services include therapeutic goal-directed activities and/or exercises used to improve mobility and ADL functions when such functions have been impaired due to illness or injury. Services must be provided by an occupational therapist appropriately licensed in the state in which he or she practices.

(F) **Wellness resource skills development.** Services include providing direction and coordinating support activities that promote physical health. The focus of these activities should include areas such as nutrition, exercise, support to avert and manage physical health concerns like heart disease, diabetes, and cholesterol, and guidance on the effects that medications have on physical health. Services can include individual/group support, exercise groups, and individual physical wellness plan development, implementation, and assistance.

(3) **Modifications to active treatment.** When a member is too physically ill, or his or her acuity level precludes him or her from active behavioral health treatment, documentation must demonstrate that alternative clinically-appropriate services were provided.

(f) Active treatment components, furnished during a partial treatment week, are provided as per item (1) through (4) below. A chart outlining active treatment component requirements and timelines may also be found at www.okhca.org. Assessments/evaluations may serve as the initial individual or family session if completed by an LBHP or licensure candidate. Start and stop time must be documented. Active treatment begins the day of admission. Days noted are calendar days.

(1) **Individual treatment provided by the physician, APRN or PA.**

(A) In Acute, by day two (2), one (1) visit is required. By day four (4), two (2) visits are required. By day seven (7), three (3) visits are required.

(B) In Acute II and PRTFs, one (1) visit during admission week is required. In PRTFs, one (1) visit during the admission week is required, then once a week thereafter. Individual treatment provided by the physician, APRN with psychiatric certification or PA will never exceed ten (10) days between sessions in Acute II and PRTFs, never exceed seven (7) days in specialty Acute II and specialty PRTFs. The completion of a psychiatric evaluation or a combined psychiatric evaluation and a history and physical (H&P) evaluation may count as the first visit if the evaluation was personally rendered by the psychiatrist,

APRN with psychiatric certification or PA. If the member is admitted on the last day of the admission week, then the member must be seen by a physician, APRN with psychiatric certification or PA within sixty (60) hours of admission time.

(2) Individual therapy.

(A) In Acute, by day three (3), thirty (30) minutes of treatment are required. By day five (5), one (1) hour of treatment is required. Beginning on day seven (7), two (2) hours of treatment are required each week. This does not include admission assessments/evaluations or psychosocial evaluations unless personally (face to face) rendered by the LBHP or licensure candidate.

(B) In Acute II and PRTFs, by day six (6), thirty (30) minutes of treatment must be documented. Beginning on day seven (7), one (1) hour of treatment is required each week. The treatment week is defined as Sunday through Saturday. Individual therapy may not exceed a total of ten (10) days between sessions. This does not include admission assessment/evaluation or psychosocial evaluations unless personally (face to face) rendered by the LBHP or licensure candidate.

(3) Family therapy.

(A) In Acute, by day six (6), thirty (30) minutes of treatment must be documented. Beginning on day seven (7), one (1) hour of treatment is required each week. This does not include admission assessments/evaluation or psychosocial evaluations unless personally (face to face) rendered by the LBHP or licensure candidate and the assessments/evaluation or psychosocial evaluation has not been used to substitute the initial individual therapy requirement.

(B) In Acute II and PRTFs, by day six (6), thirty (30) minutes of treatment must be documented. Beginning on day seven (7), one (1) hour of treatment is required each week. This does not include admissions assessment/evaluation or psychosocial evaluation unless personally (face to face) rendered by the LBHP or licensure candidate and the assessment/evaluation or psychosocial evaluation has not been used to substitute the initial individual therapy requirement. Family therapy provided by the LBHP or licensure candidate should not exceed ten (10) days in between sessions.

(4) Process group therapy.

(A) In Acute, by day three (3), one (1) hour of treatment is required. By day five (5), two (2) hours of treatment are required. Beginning on day seven (7), three (3) hours of treatment are required each week.

(B) In Acute II and PRTFs, by day five (5), one (1) hour of treatment is required. Beginning on day seven (7), two (2) hours of treatment are required each week.

(g) When an individual is determined to be too ill to participate in treatment, as determined by medical/nursing staff [registered nurse (RN)/licensed practical nurse (LPN)], documentation must be in the record clearly indicating the reason, limitations, and timeframe for those services to be excused without penalty.

[Source: Added at 23 Ok Reg 2508, eff 6-25-06 ; Amended at 24 Ok Reg 2880, eff 7-1-07 (emergency); Amended at 25 Ok Reg 1161, eff 5-25-08 ; Amended at 27 Ok Reg 2737, eff 7-20-10 (emergency); Amended at 28 Ok Reg 1452, eff 6-25-11 ; Amended at 30 Ok Reg 1203, eff 7-1-13 ; Amended at 31 Ok Reg 1713, eff 9-12-14 ; Amended at 32 Ok Reg 1102, eff 8-27-15 ; Amended at 33 Ok Reg 885, eff 9-1-16 ; Amended at 34 Ok Reg 714, eff 9-1-17 ; Amended at 36 Ok Reg 914, eff 9-1-19 ; Amended at 37 Ok Reg 1573, eff 9-14-20 ; Amended at 39 Ok Reg 1526, eff 9-12-22 ; Amended at 40 Ok Reg 373, eff 11-4-22 (emergency); Amended at 40 Ok Reg 2245, eff 9-11-23]

317:30-5-95.35. Certificate of need requirements for children in psychiatric hospitals and PRTFs

(a) **General requirements.** This Section establishes the requirements for certification of the need for inpatient psychiatric services provided to individuals under twenty-one (21) years of age in psychiatric hospitals, in accordance with Section 1905(a) 16 and (h) of the Social Security Act, and in PRTFs, in accordance with 42 C.F.R. § 483.354. Pursuant to this federal law, a team, consisting of physicians and other qualified personnel, shall determine that inpatient services are necessary and can reasonably be expected to improve the member's condition. These requirements do not apply to an admission to a psychiatric unit of a general hospital.

(b) **Definitions.** The following words and terms, when used in this chapter, shall have the following meanings unless the context clearly indicates otherwise.

(1) **"Independent team"** means a team that is not associated with the facility, such that no team member has an employment or consultant relationship with the admitting facility. The independent team shall include a licensed physician who has competence in diagnosis and treatment of mental illness, preferably child psychiatry, and who has knowledge of the member's clinical condition and situation. The independent team shall also include at least one (1) other LBHP.

(2) **"Interdisciplinary team"** means, as defined by 42 C.F.R. § 441.156, a team of physicians and other personnel who are employed by, or who provide services to, SoonerCare members in the facility or program. The interdisciplinary team must include, at a minimum, either a board-eligible or board-certified psychiatrist; or, a licensed physician and a psychologist licensed by the Oklahoma State Board of Examiners of Psychologists (OSBEP) who has a doctoral degree in clinical psychology; or, a licensed physician with specialized training and experience in the diagnosis and treatment of mental diseases, and a psychologist licensed by the OSBEP. The interdisciplinary team must also include one (1) of the following:

(A) A licensed clinical social worker;

(B) A registered nurse (RN) with specialized training or one (1) year of experience in treating mentally ill

individuals;

(C) A psychologist licensed by the OSBEP who has a doctoral degree in clinical psychology; or

(D) An occupational therapist who is licensed by the state in which the individual is practicing, if applicable, and who has specialized training or one (1) year of experience in treating mentally ill individuals.

(c) **Certification of the need for services.** As described in 42 C.F.R. § 441.152, the certification shall be made by a team, either independent or interdisciplinary, as specified in (d), below, and shall certify that:

(1) Ambulatory care resources available in the community do not meet the treatment needs of the member;

(2) Proper treatment of the member's psychiatric condition requires services on an inpatient basis under the direction of a physician; and

(3) Services can reasonably be expected to improve the member's condition or prevent further regression so that inpatient services would no longer be needed.

(d) **Certification for admission.** The certification of the need for services, as stated in (c), above, shall be made by the appropriate team, in accordance with 42 C.F.R. § 441.153 and as specified as follows:

(1) Certification for the admission of an individual who is a member when admitted to a facility or program shall be made by an independent team, as described in (b)(1), above.

(2) Certification for an inpatient applying for SoonerCare while in the facility or program shall be made by an interdisciplinary team responsible for the plan of care and as described in (b)(2), above.

(3) Certification of an emergency admission of a member shall be made by the interdisciplinary team responsible for the plan of care within fourteen (14) days after admission, in accordance with 42 C.F.R. § 441.156.

(c) Services provided by treatment team members not meeting the above credentialing requirements are not SoonerCare compensable and can not be billed to the SoonerCare member.

[Source: Added at 23 Ok Reg 2508, eff 6-25-06 ; Amended at 24 Ok Reg 2880, eff 7-1-07 (emergency); Amended at 25 Ok Reg 1161, eff 5-25-08 ; Amended at 27 Ok Reg 816, eff 3-3-10 through 7-14-10 (emergency)¹; Amended at 27 Ok Reg 2737, eff 7-20-10 (emergency); Amended at 28 Ok Reg 1452, eff 6-25-11 ; Amended at 30 Ok Reg 1203, eff 7-1-13 ; Amended at 33 Ok Reg 891, eff 9-1-16 ; Amended at 35 Ok Reg 1428, eff 9-14-18 ; Amended at 37 Ok Reg 1573, eff 9-14-20]

Editor's Note: ¹*This emergency action expired without being superseded by a permanent action. Upon expiration of an emergency amendatory action, the last effective permanent text is reinstated. Therefore, on 7-15-10 (after the 7-14-10 expiration of this emergency action), the text of 317:30-5-95.35 reverted back to the permanent text that became effective 5-25-08, as last published in the 2009 OAC supplement, and remained as such until amended again by emergency action on 7-20-10.*

317:30-5-95.36. Treatment team for inpatient children's services

An interdisciplinary team of a physician, licensed behavioral health professionals, registered nurse, member, parent/legal guardian for members under the age of 18, and other personnel who provide services to members in the facility must develop the individual plan of care, oversee all components of the active treatment and provide the services appropriate to their respective discipline. Based on education and experience, preferably including competence in child psychiatry, the teams must be:

- (1) capable of assessing the member's immediate and long range therapeutic needs, developmental priorities and personal strengths and liabilities;
- (2) capable of assessing the potential resources of the member's family, and actively involving the family of members under the age of 18 in the ongoing plan of care;
- (3) capable of setting treatment objectives;
- (4) capable of prescribing therapeutic modalities to achieve the plan objectives;
- (5) capable of developing appropriate discharge criteria and plans; and
- (6) trained in a recognized behavioral/management intervention program such as MANDT System, Controlling Aggressive Patient Environment (CAPE), SATORI, Professional Assault Crisis Training (PRO-ACT), or a trauma informed methodology with the utmost focus on the minimization of seclusion and restraints.

[Source: Added at 23 Ok Reg 2508, eff 6-25-06 ; Amended at 24 Ok Reg 2880, eff 7-1-07 (emergency); Amended at 25 Ok Reg 1161, eff 5-25-08 ; Amended at 27 Ok Reg 2737, eff 7-20-10 (emergency); Amended at 28 Ok Reg 1452, eff 6-25-11 ; Amended at 32 Ok Reg 1109, eff 8-27-15]

317:30-5-95.37. Medical, psychiatric, and social evaluations for inpatient services for children

The member's medical record must contain complete medical, psychiatric, and social evaluations.

- (1) These evaluations are considered critical documents to the integrity of care and treatment and must be completed as follows:
 - (A) History and physical evaluation must be completed within twenty-four (24) hours of admission by a licensed independent practitioner [Allopathic Doctor, Osteopathic Doctor, Advanced Practice Registered Nurse (APRN), or Physician Assistant (PA)] in Acute, Acute II, and PRTFs.
 - (B) Psychiatric evaluation must be completed within sixty (60) hours of admission by an Allopathic or Osteopathic physician with a current license and a board certification/eligible in psychiatry. APRN with a psychiatric certification or PA in Acute, Acute II, and PRTFs.
 - (C) Psychosocial evaluation must be completed within seventy-two (72) hours of an Acute admission, and within seven (7) calendar days of admission to Acute II and PRTFs by a licensed independent practitioner (Allopathic Doctor, Osteopathic Doctor, APRN, or PA), LBHP, or licensure candidate.

(2) Each of the evaluations must be clearly identified as such and must be signed and dated by the evaluators.

(3) Each of the evaluations must be completed when the member changes levels of care if the existing evaluation is more than thirty (30) calendar days from admission. For continued stays at the same level of care, evaluations remain current for twelve (12) months from the date of admission and must be updated annually within seven (7) calendar days of that anniversary date.

(4) Existing evaluations of thirty (30) days or less may be used when a member changes provider or level of care. The evaluation(s) must be reviewed, updated as necessary, and signed and dated by the appropriate level of professional as defined by the type of evaluation.

[Source: Added at 23 Ok Reg 2508, eff 6-25-06 ; Amended at 27 Ok Reg 2737, eff 7-20-10 (emergency); Amended at 28 Ok Reg 1452, eff 6-25-11 ; Amended at 30 Ok Reg 1203, eff 7-1-13 ; Amended at 32 Ok Reg 1107, eff 8-27-15 ; Amended at 33 Ok Reg 891, eff 9-1-16 ; Amended at 37 Ok Reg 1573, eff 9-14-20 ; Amended at 39 Ok Reg 1526, eff 9-12-22 ; Amended at 40 Ok Reg 373, eff 11-4-22 (emergency); Amended at 40 Ok Reg 2245, eff 9-11-23]

317:30-5-95.38. Nursing services for children

Each facility must have a qualified director of psychiatric nursing. In addition to the director of nursing, there must be adequate numbers of registered nurses (RNs), licensed practical nurses (LPNs), and mental health workers to provide nursing care necessary under the active treatment program and to maintain progress notes on each member. The progress note must contain recommendations for revisions in the individual plan of care (IPC), as needed, as well as an assessment of the member's progress as it relates to the IPC goals and objectives.

[Source: Added at 23 Ok Reg 2508, eff 6-25-06 ; Amended at 27 Ok Reg 2737, eff 7-20-10 (emergency); Amended at 28 Ok Reg 1452, eff 6-25-11 ; Amended at 37 Ok Reg 1573, eff 9-14-20 ; Amended at 39 Ok Reg 1526, eff 9-12-22]

317:30-5-95.39. Restraint, seclusion, and serious occurrence reporting requirements for members under the age of twenty-one (21)

(a) All PRTFs must comply with the condition of participation for restraint or seclusion, as is established by 42 C.F.R. §§ 483.350 through 483.376, which is hereby incorporated by reference in its entirety. All general and psychiatric hospitals must comply with the standard for restraint or seclusion, as is established by 42 C.F.R. § 482.13(e) - (g), which is hereby incorporated by reference in its entirety. In the case of any inconsistency or duplication between these federal regulations and OAC 317:30-5-95.39, the federal regulations shall prevail, except where OAC 317:30-5-95.39 and/or other Oklahoma law is more protective of a member's health, safety, or well-being.

(b) Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the member, a staff member, or others from harm and may only be imposed to ensure the immediate physical safety of the member, a staff member, or others. The use of restraint or seclusion must be in accordance with a

written modification to the member's individual plan of care. The type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the member or others from harm. Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order. Mechanical restraints will not be used on children under age eighteen (18).

(1) Each facility must have policies and procedure to describe the conditions in which restraint or seclusion would be utilized, the behavioral/management intervention program followed by the facility, and the documentation required. Restraint or seclusion may only be ordered by the following individuals trained in the use of emergency safety interventions: a Physician; a Physician Assistant (PA); or an Advanced Practice Registered Nurse (APRN) with prescriptive authority. If, however, the member's treatment team physician is available, then only he or she can order restraint or seclusion. Each order for restraint or seclusion may only be renewed in accordance with the following limits for up to a total of twenty-four (24) hours:

(A) four (4) hours for adults eighteen (18) to twenty-one (21) years of age;

(B) two (2) hours for children and adolescents nine (9) to seventeen (17) years of age; or

(C) one (1) hour for children under nine (9) years of age.

(2) An order for the use of restraint/seclusion must never be written as a standing order or on an as-needed basis.

(3) The documentation required to ensure that restraint or seclusion was appropriately implemented and monitored will include, at a minimum:

(A) documentation of events leading to intervention used to manage the violent or self-destructive behaviors that jeopardize the immediate physical safety of the member or others;

(B) documentation of alternatives or less restrictive interventions attempted;

(C) a signed order for restraint/seclusion that includes the name of the individual ordering the restraint/seclusion, the date and time the order was obtained, and the length of time for which the order was authorized;

(D) the time the restraint/seclusion actually began and ended;

(E) the name of staff involved in the restraint/seclusion;

(F) documentation sufficient to show the member was monitored in accordance with 42 C.F.R. § 482.13(e) (for general and psychiatric hospitals) or 42 C.F.R. §§ 483.362 and 483.364 (for PRTFs), as applicable;

(G) the time and results of a face-to-face assessment completed within one (1) hour after initiation of the restraint/seclusion by a Physician, PA, APRN with prescriptive authority, or Registered Nurse, who has been trained in the use of emergency safety interventions. The assessment must evaluate the member's well-being,

including those criteria set forth in 42 C.F.R. § 482.13(e) (for general and psychiatric hospitals) or 42 C.F.R. § 483.358(f) (for PRTFs), as applicable;

(H) in the event the face-to-face assessment was completed by anyone other than the member's treatment team physician, documentation that he or she consulted the member's treatment team physician as soon as possible after completion of the face-to-face assessment;

(I) debriefing of the child and staff involved in the emergency safety intervention within twenty-four (24) hours, in accordance with 42 C.F.R. § 483.370, as applicable;

(J) debriefing of all staff involved in the emergency safety intervention and appropriate supervisory and administrative staff within twenty-four (24) hours, in accordance with 42 C.F.R. § 483.370, as applicable; and

(K) for minors, notification of the parent(s)/guardian(s).

(c) Serious occurrences, including death, serious injury, or suicide attempt, must be reported as follows:

(1) In accordance with 42 C.F.R. § 483.374, PRTFs must notify the OHCA Behavioral Health Unit and Oklahoma Department of Human Services (DHS) by phone no later than 5:00 p.m. on the business day following a serious occurrence and disclose, at a minimum: the name of the member involved in the serious occurrence; a description of the occurrence; and the name, street address, and telephone number of the facility.

(A) Within three (3) days of the serious occurrence, a PRTF must also submit a written Facility Critical Incident Report to the OHCA Behavioral Health Unit containing: the information in OAC 317:30-5-95.39(c)(1), above; and any available follow-up information regarding the member's condition, debriefings, and programmatic changes implemented (if applicable). A copy of this report must be maintained in the member's record, along with the names of the persons at OHCA and DHS to whom the occurrence was reported. A copy of the report must also be maintained in the incident and accident report logs kept by the facility.

(B) In the case of a minor, the PRTF must also notify the member's parent(s) or legal guardian(s) as soon as possible, and in no case later than twenty-four (24) hours after the serious occurrence.

(2) In addition to the requirements in paragraph (1), above, the death of any member must be reported in accordance with 42 C.F.R. § 482.13(g) (hospital reporting requirements for deaths associated with the use of seclusion or restraint) or 42 C.F.R. § 483.374(c) (PRTF reporting requirements for deaths), as applicable.

(d) In accordance with 42 C.F.R. § 483.374(a), OHCA requires all PRTFs that provide SoonerCare inpatient psychiatric services to members under age twenty-one (21) to attest in writing at the time of contracting, that

the facility is in compliance with all federal standards governing the use of restraint and seclusion. The attestation letter must be signed by the facility director, and must include, at a minimum:

- (1) the name, address, and telephone number of the facility, and its provider identification number;
- (2) the name and signature of the facility director;
- (3) the date the attestation is signed;
- (4) a statement certifying that the facility currently meets all of the federal requirements governing the use of restraint and seclusion;
- (5) a statement acknowledging the right of OHCA, CMS, and/or any other entity authorized by law, to conduct an on-site survey at any time to validate the facility's compliance with 42 C.F.R. §§ 483.350 through 483.376, to investigate complaints lodged against the facility, and to investigate serious occurrences;
- (6) a statement that the facility will notify the OHCA if it is out of compliance with 42 C.F.R. §§ 483.350 through 483.376; and
- (7) a statement that the facility will submit a new attestation of compliance in the event the facility director changes, for any reason.

[Source: Added at 23 Ok Reg 2508, eff 6-25-06 ; Amended at 24 Ok Reg 2880, eff 7-1-07 (emergency); Amended at 25 Ok Reg 1161, eff 5-25-08 ; Amended at 27 Ok Reg 2737, eff 7-20-10 (emergency); Amended at 28 Ok Reg 1452, eff 6-25-11 ; Amended at 31 Ok Reg 1713, eff 9-12-14 ; Amended at 32 Ok Reg 1109, eff 8-27-15 ; Amended at 35 Ok Reg 516, eff 2-27-18 (emergency); Amended at 35 Ok Reg 1428, eff 9-14-18]

317:30-5-95.4. Individual plan of care for adults aged twenty-one (21) to sixty-four (64)

(a) Before or immediately after admission to a psychiatric unit of a general hospital or psychiatric hospital, the attending physician or staff physician must establish a written plan of care for each member aged twenty-one (21) to sixty-four (64). The plan of care must include:

- (1) Diagnoses, symptoms, complaints, and complications indicating the need for admission;
- (2) A description of the functional level of the individual;
- (3) Objectives;
- (4) Any order for medication, treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the member;
- (5) Plans for continuing care, including review and modification to the plan of care; and
- (6) Plans for discharge.

(b) The attending or staff physician and other treatment team personnel involved in the member's care must review each plan of care at least every seven (7) days.

(c) All plans of care and plan of care reviews must be clearly identified as such in the member's medical records. All must be signed and dated by the physician, RN, LBHP or licensure candidate, member, and other treatment team members that provide individual, family, and group therapy in the required review interval. Licensure candidate signatures

must be co-signed. All plans of care and plan of care reviews must be signed by the member upon completion, except when a member is too physically ill or his or her acuity level precludes him or her from signing. If the member has designated an advocate, the advocate's signature is also required on all plans of care and plan of care reviews. If the member was too physically ill or his or her acuity level precluded him or her from signing the plan of care and/or the plan of care review at the time of completion, the member must sign the plan when his or her condition improves, but before discharge.

(d) The plan of care must document appropriate member participation in the development and implementation of the treatment plan.

[Source: Added at 23 Ok Reg 2508, eff 6-25-06 ; Amended at 27 Ok Reg 2737, eff 7-20-10 (emergency); Amended at 28 Ok Reg 1452, eff 6-25-11 ; Amended at 32 Ok Reg 1105, eff 8-27-15 ; Amended at 35 Ok Reg 1428, eff 9-14-18 ; Amended at 37 Ok Reg 1573, eff 9-14-20 ; Amended at 40 Ok Reg 2236, eff 9-11-23]

317:30-5-95.40. Other required standards

The provider is required to maintain all programs and services according to applicable C.F.R. requirements, the Joint Commission (TJC) and American Osteopathic Association (AOA) standards for behavioral health care, Oklahoma State Department of Health's (OSDH) hospital standards for psychiatric care, and Oklahoma Department of Human Services (OKDHS) licensing standards for residential treatment facilities. PRTFs may substitute the Commission on Accreditation of Rehabilitation Facilities (CARF) accreditation in lieu of TJC or AOA accreditation. In addition to federal requirements, out-of-state inpatient psychiatric facilities must adhere to OAC 317:30-5-95 and 317:30-5-95.24.

[Source: Added at 23 Ok Reg 2508, eff 6-25-06 ; Amended at 27 Ok Reg 2737, eff 7-20-10 (emergency); Amended at 28 Ok Reg 1452, eff 6-25-11 ; Amended at 37 Ok Reg 1573, eff 9-14-20 ; Amended at 40 Ok Reg 362, eff 11-4-22 (emergency); Amended at 40 Ok Reg 2204, eff 9-11-23]

317:30-5-95.41. Documentation of records for children receiving inpatient services

(a) All documentation for services provided under active treatment must be documented in an individual note and reflect the content of each session provided. Individual, family, process group, expressive group, individual rehabilitative, and group rehabilitative services documentation must include, at a minimum, the following:

- (1) Date;
- (2) Start and stop time for each session;
- (3) Dated signature of the therapist and/or staff that provided the service;
- (4) Credentials of the therapist;
- (5) Specific problem(s) addressed (problems must be identified on the plan of care);
- (6) Method(s) used to address problems;
- (7) Progress made towards goals;
- (8) Member's response to the session or intervention; and
- (9) Any new problem(s) identified during the session.

(b) Signatures of the member, parent/guardian for members under the age of eighteen (18), physician, LBHP, and registered nurse (RN) are required on the individual plan of care (IPC) and all plan of care reviews. The IPC and plan of care review are not valid until signed and separately dated by the member, parent/legal guardian for members under the age of eighteen (18), physician, RN, LBHP, and all other requirements are met. All treatment team staff providing individual therapy, family therapy, and process group therapy must sign the IPC and all plan of care reviews. All plans of care and plan of care reviews must be signed by the member upon completion, except when a member is too physically ill, or the member's acuity level precludes him/her from signing. If the member is too physically ill or the member's acuity level precludes him/her from signing the plan of care and/or the plan of care review at the time of completion, the member must sign the plan when his/her condition improves but before discharge. Documentation should indicate the reason the member was unable to sign and when the next review will occur to obtain the signature.

(c) Candidates for licensure for licensed professional counselor, social work (clinical specialty only), licensed marital and family therapist, licensed behavioral practitioner, licensed alcohol and drug counselor, and psychology (mental health specialty only) can provide assessments, psychosocial evaluations, individual therapy, family therapy, and process group therapy as long as they are involved in supervision that complies with their respective, approved licensing regulations and licensing boards. Additionally, their work must be co-signed and dated by a fully-licensed LBHP in good standing, who is a member on the treatment team. Individuals who have met their supervision requirements and are waiting to be licensed in one (1) of the areas of practice in OAC 317:30-5-240.3(a)(2) must have their work co-signed by a fully-licensed LBHP in good standing, who is a member on the treatment team. All co-signatures by fully-licensed LBHPs in good standing, must be accompanied by the date that the co-signature was made. Documentation of the service is not considered complete until it is signed and dated by a fully-licensed LBHP in good standing.

[Source: Added at 23 Ok Reg 2508, eff 6-25-06 ; Amended at 24 Ok Reg 2880, eff 7-1-07 (emergency); Amended at 25 Ok Reg 1161, eff 5-25-08 ; Amended at 30 Ok Reg 1203, eff 7-1-13 ; Amended at 33 Ok Reg 885, eff 9-1-16 ; Amended at 37 Ok Reg 1573, eff 9-14-20]

317:30-5-95.42. Service quality review (SQR) of psychiatric facilities and residential substance use disorder (SUD) facilities

(a) The SQR conducted by the OHCA or its designated agent meets the utilization control requirements as set forth in 42 C.F.R. Part 456.

(b) There will be an SQR of each in-state psychiatric facility and residential SUD facility that provides services to SoonerCare members which will be performed by the OHCA or its designated agent. Out-of-state facilities that provide services to SoonerCare members will be reviewed according to the procedures outlined in the Medical Necessity Manual. Ad hoc reviews may be conducted at the discretion of the agency.

- (c) The OHCA will designate the members of the SQR team. The SQR team will consist of one (1) to three (3) team members and will be comprised of LBHPs or registered nurses (RNs).
- (d) The SQR will include, but not be limited to, review of facility and clinical record documentation and may include observation and contact with members. The clinical record review will consist of records of members currently at the facility as well as records of members for which claims have been filed with OHCA for acute, PRFF, or residential SUD levels of care. The SQR includes validation of compliance with policy, which must be met for the services to be compensable.
- (e) Following the SQR, the SQR team will report its findings in writing to the facility. A copy of the final report will be sent to the facility's accrediting agency, as well as the State Survey Agency, if applicable, and any licensing agencies.
- (f) Deficiencies identified during the SQR may result in full or partial recoupment of paid claims. The determination of whether to assess full or partial recoupment shall be at the discretion of the OHCA based on the severity of the deficiencies.
- (g) Any days during which the facility is determined to be out of compliance with Federal Conditions of Participation, excluding residential SUD facilities, or in which a member does not meet medical necessity criteria may result in full recoupment. Full recoupment may also result from a facility's failure to provide requested documentation within the timeframes indicated on requests for such documents or if the SQR team is denied timely admittance to a facility and/or access to facility records during any on-site portion of the SQR.
- (h) Items which may result in full or partial recoupment of paid claims shall include, but not be limited to:
- (1) **Assessments and evaluations.** Assessments and evaluations must be completed, with dated signature(s), by qualified staff within the timeframes outlined in Oklahoma Administrative Code (OAC) 317:30-5-95.6, 317:30-5-95.37, and 317:30-5-95.47(1).
 - (2) **Plan of care.** Plans of care must be completed, with all required dated signatures within the timeframes described in OAC 317:30-5-95.4, 317:30-5-96.33, and 317:30-5-95.47(2).
 - (3) **Certification of need (CON).** CONs for psychiatric facilities must be completed by the appropriate team and in the chart within the timeframes outlined in 42 C.F.R. §§ 441.152, 456.160, and 456.481.
 - (4) **Active treatment.** Treatment must be documented in the chart at the required frequency by appropriately qualified staff as described in OAC 317:30-5-95.5, 317:30-5-95.7, 317:30-5-95.8, 317:30-5-95.9, 317:30-5-95.10, 317:30-5-95.34, and 317:30-5-95.46(b).
 - (5) **Documentation of services.** Services must be documented in accordance with OAC 317:30-5-95.4, 317:30-5-95.5, 317:30-5-95.8, 317:30-5-95.10, 317:30-5-95.41, 317:30-5-95.52 and 317:30-5-95.47 and 42 C.F.R. §§ 412.27(c)(4) and 482.61. Documentation with missing elements or documentation that does not clearly demonstrate the therapeutic appropriateness and benefit of the service may result in recoupment.

(6) **Staffing.** Staffing must meet the ratios described in OAC 317:30-5-95.24(b)-(d) & (h) and OAC 317:30-5-95.38 per unit/per shift; and credentialing requirements as outlined in OAC 317:30-5-95.8, 317:30-5-95.9, 317:30-5-95.35, 317:30-5-95.36, 317:30-5-95.46 (b) and 42 C.F.R. §§ 412.27(d), 441.153, 441.156, and 482.62.

(7) **Restraint/seclusion.** Orders for restraint and seclusion must be completely and thoroughly documented with all required elements as described in OAC 317:30-5-95.39 and 42 C.F.R. § 482.13(e) & (f) and 42 C.F.R. Part 483. Documentation must support the appropriateness and necessity for the use of restraint/seclusion. For PRTFs, documentation must include evidence that staff and resident debriefings occurred as required by OAC 317:30-5-95.39 and 42 C.F.R. Part 483. For residential SUD facilities, restraint may only be used when less restrictive interventions, according to facility policy, have been attempted or when an immediate intervention is required to protect the resident, a staff member, or others. A written incident report must be completed within twenty-four (24) hours following each use of physical restraint.

(i) If the review findings have resulted in a recoupment, the days and/or services involved will be reported in the notification.

(j) In the event that CMS recoups from OHCA an amount that exceeds the provider's liability for findings described in this Section, the provider will not be held harmless and will be required to reimburse OHCA the total federal amount identified by CMS and/or its designated audit contractor, limited to the amount of the original paid claim less any previously recouped amounts.

(k) Penalties of non-compensable days which are the result of the facility's failure to appropriately provide and document the services described herein, or adhere to applicable accreditation, certification, and/or state licensing standards, are not compensable or billable to the member or the member's family.

(l) Facilities that are determined to owe recoupment of paid claims will have the ability to request a reconsideration of the findings. Details and instructions on how to request a reconsideration will be part of the report documentation sent to the facility.

(m) Facilities that are determined by the SQR process to be out of compliance in significant areas will be required to submit a Corrective Action Plan (CAP) detailing steps being taken to bring performance in line with requirements. Facilities that are required to submit a CAP may be further assessed through a formal, targeted post-CAP review process.

[Source: Added at 23 Ok Reg 2508, eff 6-25-06 ; Amended at 24 Ok Reg 2880, eff 7-1-07 (emergency); Amended at 25 Ok Reg 1161, eff 5-25-08 ; Amended at 27 Ok Reg 2737, eff 7-20-10 (emergency); Amended at 28 Ok Reg 1452, eff 6-25-11 ; Amended at 30 Ok Reg 1203, eff 7-1-13 ; Amended at 31 Ok Reg 1713, eff 9-12-14 ; Amended at 32 Ok Reg 1107, eff 8-27-15 ; Amended at 33 Ok Reg 885, eff 9-1-16 ; Amended at 37 Ok Reg 1573, eff 9-14-20 ; Amended at 38 Ok Reg 428, eff 12-18-20 (emergency); Amended at 38 Ok Reg 1023, eff 9-1-21 ; Amended at 40 Ok Reg 2236, eff 9-11-23]

317:30-5-95.43. Residential substance use disorder treatment

(a) **Purpose.** The purpose of sections OAC 317:30-5-95.43 - 317:30-5-95.49 is to establish the procedures and requirements for residential treatment facilities providing SUD treatment services.

(b) **Definitions.** The following words and terms, when used in the aforementioned sections, shall have the following meanings unless the context clearly indicates otherwise.

(1) **"ASAM"** means the American Society of Addiction Medicine.

(2) **"ASAM criteria"** means the most recent edition of the American Society of Addiction Medicine's published criteria for admission to treatment, continued services, and discharge.

(3) **"ASAM levels of care"** means the different options for treatment as described below and in the current edition of the ASAM criteria that vary according to the intensity of the services offered. Each treatment option is a level of care.

(A) **"ASAM level 3"** means residential and inpatient services and encompasses ASAM levels 3.1, 3.3, 3.5 and 3.7.

(B) **"ASAM level 3.1"** means clinically managed low-intensity residential services for adolescents and adults. This level of care typically provides at least five (5) hours of clinical services a week and provides a twenty-four (24) hour living support and structure with trained personnel. The corresponding service description for this level of care is halfway house services.

(C) **"ASAM level 3.3"** means clinically managed population-specific high-intensity residential services. This level of care is for adults only and typically offers twenty-four (24) hour care with trained personnel and is designed to accommodate individuals with cognitive or other impairments. The corresponding service description for this level of care is residential treatment for adults with co-occurring disorders.

(D) **"ASAM level 3.5"** means clinically managed medium-intensity residential services for adolescents and clinically managed high-intensity residential services for adults. This level of care provides twenty-four (24) hour care and offers a wide range of therapeutic services. The corresponding service descriptions for this level of care are residential treatment and intensive residential treatment.

(E) **"ASAM level 3.7"** means medically monitored high-intensity inpatient services for adolescents and medically monitored intensive inpatient withdrawal management for adults. This level of care provides twenty-four (24) hour nursing care with physician supervision and medication availability. This level of care is appropriate for individuals withdrawing from alcohol or other drugs with subacute biomedical and emotional, behavioral, or cognitive problems severe enough to require inpatient treatment but for whom hospitalization is not necessary. The corresponding service description for this level of care is

medically supervised withdrawal management.

(4) **"Care management services"** means an assessment of a member, development of a care plan, and referral and linkage to SUD community supports and community-based or lower level of care services to promote continued recovery after the individual discharges from the treatment facility.

(5) **"Co-occurring disorder (COD)"** means any combination of mental health symptoms and SUD symptoms or diagnoses that affect a member and are typically determined by the Diagnostic and Statistical Manual of Mental Disorders (DSM).

(6) **"DSM"** means the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association.

(7) **"ODMHSAS"** means the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS).

(8) **"Per diem"** means an all-inclusive rate for covered SUD treatment services provided each day during a facility stay.

(9) **"Rehabilitation services"** means face-to-face individual or group services provided by qualified staff to develop skills necessary to perform activities of daily living and successful integration into community life. Rehabilitation services for substance use disorders are also referred to as skill development services.

(10) **"Service plan"** means the document used during the process by which an LBHP or a licensure candidate and the member together and jointly identify and rank problems, establish agreed-upon immediate short-term and long-term goals, and decide on the treatment process and resources to be utilized.

(11) **"Substance use disorder (SUD)"** means alcohol or drug dependence, or psychoactive SUD as defined by the most recent DSM criteria.

(12) **"Therapeutic services"** means professional services during which members engage in identifying, addressing and/or resolving issues identified in the member's service plan.

(13) **"Treatment hours B residential"** means the structured hours in which a member is involved in receiving professional services to assist in achieving recovery.

[Source: Added at 38 Ok Reg 428, eff 12-18-20 (emergency); Added at 38 Ok Reg 1023, eff 9-1-21 ; Amended at 40 Ok Reg 2172, eff 9-11-23]

317:30-5-95.44. Residential substance use disorder (SUD) - Eligible providers and requirements

(a) Eligible providers shall:

(1) Have and maintain current certification from the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) as a residential level of care provider of SUD treatment services, unless exempt from state jurisdiction or an exempted entity as defined in Section 3-415 of Title 43A of the Oklahoma Statutes;

(2) Have a contract with the OHCA;

(3) Have a Certificate of Need, if required by ODMHSAS in accordance with OAC 450:18-17-2 or OAC 450:24-27-2.

(4) Have a current accreditation status appropriate to provide residential behavioral health services from:

(A) The Joint Commission; or

(B) The Commission on Accreditation of Rehabilitative Facilities (CARF); or

(C) The Council on Accreditation (COA).

(b) Providers certified by ODMHSAS as a residential level of care provider of SUD treatment services prior to October 1, 2020 shall have until January 1, 2022 to obtain accreditation as required in (4) above.

(c) Residential treatment facilities providing SUD treatment services to individuals under the age of eighteen (18) must have a residential child care facility license from the Oklahoma Department of Human Services (DHS). Residential treatment facilities providing child care services must have a child care center license from DHS.

[Source: Added at 38 Ok Reg 428, eff 12-18-20 (emergency); Added at 38 Ok Reg 1023, eff 9-1-21]

317:30-5-95.45. Residential substance use disorder (SUD) - Coverage by category

(a) **Adults.** Members age twenty-one (21) to sixty-four (64) who meet eligibility and clinical criteria may receive medically necessary residential treatment for SUD.

(1) The member must meet residential level of care as determined through completion of the designated ASAM placement tool no more than seven (7) days prior to a SUD admission and/or extension request and as required in the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) Prior Authorization Manual.

(2) Each presenting member for SUD treatment shall be assessed, according to ASAM criteria, which includes a list of symptoms for all six (6) dimensions and each level of care to determine a clinically appropriate placement in the least restrictive level of care.

(b) **Children.** Children are covered according to their age group as described in OAC 317:30-5-95.46 and 317:30-5-95.47 and as specified by ODMHSAS.

(c) **Individuals with dependent children.** Coverage for individuals with dependent children is the same as adults and/or children.

[Source: Added at 38 Ok Reg 428, eff 12-18-20 (emergency); Added at 38 Ok Reg 1023, eff 9-1-21 ; Amended at 40 Ok Reg 2236, eff 9-11-23]

317:30-5-95.46. Residential substance use disorder (SUD) - Covered services and medical necessity criteria

(a) In order for the services described in this Section to be covered, individuals shall:

(1) Be diagnosed with an SUD as described in the most recent edition of the DSM; and

(2) Meet residential level of care as determined through completion of the designated ASAM placement tool as required by the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS).

(3) For additional medical necessity criteria, refer to the ODMHSAS Prior Authorization Manual available at <http://www.odmhsas.org/arc.htm>.

(b) Coverage includes the following services:

(1) Clinically managed low intensity residential services (ASAM Level 3.1).

(A) Halfway house services - Individuals age thirteen (13) to seventeen (17).

(i) **Service description.** This service places a major emphasis on continuing SUD care and community ancillary services in an environment supporting continued abstinence. The facility shall have scheduled services to assess and address the individual needs of each member. Services include individual, family, and/or group therapy, individual and/or group rehabilitation services, care management, crisis intervention, and for members age sixteen (16) and older, community recovery support services. Group therapy is limited to a total of six (6) individuals. Rehabilitation services shall not exceed a staffing ratio of eight (8) individuals to one (1) qualified provider.

(ii) **Staffing requirements.** A licensed physician must be available by telephone twenty-four (24) hours a day, seven (7) days a week. A minimum of two (2) direct care and/or clinical staff must be on-site and awake twenty-four (24) hours a day, seven (7) days a week. Staffing ratios shall not exceed those specified in OAC 340:110-3-153.2. All staff who provide treatment services shall meet qualifications in accordance with the Oklahoma Medicaid State Plan and OAC 450:18.

(iii) **Treatment hours.** A minimum of six (6) treatment hours per week shall be provided. A week begins on Sunday and ends on Saturday.

(B) Halfway house services - Individuals age eighteen (18) to sixty-four (64).

(i) **Service description.** This service places a major emphasis on continuing SUD care and community ancillary services in an environment supporting continued abstinence. The facility shall have scheduled services to assess and address the individual needs of each member. Services include individual, family, and/or group therapy, individual and/or group rehabilitation services, care management, crisis intervention, and community recovery support services. Group therapy is limited

to a total of eight (8) individuals. Rehabilitation services shall not exceed a staffing ratio of fourteen (14) individuals to one (1) qualified provider.

(ii) **Staffing requirements.** A licensed physician must be available by telephone twenty-four (24) hours a day, seven (7) days a week. Additional clinical and/or direct care staff must be on-site and awake twenty-four (24) hours a day, seven (7) days a week. All staff who provide treatment services shall meet qualifications in accordance with the Oklahoma Medicaid State Plan and OAC 450:18.

(iii) **Treatment hours.** A minimum of six (6) treatment hours per week shall be provided. A week begins on Sunday and ends on Saturday.

(C) Halfway house services - Individuals with minor dependent children or women who are pregnant.

(i) **Service description.** This service provides a planned regimen of twenty-four (24) hours, seven (7) days a week, supervised living arrangements, to include professionally directed evaluation, care, and treatment. The facility shall have scheduled services to assess and address the individual needs of each member. Services include individual, family, and/or group therapy, individual and/or group rehabilitation services, care management, crisis intervention, and community recovery support services. Group therapy is limited to a total of eight (8) individuals for adults a total of six (6) individuals for children. Rehabilitation services shall not exceed a staffing ratio of fourteen (14) individuals to one (1) qualified provider for adults and eight (8) individuals to one (1) qualified provider for children.

(ii) **Staffing requirements.** A licensed physician must be available by telephone twenty-four (24) hours a day, seven (7) days a week. Additional clinical and/or direct care staff must be on-site twenty-four (24) hours a day, seven (7) days a week. All staff who provide treatment services shall meet qualifications in accordance with the Oklahoma Medicaid State Plan and OAC 450:18.

(iii) **Treatment services for dependent children.** Services are available to the child when provided to address the impacts related to the parent's addiction, including, but not limited to, individual and family therapy. Compliance with separate provider qualifications, in accordance with OAC 317:30-5-240.2, is required for other treatment services provided to dependent children by the residential SUD provider. Provision of such

treatment services shall be provided in accordance with OAC 317:30-5, Part 21.

(iv) **Treatment hours.** A minimum of six (6) treatment hours per week shall be provided to the individual with minor dependent children and women who are pregnant. A week begins on Sunday and ends on Saturday. Dependent children shall be provided treatment services in accordance with the child's service plan if services are provided by the residential SUD provider.

(2) **Clinically managed, population specific, high intensity residential services (ASAM Level 3.3).** This service includes residential treatment for adults with co-occurring disorders.

(A) **Service description.** This service provides a planned regimen of twenty-four (24) hours, seven (7) days a week, structured evaluation, care, and treatment. Daily treatment service shall be provided to assess and address individual needs of the member. Services include individual, family, and group therapy, individual and/or group rehabilitation services, crisis intervention, care management, and community recovery support services. Psychiatric and/or psychological and/or mental health evaluations shall be completed on all members. In addition to the requirements in OAC 317:30-5-95.47, the service plan shall address the member's mental health needs and medications. The member's medications shall be re-assessed a minimum of once every thirty (30) days and monitoring of medications shall be provided. Group therapy is limited to a total of eight (8) individuals. Rehabilitation services shall not exceed a staffing ratio of fourteen (14) individuals to one (1) qualified provider. Treatment services must address both mental health and SUD needs as identified in the service plan.

(B) **Staffing requirements.** A licensed psychiatrist must be available by telephone twenty-four (24) hours a day, seven (7) days a week. Additional staff must be on-site twenty-four (24) hours a day, seven (7) days a week. All staff who provide treatment services shall meet qualifications in accordance with the Oklahoma Medicaid State Plan and OAC 450:18.

(C) **Treatment hours.** A weekly minimum of twenty-four (24) service hours shall be provided, which shall include a minimum of one (1) hour of individual, group, or family therapy and a minimum of seven (7) hours of individual or group rehabilitation services. A week begins on Sunday and ends on Saturday. A maximum of seven (7) hours per week of community (peer) recovery support services may count toward the weekly required treatment hours.

(3) **Clinically managed medium and high intensity (ASAM Level 3.5).**

(A) Residential treatment, medium intensity - individuals age thirteen (13) to seventeen (17).

(i) **Service description.** This service provides a planned regimen of twenty-four (24) hours / seven (7) day a week, professionally directed evaluation, care, and treatment. A multidisciplinary team approach shall be utilized in providing daily treatment services to assess and address the individual needs of each member, including individual, family, and/or group therapy, individual and/or group rehabilitation services, care management, crisis intervention, and, for members age sixteen (16) or older, community recovery support services. Group therapy is limited to a total of six (6) individuals. Rehabilitation services shall not exceed a staffing ratio of eight (8) individuals to one (1) qualified provider.

(ii) **Staffing requirements.** A licensed physician must be available by telephone twenty-four (24) hours a day, seven (7) days a week. A minimum of two (2) direct care and/or clinical staff must be on-site and awake twenty-four (24) hours a day, seven (7) days a week. Staffing ratios shall not exceed those specified in OAC 340:110-3-153.2. All staff who provide treatment services shall meet qualifications in accordance with the Oklahoma Medicaid State Plan and OAC 450:18.

(iii) **Treatment hours.** A weekly minimum of fifteen (15) treatment hours for members attending academic training and twenty-four (24) treatment hours for members not attending academic training shall be provided. Weekly treatment hours shall include a minimum of one (1) hour of individual, family and/or group therapy and a minimum of seven (7) hours of individual or group rehabilitation services. A maximum of seven (7) hours per week of community (peer) recovery support services may count toward the weekly required treatment hours. A week begins on Sunday and ends on Saturday.

(B) Residential treatment, high intensity - adults.

(i) **Service description.** This service provides a planned regimen of twenty-four (24) hours / seven (7) day a week, professionally directed evaluation, care, and treatment. Daily treatment service shall be provided to assess and address individual needs of each member. Services include individual, family, and/or group therapy, individual and/or group rehabilitation services, crisis intervention, care management, and community recovery support services. Group therapy is limited to a total of eight

(8) individuals. Rehabilitation services shall not exceed a staffing ratio of fourteen (14) individuals to one (1) qualified provider.

(ii) **Staffing requirements.** A licensed physician must be available by telephone twenty-four (24) hours a day, seven (7) days a week. Additional clinical and/or direct care staff must be on-site twenty-four (24) hours a day, seven (7) days a week. All staff who provide treatment services shall meet qualifications in accordance with the Oklahoma Medicaid State Plan and OAC 450:18.

(iii) **Treatment hours.** A weekly minimum of twenty-four (24) service hours shall be provided, which shall include a minimum of one (1) hour of individual, family, and/or group therapy and a minimum of seven (7) hours of individual or group rehabilitation services. A maximum of seven (7) hours per week of community (peer) recovery support services may count toward the weekly required treatment hours. A week begins on Sunday and ends on Saturday.

(C) Intensive residential treatment, high intensity - adults.

(i) **Service description.** This service provides a planned regimen of twenty-four (24) hours / seven (7) day a week, professionally directed evaluation, care, and treatment. Daily treatment service shall be provided to assess and address individual needs of each member. Services include individual, family, and/or group therapy, individual and/or group rehabilitation services, crisis intervention, care management, and community recovery support services. Group therapy is limited to a total of eight (8) individuals. Rehabilitation services shall not exceed a staffing ratio of fourteen (14) individuals to one (1) qualified provider.

(ii) **Staffing requirements.** A licensed psychiatrist must be available by telephone twenty-four (24) hours a day, seven (7) days a week. Additional clinical and/or direct care staff must be on-site twenty-four (24) hours a day, seven (7) days a week. All staff who provide treatment services shall meet qualifications in accordance with the Oklahoma Medicaid State Plan and OAC 450:18.

(iii) **Treatment hours.** A weekly minimum of thirty-seven (37) service hours shall be provided, which shall include a minimum of four (4) hours of individual, family, and/or group therapy and a minimum of seven (7) hours of individual or group rehabilitation services. A maximum of eleven (11) hours per week of community (peer) recovery

support services may count toward the weekly required treatment hours. A week begins on Sunday and ends on Saturday.

(D) Intensive residential treatment, high intensity - individuals age thirteen (13) to seventeen (17).

(i) **Service description.** This service provides a planned regimen of twenty-four (24) hours / seven (7) day a week, professionally directed evaluation, care, and treatment. Daily treatment service shall be provided to assess and address individual needs of each member. Services include individual, family, and/or therapy, individual and/or group rehabilitation services, crisis intervention, care management, and, for members age sixteen (16) or older, community recovery support services. Group therapy is limited to a total of six (6) individuals. Rehabilitation services shall not exceed a staffing ratio of eight (8) individuals to one (1) qualified provider.

(ii) **Staffing requirements.** A licensed psychiatrist must be available by telephone twenty-four (24) hours a day, seven (7) days a week. Additional clinical and/or direct care staff must be on-site twenty-four (24) hours a day, seven (7) days a week. Staffing ratios shall not exceed those specified in OAC 340:110-3-153.2. All staff who provide treatment services shall meet qualifications in accordance with the Oklahoma Medicaid State Plan and OAC 450:18.

(iii) **Treatment hours.** A weekly minimum of thirty-seven (37) service hours shall be provided, which shall include a minimum of four (4) hours of individual, family, or group therapy and a minimum of seven (7) hours of individual or group rehabilitation services. A maximum of eleven (11) hours per week of community (peer) recovery support services may count toward the weekly required treatment hours. A week begins on Sunday and ends on Saturday.

(E) Residential treatment for individuals with minor dependent children and women who are pregnant.

(i) **Service description.** This service provides a planned regimen of twenty-four (24) hours / seven (7) day a week, professionally directed evaluation, care, and treatment. The facility shall provide SUD treatment services to assess and address individual needs of each member. Services include individual, family, and/or group therapy, individual and/or group rehabilitation services, crisis intervention, care management, and community recovery support services. Group therapy is limited to a total

of eight (8) individuals for adults a total of six (6) individuals for children. Rehabilitation services shall not exceed a staffing ratio of fourteen (14) individuals to one (1) qualified provider for adults and eight (8) individuals to one (1) qualified provider for children.

(ii) **Staffing requirements.** A licensed physician must be available by telephone twenty-four (24) hours a day, seven (7) days a week. Additional staff must be on-site twenty-four (24) hours a day, seven (7) days a week. All staff who provide treatment services shall meet qualifications in accordance with the Oklahoma Medicaid State Plan and OAC 450:18.

(iii) **Treatment services for dependent children.** Services are available to the child when provided to address the impacts related to the parent's addiction, including but not limited to individual and family therapy. Compliance with separate provider qualifications, in accordance with OAC 317:30-5-240.2, is required for other treatment services provided to dependent children by the residential SUD provider. Provision of such treatment services shall be provided in accordance with OAC 317:30-5, Part 21.

(iv) **Treatment hours.** A minimum of twenty-four (24) service hours shall be provided to the individual with minor dependent children and women who are pregnant. Treatment hours shall include a minimum of one (1) hour of individual, family, and/or group therapy and a minimum of seven (7) hours of individual or group rehabilitation services. A maximum of seven (7) hours per week of community (peer) recovery support services may count toward the weekly required treatment hours. A week begins on Sunday and ends on Saturday. Dependent children shall be provided treatment services in accordance with the child's service plan if services are provided by the residential SUD provider.

(F) Intensive residential treatment for individuals with dependent children and women who are pregnant.

(i) **Service description.** This service provides a planned regimen of twenty-four (24) hours / seven (7) day a week, professionally directed evaluation, care, and treatment. The facility shall provide SUD treatment services to assess and address individual needs of each member. Services include individual, family, and/or group therapy, individual and/or group rehabilitation services, crisis intervention,

care management, and community recovery support services. Group therapy is limited to a total of eight (8) individuals for adults a total of six (6) individuals for children. Rehabilitation services shall not exceed a staffing ratio of fourteen (14) individuals to one (1) qualified provider for adults and eight (8) individuals to one (1) qualified provider for children.

(ii) **Staffing requirements.** A licensed psychiatrist must be available by telephone twenty-four (24) hours a day, seven (7) days a week. Additional clinical and/or direct care staff must be on-site twenty-four (24) hours a day, seven (7) days a week. All staff who provide treatment services shall meet qualifications in accordance with the Oklahoma Medicaid State Plan and OAC 450:18.

(iii) **Treatment services for dependent children.** Services are available to the child when provided to address the impacts related to the parent's addiction, including but not limited to individual and family therapy. Compliance with separate provider qualifications, in accordance with OAC 317:30-5-240.2, is required for other treatment services provided to dependent children by the residential SUD provider. Provision of such treatment services shall be provided in accordance with OAC 317:30-5, Part 21.

(iv) **Treatment hours.** A weekly minimum of thirty-five (35) service hours shall be provided to the individual with minor dependent children and women who are pregnant. Treatment hours shall include a minimum of four (4) hours of individual, family, and/or group therapy and a minimum of seven (7) hours of individual and/or group rehabilitation services. A maximum of eleven (11) hours per week of community (peer) recovery support services may count toward the weekly required treatment hours. A week begins on Sunday and ends on Saturday. Dependent children shall be provided treatment services in accordance with the child's service plan if services are provided by the residential SUD provider.

(4) Medically monitored high intensity withdrawal management (ASAM Level 3.7).

(A) Medically supervised withdrawal management - individuals age thirteen (13) to seventeen (17).

(i) **Service description and requirements.** This service is provided under the direction of a licensed physician and a licensed registered nurse supervisor, for members who are withdrawing or are intoxicated from alcohol or other drugs.

Members shall be assessed as currently experiencing no apparent medical or neurological symptoms that would require hospitalization. Daily SUD withdrawal management treatment services shall be provided, which include, but are not limited to, taking of vital signs (temperature, pulse, respiration rate, blood pressure), documentation of fluid and food intake a minimum of one (1) time every six (6) hours or more often as indicated by the member's condition. Medications shall be prescribed if needed during withdrawal management. The medications are to include those needed for physical health issues and mental impairment if acquired during the withdrawal process.

(ii) **Staffing requirements.** A licensed physician providing supervision of withdrawal management must be available on site or on call twenty-four (24) hours a day, seven (7) days a week. A licensed nurse must provide twenty-four (24) hours a day, seven (7) days a week monitoring and statutorily approved personnel administer medication. A minimum of two (2) medical and/or clinical/direct care staff must be on-site and awake twenty-four (24) hours a day, seven (7) days a week. Staffing ratios shall not exceed those specified in OAC 340:110-3-153.2.

(B) Medically supervised withdrawal management - adults.

(i) **Service description and requirements.** This service is provided under the direction of a licensed physician and a licensed registered nurse supervisor, for members who are withdrawing or are intoxicated from alcohol or other drugs. Members shall be assessed as currently experiencing no apparent medical or neurological symptoms that would require hospitalization. Daily SUD withdrawal management treatment services shall be provided, which include, but are not limited to, taking of vital signs (temperature, pulse, respiration rate, blood pressure), documentation of fluid and food intake a minimum of one (1) time every six (6) hours or more often as indicated by the member's condition. Medications prescribed if needed during withdrawal management. The medications are to include those needed for physical health issues and mental impairment if acquired during the withdrawal process.

(ii) **Staffing requirements.** A licensed physician providing supervision of withdrawal management must be available on site or on call twenty-four (24)

hours a day, seven (7) days a week. A licensed nurse must provide twenty-four (24) hours a day, seven (7) days a week monitoring and statutorily approved personnel administer medication.

[Source: Added at 38 Ok Reg 428, eff 12-18-20 (emergency); Added at 38 Ok Reg 1023, eff 9-1-21 ; Amended at 40 Ok Reg 2236, eff 9-11-23]

317:30-5-95.47. Residential substance use disorder (SUD) - Individualized service plan requirements

All SUD services provided in residential treatment facilities are rendered as a result of an individual assessment of the member's needs and documented in the service plan.

(1) **Assessment.** A biopsychosocial assessment shall be completed for members receiving ASAM Level 3.1, 3.3, or 3.5 services, including dependent children receiving services from the residential SUD provider, to gather sufficient information to assist the member in developing an individualized service plan. The assessment must also list a diagnosis that corresponds to current Diagnostic and Statistical Manual of Mental Disorders (DSM) standards and the member's past and current psychiatric medications. The assessment must be completed by an LBHP or licensure candidate. Licensure candidate signatures must be co-signed by a fully-licensed LBHP in good standing. Assessments for ASAM Level 3.7 services shall be completed in accordance with (E) below.

(A) **Assessments for adolescents.** A biopsychosocial assessment using the Teen Addiction Severity Index (T-ASI) shall be completed. A physical examination shall be conducted by a licensed physician to include, at a minimum, a physical assessment, health history, immunization status, and evaluation of motor development and function, speech, hearing, visual, and language functioning.

(B) **Assessments for adults.** A biopsychosocial assessment using the Addiction Severity Index (ASI) shall be completed.

(C) **Assessments for dependent children.** Assessment of children (including infants) accompanying their parent into treatment and receiving services from the residential SUD provider shall include the following items:

- (i) Parent-child relationship;
- (ii) Physical and psychological development;
- (iii) Educational needs;
- (iv) Parent related issues; and
- (v) Family issues related to the child.

(D) **Assessments for parents/pregnant women.** Assessment of the parent and/or pregnant women bringing their children into treatment shall include the following items:

- (i) Parenting skills;

- (ii) Knowledge of age appropriate behaviors;
- (iii) Parental coping skills;
- (iv) Personal issues related to parenting; and
- (v) Family issues as related to the child.

(E) **Assessments for medically supervised withdrawal management.** In accordance with OAC 450:18-13-61, a medical assessment for the appropriateness of placement shall be completed and documented by a licensed physician during the admission process. The assessment shall provide a diagnosis that corresponds to current DSM standards.

(F) **Assessment timeframes.** Biopsychosocial assessments shall be completed within two (2) days of admission or during the admission process for medically supervised withdrawal management.

(2) **Service plan.** Pursuant to OAC 450:18-7-81, a service plan shall be completed for each member receiving ASAM Level 3.1, 3.3, or 3.5 services, including dependent children receiving services from the residential SUD provider. The service plan is performed with the active participation of the member and a support person or advocate, if requested by the member. In the case of children under the age of sixteen (16), it is performed with the participation of the parent or guardian, if allowed by law, and the child as age and developmentally appropriate. Service plans for ASAM Level 3.7 services shall be developed in accordance with (D) below.

(A) **Service plan development.** The service plan shall:

- (i) Be completed by an LBHP or licensure candidate. Licensure candidate signatures must be co-signed by a fully-licensed LBHP in good standing.
- (ii) Provide the formation of measurable service objectives and reflect ongoing changes in goals and objectives based upon member's progress or preference or the identification of new needs, challenges, and problems.
- (iii) Be developed after and based on information obtained in the assessment and includes the evaluation of the assessment information by the clinician and the member.
- (iv) Have an overall general focus on recovery which, for adults, may include goals like employment, independent living, volunteer work, or training, and for children, may include areas like school and educational concerns and assisting the family in caring for the child in the least restrictive level of care.

(B) **Service plan content.** Service plans must include dated signatures for the member [if age fourteen (14) or older], the parent/guardian (if required by law), and the LBHP or licensure candidate. Licensure candidate

signatures must be co-signed by a fully-licensed LBHP in good standing. If the member is eligible to self-consent to treatment pursuant to state law, a parent/guardian signature is not required. Signatures must be obtained after the service plan is completed. The contents of a service plan shall address the following:

- (i) Member strengths, needs, abilities, and preferences;
- (ii) Identified presenting challenges, needs, and diagnosis;
- (iii) Goals for treatment with specific, measurable, attainable, realistic, and time-limited objectives;
- (iv) Type and frequency of services to be provided;
- (v) Description of member's involvement in, and response to, the service plan;
- (vi) The service provider who will be rendering the services identified in the service plan; and
- (vii) Discharge criteria that are individualized for each member and beyond that which may be stated in the ASAM criteria.

(C) **Service plan updates.** Service plan updates shall occur a minimum of once every thirty (30) days while services are provided. Service plan updates must include dated signatures for the member [if age fourteen (14) or older], the parent/guardian (if required by law), and the LBHP or licensure candidate. Licensure candidate signatures must be co-signed by a fully-licensed LBHP in good standing. If the member is eligible to self-consent to treatment pursuant to state law, a parent/guardian signature is not required. Signatures must be obtained after the service plan is completed. Service plan updates shall address the following:

- (i) Progress on previous service plan goals and/or objectives;
- (ii) A statement documenting a review of the current service plan and an explanation if no changes are to be made to the service plan;
- (iii) Change in goals and/or objectives based upon member's progress or identification of new needs and challenges;
- (iv) Change in frequency and/or type of services provided;
- (v) Change in staff who will be responsible for providing services on the plan; and
- (vi) Change in discharge criteria.

(D) **Service plans for medically supervised withdrawal management.** Pursuant to OAC 450:18-7-84, a service plan shall be completed for each member receiving ASAM Level 3.7 services that addresses the medical stabilization treatment and services needs of the member. Service plans shall be completed by a licensed physician or

licensed registered nursing staff and must include a dated signature of the member [if age fourteen (14) or older], the parent/guardian (if required by law), and the primary service practitioner. The service plan shall provide a diagnosis that corresponds to current DSM standards.

(E) **Service plan timeframes.** Service plans shall be completed within four (4) days of admission, except for service plans for individuals receiving medically supervised withdrawal management services, which must be completed within three (3) hours of admission.

(3) **Progress notes.** Progress notes shall chronologically describe the services provided, the member's response to the services provided, and the member's progress in treatment.

(A) **Content.** Progress notes shall address the following:

- (i) Date;
- (ii) Member's name;
- (iii) Start and stop time for each timed treatment session or service;
- (iv) Dated signature of the service provider;
- (v) Credentials of the service provider;
- (vi) Specific service plan needs, goals and/or objectives addressed;
- (vii) Services provided to address needs, goals, and/or objectives;
- (viii) Progress or barriers to progress made in treatment as it relates to the goals and/or objectives;
- (ix) Member (and family, when applicable) response to the session or service provided; and
- (x) Any new needs, goals and/or objectives identified during the session or service.

(B) **Frequency.** Progress notes shall be completed in accordance with the following timeframes:

- (i) Progress notes for therapy, crisis intervention and care management must be documented in an individual note and reflect the content of each session provided.
- (ii) Documentation for rehabilitation and community recovery support services must include daily member sign-in/sign-out record of member attendance (including date, time, type of service and service focus), and a daily progress note or a summary progress note weekly.

(4) **Transition/discharge planning.** All facilities shall assess each member for appropriateness of discharge from a treatment program. Each member shall be assessed using the ASAM placement tool to determine a clinically appropriate setting in the least restrictive level of care.

(A) **Transition/discharge plans.** Transition/discharge plans shall be developed with the knowledge and cooperation of the member. The transition/discharge plan

shall be included in the discharge summary. The discharge plan is to include, at a minimum, recommendations for continued treatment services and other appropriate community resources. Appointments for outpatient therapy and other services, as applicable, should be scheduled prior to discharge from residential care. Development of the transition/discharge plan shall begin no later than two (2) weeks after admission.

(B) **Discharge summary.** The discharge summary shall document the member's progress made in treatment and response to services rendered. A completed discharge summary shall be entered in each member's record within fifteen (15) days of the member completing, transferring, or discontinuing services. The summary must be signed and dated by the staff member completing the summary.

[Source: Added at 38 Ok Reg 428, eff 12-18-20 (emergency); Added at 38 Ok Reg 1023, eff 9-1-21 ; Amended at 40 Ok Reg 2236, eff 9-11-23]

317:30-5-95.48. Staff training

(a) All clinical and direct care staff shall have non-physical intervention training in techniques and philosophies addressing appropriate non-violent interventions for potentially physical interpersonal conflicts, staff attitudes which promote dignity and enhanced self-esteem, keys to effective communication skills, verbal and non-verbal interaction and non-violent intervention within thirty (30) days of being hired with updates each calendar year thereafter.

(b) All staff shall receive training in accordance with OAC 450:18-9-3(f).

[Source: Added at 38 Ok Reg 428, eff 12-18-20 (emergency); Added at 38 Ok Reg 1023, eff 9-1-21]

317:30-5-95.49. Medication policies and records

(a) The facility shall have policies in place addressing the safe storage, handling, and administration of medications.

(b) Medication records shall be maintained in accordance with OAC 450:18-7-144.

[Source: Added at 38 Ok Reg 428, eff 12-18-20 (emergency); Added at 38 Ok Reg 1023, eff 9-1-21]

317:30-5-95.5. Physician review of prescribed medications for adults age 21 to 64

All prescribed medications for adults age 21 to 64 must be reviewed by the physician at least every seven days; the review must be documented in the member's medical record by the physician signing his/her name and title and dating the orders.

[Source: Added at 23 Ok Reg 2508, eff 6-25-06 ; Amended at 27 Ok Reg 2737, eff 7-20-10 (emergency); Amended at 28 Ok Reg 1452, eff 6-25-11]

317:30-5-95.50. Residential substance use disorder (SUD) - Reimbursement

(a) In order to be eligible for payment, residential treatment providers of SUD treatment services must have an approved provider agreement on file with the OHCA. Through this agreement, the residential provider assures that they are in compliance with all applicable federal and State Medicaid law and regulations, including, but not limited to, OHCA administrative rules, ODMHSAS administrative rules, and the Oklahoma Medicaid State Plan.

(b) Covered SUD treatment services for adolescents and adults in SUD residential treatment shall be reimbursed utilizing the per diem rates for each level of care. All SUD residential treatment services must be prior authorized by the OHCA or its designated agent before the service is rendered by an eligible provider. Without prior authorization, payment is not authorized.

(c) Separate payment may be made for medications, physician services, and treatment services provided to dependent children in accordance with the Oklahoma Medicaid State Plan. Separate payment for such services will follow existing prior authorization requirements, if applicable.

(d) Treatment services for dependent children accompanying a parent to treatment shall be reimbursed on a fee-for-service basis in accordance with the Oklahoma Medicaid State Plan. Outpatient services rendered to dependent children may be provided by the residential facility if appropriately certified or a separate outpatient provider. Such services shall not duplicate any services provided by the residential provider that are reimbursed through the residential per diem rate.

(e) The following services are excluded from coverage/reimbursement:

- (1) Room and board;
- (2) Services or components that are not provided to or exclusively for the treatment of the member;
- (3) Services or components of services of which the basic nature is to supplant housekeeping or basic services for the convenience of a member receiving covered services;
- (4) Physician directed services and medications (these services are reimbursed outside of the residential SUD per diem);
- (5) Telephone calls or other electronic contacts (not inclusive of telehealth); and
- (6) Field trips, social, or physical exercise activity groups.

[Source: Added at 38 Ok Reg 1023, eff 9-1-21 ; Amended at 40 Ok Reg 2172, eff 9-11-23]

317:30-5-95.51. Residential substance use disorder (SUD) - reporting of suspected child abuse/neglect

Instances of child abuse and/or neglect are to be reported in accordance with state law, including, but not limited to, Section (§) 1-2-101 of Title 10A of the Oklahoma Statutes and 43A O.S. § 10-104. Any person suspecting child abuse or neglect shall immediately report it to the Oklahoma Department of Human Services (OKDHS) hotline, at 1-800-522-3511; any person suspecting abuse, neglect, or exploitation of a

vulnerable adult shall immediately report it to the local DHS County Office, municipal or county law enforcement authorities, or, if the report occurs after normal business hours, the OKDHS hotline. Health care professionals who are requested to report incidents of domestic abuse by adult victims with legal capacity shall promptly make a report to the nearest law enforcement agency, per 22 O.S. § 58.

[Source: Added at 40 Ok Reg 2236, eff 9-11-23]

317:30-5-95.52. Documentation of records for adults receiving inpatient services

(a) All documentation for services provided under active treatment must be documented in an individual note and reflect the content of each session provided. Services documentation must include, at a minimum, the following:

- (1) Date;
- (2) Start and stop time for each session;
- (3) Dated signature of the therapist and/or staff that provided the service;
- (4) Credentials of the therapist;
- (5) Specific problem(s) addressed (problems must be identified on the plan of care);
- (6) Method(s) used to address problems;
- (7) Progress made towards goals;
- (8) Member's response to the session or intervention; and
- (9) Any new problem(s) identified during the session.

(b) Signatures of the member, legal guardian (if applicable), physician, LBHP, and registered nurse (RN) are required on the individual plan of care (IPC) and all plan of care reviews. The IPC and plan of care review are not valid until signed and separately dated by the member, legal guardian (if applicable), physician, RN, LBHP, and all other requirements are met. All treatment team staff providing therapy services must sign the IPC and all plan of care reviews. All plans of care and plan of care reviews must be signed by the member upon completion, except when a member is too physically ill, or the member's acuity level precludes him/her from signing. If the member is too physically ill or the member's acuity level precludes him/her from signing the plan of care and/or the plan of care review at the time of completion, the member must sign the plan when his/her condition improves but before discharge.

Documentation should indicate the reason the member was unable to sign and when the next review will occur to obtain the signature.

(c) Candidates for licensure for licensed professional counselor, social work (clinical specialty only), licensed marital and family therapist, licensed behavioral practitioner, licensed alcohol and drug counselor, and psychology (mental health specialty only) can provide assessments, psychosocial evaluations, individual therapy, family therapy, and process group therapy as long as they are involved in supervision that complies with their respective, approved licensing regulations and licensing boards. Additionally, their work must be co-signed and dated by a fully-licensed LBHP in good standing, who is a member on the treatment

team. Individuals who have met their supervision requirements and are waiting to be licensed in one (1) of the areas of practice in OAC 317:30-5-240.3(a)(2) must have their work co-signed by a fully-licensed LBHP in good standing, who is a member on the treatment team. All co-signatures by fully-licensed LBHPs in good standing, must be accompanied by the date that the co-signature was made. Documentation of the service is not considered complete until it is signed and dated by a fully-licensed LBHP in good standing.

[Source: Added at 40 Ok Reg 2236, eff 9-11-23]

317:30-5-95.6. Medical, psychiatric, and social evaluations for adults aged twenty-one (21) to sixty-four (64)

The record for an adult member aged twenty-one (21) to sixty-four (64) must contain complete medical, psychiatric, and social evaluations.

(1) The evaluations must be completed as follows:

(A) History and physical must be completed within twenty-four (24) hours of admission by a licensed independent practitioner [Allopathic Doctor, Osteopathic Doctor, Advanced Practice Registered Nurse (APRN), or Physician Assistant (PA)].

(B) Psychiatric evaluation must be completed within sixty (60) hours of admission by an Allopathic or Osteopathic Physician with a current license and a board certification/eligible in psychiatry, an APRN with a psychiatric certification or a PA.

(C) Psychosocial evaluation must be completed within seventy-two (72) hours of admission by a licensed independent practitioner (Allopathic Doctor, Osteopathic Doctor, APRN, or PA), an LBHP, or a licensure candidate as defined in OAC 317:30-5-240.3.

(2) The evaluations must be clearly identified as such and must be signed and dated by the evaluator.

[Source: Added at 23 Ok Reg 2508, eff 6-25-06 ; Amended at 27 Ok Reg 2737, eff 7-20-10 (emergency); Amended at 28 Ok Reg 1452, eff 6-25-11 ; Amended at 32 Ok Reg 1107, eff 8-27-15 ; Amended at 35 Ok Reg 1428, eff 9-14-18 ; Amended at 40 Ok Reg 373, eff 11-4-22 (emergency); Amended at 40 Ok Reg 2245, eff 9-11-23]

317:30-5-95.7. Active treatment for adults age 21 to 64

Active treatment must be provided to each adult member age 21 to 64. The active treatment program must be appropriate to the needs of the member and be directed toward restoring and maintaining optimal levels of physical and psychiatric-social functioning. The services and individual plan of care must be recovery focused, trauma informed, and specific to culture, age and gender.

[Source: Added at 23 Ok Reg 2508, eff 6-25-06 ; Amended at 24 Ok Reg 2880, eff 7-1-07 (emergency); Amended at 25 Ok Reg 1161, eff 5-25-08]

317:30-5-95.8. Nursing services for adults age 21 to 64

Each facility providing nursing services to adults age 21 to 64 must have a qualified Director of Psychiatric Nursing. In addition to the Director of Nursing, there must be adequate numbers of registered nurses, licensed practical nurses, and mental health workers to provide nursing care necessary under the active treatment program and to maintain progress notes on each member. A registered nurse must document member progress at least weekly. The progress notes must contain recommendations for revisions in the treatment plan, as needed, as well as an assessment of the member's progress as it relates to the treatment plan goals and objectives.

[Source: Added at 23 Ok Reg 2508, eff 6-25-06 ; Amended at 27 Ok Reg 2737, eff 7-20-10 (emergency); Amended at 28 Ok Reg 1452, eff 6-25-11]

317:30-5-95.9. Therapeutic services for adults aged 21 to 64

An interdisciplinary team of a physician, licensed behavioral health professional(s) (LBHP), Registered Nurse, and other staff who provide services to adult members aged twenty-one (21) to sixty-four (64) in the facility oversee all components of the active treatment and provide services appropriate to each team member's respective discipline. The team developing the individual plan of care must include, at a minimum, the following:

- (1) Allopathic or Osteopathic Physician with a current license and a board certification/eligible in psychiatry, or a current resident in psychiatry practicing as described in OAC 317:30-5-2(a)(1)(U);
and
- (2) An LBHP licensed to practice by one of the boards in (A) through (F):
 - (A) Psychology (health service specialty only);
 - (B) Social Work (clinical specialty only);
 - (C) Licensed Professional Counselor;
 - (D) Licensed Behavioral Practitioner;
 - (E) Licensed Marital and Family Therapist;
 - (F) Licensed Alcohol and Drug Counselor; or
 - (G) Advanced Practice Registered Nurse (APRN) (certified in a psychiatric mental health specialty, licensed as a Registered Nurse with a current certification of recognition from the Board of Nursing in the state in which the services are provided);
- (3) Under the supervision of an LBHP, a licensure candidate actively and regularly receiving board approved supervision to become licensed by one of the boards in A through F above, and extended supervision if the board's supervision requirement is met but the individual is not yet licensed, may be a part of the team; and
- (4) A Registered Nurse with a minimum of two (2) years of experience in a mental health treatment setting.

[Source: Added at 23 Ok Reg 2508, eff 6-25-06 ; Amended at 27 Ok Reg 2737, eff 7-20-10 (emergency); Amended at 28 Ok Reg 1452, eff 6-25-11 ; Amended at 32 Ok Reg 1109, eff 8-27-15 ; Amended at 35 Ok Reg 1428, eff 9-14-18]

317:30-5-96. Reimbursement for inpatient services [REVOKED]

[Source: Added at 17 Ok Reg 3469, eff 8-01-00 (emergency); Added at 18 Ok Reg 1130, eff 5-11-01 ; Amended at 19 Ok Reg 2762, eff 4-30-02 (emergency); Amended at 20 Ok Reg 1193, eff 5-27-03 ; Amended at 22 Ok Reg 404, eff 12-1-04 (emergency); Amended at 21 Ok Reg 2486, eff 7-11-05 ; Revoked at 23 Ok Reg 2508, eff 6-25-06]

317:30-5-96.1. Cost reports [REVOKED]

[Source: Added at 17 Ok Reg 3469, eff 8-01-00 (emergency); Added at 18 Ok Reg 1130, eff 5-11-01 ; Revoked at 23 Ok Reg 2508, eff 6-25-06]

317:30-5-96.2. Payments definitions

The following words and terms, when used in OAC 317:30-5-96.3 through 317:30-5-96.7, shall have the following meaning, unless the context clearly indicates otherwise:

"Add-on payment" means an additional payment added to the per diem to recognize the increased cost of serving members with complex needs in a PRTF or Acute II.

"Allowable costs" means costs necessary for the efficient delivery of member care.

"Ancillary services" means the services for which charges are customarily made in addition to routine services. Ancillary services include, but are not limited to, physical therapy, speech therapy, laboratory, radiology, and prescription drugs.

"Border status" means a placement in a state that does not border Oklahoma. Reimbursement for out-of-state services is made in accordance with OAC 317:30-3-89 through 317:30-3-92 and the Oklahoma Medicaid State Plan.

"Developmentally disabled child" means a child with deficits in adaptive behavior originating during the developmental period. This condition may exist concurrently with a significantly subaverage general intellectual functioning.

"Eating disorder programs" means acute or intensive residential behavioral, psychiatric, and medical services provided in a discreet unit to individuals experiencing an eating disorder.

"Professional services" means services of a physician, psychologist, or dentist legally authorized to practice medicine and/or surgery by the state in which the function is performed.

"Routine services" means services that are considered routine in the Acute II and PRTF levels of care setting. Routine services include, but are not limited to:

- (A) Room and board;
- (B) Treatment program components;
- (C) Psychiatric treatment;
- (D) Professional consultation;
- (E) Medical management;
- (F) Crisis intervention;
- (G) Transportation;
- (H) Rehabilitative services;
- (I) Case management;

- (J) Interpreter services (if applicable);
- (K) Routine health care for individuals in good physical health; and
- (L) Laboratory services for a substance abuse/detoxification program.

"Specialty treatment program/specialty unit" means Acute or other intensive behavioral, psychiatric, and medical services that provide care to a population with special needs or issues such as developmentally disabled, intellectually disabled, autistic/Asperger's, eating disorders, sexual offenders, or reactive attachment disorders. These members require a higher level of care and staffing ratio than a standard PRTF and typically have multiple problems.

"Treatment program components" means therapies, activities of daily living, and rehabilitative services furnished by physician/psychologist or other licensed mental health professionals.

"Usual and customary charges" means the uniform charges listed in a provider's established charge schedule which is in effect and applied consistently to most members and recognized for program reimbursement. To be considered "customary" for reimbursement, a provider's charges for like services must be imposed on most members regardless of the type of member treated or the party responsible for payment of such services.

[Source: Added at 23 Ok Reg 2508, eff 6-25-06 ; Amended at 24 Ok Reg 678, eff 2-1-07 (emergency); Amended at 24 Ok Reg 2113, eff 6-25-07 ; Amended at 24 Ok Reg 2880, eff 7-1-07 (emergency); Amended at 25 Ok Reg 1161, eff 5-25-08 ; Amended at 27 Ok Reg 2737, eff 7-20-10 (emergency); Amended at 28 Ok Reg 1452, eff 6-25-11 ; Amended at 29 Ok Reg 1076, eff 6-25-12 ; Amended at 37 Ok Reg 1573, eff 9-14-20]

317:30-5-96.3. Methods of payment

(a) Reimbursement.

(1) Covered inpatient psychiatric chemical dependency detoxification/withdrawal management services will be reimbursed using one (1) of the following methodologies:

- (A) Diagnosis related group (DRG);
- (B) Cost-based; or
- (C) A predetermined per diem payment.

(2) For members twenty-one (21) to sixty-four (64) years of age, payment shall not be made for any inpatient psychiatric episodes over sixty (60) days in a facility that qualifies as an IMD.

(b) Levels of care.

(1) Acute.

(A) Payment will be made to psychiatric units within general medical surgical hospitals and critical access hospitals utilizing a DRG methodology. [See OAC 317:30-5-41]. Psychiatric professional (physicians and psychologists) services provided in conjunction with the inpatient stay are separately payable from the DRG paid to the hospital;

(B) Payment will be made to psychiatric hospitals utilizing a predetermined statewide per diem payment for all facility services provided during the inpatient stay.

Psychiatric professional (physicians and psychologists) services provided in conjunction with the inpatient stay are separately payable from the per diem paid to the hospital. Rates vary for public and private providers.

(2) **Acute II.**

(A) Payment will be made to in-state psychiatric hospitals or inpatient psychiatric programs utilizing a predetermined all-inclusive per diem payment for routine, ancillary, and professional services.

(B) Public facilities will be reimbursed using either the statewide or facility-specific interim rates and settled to total allowable costs as determined by analyses of the cost reports (Form CMS 2552) filed with the OHCA.

(3) **PRTFs.**

(A) A pre-determined per diem payment will be made to private PRTFs with sixteen (16) beds or less for routine services. All other services are separately billable.

(B) A predetermined all-inclusive per diem payment will be made for routine, ancillary, and professional services to private facilities with more than sixteen (16) beds.

(C) Public facilities will be reimbursed using either the statewide or facility-specific interim rates and settled to total allowable costs as determined by analyses of the cost reports (Form CMS 2552) filed with the OHCA.

(c) **Out-of-state services.**

(1) **Border and "border status" placements.** Facilities are reimbursed in the same manner as in-state hospitals or PRTFs. Refer to OAC 317:30-3-90 and 317:30-3-91.

(2) **Out-of-state placements.** In the event comparable services cannot be purchased from an Oklahoma facility and the current payment levels are insufficient to obtain access for the member, the OHCA may negotiate a predetermined, all-inclusive per diem rate for specialty programs/units. An incremental payment adjustment may be made for one (1): one (1) staffing (if clinically appropriate and prior authorized). Payment may be up to, but no greater, than usual and customary charges. The one (1): one (1) staffing adjustment is limited to sixty (60) days annually. Refer to OAC 317:30-3-90 and 317:30-3-91.

(d) **Add-on payments.**

(1) Additional payment shall only be made for services that have been prior authorized by OHCA or its designee and determined to be medically necessary. For medical necessity criteria applicable for the add-on payment(s), refer to the SoonerCare Medical Necessity Criteria Manual for Inpatient Behavioral Health Services found on the OHCA website.

(2) SoonerCare shall provide additional payment for the following services rendered in an Acute II and PRTF, as per the Oklahoma Medicaid State Plan.

(A) **Intensive treatment services (ITS) add-on.**

Payment shall be made for members requiring intensive staffing supports.

(B) **Prospective complexity add-on.** Payment shall be made to recognize the increased cost of serving members with a mental health diagnosis complicated with non-verbal communication.

(C) **Specialty add-on.** Payment shall be made to recognize the increased cost of serving members with complex needs.

(e) **Services provided under arrangement.**

(1) **Case management transitioning services.**

(A) Services for the provision of case management transitioning services to existing members are considered to be inpatient psychiatric services, when services exceed and do not duplicate ordinary inpatient discharge planning during the last thirty (30) days of a covered acute or residential stay.

(B) Payment for case management transitioning services provided under arrangement with the inpatient provider will be directly reimbursed to a qualified community-based provider.

(2) **Evaluation and psychological testing by a licensed psychologist.**

(A) Services for the provision of evaluation and psychological testing by a licensed psychologist to existing members are considered to be inpatient psychiatric services, when services exceed and do not duplicate ordinary inpatient discharge planning during the last thirty (30) days of a covered acute or residential stay.

(B) Payment for evaluation and psychological testing by a licensed psychologist for services provided under arrangement with the inpatient provider will be directly reimbursed to a qualified provider in accordance with the Oklahoma Medicaid State Plan.

[Source: Added at 23 Ok Reg 2508, eff 6-25-06 ; Amended at 27 Ok Reg 710, eff 2-4-10 (emergency); Amended at 27 Ok Reg 1470, eff 6-11-10 ; Amended at 27 Ok Reg 2737, eff 7-20-10 (emergency); Amended at 28 Ok Reg 1452, eff 6-25-11 ; Amended at 34 Ok Reg 714, eff 9-1-17 ; Amended at 37 Ok Reg 1573, eff 9-14-20 ; Amended at 38 Ok Reg 428, eff 12-18-20 (emergency); Amended at 38 Ok Reg 1023, eff 9-1-21]

317:30-5-96.4. Outlier intensity adjustment

Subject to approval by the Centers for Medicare and Medicaid Services (CMS), an outlier payment may be made to instate hospitals and PRTF's on a case by case basis, to promote access for those members who require expensive care. The intent of the outlier adjustment is to reflect the increased staffing requirements, co-morbidities and longer lengths of stay, for children with developmental disabilities or eating disorders. This adjustment is limited to 60 days annually.

[Source: Added at 23 Ok Reg 2508, eff 6-25-06 ; Amended at 27 Ok Reg 2737, eff 7-20-10 (emergency); Amended at 28 Ok Reg 1452, eff 6-25-11]

317:30-5-96.5. Disproportionate share hospitals (DSH)

Reimbursement for DSH is determined in accordance with the methodology for inpatient hospital services as described in Attachment 4.19 A of the Medicaid State Plan. Copies of the plan may be obtained by writing the Oklahoma Health Care Authority, 4345 North Lincoln Boulevard, Oklahoma City, OK 73105 or may be downloaded from the OHCA website.

[Source: Added at 23 Ok Reg 2508, eff 6-25-06 ; Amended at 34 Ok Reg 612, eff 9-1-17]

317:30-5-96.6. Payment for Medicare/Medicaid dual eligible individuals

(a) **For dual eligible members.** Payment is made for Medicare-related deductibles and/or coinsurance.

(b) **For individuals who are not eligible for Part A services.** For individuals who have exhausted Medicare Part A benefits, claims must be accompanied by a statement from the Medicare Part A Regional Administrative Contractor showing the date benefits were exhausted.

[Source: Added at 23 Ok Reg 2508, eff 6-25-06 ; Amended at 36 Ok Reg 920, eff 9-1-19]

317:30-5-96.7. Cost reports

Each hospital or PRTF submits to the OHCA its Medicare Cost Report (HCFA 2552), including Medicaid-specific information (as appropriate), for the annual cost reporting period. PRTFs who do not file a Medicare Cost Report must submit a cost report in a format designated by the OHCA. Failure to submit the required completed cost report is grounds for the OHCA to determine that a provider is not in compliance with its contractual requirements. The OHCA enters into a Common Audit Agreement with a designated fiscal intermediary to audit Medicaid cost reports. Hospitals submit a copy of their cost reports to this designated fiscal intermediary. All payments made to providers are subject to adjustment based upon final (audited) cost report information.

[Source: Added at 23 Ok Reg 2508, eff 6-25-06 ; Amended at 27 Ok Reg 2737, eff 7-20-10 (emergency); Amended at 28 Ok Reg 1452, eff 6-25-11]

317:30-5-96.8. Psychiatric Residential Treatment Facility payments to subcontractors

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

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

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

(d) The subcontractor may not bill the SoonerCare member until the PRTF has refused payment.

[Source: Added at 25 Ok Reg 673, eff 2-1-08 through 7-14-08 (emergency)¹; Added at 25 Ok Reg 2703, eff 7-25-08]

Editor's Note: ¹*This emergency action expired before being superseded by a permanent action. Upon expiration of an emergency action enacting a new Section, the Section is no longer effective. Therefore, on 7-15-08 (after the 7-14-08 expiration of this emergency action), Section 317:30-5-96.8 was no longer effective, and remained as such until added again by permanent action on 7-25-08.*

317:30-5-97. Reporting abuse and/or neglect

Instances of abuse and/or neglect are to be reported in accordance with state law, including, but not limited to, 10A O.S. § 1-2-101 and 43A O.S. § 10-104. Any person suspecting child abuse or neglect shall immediately report it to the Oklahoma Department of Human Services (DHS) hotline, at 1-800-522-3511; any person suspecting abuse, neglect, or exploitation of a vulnerable adult shall immediately report it to the local DHS County Office, municipal or county law enforcement authorities, or, if the report occurs after normal business hours, the DHS hotline. Health care professionals who are requested to report incidents of domestic abuse by adult victims with legal capacity shall promptly make a report to the nearest law enforcement agency, per 22 O.S. § 58.

[Source: Added at 17 Ok Reg 3469, eff 8-01-00 (emergency); Added at 18 Ok Reg 1130, eff 5-11-01 ; Amended at 26 Ok Reg 2081, eff 6-25-09 ; Amended at 35 Ok Reg 1428, eff 9-14-18]

317:30-5-98. Claim Form [REVOKED]

[Source: Added at 17 Ok Reg 3469, eff 8-01-00 (emergency); Added at 18 Ok Reg 1130, eff 5-11-01 ; Revoked at 19 Ok Reg 2134, eff 6-27-02]

PART 7. LABORATORIES (INDEPENDENT, PHYSICIAN, AND HOSPITAL)

317:30-5-100. Laboratory services

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

(1) **Physician and clinic provider laboratories.** Physician and clinic providers may be reimbursed for compensable clinical diagnostic laboratory services only when they personally perform or supervise the performance of the test. If a physician or clinic provider refers specimen to a certified laboratory or a hospital laboratory serving outpatients, the certified laboratory or the hospital must bill for performing the test.

(2) **Independent and hospital laboratories.** Independent and hospital laboratories will be required to submit a letter to OHCA Provider Enrollment along with their other required contracting documents. The reference laboratory must be identified on the claim as well as the following information for any and all reference laboratories:

(A) Name;

(B) Address; and

(C) Clinical Laboratory Improvement Amendment of 1988 (CLIA) ID.

(3) **Compensable services for independent, physician and hospital laboratories.**

(A) Reimbursement for lab services is made in accordance with CLIA. These regulations provide that payment may be made only for services furnished by a laboratory that meets CLIA conditions, including those furnished in physicians' offices. Regulations specify that any and every facility which tests human specimens for the purpose of providing information for the diagnosis, prevention, or treatment of any disease, or impairment of, or the assessment of the health of human beings is subject to CLIA. All facilities which perform these tasks must make application for certification by CMS. Eligible SoonerCare providers must be certified under the CLIA program and have obtained a CLIA ID number from CMS and have a current contract on file with the OHCA. Providers performing laboratory services must have the appropriate CLIA certification specific to the level of testing performed.

(B) Only medically necessary laboratory services are compensable.

(i) Testing must be medically indicated as evidenced by member-specific indications in the medical record.

(ii) Testing is only compensable if the results will affect member care and are performed to diagnose conditions and illnesses with specific symptoms.

(iii) Testing is only compensable if the services are performed in furtherance of the diagnosis and/or treatment of conditions that are covered under SoonerCare.

(C) Laboratory testing must be ordered by the physician or non-physician provider and must be individualized to the member and the member's medical history, or assessment indicators as evidenced in the medical documentation.

(D) Laboratory testing for routine diagnostic or screening tests following clinical guidelines such as those found in the American Academy of Pediatrics (AAP) Bright Futures' periodicity schedule, the United States Preventive Services Task Force (USPSTF) A and B recommendations, the American Academy of Family Practitioners (AAFP), or other nationally recognized medical professional academy or society standards of care, is compensable. Additionally, such sources as named in this subdivision should meet medical necessity criteria as outlined in Oklahoma Administrative Code (OAC) 317:30-3-1(f).

(4) Non-compensable laboratory services.

(A) Laboratory testing for routine diagnostic or screening tests not supported by the clinical guidelines of a nationally recognized medical professional academy or society standard of care, and/or testing that is performed without apparent relationship to treatment or diagnosis of a specific illness, symptom, complaint or injury is not covered.

(B) Non-specific, blanket panel or standing orders for laboratory testing or lab panels which have no impact on the member's plan of care are not covered.

(C) Split billing or dividing the billed services for the same member for the same date of service by the same rendering laboratory into two (2) or more claims is not allowed.

(D) Separate payment is not made for blood specimens obtained by venipuncture or urine specimens collected by a provider who is also performing the laboratory testing as these services are considered part of the laboratory analysis.

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

(F) Billing multiple units of nucleic acid detection for individual infectious organisms when testing for more than one (1) infectious organism in a specimen is not permissible. Instead, OHCA considers it appropriate to bill a single unit of a procedure code indicated for multiple organism testing.

(G) Billing multiple Current Procedural Terminology (CPT) codes or units for molecular pathology tests that examine multiple genes or incorporate multiple types of genetic

analysis in a single run or report is not permissible. Instead, OHCA considers it appropriate to bill a single CPT code for such test. If an appropriate code does not exist, then one (1) unit for an unlisted molecular pathology procedure may be billed.

(5) Covered services by a pathologist.

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

(B) Full service or interpretation of surgical pathology for outpatient surgery performed in an outpatient hospital or ambulatory surgery center setting.

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

(A) Experimental or investigational procedures. For more information regarding experimental or investigational including clinical trials, see OAC 317:30-3-57.1.

(B) Interpretation of clinical laboratory procedures.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 27 Ok Reg 704, eff 2-4-10 (emergency); Amended at 27 Ok Reg 1450, eff 6-11-10 ; Amended at 40 Ok Reg 2197, eff 9-11-23]

317:30-5-101. Drug screening and testing

(a) **Purpose.** Drug testing is performed for undisclosed drug use and/or abuse, and to verify compliance with treatment. Testing for drugs of abuse to monitor treatment compliance should be included in the treatment plan for pain management when chronic opioid therapy is involved.

(1) Qualitative (presumptive) drug testing may be used to determine the presence or absence of a drug or drug metabolite in the sample and is expressed as a positive or negative result. Qualitative testing can be performed by a Clinical Laboratory Improvement Amendment of 1988 (CLIA) waived or moderate complexity test, or by a high complexity testing method.

(2) Quantitative (definitive) drug testing is specific to the drug or metabolite being tested and is expressed as a numeric result or numeric level which verifies concentration.

(3) Specimen validity testing is used to determine if a specimen has been diluted, adulterated, or substituted. Specimen validity tests include, but are not limited to, creatinine, oxidants, specific gravity, urine pH, nitrates, and alkaloids.

(b) **Eligible providers.** Providers performing drug testing should have CLIA certification specific to the level of testing performed as described in Oklahoma Administrative Code (OAC) 317:30-5-100(1)(A).

(c) **Compensable services.** Drug testing must be ordered by the physician or non-physician provider and must be individualized to the member and the member's medical history and/or assessment indicators as evidenced in the medical documentation.

(1) Compensable testing must be medically indicated as evidenced by member specific indications in the medical record.

(A) Testing is only compensable if the results will affect member care.

(B) Drugs or drug classes being tested should reflect only those likely to be present.

(2) The frequency of drug screening and/or testing is determined by the member's history, member's physical assessment, behavioral assessment, risk assessment, treatment plan and medication history.

(3) Quantitative (definitive) drug testing may be indicated for the following:

(A) To identify a specific substance or metabolite that is inadequately detected or undetectable by a qualitative (presumptive) test; or

(B) To definitively identify specific drugs in a large family of drugs; or

(C) To identify drugs when a definitive concentration of a drug is needed to guide management; or

(D) To identify a negative, or confirm a positive, qualitative (presumptive) result that is inconsistent with a member's self-report, presentation, medical history or current prescribed medication plan; or

(E) To identify a non-prescribed medication or illicit use for ongoing safe prescribing of controlled substances.

(d) **Non-compensable services.** The following tests are not medically necessary and therefore not covered by the OHCA:

(1) Specimen validity testing is considered a quality control measure and is not separately compensable;

(2) Drug testing for member sample sources of saliva, oral fluids, or hair;

(3) Testing of two (2) different specimen types (urine and blood) from the same member on the same date of service;

(4) Drug testing for medico-legal purposes (court-ordered drug screening) or for employment purposes;

(5) Non-specific, blanket panel or standing orders for drug testing, routine testing of therapeutic drug levels, or drug panels which have no impact to the member's plan of care;

(6) Scheduled and routine drug testing (i.e., testing should be random);

(7) Reflex testing for any drug is not medically indicated without specific documented indications;

(8) Confirmatory testing exceeding three specific drug classes at an interval of greater than every thirty (30) days will require specific documentation in the medical record to justify the medical necessity of testing; and

(9) Quantitative (definitive) testing of multiple drug levels that are not specific to the member's medical history and presentation are not allowed. Justification for testing for each individual drug or drug class level must be medically indicated as reflected in the medical record documentation.

(e) **Documentation requirements.** The medical record must contain documents to support the medical necessity of drug screening and/or

testing. Medical records must be furnished on request and may include, but are not limited to, the following:

- (1) A current treatment plan;
- (2) Member history and physical;
- (3) Review of previous medical records if treated by a different physician for pain management;
- (4) Review of all radiographs and/or laboratory studies pertinent to the member's condition;
- (5) Opioid agreement and informed consent of drug testing, as applicable;
- (6) List of prescribed medications;
- (7) Risk assessment, as identified by use of a validated risk assessment tool/questionnaire, with appropriate risk stratification noted and utilized;
- (8) Office/provider monitoring protocols, such as random pill counts; and
- (9) Review of prescription drug monitoring data or pharmacy profile as warranted.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 14 Ok Reg 757, eff 1-24-97 (emergency); Amended at 14 Ok Reg 1792, eff 5-27-97 ; Amended at 14 Ok Reg 2394, eff 5-28-97 (emergency); Amended at 15 Ok Reg 1528, eff 5-11-98 ; Amended at 16 Ok Reg 3413, eff 7-1-99 (emergency); Amended at 17 Ok Reg 1204, eff 5-11-00 ; Amended at 40 Ok Reg 2197, eff 9-11-23]

317:30-5-102. Molecular diagnostic testing utilizing polymerase chain reaction for infectious diseases

(a) **Definitions.** The following words and terms, when used in this Section, shall have the following meaning, unless the context clearly indicates otherwise.

- (1) "**Amplified probe technique**" means technique without quantification, a detection method in which the sensitivity of the assay is improved over direct probe techniques.
- (2) "**Direct probe technique**" means detection methods where nucleic acids are detected without initial amplification processing.
- (3) "**Polymerase chain reaction (PCR)**" means a biochemical laboratory technique used to make thousands or even millions of copies of a segment of DNA. It is commonly used to amplify a small amount of specifically targeted DNA from among a mixture of DNA samples. It is also known as Nucleic Acid Amplification Test (NAAT).
- (4) "**Probe with quantification technique**" means methods used to report absolute or relative amounts of nucleic acid sequences in the original sample.

(b) **Medical necessity.**

- (1) PCR testing for infectious diseases, following clinical guidelines such as those set forth by the Infectious Disease Society of America's (IDSA) or other nationally recognized medical professional academy or society standards of care, may be compensable.
- (2) For the full PCR guideline which includes medical necessity and prior authorization criteria, and a list of codes that require

authorization, please refer to <https://oklahoma.gov/ohca/mau>.

(c) **Documentation.**

(1) The medical record must contain documentation that the testing is expected to influence treatment of the condition towards which the testing is directed.

(2) The laboratory or billing provider must have on file the physician requisition which sets forth the diagnosis or condition that warrants the test(s).

(3) Examples of documentation requirements for the ordering provider include, but are not limited to, history and physical exam findings that support the decision making, problems/diagnoses, relevant data (e.g., lab testing results).

(4) Documentation requirements for the performing laboratory include, but are not limited to, lab accreditation, test requisition, test records, preliminary and final report, and quality control record.

(5) Documentation requirements for lab developed tests/protocols include diagnostic test/assay, lab manufacturer, names of comparable assays/services (if relevant), descriptions of assay, analytical validity evidence, clinical validity evidence, and clinical utility.

(6) Billing providers are required to code specificity; however, if an unlisted or not otherwise specified Current Procedural Terminology (CPT) code is used, the documentation must clearly identify the unique procedure performed. When multiple procedure codes are submitted (unique, unlisted, and/or not otherwise specified), the documentation supporting each code should be easily identifiable. If the billed code cannot be linked to the documentation during review, the service may be denied.

(7) When the documentation does not meet the criteria for the service rendered/requested or the documentation does not establish the medical necessity for the service, the service may be denied as not reasonable and necessary.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 40 Ok Reg 2197, eff 9-11-23]

317:30-5-103. Coverage and payment

(a) **Payment eligibility.** To be eligible for payment as a laboratory/pathology service, the service must be:

(1) Ordered and provided by or under the direction of a physician or other licensed practitioner within the scope of practice as defined by state law;

(2) Provided in a hospital, physician, or independent laboratory;

(3) Directly related to the diagnosis and treatment of a medical condition;

(4) Authorized under the laboratory's Clinical Laboratory Improvement Amendment of 1988 (CLIA) certification; and

(5) Considered medically necessary as defined in Oklahoma Administrative Code 317:30-3-1(f) and 317:30-5-100.

(b) **Payment for inpatient/outpatient services.** Payment is made to laboratories for medically necessary services to children and adults as follows:

(1) **Inpatient services.**

(A) Claims for inpatient anatomical pathology must be billed by the individual pathologist performing the examination.

(B) Inpatient consultations by pathologists are compensable. Claim form must include referring physician, diagnosis, and test(s) for which the consultation was requested.

(2) **Outpatient services.**

(A) For children, payment is made for medically necessary outpatient clinical laboratory services which are provided in conjunction with physician office visits that are compensable under EPSDT.

(B) For adults, payment is made for medically necessary outpatient services.

(c) **Payment rates.** Payment will be made for covered laboratory services in accordance with methodology approved under the Oklahoma Medicaid State Plan.

(d) **Vocational rehabilitation.** Payment for laboratory services is made for those vocational rehabilitation services which are preauthorized by the member's counselor.

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

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 40 Ok Reg 2197, eff 9-11-23]

317:30-5-104. Non-covered procedures

The following procedures by laboratories are not covered:

- (1) Tissue examinations of teeth and foreign objects.
- (2) Tissue examination of lens after cataract surgery except when the member is under twenty-one (21) years of age.
- (3) Charges for autopsy.
- (4) Hair analysis for trace metal analysis.
- (5) Procedures deemed experimental or investigational. For more information regarding experimental or investigational including clinical trials, see Oklahoma Administrative Code 317:30-3-57.1.
- (6) Professional component charges for inpatient clinical laboratory services.
- (7) Inpatient clinical laboratory services.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 19 Ok Reg 2922, eff 7-1-02 (emergency); Amended at 20 Ok Reg 1193, eff 5-27-03 ; Amended at 40 Ok Reg 2197, eff 9-11-23]

317:30-5-105. Non-covered procedures [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 38 Ok Reg 970, eff 9-1-21 ; Revoked at 40 Ok Reg 2197, eff 9-11-23]

317:30-5-106. Payment rates [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 17 Ok Reg 3358, eff 8-1-01 (emergency); Amended at 18 Ok Reg 1130, eff 5-11-01 ; Amended at 31 Ok Reg 1664, eff 9-12-14 ; Revoked at 40 Ok Reg 2197, eff 9-11-23]

317:30-5-107. Claim form [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 19 Ok Reg 2134, eff 6-27-02]

PART 8. REHABILITATION HOSPITALS

317:30-5-110. Eligible providers

To be eligible for reimbursement, all licensed rehabilitation hospitals must be Medicare certified and have a current contract on file with the Oklahoma Health Care Authority (OHCA).

[Source: Added at 23 Ok Reg 239, eff 10-3-05 (emergency); Added at 23 Ok Reg 1346, eff 5-25-06]

317:30-5-111. Coverage for adults

For persons twenty-one (21) years of age or older, payment is made to hospitals for inpatient services as described in this section.

(1) All general inpatient hospital services which are not provided under the Diagnosis Related Group (DRG) payment methodology for all persons twenty-one (21) years of age or older is limited to ninety (90) days per person per state fiscal year (July 1 through June 30). The ninety (90) day limitation applies to both hospital and physician services. No exceptions or extensions will be made to the ninety (90) day inpatient services limitation.

(2) All inpatient stays are subject to post-payment utilization review by the Oklahoma Health Care Authority's (OHCA) designated Quality Improvement Organization (QIO). These reviews are based on severity of illness and intensity of treatment.

(A) It is the policy and intent of OHCA to allow hospitals and physicians the opportunity to present any and all documentation available to support the medical necessity of an admission and/or extended stay of a SoonerCare member. If the QIO, upon their initial review determines the admission should be denied, a notice is issued to the facility and the attending physician advising them of the decision. This notice also advises that a reconsideration request may be submitted within the specified time frame on the notice and consistent with the Medicare guidelines. Additional information submitted with the reconsideration request is reviewed by the QIO that utilizes an

independent physician advisor. If the denial decision is upheld through this review of additional information, the QIO sends written notification of the denial decision to the hospital, attending physician and the OHCA. Once the OHCA has been notified, the overpayment is processed as per the final denial determination.

(B) If the hospital or attending physician did not request reconsideration from the QIO, the QIO informs OHCA there has been no request for reconsideration and as a result their initial denial decision is final. OHCA, in turn, processes the overpayment as per the denial notice sent to the OHCA by the QIO.

(C) If an OHCA, or its designated agent, review results in denial and the denial is upheld throughout the appeal process and refund from the hospital and physician is required, the member cannot be billed for the denied services.

(3) If a hospital or physician believes that a hospital admission or continued stay is not medically necessary and thus not compensable but the member insists on treatment, the member should be informed that he/she will be personally responsible for all charges. If a claim is filed and paid and the service is later denied, the patient is not responsible.

(4) Payment is made to a participating hospital for hospital based physician's services. The hospital must have a Hospital-Based Physician's contract with OHCA for this method of billing.

(5) Outpatient services for adults are covered as listed in Oklahoma Administrative Code 317:30-5-42.1.

[Source: Added at 23 Ok Reg 239, eff 10-3-05 (emergency); Added at 23 Ok Reg 1346, eff 5-25-06 ; Amended at 25 Ok Reg 112, eff 10-1-07 (emergency); Amended at 25 Ok Reg 1192, eff 5-25-08 ; Amended at 37 Ok Reg 1601, eff 9-14-20]

317:30-5-112. Coverage for children

Payment is made to rehabilitation hospitals for medical services for persons under the age of 21 within the scope of the Authority's Medical Programs, provided the services are reasonable for the diagnosis and treatment of illness or injury, or to improve the functioning of a malformed body member. Medical and surgical services are comparable to those listed for adults except all medically necessary inpatient hospital services, other than psychiatric services, for all persons under the age of 21 will not be limited.

[Source: Added at 23 Ok Reg 239, eff 10-3-05 (emergency); Added at 23 Ok Reg 1346, eff 5-25-06]

317:30-5-113. Medicare eligible individuals

Payment is made to hospitals for services to Medicare eligible individuals as set forth in this section.

(1) Individuals eligible for Part A and Part B.

(A) Payment is made utilizing the Medicaid allowable for comparable Part B services.

(B) Payment is made for the coinsurance and/or deductible for Part A services for categorically needy individuals.

(2) **Individuals who are not eligible for Part A services.**

(A) The Part B services are to be filed with Medicare. Any monies received from Medicare and any coinsurance and/or deductible monies received from OHCA must be shown as a third party resource on the appropriate claim form for inpatient per diem. The inpatient per diem should be filed with the fiscal agent along with a copy of the Medicare Payment Report.

(B) For individuals who have exhausted Medicare Part A benefits, claims must be accompanied by a statement from the Medicare Part A intermediary showing the date benefits were exhausted.

[Source: Added at 23 Ok Reg 239, eff 10-3-05 (emergency); Added at 23 Ok Reg 1346, eff 5-25-06]

317:30-5-114. Reimbursement

Payment is made at the lesser of the facilities usual and customary fee or the OHCA fixed per diem rate.

[Source: Added at 23 Ok Reg 239, eff 10-3-05 (emergency); Added at 23 Ok Reg 1346, eff 5-25-06]

PART 9. LONG-TERM CARE FACILITIES

317:30-5-120. Eligible providers

Long term care facilities may receive payment for the provision of nursing care under the Title XIX Medicaid Program only when they are properly licensed and certified by the Oklahoma Department of Health, meet Federal and State requirements and hold a valid contract with the Oklahoma Health Care Authority (OHCA) to provide long term care services. All long term care facility contracts are time limited with specific effective and expiration dates.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 13 Ok Reg 1203, eff 1-9-96 (emergency); Amended at 13 Ok Reg 2523, eff 6-27-96 ; Amended at 14 Ok Reg 265, eff 9-17-96 (emergency); Amended at 14 Ok Reg 1780, eff 5-27-97 ; Amended at 34 Ok Reg 626, eff 9-1-17]

317:30-5-121. Coverage by category

(a) **Adults.** Payment is made for compensable long term care for adults after the member has been determined medically eligible to receive such care.

(b) **Children.** Coverage for children is the same as adults.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 13 Ok Reg 1203, eff 1-9-95 (emergency); Amended at 13 Ok Reg 2523, eff 6-27-96 ; Amended at 18 Ok Reg 2557, eff 6-25-01 ; Amended at 34 Ok Reg 626, eff 9-1-17]

317:30-5-122. Levels of care

(a) This rule sets forth the criteria used to determine whether an individual who is seeking SoonerCare payment for long term care services needs services at the level of Skilled Nursing Facility, or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). The criteria set forth in this Section must be used when determining level of care for individuals seeking SoonerCare coverage of either facility-based institutional long term care services or Home and Community Based Services (HCBS) Waivers.

(b) The level of care provided by a long term care facility or through a HCBS Waiver is based on the nature of the person's needs and the care, services, and treatment required from appropriately qualified personnel. The level of care review is a determination of an individual's physical, mental, and social/emotional status to determine the appropriate level of care required. In addition to level of care requirements, other applicable eligibility criteria must be met.

(1) **Skilled Nursing facility.** Payment is made for the Part A coinsurance and deductible for Medicare covered skilled nursing facility care for dually eligible, categorically needy individuals.

(2) **Nursing Facility.** Care provided by a nursing facility to members 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 Individuals with Intellectual Disabilities.** Care for persons with intellectual disabilities or related conditions to provide health and/or habilitative services in a protected residential setting. To qualify for ICF/IID level of care, persons must have substantial functional limitations in three or more of the following areas of major life activity:

(A) **Self-care.** The individual requires assistance, training, or supervision to eat, dress, groom, bathe, or use the toilet.

(B) **Understanding and use of language.** The individual lacks functional communication skills, requires the use of assistive devices to communicate, does not demonstrate an understanding of requests, or is unable to follow two-step instructions.

(C) **Learning.** The individual has a valid diagnosis of intellectual disability as defined in the Diagnostic and Statistical Manual of Mental Disorders.

(D) **Mobility.** The individual requires the use of assistive devices to be mobile and cannot physically self-evacuate from a building during an emergency without assistive device.

(E) **Self-direction.** The individual is seven (7) years old or older and significantly at risk in making age appropriate decisions or an adult who is unable to provide informed consent for medical care, personal safety, or for legal, financial, habilitative, or residential issues, and/or has been declared legally incompetent. The individual is a danger to himself or others without supervision.

(F) **Capacity for independent living.** The individual who is seven (7) years old or older and is unable to locate and use a telephone, cross the street safely, or understand that it is unsafe to accept rides, food, or money from strangers. Or an adult who lacks basic skills in the areas of shopping, preparing food, housekeeping, or paying bills.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 13 Ok Reg 1203, eff 1-9-95 (emergency); Amended at 13 Ok Reg 2523, eff 6-27-96 ; Amended at 19 Ok Reg 2938, eff 7-1-02 (emergency); Amended at 20 Ok Reg 1193, eff 5-27-03 ; Amended at 23 Ok Reg 263, eff 10-3-05 (emergency); Added at 23 Ok Reg 1356, eff 5-25-06 ; Amended at 26 Ok Reg 248, eff 12-1-08 (emergency); Amended at 26 Ok Reg 1052, eff 5-11-09 ; Amended at 28 Ok Reg 1409, eff 6-25-11 ; Amended at 29 Ok Reg 1076, eff 6-25-12 ; Amended at 30 Ok Reg 371, eff 1-28-13 (emergency); Amended at 30 Ok Reg 1123, eff 7-1-13 ; Amended at 34 Ok Reg 626, eff 9-1-17]

317:30-5-123. Member certification for long-term care

(a) **Medical eligibility.** Initial approval of medical eligibility for long-term care is determined by the Oklahoma Department of Human Services (DHS) area nurse, or nurse designee. The certification is obtained by the facility at the time of admission.

(1) **Preadmission screening.** Federal regulations govern the State's responsibility for Preadmission Screening and Resident Review (PASRR) for individuals with mental illness and intellectual disability. PASRR applies to the screening or reviewing of all individuals for mental illness, intellectual disability, or related conditions who apply to or reside in a Title XIX certified nursing facility (NF), regardless of the source of payment for the NF services and/or the individual's or resident's known diagnoses. Individuals referred for admission to a NF must be screened for a major mental disorder, diagnosable under the most current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). The NF must independently evaluate the Level I PASRR screen regardless of who completes the form and determine whether or not to admit an individual to the facility. Nursing facilities which inappropriately admit a person without a PASRR screen are subject to recoupment of funds. PASRR is a requirement for nursing facilities with dually certified (both Medicare and Medicaid) beds. There are no PASRR requirements for Medicare skilled beds that are not dually certified, nor is PASRR required for individuals seeking residency in an intermediate care facility for individuals with intellectual disabilities (ICF/IID).

(2) **PASRR Level I screen.**

(A) Form LTC-300R, Nursing Facility Level of Care Assessment, must be completed by an authorized NF official or designee. An authorized NF official or designee must consist of one (1) of the following:

- (i) The NF administrator or co-administrator;
- (ii) A licensed nurse, social service director, or social worker from the NF; or
- (iii) A licensed nurse, social service director, or social worker from the hospital.

(B) Prior to admission, the authorized NF official must evaluate the properly completed Oklahoma Health Care Authority (OHCA) Form LTC-300R and the Minimum Data Set (MDS), if available. Any other readily available medical and social information is also used to determine if there currently exists any indication of mental illness, an intellectual disability, or other related condition, or if such condition existed in the applicant's past history. Form LTC-300R constitutes the Level I PASRR screen and is utilized in determining whether or not a Level II assessment is necessary prior to allowing the member to be admitted. The NF is also responsible for consulting with the Level of Care Evaluation Unit (LOCEU) regarding any information on a mental illness, intellectual disability or related condition that becomes known either from completion of the MDS or throughout the resident's stay.

(C) The NF is responsible for determining from the evaluation whether or not the member can be admitted to the facility. A "yes" response to any question from Form LTC-300R, Section E, will require the facility to contact the LOCEU for a consultation to determine if a Level II assessment is needed. If there is any question as to whether or not there is evidence of mental illness, an intellectual disability, or related condition, LOCEU should be contacted prior to admission. The original Form LTC-300R must be submitted electronically or by mail to the LOCEU within ten (10) days of the resident admission. SoonerCare payment may not be made for a resident whose LTC-300R requirements have not been satisfied in a timely manner.

(D) Upon receipt and review of the Form LTC-300R, the LOCEU may, in coordination with the DHS area nurse, re-evaluate whether a Level II PASRR assessment may be required. If a Level II assessment is not required, the process of determining medical eligibility continues. If a Level II is required, a medical decision is not made until the results of the Level II assessment are known.

(3) Level II Assessment for PASRR.

(A) Any one of the following three (3) circumstances will allow a member to enter the NF without being subjected to a Level II PASRR assessment.

(i) The member has no current indication of mental illness, intellectual disability, or other related condition and there is no history of such condition in the member's past.

(ii) The member does not have a diagnosis of intellectual disability or related condition.

(iii) An individual may be admitted to a NF if he/she has indications of mental illness, intellectual disability, or other related condition, but is not a danger to self and/or others, and is being released

from an acute care hospital as part of a medically prescribed period of recovery (exempted hospital discharge). If an individual is admitted to a NF based on an exempted hospital discharge, it is the responsibility of the NF to ensure that the individual is either discharged by the 30th day or that a Level II has been requested and is in process. An exempted hospital discharge is allowed only if all three (3) of the following conditions are met:

- (I) The individual must be admitted to the NF directly from a hospital after receiving acute inpatient care at the hospital (not including psychiatric facilities);
- (II) The individual must require NF services for the condition for which he/she received care in the hospital; and
- (III) The attending physician must certify in writing before admission to the facility that the individual is likely to require less than thirty (30) days of NF services. The NF will be required to furnish this documentation to OHCA upon request.

(B) If the member has current indications of mental illness, intellectual disability, or other related condition, or if there is a history of such condition in the member's past, the member cannot be admitted to the NF until the LOCEU is contacted for consultation to determine if a Level II PASRR assessment must be performed. Results of any Level II PASRR assessment ordered must indicate that NF care is appropriate prior to allowing the member to be admitted.

(C) The OHCA LOCEU authorizes advance group determinations for the mental illness and intellectual disability authorities in the following categories listed in (i) through (iii) of this subparagraph. Preliminary screening by the LOCEU may indicate eligibility for NF level of care prior to consideration of the provisional admission.

(i) **Provisional admission in cases of delirium.**

Any person with mental illness, intellectual disability, or related condition that is not a danger to self and/or others, may be admitted to a Title XIX certified NF if the individual is experiencing a condition that precludes screening, i.e., effects of anesthesia, medication, unfamiliar environment, severity of illness, or electrolyte imbalance.

- (I) A Level II evaluation is completed immediately after the delirium clears. The LOCEU must be provided with written documentation by a physician that supports

the individual's condition which allows provisional admission as defined in (i) of this subparagraph.

(II) Payment for NF services will not be made after the provisional admission ending date. If an individual is determined to need a longer stay, the individual must receive a Level II evaluation before continuation of the stay may be permitted and payment made for days beyond the ending date.

(ii) **Provisional admission in emergency situations.** Any person with mental illness, intellectual disability, or related condition, who is not a danger to self and/or others, may be admitted to a Title XIX certified NF for a period not to exceed seven (7) days pending further assessment in emergency situations requiring protective services. The request for Level II evaluation must be made immediately upon admission to the NF if a longer stay is anticipated. The LOCEU must be provided with written documentation from DHS Adult Protective Services which supports the individual's emergency admission. Payment for NF services will not be made beyond the emergency admission ending date.

(iii) **Respite care admission.** Any person with mental illness, intellectual disability, or related condition, who is not a danger to self and/or others, may be admitted to a Title XIX certified NF to provide respite to in-home caregivers to whom the individual is expected to return following the brief NF stay. Respite care may be granted up to fifteen (15) consecutive days per stay, not to exceed thirty (30) days per calendar year.

(I) In rare instances, such as illness of the caregiver, an exception may be granted to allow thirty (30) consecutive days of respite care. However, in no instance can respite care exceed thirty (30) days per calendar year.

(II) Respite care must be approved by LOCEU staff prior to the individual's admission to the NF. The NF provides the LOCEU with written documentation concerning circumstances surrounding the need for respite care, the date the individual wishes to be admitted to the facility, and the date the individual is expected to return to the caregiver. Payment for NF services will not be made

after the respite care ending date.

(4) Resident Review.

(A) The facility's routine resident assessment will identify those individuals previously undiagnosed as intellectually disabled or mentally ill. A new condition of intellectual disability or mental illness must be referred to LOCEU by the NF for determination of the need for the Level II assessment. The facility's failure to refer such individuals for a Level II assessment may result in recoupment of funds.

(B) A Level II resident review may be conducted the following year for each resident of a NF who was found to experience a serious mental illness with no primary diagnosis of dementia on his or her preadmission Level II, to determine whether, because of the resident's physical and mental condition, the resident requires the level of services provided by a NF and whether the resident requires specialized services.

(C) A significant change in a resident's mental condition could trigger a Level II resident review. If such a change should occur in a resident's condition, it is the responsibility of the NF to notify the LOCEU of the need to conduct a resident review.

(5) Results of Level II Preadmission Assessment and Resident Review. Through contractual arrangements between the OHCA and the mental illness or intellectual disability authorities, individualized assessments are conducted and findings presented in written evaluations. The evaluations determine if NF services are needed, if specialized services or less than specialized services are needed, and if the individual meets the federal PASRR definition of mental illness, intellectual disability, or related conditions. Evaluations are delivered to the LOCEU to process formal, written notification to member, guardian, NF, and interested parties.

(6) Readmissions and interfacility transfers. The preadmission screening process does not apply to readmission of an individual to a NF after transfer for a continuous hospital stay, and then back to the NF. There is no specific time limit on the length of absence from the NF for the hospitalization. Interfacility transfers are also subject to preadmission screening. In the case of transfer of a resident from a NF to a hospital or to another NF, the transferring NF is responsible for ensuring that copies of the resident's most recent LTC-300R and any PASRR evaluations accompany the transferring resident. The receiving NF must submit an updated LTC-300R that reflects the resident's current status to LOCEU within ten (10) days of the transfer. Failure to do so could result in possible recoupment of funds. LOCEU should also be contacted prior to admitting out-of-state NF applicants with mental illness, intellectual disability, or related condition, so that PASRR needs can be ascertained. Any PASRR evaluations previously completed by the referring state should be forwarded

to LOCEU as part of this PASRR consultation.

(7) PASRR appeals process.

(A) Any individual who has been adversely affected by any PASRR determination made by the State in the context of either a preadmission screening or an annual resident review may appeal that determination by requesting a fair hearing. If the individual does not consider the PASRR decision a proper one, the individual or their authorized representative must contact the local county DHS office to discuss a hearing. Forms for requesting a fair hearing (DHS Form 13MP001E, Request for a Fair Hearing), as well as assistance in completing the forms, can be obtained at the local county DHS office. Any request for a hearing must be received by OHCA within thirty (30) days of the date of written notice. Appeals of these decisions are available under Oklahoma Administrative Code (OAC) 317:2-1-2. All individuals seeking an appeal have the same rights, regardless of source of payment. Level I determinations are not subject to appeal.

(B) When the individual is found to experience mental illness, intellectual disability, or related condition through the Level II assessment, the PASRR determination made by the mental illness or intellectual disability authorities cannot be countermanded by the OHCA, either in the claims process or through other utilization control/review processes, or by the State Department of Health. Only appeals determinations made through the fair hearing process may overturn a PASRR determination made by the mental illness or intellectual disability authorities.

(b) Determination of Title XIX medical eligibility for long-term care. The determination of medical eligibility for care in a NF is made by the DHS area nurse, or nurse designee. The procedures for determining NF program medical eligibility are found in OAC 317:35-19. Determination of ICF/IID medical eligibility is made by LOCEU. The procedures for obtaining and submitting information required for a decision are outlined below.

(1) **Pre-approval of medical eligibility.** Pre-approval of medical eligibility for private ICF/IID care is based on results of a current comprehensive psychological evaluation by a licensed psychologist or state staff psychologist, documentation of intellectual disability or related condition prior to age twenty-two (22), and the need for active treatment according to federal standards. Pre-approval is made by LOCEU analysts.

(2) **Medical eligibility for ICF/IID services.** Within thirty (30) calendar days after services begin, the facility must submit the original of the Nursing Facility Level of Care Assessment (Form LTC 300) to LOCEU. Required attachments include current (within ninety (90) days of requested approval date) medical information signed by a physician, a current (within twelve (12) months of requested approval date) psychological evaluation, a copy of the pertinent section of the individual development plan

or other appropriate documentation relative to discharge planning and the need for ICF/IID level of care, and a statement that the member is not an imminent threat of harm to self or others (i.e., suicidal or homicidal). If pre-approval was determined by LOCEU and the above information is received, medical approval will be entered on Medical Eligibility Determination Application Tracking System (MEDATS).

(3) **Categorical relationship.** Categorical relationship must be established for determination of eligibility for long-term medical care. If categorical relationship to disability has not already been established, the proper forms and medical information are submitted to LOCEU. (Refer to OAC 317:35-5-4). In such instances, LOCEU will render a decision on categorical relationship using the same definition as used by the Social Security Administration (SSA). A follow-up is required by the DHS worker with SSA to be sure that their disability decision agrees with the decision of LOCEU.

[**Source:** Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Amended at 13 Ok Reg 1203, eff 1-9-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 13 Ok Reg 2523, eff 6-27-96 ; Amended at 14 Ok Reg 265, eff 9-17-96 (emergency); Amended at 14 Ok Reg 1780, eff 5-27-97 ; Amended at 18 Ok Reg 2557, eff 6-25-01 ; Amended at 22 Ok Reg 96, eff 7-1-04 (emergency); Amended at 21 Ok Reg 2489, eff 7-11-05 ; Amended at 23 Ok Reg 771, eff 3-9-06 (emergency); Amended at 23 Ok Reg 2537, eff 6-25-06 ; Amended at 24 Ok Reg 2819, eff 7-1-07 (emergency); Amended at 25 Ok Reg 1200, eff 5-25-08 ; Amended at 29 Ok Reg 1088, eff 6-25-12 ; Amended at 34 Ok Reg 626, eff 9-1-17 ; Amended at 36 Ok Reg 889, eff 9-1-19]

317:30-5-124. Facility licensure

(a) **Nursing home license required.** A NF must meet state nursing home licensing standards to provide, on a regular basis, health related care and services to individuals who do not require hospital care.

(1) In order for long term care facilities to receive payment from the OHCA for the provision of nursing care, they must be currently licensed under provisions of Title 63 O.S., Nursing Home Care Act, Section 1-1900.1, et seq.

(2) The State Department of Health is responsible for the issuance, renewal, suspension, and revocation of a facility's license in addition to the enforcement of the standards. The denial, suspension, or revocation of a facility's license is subject to appeal to the State Department of Health. All questions regarding a facility's license should be directed to the State Department of Health.

(b) **Certification survey.** The State Department of Health is designated as the State Survey Agency and is responsible for determining a long term care facility's compliance with Title XIX requirements. The results of the survey are forwarded to the OHCA by the State Survey Agency.

(c) **Certification period.** The certification period of a long term care facility is determined by the State Survey Agency. In the event the facility's deficiencies are found to be of such serious nature as to jeopardize the health and safety of the member, the State Survey Agency may terminate (de-certify) the facility's certification period and notify the OHCA. Upon notification by the State Survey Agency, the OHCA will notify the facility by certified letter that the contract is being terminated.

The letter will indicate the effective date and specify the time period that payment may continue in order to allow orderly relocation of the members. The decision to terminate a facility's certification by the State Survey Agency is subject to appeal to the State Department of Health.

(d) **Certification with deficiencies.** Certification of any facility that has been found to have deficiencies by the State Survey Agency will be governed by 42 CFR 442.110 (certification period for ICF/IID with standard-level deficiencies) or 42 CFR 442.117 (termination of certification for ICFs/IID whose deficiencies pose immediate jeopardy).

(e) **Contract procedures.**

(1) A facility participating in the Medicaid program will be notified by the OHCA 75 days prior to the expiration of the existing contract. The facility must complete a new contract to continue participation in the SoonerCare program.

(2) When the contract is received, approved by the OHCA, and the HCFA-1539 has been received from the State Department of Health indicating the facility's certification period, the contract will be completed.

(3) Intermediate care facilities for individuals with intellectual disabilities (ICF/IID) wishing to participate in the ICF/IID program must be approved and certified by the State Survey Agency as being in compliance with the ICF/IID regulations (42 CFR 442 Subpart C). It is the responsibility of a facility to request the State Survey Agency perform a survey of compliance with ICF/IID regulations.

(A) When the OHCA has received notification of a facility's approval as an ICF/IID and the Title XIX survey of compliance has begun, the contract will be sent to the facility for completion.

(B) A facility which has been certified as an ICF/IID and has a contract with the OHCA will be paid only for members that have been approved for ICF/IID level of care. When the facility is originally certified to provide ICF/IID services, payment for member's currently residing in the facility who are approved for a NF level of care will be made if such care is appropriate to the member's needs.

(f) **New facilities.** Any new facility in Oklahoma must receive a Certificate of Need from the State Department of Health. It is the responsibility of the new facility to request the State Survey Agency to perform a survey for Title XIX compliance.

(1) When construction of a new facility is completed and licensure and certification is imminent, facilities wishing to participate in the Title XIX Medicaid Program may apply electronically to become a Medicaid contracted provider.

(2) In no case can payment be made for any period prior to the effective date of the facility's certification.

(g) **Change of ownership.** The acquisition of a facility operation, either whole or in part, by lease or purchase, or if a new Federal Employer Identification Number is required, constitutes a change of ownership. The new owner must follow provisions of the Nursing Home Care Act at

Title 63 O.S. Section 1-1905 (D) (relating to transfers in ownership) and OAC 310:675-3-8 (relating to notice of change), as applicable. When such change occurs, it is necessary that a new contract be completed between the new owner and the OHCA in order that payment can continue for the provision of nursing care.

(1) **License changes due to change of ownership.** State Law prescribes specific requirements regarding the transfer of ownership of a NF from one person to another. When a transfer of ownership is contemplated, the buyer/seller or lessee/lessor must notify the State Department of Health prior to the final transfer and apply for a new facility license.

(2) **Certificate of Need.** A change of ownership is subject to review by the State Department of Health. Any person contemplating the acquisition of a NF should contact the State Department of Health for further information regarding Certificate of Need requirements.

(A) The new owner must obtain a Certificate of Need as well as a new facility license from the State Department of Health. Pending notification of licensure, no changes will be made to the OHCA's facility records with the exception of change in administrator or change in name, if applicable.

(B) When a change in ownership does occur, the OHCA will automatically assign the contract to the new owner per federal regulation. By signing the contract, the new owner is representing to the OHCA that they meet the requirements of the contract and the requirements for participation in the Medicaid program. The new owner's contract is subject to the prior owner's contract terms and conditions that were in effect at the time of transfer of ownership, including compliance with all appropriate federal regulations.

(h) A nursing facility or ICF/IID dissatisfied with an action taken by the OHCA that is appealable as a matter of right pursuant to Subpart D of Part 431 of Title 42 of the Code of Federal Regulations, shall be afforded a hearing as provided by 42 CFR 431.153 or 431.154.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 14 Ok Reg 265, eff 9-17-96 (emergency); Amended at 14 Ok Reg 1780, eff 5-27-97 ; Amended at 23 Ok Reg 771, eff 3-9-06 (emergency); Amended at 23 Ok Reg 2440, eff 6-25-06 ; Amended at 34 Ok Reg 626, eff 9-1-17]

317:30-5-125. Trust funds

When a new member is admitted to a nursing facility, the administrator will complete and send to the county office the Management of Recipient's Funds form to indicate whether or not the member has requested the administrator to handle personal funds. If the administrator agrees to handle the member's funds, the Management of Recipient's Funds form will be completed each time funds or other items of value, other than monthly income, are received.

(1) The facility may use electronic ledgers and bank statements as the source documentation for each member for whom they are holding funds or other items of value. This information must be available at all times for inspection and audit purposes. The facility must have written policies that ensure complete accounting of the member's personal funds. All member funds which are handled by the facility must be clearly identified and maintained separately from funds belonging to the facility or to private patients. When the total sum of all funds for all members is \$250.00 or more, they must be deposited by the facility in a local bank account designated as "Recipient's Trust Funds." The funds are not to be commingled with the operating funds of the facility. Each resident in an ICF/IID facility must be allowed to possess and use money in normal ways or be learning to do so.

(2) The facility is responsible for notifying the county office at any time a member's account reaches or exceeds the maximum reserve by use of the Accounting-Recipient's Personal Funds and Property form. This form is also prepared by the facility when the member dies or is transferred or discharged, and at the time of the county eligibility review of the member.

(3) The Management of Recipient's Funds form, the Accounting-Recipient's Personal Funds and Property form, and the Ledger Sheets for Recipient's Account are available online at www.okdhs.org.

(4) When the ownership or operation of the facility is discontinued or where the facility is sold and the members' trust funds are to be transferred to a successor facility, the status of all members' trust funds must be verified by the OHCA and/or the buyer must be provided with written verification by an independent public accountant of all residents' monies and properties being transferred, and a signed receipt obtained from the owner. All transfers of a member's trust funds must be acknowledged, in writing, by the transferring facility and proper receipts given by the receiving facility.

(5) Unclaimed funds or other property of deceased members, with no known heirs, must be reported to the Oklahoma Tax Commission.

(6) It is permissible to use an individual trust fund account to defray the cost of last illness, outstanding personal debts and burial expenses of a deceased member of the OHCA; however, any remaining balance of unclaimed funds must be reported to the Oklahoma Tax Commission. The Unclaimed Property Division, Oklahoma Tax Commission, State Capitol Complex, Oklahoma City, Oklahoma, is to be notified for disposition instructions on any unclaimed funds or property. No money is to be sent to the Oklahoma Tax Commission until so instructed by the Unclaimed Property Division.

(7) Books, records, ledgers, charge slips and receipts must be on file in the facility for a period of six (6) years and available at all times in the facility for inspection and audit purposes.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 14 Ok Reg 265, eff 9-17-96 (emergency); Amended at 14 Ok Reg 1780, eff 5-27-97 ; Amended at 34 Ok Reg 626, eff 9-1-17]

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

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

(1) Effective July 1, 1994, the nursing facility may receive payment for a maximum of seven (7) days of therapeutic leave per calendar year for each recipient to reserve the bed.

(2) No payment shall be made to a nursing facility for hospital leave.

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

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

(5) Therapeutic leave balances are recorded on the Medicaid Management Information System (MMIS). When a patient moves to another facility, it is the responsibility of the transferring facility to forward the patient's leave records to the receiving facility.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 13 Ok Reg 909, eff 8-1-95 (emergency); Amended at 13 Ok Reg 395, eff 1-1-96 (emergency); Amended at 13 Ok Reg 1675, eff 5-27-96 ; Amended at 14 Ok Reg 265, eff 9-17-96 (emergency); Amended at 14 Ok Reg 1780, eff 5-27-97 ; Amended at 25 Ok Reg 2668, eff 7-25-08 ; Amended at 31 Ok Reg 662, eff 7-1-14 (emergency); Amended at 31 Ok Reg 1635, eff 9-12-14 ; Amended at 31 Ok Reg 683, eff 9-12-14 (emergency); Amended at 32 Ok Reg 1040, eff 8-27-15]

317:30-5-127. Notification of nursing facility changes

It is important that the nursing facility keep the OHCA Provider Enrollment and Contracts Unit informed of any change in administrator, operator, mailing address, or telephone number of the facility. Inaccurate information can cause a delay in receipt of payments or correspondence. The facility should also report all changes to the State Department of Health and the Oklahoma State Board of Nursing Homes.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 18 Ok Reg 2557, eff 6-25-01 ; Amended at 34 Ok Reg 626, eff 9-1-17]

317:30-5-128. Private rooms [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 14 Ok Reg 265, eff 9-17-96 (emergency); Amended at 14 Ok Reg 1780, eff 5-27-97 ; Revoked at 34 Ok Reg 626, eff 9-1-17]

317:30-5-129. Required monthly notifications

(a) The Notification Regarding Patient in a Nursing Facility or ICF/IID form is completed and forwarded to the local DHS office by the facility each time a member is admitted to or discharged from the facility.

(b) A Computer Generated Notice or the Notice to Client Regarding Long-Term Medical Care form is used by the county office to notify the member and the facility of the amount of money, if any, the member is responsible for paying to the facility and the action taken with respect to the member's eligibility for nursing facility care. This form reflects dates of transfer between facilities and termination of eligibility for any reason.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 13 Ok Reg 1675, eff 5-27-96 ; Amended at 13 Ok Reg 909, eff 8-1-96 (emergency); Amended at 14 Ok Reg 265, eff 9-17-96 (emergency); Amended at 14 Ok Reg 1780, eff 5-27-97 ; Amended at 15 Ok Reg 706, eff 12-15-97 (emergency); Amended at 15 Ok Reg 1528, eff 5-11-98 ; Amended at 17 Ok Reg 3509, eff 9-1-00 (emergency); Amended at 18 Ok Reg 1130, eff 5-11-01 ; Amended at 21 Ok Reg 2466, eff 7-11-05 ; Amended at 34 Ok Reg 626, eff 9-1-17]

317:30-5-130. Inspections of care in Intermediate Care Facilities for the Mentally Retarded (ICF/MR)

The Oklahoma Health Care Authority (OHCA) is responsible for periodic inspections of care and services in each ICF/MR providing services for Title XIX applicants and recipients. The inspection of care reviews are made by the OHCA or its designated agent. The frequency of inspections is based on the quality of care and service being provided in a facility and the condition of recipients in the facility. However, the care and services provided to each recipient in the facility must be inspected at least annually. No notification of the time of the inspection will be given to the facility prior to the inspections.

- (1) The purpose of periodic inspections is to determine:
 - (A) The level of care required by each patient for whom Title XIX benefits have been requested or approved.
 - (B) The adequacy of the services available in the particular facility to meet the current health, rehabilitative and social needs of each recipient in an ICF/MR and promote the maximum physical, mental, and psychosocial functioning of the recipient receiving care in such facility.
 - (C) The necessity and desirability of the continued placement of each patient in such facility.
 - (D) The feasibility of meeting the health care needs and the recipient's rehabilitative needs through alternative institutional or noninstitutional services.
 - (E) If each recipient in an institution for the mentally retarded or persons with related conditions is receiving active treatment.

(2) Each applicant and recipient record will be reviewed for the purpose of determining adequacy of services, unmet needs and appropriateness of placement. Personal contact with and observation of each recipient will occur during the visit. This may necessitate observing recipients at sites outside of the facility.

(A) Record reviews will include confirmation of whether:

(i) All required evaluations including medical, social and psychological are complete and current.
(ii) The habilitation plan is complete and current.
(iii) All ordered services are provided and properly recorded.

(iv) The attending physician reviews prescribed medications at least quarterly.

(v) Tests or observations of each recipient indicated by his medication regimen are made at appropriate times and properly recorded.

(vi) Physicians, nurse, and other professional progress notes are made as required and appear consistent with the observed condition of the recipient.

(vii) There is a habilitation plan to prevent regression and reflects progress toward meeting objectives of the plan.

(viii) All recipient needs are met by the facility or through arrangements with others.

(ix) The recipient needs continued placement in the facility or there is an appropriate plan to transfer the recipient to an alternate method of care.

(B) Observations and personal contact with recipients will include confirmation of whether:

(i) The habilitation plans are followed.

(ii) All ordered services are provided.

(iii) The condition of the recipient is consistent with progress notes.

(iv) The recipient is clean and is receiving adequate hygiene services.

(v) The recipient is free of signs of malnutrition, dehydration and preventable injuries.

(vi) The recipient is receiving services to maintain maximum physical, mental, and psychosocial functioning.

(vii) The recipient needs any service that is not furnished by the facility or through arrangements with others.

(3) A full and complete report of observations, conclusions and recommendations are required concerning:

(A) The adequacy, appropriateness, and quality of all services provided in the facility or through other arrangements, including physician services to recipients; and

(B) Specific findings about individual recipients in the facility.

(4) The inspection report must include the dates of the inspection and the names and qualifications of the individuals conducting the inspection. A copy of each inspection report will be sent to:

(A) The facility inspected;

(B) The facility's utilization review committee;

(C) The agency responsible for licensing, certification, or approval of the facility for purposes of Medicare and Medicaid; and

(D) Other state agencies that use the information in the reports to perform their official function, including if inspection reports concern Institutions for Mental Diseases (IMDs), the appropriate State mental health authorities.

(5) The Oklahoma Health Care Authority will take corrective action as needed based on required reports and recommendations.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 13 Ok Reg 2317, eff 4-30-96 (emergency); Amended at 14 Ok Reg 265, eff 9-17-96 (emergency); Amended at 14 Ok Reg 1780, eff 5-27-97]

317:30-5-131. Rates of payments

(a) Rates of payments shown on the Fee Schedule for Nursing Facilities and ICF/MR's are based on the cost of the nursing facility level of care provided and the nursing care staffing pattern. The rate of payment to a nursing facility is also determined by the type of facility and quality of care rating.

(b) A rate of payment established by the facility for private patients is not under the jurisdiction of OHCA. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State Plan for all individuals regardless of source of payment. The facility may charge any amount for services furnished to non-Medicaid residents consistent with the written notice requirements describing the charges found at 42 CFR 483.10.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 14 Ok Reg 265, eff 9-17-96 (emergency); Amended at 14 Ok Reg 1780, eff 5-27-97 ; Amended at 15 Ok Reg 706, eff 12-15-97 (emergency); Amended at 15 Ok Reg 1528, eff 5-11-98 ; Amended at 24 Ok Reg 2819, eff 7-1-07 (emergency); Amended at 25 Ok Reg 1200, eff 5-25-08]

317:30-5-131.1. Wage enhancement [REVOKED]

[Source: Added at 15 Ok Reg 1887, eff 3-17-98 (emergency); Added at 16 Ok Reg 1429, eff 5-27-99 ; Amended at 16 Ok Reg 3613, eff 8-3-99 (emergency); Amended at 17 Ok Reg 1204, eff 5-11-00 ; Amended at 23 Ok Reg 771, eff 3-9-06 (emergency); Amended at 23 Ok Reg 2440, eff 6-25-06 ; Amended at 30 Ok Reg 1195, eff 7-1-13 ; Revoked at 35 Ok Reg 417, eff 1-9-18 (emergency); Revoked at 35 Ok Reg 1408, eff 9-14-18]

317:30-5-131.2. Quality of care fund requirements and report

(a) **Definitions.** The following words and terms, when used in this Section, have the following meaning, unless the context clearly indicates

otherwise:

- (1) "**Annualize**" means that the calculations, including, for example, total patient days, gross revenue, or contractual allowances and discounts, is divided by the total number of applicable days in the relevant time period.
- (2) "**Direct-Care Staff**" means any nursing or therapy staff who provides direct, hands-on care to residents in a nursing facility and intermediate care facility for individuals with intellectual disabilities pursuant to Section 1-1925.2 of Title 63 of the Oklahoma Statutes, pursuant to OAC 310:675-1 et seq., and as defined in subsection (c) of this Section.
- (3) "**Major Fraction Thereof**" means an additional threshold for direct-care-staff-to-resident ratios at which another direct-care staff person(s) is required due to the peak in-house resident count exceeding one-half of the minimum direct-care-staff-to-resident ratio pursuant to Section 1-1925.2 of Title 63 of the Oklahoma Statutes.
- (4) "**Nursing Facility and Intermediate Care Facility for Individuals with Intellectual Disabilities**" means any home, establishment, or institution or any portion thereof, licensed by the Oklahoma State Department of Health (OSDH) as defined in Section 1-1902 of Title 63 of the Oklahoma Statutes.
- (5) "**Peak In-House Resident Count**" means the maximum number of in-house residents at any point in time during the applicable shift.
- (6) "**Quality of Care Fee**" means the fee assessment created for the purpose of quality care enhancements pursuant to Section 2002 of Title 56 of the Oklahoma Statutes upon each nursing facility and intermediate care facility for individuals with intellectual disabilities licensed in this state.
- (7) "**Quality of Care Fund**" means a revolving fund established in the State Treasury pursuant to Section 2002 of Title 56 of the Oklahoma Statutes.
- (8) "**Quality of Care Report**" means the monthly report developed by the Oklahoma Health Care Authority (OHCA) to document the staffing ratios, total patient gross receipts, total patient days, and minimum wage compliance for specified staff for each nursing facility and intermediate care facility for individuals with intellectual disabilities licensed in the state.
- (9) "**Service Rate**" means the minimum direct-care-staff-to-resident rate pursuant to Section 1-1925.2 of Title 63 of Oklahoma Statutes and pursuant to OAC 310:675-1 et seq.
- (10) "**Staff Hours Worked by Shift**" means the number of hours worked during the applicable shift by direct-care staff.
- (11) "**Staffing Ratios**" means the minimum direct-care-staff-to-resident ratios pursuant to Section 1-1925.2 of Title 63 of the Oklahoma Statutes and pursuant to OAC 310:675-1 et seq.
- (12) "**Total Gross Receipts**" means all cash received in the current Quality of Care Report month for services rendered to all residents in the facility. Receipts should include all Medicaid, Medicare, private pay, and insurance including receipts for items

not in the normal per diem rate. Charitable contributions received by the nursing facility are not included.

(13) **"Total Patient Days"** means the monthly patient days that are compensable for the current monthly Quality of Care Report.

(b) Quality of care fund assessments.

(1) The OHCA was mandated by the Oklahoma Legislature to assess a monthly service fee to each licensed nursing facility in the state. The fee is assessed on a per patient day basis. The amount of the fee is uniform for each facility type. The fee is determined as six percent (6%) of the average total gross receipts divided by the total days for each facility type.

(2) Annually, the Nursing Facilities Quality of Care Fee shall be determined by using the daily patient census and patient gross receipts report received by the OHCA for the most recent available twelve months and annualizing those figures. Also, the fee will be monitored to never surpass the federal maximum.

(3) The fee is authorized through the Medicaid State Plan and by the Centers for Medicare and Medicaid Services regarding waiver of uniformity requirements related to the fee.

(4) Monthly reports of Gross Receipts and Census are included in the monthly Quality of Care Report. The data required includes, but is not limited to, the Total Gross Receipts and Total Patient Days for the current monthly report.

(5) The method of collection is as follows:

(A) The OHCA assesses each facility monthly based on the reported patient days from the Quality of Care Report filed two months prior to the month of the fee assessment billing. As defined in this subsection, the total assessment is the fee times the total days of service. The OHCA notifies the facility of its assessment by the end of the month of the Quality of Care Report submission date.

(B) Payment is due to the OHCA by the 15th of the following month. Failure to pay the amount by the 15th or failure to have the payment mailing postmarked by the 13th will result in a debt to the State of Oklahoma and is subject to penalties of 10 percent (10%) of the amount and interest of 1.25 percent (1.25%) per month. The Quality of Care Fee must be submitted no later than the 15th of the month. If the 15th falls upon a holiday or weekend (Saturday-Sunday), the fee is due by 5 p.m., Central Standard Time (CST), of the following business day (Monday-Friday).

(C) The monthly assessment, including applicable penalties and interest, must be paid regardless of any appeals action requested by the facility. If a provider fails to pay the OHCA the assessment within the time frames noted on the second invoice to the provider, the assessment, applicable penalty, and interest will be deducted from the facility's payment. Any change in payment amount resulting from an appeals decision will be

adjusted in future payments. Adjustments to prior months' reported amounts for gross receipts or patient days may be made by filing an amended part C of the Quality of Care Report.

(D) The Quality of Care fee assessments excluding penalties and interest are an allowable cost for OHCA cost reporting purposes.

(E) The Quality of Care fund, which contains assessments collected including penalties and interest as described in this subsection and any interest attributable to investment of any money in the fund, must be deposited in a revolving fund established in the State Treasury. The funds will be used pursuant to Section 2002 of Title 56 of the Oklahoma Statutes.

(c) Quality of care direct-care-staff-to resident-ratios.

(1) All nursing facilities and intermediate care facilities for individuals with intellectual disabilities (ICFs/IID) subject to the Nursing Home Care Act, in addition to other state and federal staffing requirements, must maintain the minimum direct-care-staff-to-resident ratios or direct-care service rates as cited in Section 1-1925.2 of Title 63 of the Oklahoma Statutes and pursuant to OAC 310:675-1 et seq.

(2) For purposes of staff-to-resident ratios, direct-care staff are limited to the following employee positions:

- (A) Registered Nurse;
- (B) Licensed Practical Nurse;
- (C) Nurse Aide;
- (D) Certified Medication Aide;
- (E) Qualified Intellectual Disability Professional (ICFs/IID only);
- (F) Physical Therapist;
- (G) Occupational Therapist;
- (H) Respiratory Therapist;
- (I) Speech Therapist; and
- (J) Therapy Aide/Assistant.

(3) The hours of direct care rendered by persons filling non-direct care positions may be used when those persons are certified and rendering direct care in the positions listed in OAC 317:30-5-131.2(c)(2) when documented in the records and time sheets of the facility.

(4) In any shift when the direct-care-staff-to-resident ratio computation results in a major fraction thereof, direct-care staff is rounded to the next higher whole number.

(5) To document and report compliance with the provisions of this subsection, nursing facilities and ICFs/IID must submit the monthly Quality of Care Report pursuant to subsection (e) of this Section.

(d) Quality of care reports. All nursing facilities and intermediate care facilities for individuals with intellectual disabilities must submit a monthly report developed by the OHCA, the Quality of Care Report, for the purposes of documenting the extent to which such facilities are

compliant with the minimum direct-care-staff-to-resident ratios or direct-care service rates.

(1) The monthly report must be signed by the preparer and by the owner, authorized corporate officer, or administrator of the facility for verification and attestation that the reports were compiled in accordance with this section.

(2) The owner or authorized corporate officer of the facility must retain full accountability for the report's accuracy and completeness regardless of report submission method.

(3) Penalties for false statements or misrepresentation made by or on behalf of the provider are provided at 42 U.S.C. Section 1320a-7b.

(4) The Quality of Care Report must be submitted by 5 p.m. (CST) on the 15th of the following month. If the 15th falls upon a holiday or a weekend (Saturday-Sunday), the report is due by 5 p.m. (CST) of the following business day (Monday - Friday).

(5) The Quality of Care Report will be made available in an electronic version for uniform submission of the required data elements.

(6) Facilities must submit the monthly report through the OHCA Provider Portal.

(7) Should a facility discover an error in its submitted report for the previous month only, the facility must provide to the Long-term Care Financial Management Unit written notification with adequate, objective, and substantive documentation within five business days following the submission deadline. Any documentation received after the five business day period will not be considered in determining compliance and for reporting purposes by the OHCA.

(8) An initial administrative penalty of \$150.00 is imposed upon the facility for incomplete, unauthorized, or non-timely filing of the Quality of Care Report. Additionally, a daily administrative penalty will begin upon the OHCA notifying the facility in writing that the report was not complete or not timely submitted as required. The \$150.00 daily administrative penalty accrues for each calendar day after the date the notification is received. The penalties are deducted from the Medicaid facility's payment. For 100 percent (100%) private pay facilities, the penalty amount(s) is included and collected in the fee assessment billings process. Imposed penalties for incomplete reports or non-timely filing are not considered for OHCA cost reporting purposes.

(9) The Quality of Care Report includes, but is not limited to, information pertaining to the necessary reporting requirements in order to determine the facility's compliance with subsections (b) and (c) of this Section. Such reported information includes, but is not limited to: total gross receipts, patient days, available bed days, direct care hours, Medicare days, Medicaid days, number of employees, monthly resident census, and tenure of certified nursing assistants, nurses, directors of nursing, and administrators.

(10) Audits may be performed to determine compliance pursuant to subsections (b), and (c) of this Section.

Announced/unannounced on-site audits of reported information may also be performed.

(11) Direct-care-staff-to-resident information and on-site audit findings pursuant to subsection (c), will be reported to the OSDH for their review in order to determine "willful" non-compliance and assess penalties accordingly pursuant to Title 63 Section 1-1912 through Section 1-1917 of the Oklahoma Statutes. The OSDH informs the OHCA of all final penalties as required in order to deduct from the Medicaid facility's payment. Imposed penalties are not considered for OHCA Cost Reporting purposes.

(12) Under OAC 317:2-1-2, long-term care facility providers may appeal the administrative penalty described in (b)(5)(B) and (d)(8) of this section.

(13) Facilities that have been authorized by the OSDH to implement flexible staff scheduling must comply with OAC 310:675-1 et seq. The authorized facility is required to complete the flexible staff scheduling section of Part A of the Quality of Care Report. The owner, authorized corporate officer, or administrator of the facility must complete the flexible staff scheduling signature block, acknowledging their OSDH authorization for flexible staff scheduling.

[Source: Added at 17 Ok Reg 3509, eff 9-1-00 (emergency); Added at 18 Ok Reg 255, eff 11-21-00 (emergency); Added at 18 Ok Reg 780, eff 1-23-01 (emergency); Added at 18 Ok Reg 1130, eff 5-11-01 ; Amended at 19 Ok Reg 69, eff 9-1-01 (emergency); Amended at 19 Ok Reg 1067, eff 5-13-02 ; Amended at 20 Ok Reg 160, eff 9-26-02 (emergency); Amended at 20 Ok Reg 1216, eff 5-27-03 ; Amended at 20 Ok Reg 1928, eff 6-26-03 ; Amended at 22 Ok Reg 99, eff 4-1-04 (emergency); Amended at 22 Ok Reg 2467, eff 7-11-05 ; Amended at 23 Ok Reg 771, eff 3-9-06 (emergency); Amended at 23 Ok Reg 2440, eff 6-25-06 ; Amended at 24 Ok Reg 2821, eff 6-1-07 through 7-14-08 (emergency)¹; Amended at 25 Ok Reg 2668, eff 7-25-08 ; Amended at 30 Ok Reg 1195, eff 7-1-13 ; Amended at 33 Ok Reg 843, eff 9-1-16 ; Amended at 34 Ok Reg 626, eff 9-1-17 ; Amended at 35 Ok Reg 417, eff 1-9-18 (emergency); Amended at 35 Ok Reg 1408, eff 9-14-18 ; Amended at 38 Ok Reg 406, eff 12-18-20 (emergency); Amended at 38 Ok Reg 985, eff 9-1-21]

Editor's Note: ¹*This emergency action expired on 7-14-08 before being superseded by a permanent action. Upon expiration of an emergency amendatory action, the last effective permanent text is reinstated. Therefore, on 7-15-08 (after the 7-14-08 expiration of the emergency action), the text of 317:30-5-131.2 reverted back to the permanent text that became effective 6-25-06, as was last published in the 2006 Edition of the OAC, and remained as such until amended by permanent action on 7-25-08.*

317:30-5-132. Cost reports

Each Medicaid-participating long-term care facility is required to submit an annual uniform cost report, designed by the Oklahoma Health Care Authority (OHCA), for the state fiscal year just completed. The state fiscal year is July 1 through June 30. The reports must be submitted to the OHCA on or before October 31st following the end of the state fiscal year just completed.

(1) The report must be prepared on the basis of generally accepted accounting principles and the accrual basis of accounting, except as otherwise specified in the cost report instructions. The OHCA's cost report instructions are publicly available on the OHCA's website (www.okhca.org), in the Nursing Home Cost Report Instruction Manual: A Guide for Entering Annual Nursing Home Cost Report Data via the OHCA Secure Site (hereinafter referred to as "Cost Report Instruction Manual").

(2) The cost report must be filed using the Secure Website, as set forth in the Cost Report Instruction Manual.

(3) When there is a change of operation or ownership, the selling or closing ownership is required to file a cost report for that portion of the fiscal year it was in operation. The successor ownership is correspondingly required to file a cost report for that portion of the fiscal year it was in operation. These "Partial Year Reports" must be filed on paper or electronically by e-mail (not on the Secure Website system) to the Finance Division of the OHCA on the forms and by the instructions found in the Cost Report Instruction Manual.

(4) A long-term care facility may request an extension of time to submit an annual cost report, not to exceed fifteen (15) calendar days. Extensions of time shall be requested by a letter addressed to the Finance Division or by email, as is set forth in the Cost Report Instruction Manual. Any such request must be received by October 31, and must explain the good faith reason for the extension. OHCA shall provide a written notice of any denial of a request for an extension, which shall become effective on the date it is sent to the long-term care facility. Decisions to deny requests for extensions are solely within the discretion of the OHCA and are not administratively appealable.

(5) All reports may be subject to on-site audits. An on-site audit may result in cost adjustment(s), by which the OHCA, or its designee, identifies and corrects for costs that were included in the cost report. The OHCA or its designee shall provide written notice of any cost adjustment(s) it makes to a cost report, to the long-term care facility affected by the cost adjustment(s). Such notice shall contain, but is not limited to, a written list of the audit findings with a summary explanation of why any cost is deemed non-allowable.

(6) In accordance with 63 Oklahoma Statute § 1-1925.2, a long-term care facility may contest any cost adjustment(s) it disagrees with by requesting reconsideration of the cost adjustment(s), and/or by requesting an administrative appeal of the cost adjustment(s), pursuant to Oklahoma Administrative Code (OAC) 317:30-5-132.1 and OAC 317:2-1-17, respectively.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 14 Ok Reg 265, eff 9-17-96 (emergency); Amended at 14 Ok Reg 1780, eff 5-27-97 ; Amended at 15 Ok Reg 4204, eff 7-20-98 (emergency); Amended at 16 Ok Reg 1429, eff 5-27-99 ; Amended at 17 Ok Reg 3509, eff 9-1-00 (emergency); Amended at 18 Ok Reg 497, eff 1-1-01 (emergency); Amended at 18 Ok Reg 1130, eff 5-11-01 ; Amended at 25 Ok Reg 2668, eff 7-25-08 ; Amended at 30 Ok Reg 1195, eff 7-1-13 ; Amended at 34 Ok Reg 626, eff 9-1-17 ; Amended at 37 Ok Reg 214, eff 10-25-19 (emergency); Amended at 37 Ok Reg 1506, eff 9-14-20]

317:30-5-132.1. Reconsideration of cost report adjustments

(a) A long-term care facility may request reconsideration of cost report adjustment(s)/finding(s) within thirty (30) calendar days of the date of notification of the cost adjustment(s) by submitting a request for reconsideration to the Oklahoma Health Care Authority (OHCA), Chief Financial Officer (CFO), Finance/NF Cost Reporting, 4345 North Lincoln Boulevard, Oklahoma City, Oklahoma 73105.

(b) Simultaneous with the request for reconsideration, the long-term care facility shall submit a statement as to why the request for reconsideration is being made and may submit any new or additional information that he or she wishes the CFO or his/her designee to consider. Any request for an informal meeting according to subsection (c), below, must be made at the same time as the request for reconsideration.

(c) At the request of the long-term care facility, the reconsideration may be conducted by the CFO or his/her designee as:

(1) An informal meeting between the long-term care facility and the CFO or his/her designee; or

(2) A review by the CFO or his/her designee of the information described below:

(A) A review of all information submitted by the long-term care facility; and,

(B) A review of the cost report adjustments made by the OHCA, in order to determine the accuracy of the adjustments.

(d) The CFO or his/her designee shall send a written decision of the reconsideration to the long-term care facility within thirty (30) calendar days of the date of OHCA's receipt of the reconsideration request, or the date of any informal meeting, whichever occurs later.

(e) If the provider disagrees with the decision rendered by the CFO or his or her designee, the provider may utilize the administrative appeals process in accordance with Oklahoma Administrative Code 317:2-1-17.

[Source: Added at 37 Ok Reg 214, eff 10-25-19 (emergency); Added at 37 Ok Reg 1506, eff 9-14-20]

317:30-5-132.2. Allowable costs

The Oklahoma Health Care Authority (OHCA) shall reimburse long-term care facilities in accordance with its federally-approved Oklahoma Medicaid Plan. According to the Oklahoma Medicaid Plan, per-diem rates for long-term care facilities are established on, among other things, analyses of annual uniform cost reports. These reports may only include allowable costs, as follows:

(1) To be allowable, the costs shall be reasonable and necessary for services related to resident care, and pertinent to the operation of the long-term care facility. More specifically:

(A) To be reasonable, costs shall be such as would ordinarily be incurred for comparable services provided by comparable facilities, for example, facilities of similar size and level of care; and

(B) To be necessary, costs related to patient care must be common and accepted occurrences; and,
(C) Allowable costs for services and items directly related to resident care include routine services, as established by Oklahoma Administrative Code (OAC) 317:30-5-133.1, and quality of care assessment fees, as established by OAC 317:30-5-131.2. Ancillary services, as established by OAC 317:30-5-133.2, are not allowable costs, but may be reimbursed outside the long-term care facility rate, unless reimbursement is available from Medicare or other insurance or benefit programs.

(2) The following costs shall not be allowable:

- (A) Costs resulting from inefficient operations;
- (B) Costs resulting from unnecessary or luxurious care;
- (C) Costs related to activities not common and accepted in a long-term care facility, as determined by OHCA or its designee;
- (D) Costs that are not actually paid by the provider, including, but not limited to, costs that are discharged in bankruptcy; forgiven; or converted to a promissory note;
- (E) Costs that are paid to a related party that has not been identified on the reports;
- (F) Cost of services, facilities, and supplies furnished by organizations related to the provider, by common ownership or control, that exceed the price of comparable services, facilities, or supplies purchased by independent providers in Oklahoma, in accordance with 42 Code of Federal Regulations § 413.17; and,
- (G) Costs or financial transactions used to circumvent OHCA's applicable reimbursement rules.

(3) Allowable costs shall include only those costs that are considered allowable for Medicare purposes and that are consistent with federal Medicaid requirements. The guidelines for allowable costs in the Medicare program are set forth in the Medicare Provider Reimbursement Manual, HCFA-Pub. 15.

[Source: Added at 37 Ok Reg 214, eff 10-25-19 (emergency); Added at 37 Ok Reg 1506, eff 9-14-20]

317:30-5-133. Payment methodologies

(a) Private Nursing Facilities.

(1) **Facilities.** Private Nursing Facilities include:

- (A) Nursing Facilities serving adults (NF),
- (B) Nursing Facilities serving Aids Patients,
- (C) Nursing Facilities serving Ventilator Patients,
- (D) Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID),
- (E) Intermediate Care Facilities with 16 beds or less serving severely or profoundly intellectually disabled members, and

(F) Payment will be made for non-routine nursing facility services identified in an individual treatment plan prepared by the State Intellectual Disabilities (ID) Authority. Services are limited to individuals approved for NF and specialized services as the result of a PASRR/ID Level II screen. The per diem add-on is calculated as the difference in the statewide average standard private ID base rate and the statewide NF base rate. If the standard private ID average base rate falls below the standard NF base rate or equals the standard facility base rate for regular NFs, the payment will not be adjusted for specialized services.

(2) **Reimbursement calculations.** Rates for private NFs will be reviewed periodically and adjusted as necessary through a public process. Payment will be made to private NFs pursuant to the methodology described in the Oklahoma Title XIX State Plan.

(b) **Public Nursing Facilities.** Reimbursement for public ICFs/IID shall be based on each facility's reasonable cost and shall be paid on an interim basis with an annual retroactive adjustment. Reasonable costs shall be based on Medicare principles of cost reimbursement as set forth in the provider reimbursement manual.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 1321, eff 3-20-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 13 Ok Reg 1103, eff 1-10-96 (emergency); Amended at 13 Ok Reg 3469, eff 7-16-96 (emergency); Amended at 14 Ok Reg 1780, eff 5-27-97 ; Amended at 15 Ok Reg 3784, eff 7-1-98 (emergency); Amended at 15 Ok Reg 4204, eff 7-20-98 (emergency); Amended at 16 Ok Reg 1429, eff 5-27-99 ; Amended at 17 Ok Reg 3359, eff 9-1-00 (emergency); Amended at 17 Ok Reg 3509, eff 9-1-00 (emergency); Amended at 18 Ok Reg 1130, eff 5-11-01 ; Amended at 23 Ok Reg 31, eff 7-6-05 (emergency); Amended at 23 Ok Reg 1357, eff 5-25-06 ; Amended at 24 Ok Reg 2819, eff 7-1-07 (emergency); Amended at 25 Ok Reg 1200, eff 5-25-08 ; Amended at 30 Ok Reg 1195, eff 7-1-13 ; Amended at 34 Ok Reg 626, eff 9-1-17]

317:30-5-133.1. Routine services

(a) Nursing facility care includes routine items and services that must be provided directly or through appropriate arrangement by the facility when required by SoonerCare residents. Charges for routine services may not be made to resident's personal funds or to resident family members, guardians, or other parties who have responsibility for the resident. If reimbursement is available from Medicare or another public or private insurance or benefit program, those programs are billed by the facility. In the absence of other available reimbursement, the facility must provide routine services from the funds received from the regular SoonerCare vendor payment and the SoonerCare resident's applied income, or spend down amount.

(b) The OHCA will review the listing periodically for additions or deletions, as indicated. Routine services are member specific and provided in accordance with standard medical care. Routine services include, but are not limited to:

- (1) Regular room.
- (2) Dietary Services:
 - (A) regular diets;
 - (B) special diets;
 - (C) salt and sugar substitutes;

- (D) supplemental feedings;
 - (E) special dietary preparations;
 - (F) equipment required for preparing and dispensing tube and oral feedings; and
 - (G) special feeding devices (furnished or arranged for).
- (3) Medically related social services to attain or maintain the highest practicable physical, mental and psycho-social well-being of each resident, nursing care, and activities programs (costs for a private duty nurse or sitter are not allowed).
- (4) Personal services - personal laundry services for residents (does not include dry cleaning).
- (5) Personal hygiene items (personal care items required to be provided does not include electrical appliances such as shavers and hair dryers, or individual personal batteries), to include:
- (A) shampoo, comb, and brush;
 - (B) bath soap;
 - (C) disinfecting soaps or specialized cleansing agents when indicated to treat or prevent special skin problems or to fight infection;
 - (D) razor and/or shaving cream;
 - (E) nail hygiene services; and
 - (F) sanitary napkins, douche supplies, perineal irrigation equipment, solutions, and disposable douches.
- (6) Routine oral hygiene items, including:
- (A) toothbrushes ;
 - (B) toothpaste ;
 - (C) dental floss ;
 - (D) lemon glycerin swabs or equivalent products ; and
 - (E) denture cleaners, denture adhesives, and containers for dental prosthetic appliances such as dentures and partial dentures.
- (7) Necessary items furnished routinely as needed to all members, e.g., water pitcher, cup and tray, towels, wash cloths, hospital gowns, emesis basin, bedpan, and urinal.
- (8) The facility will furnish as needed items such as alcohol, applicators, cotton balls, tongue depressors and, first aid supplies, including small bandages, ointments and preparations for minor cuts and abrasions, and enema supplies, disposable enemas, gauze, 4 x 4's ABD pads, surgical and micropore tape, telfa gauze, ace bandages, etc.
- (9) Over the counter drugs (non-legend) not covered by the prescription drug program (PRN or routine). In general, nursing facilities are not required to provide any particular brand of non-legend drugs, only those items necessary to ensure appropriate care.
- (A) If the physician orders a brand specific non-legend drug with no generic equivalent, the facility must provide the drug at no cost to the member. If the physician orders a brand specific non-legend drug that has a generic equivalent, the facility may choose a generic equivalent, upon approval of the ordering physician;

(B) If the physician does not order a specific type or brand of non-legend drug, the facility may choose the type or brand;

(C) If the member, family, or other responsible party (excluding the nursing facility) prefers a specific type or brand of non-legend drug rather than the ones furnished by the facility, the member, family or responsible party may be charged the difference between the cost of the brand the resident requests and the cost of the brand generally provided by the facility. (Facilities are not required to provide an unlimited variety of brands of these items and services. It is the required assessment of resident needs, not resident preferences, that will dictate the variety of products facilities need to provide);

(D) Before purchasing or charging for the preferred items, the facility must secure written authorization from the member, family member, or responsible party indicating his or her desired preference, as well as the date and signature of the person requesting the preferred item. The signature may not be that of an employee of the facility. The authorization is valid until rescinded by the maker of the instrument.

(10) The facility will furnish or obtain any necessary equipment to meet the needs of the member upon physician order. Examples include: trapeze bars and overhead frames, foot and arm boards, bed rails, cradles, wheelchairs and/or geriatric chairs, foot stools, adjustable crutches, canes, walkers, bedside commode chairs, hot water bottles or heating pads, ice bags, sand bags, traction equipment, IV stands, etc.

(11) Physician prescribed lotions, ointments, powders, medications and special dressings for the prevention and treatment of decubitus ulcers, skin tears and related conditions, when medications are not covered under the Vendor Drug Program or other third party payer.

(12) Supplies required for dispensing medications, including needles, syringes including insulin syringes, tubing for IVs, paper cups, medicine containers, etc.

(13) Equipment and supplies required for simple tests and examinations, including scales, sphygmomanometers, stethoscopes, clinitest, acetest, dextrostix, pulse oximeters, blood glucose meters and test strips, etc.

(14) Underpads and diapers, waterproof sheeting and pants, etc., as required for incontinence or other care.

(A) If the assessment and care planning process determines that it is medically necessary for the resident to use diapers as part of a plan to achieve proper management of incontinence, and if the resident has a current physician order for adult diapers, then the facility must provide the diapers without charge;

(B) If the resident or the family requests the use of disposable diapers and they are not prescribed or

consistent with the facility's methods for incontinent care, the resident/family would be responsible for the expense.

(15) Oxygen for emergency use, or intermittent use as prescribed by the physician for medical necessity.

(16) Other physician ordered equipment to adequately care for the member and in accordance with standard patient care, including infusion pumps and supplies, and nebulizers and supplies, etc.

(17) Dentures and Related Services. Payment for the cost of dentures and related services is included in the daily rate for routine services. The projected schedule for routine denture services must be documented on the Admission Plan of Care and on the Annual Plan of Care. The medical records must also contain documentation of steps taken to obtain the services. When the provision of denture services is medically appropriate, the nursing facility must make timely arrangements for the provision of these services by licensed dentists. In the event denture services are not medically appropriate, the treatment plan must reflect the reason the services are not considered appropriate, e.g., the member is unable to ingest solid nutrition or is comatose, etc. When the need for dentures is identified, one set of complete dentures or partial dentures and one dental examination is considered medically appropriate every three years. One rebase and/or one reline is considered appropriate every three years. It is the responsibility of the nursing facility to ensure that the member has adequate assistance in the proper care, maintenance, identification and replacement of these items. The nursing facility cannot set up payment limits which result in barriers to obtaining denture services. However, the nursing facility may restrict the providers of denture services to providers who have entered into payment arrangements with the facility. The facility may also choose to purchase a private insurance dental coverage product for each SoonerCare member. At a minimum, the policy must cover all denture services included in routine services. The member cannot be expected to pay any co-payments and/or deductibles. If a difference of opinion occurs between the nursing facility, member, and/or family regarding the provision of dentures services, the OHCA will be the final authority. All members and/or families must be informed of their right to appeal at the time of admission and yearly thereafter. The member cannot be denied admission to a facility because of the need for denture services.

(18) Vision Services. Routine eye examinations for the purpose of medical screening or prescribing or changing glasses and the cost of glasses are included in the daily rate for routine services. This does not include follow-up or treatment of known eye disease such as diabetic retinopathy, glaucoma, conjunctivitis, corneal ulcers, iritis, etc. Treatment of known eye disease is a benefit of the member's medical plan. The projected schedule for routine vision care must be documented on the Admission Plan of Care and on the Annual Plan of Care. The medical record must contain

documentation of the steps that have been taken to access the service. When vision services are not appropriate, documentation of why vision services are not medically appropriate must be included in the treatment plan. For example, the member is comatose, unresponsive, blind, etc. Nursing Home providers may contract with individual eye care providers, providers groups or a vision plan to provide routine vision services to their members. The member cannot be expected to pay any co-payments and/or deductibles.

(A) The following minimum level of services must be included:

- (i) Individuals 21 to 40 years of age are eligible for one routine eye examination and one pair of glasses every 36 months (three years).
- (ii) Individuals 41 to 64 years of age are eligible for one routine eye examination and one pair of glasses every 24 months (2 years).
- (iii) Individuals 65 years of age or older are eligible for one routine eye examination and one pair of glasses every 12 months (yearly).

(B) It is the responsibility of the nursing facility to ensure that the member has adequate assistance in the proper care, maintenance, identification and replacement of these items. When vision services have been identified as a needed service, nursing facility staff will make timely arrangements for provision of these services by licensed ophthalmologists or optometrists. If a difference of opinion occurs between the nursing facility, member, and/or family regarding the provision of vision services, the OHCA will be the final authority. All members and/or families must be informed of their right to appeal at admission and yearly thereafter. The member cannot be denied admission to the facility because of the need for vision services.

(19) An attendant to accompany SoonerCare eligible members during SoonerRide Non-Emergency Transportation (NET). Please refer to OAC 317:30-5-326 through OAC 317:30-5-327.9 for SoonerRide rules regarding members residing in a nursing facility. And

(20) Influenza and pneumococcal vaccinations.

[Source: Added at 12 Ok Reg 3640, eff 6-21-95 (emergency); Amended at 13 Ok Reg 1645, eff 5-27-96 ; Amended at 18 Ok Reg 497, eff 1-1-01 (emergency); Amended at 18 Ok Reg 1130, eff 5-11-01 ; Amended at 19 Ok Reg 69, eff 9-1-01 (emergency); Amended at 19 Ok Reg 1067, eff 5-13-02 ; Amended at 24 Ok Reg 2095, eff 6-25-07 ; Amended at 34 Ok Reg 626, eff 9-1-17]

317:30-5-133.2. Ancillary services

(a) Ancillary services are those items which are not considered routine services. Ancillary services may be billed separately to the SoonerCare program, unless reimbursement is available from Medicare or other insurance or benefit programs. Coverage criteria, utilization controls and program limitations are specified in Part 17 of OAC 317:30-5. Ancillary

services are limited to the following services:

- (1) Services requiring prior authorization:
 - (A) External breast prosthesis and support accessories.
 - (B) Ventilators and supplies.
 - (C) Total Parenteral Nutrition (TPN), and supplies.
 - (D) Custom seating for wheelchairs.
- (2) Services not requiring prior authorization:
 - (A) Permanent indwelling or male external catheters and catheter accessories.
 - (B) Colostomy and urostomy supplies.
 - (C) Tracheostomy supplies.
 - (D) Catheters and catheter accessories.
 - (E) Oxygen and oxygen concentrators.
 - (i) PRN Oxygen. Members in nursing facilities requiring oxygen PRN will be serviced by oxygen kept on hand as part of the per diem rate.
 - (ii) Billing for Medicare eligible members. Oxygen supplied to Medicare eligible nursing home members may be billed directly to OHCA. It is not necessary to obtain a denial from Medicare prior to filing the claim with OHCA.

(b) Items not considered ancillary, but considered routine and covered as part of the routine rate include but are not limited to:

- (1) Diapers.
- (2) Underpads.
- (3) Medicine cups.
- (4) Eating utensils.
- (5) Personal comfort items.

[Source: Added at 13 Ok Reg 3640, eff 6-21-95 (emergency); Amended at 13 Ok Reg 1645, eff 5-27-96 ; Amended at 17 Ok Reg 3509, eff 9-1-00 (emergency); Amended at 18 Ok Reg 1130, eff 5-11-01 ; Amended at 25 Ok Reg 2655, eff 7-25-08]

317:30-5-133.3. Nursing home ventilator-dependent and tracheostomy care services

- (a) Admission is limited to ventilator-dependent and/or qualified tracheostomy residents.
- (b) The ventilator-dependent resident and/or qualified tracheostomy resident must meet the current nursing facility level of care criteria. (Refer to OAC 317:30-5-123.)
- (c) All criteria must be present in order for a resident to be considered ventilator-dependent:
 - (1) The resident is not able to breathe without a volume with a backup.
 - (2) The resident must be medically dependent on a ventilator for life support 6 hours per day, seven days per week.
 - (3) The resident has a tracheostomy.
 - (4) The resident requires daily respiratory therapy intervention (i.e., oxygen therapy, tracheostomy care, physiotherapy or deep suctioning). These services must be available 24 hours a day.

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

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

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

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

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

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

(f) Notwithstanding the foregoing, a ventilator-dependent or qualified tracheostomy resident who is in the process of being weaned from ventilator dependence or requiring qualified tracheostomy treatment shall continue to be considered a qualified resident until the weaning process is completed.

[Source: Added at 31 Ok Reg 1636, eff 9-12-14]

317:30-5-134. Nurse Aide Training Reimbursement

(a) Nurse Aide training programs and competency evaluation programs occur in two settings, a nursing facility setting and private training courses. Private training includes, but is not limited to, certified training offered at vocational technical institutions. This rule outlines payment to qualified nurse aides trained in either setting.

(b) In the case a nursing facility provides training and competency evaluation in a program that is not properly certified under federal law, the Oklahoma Health Care Authority may offset the nursing facility's payment for monies paid to the facility for these programs. Such action shall occur after notification to the facility of the period of non-certification and the amount of the payment by the Oklahoma Health Care Authority.

(c) In the case of nurse aide training provided in private training courses, reimbursement is made to nurse aides who have paid a reasonable fee for training in a certified training program at the time training was received. The federal regulations prescribe applicable rules regarding certification of the program and certification occurs as a result of certification by the State Survey Agency. For nurse aides to receive reimbursement for private training courses, all of the following requirements must be met:

(1) the training and competency evaluation program must be certified at the time the training occurred;

(2) the nurse aide has paid for training;

- (3) a reasonable fee was paid for training (however, reimbursement will not exceed the maximum amount set by the Oklahoma Health Care Authority of 800 dollars);
- (4) the Oklahoma Health Care Authority is billed by the nurse aide receiving the training within 12 months of the completion of the training. Reimbursement requests outside the first 12 months are not compensable;
- (5) the nurse aide has passed her or his competency evaluation;
- and
- (6) the nurse aide is employed at a SoonerCare contracted nursing facility as a nurse aide during all or part of the year after completion of the training and competency evaluation.

(d) If all the conditions in subsection (c) are met, then the Authority will compensate the nurse aide on a quarterly basis. For every qualifying month employed in a nursing facility during a quarter, OHCA will pay the previous quarter's sum of eligible expenses incurred by the nurse aide. The term "qualifying month" is defined as a period of 16 days or more within one calendar month. The terms "quarter" and "quarterly basis" are defined as three qualifying months.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 22 Ok Reg 407, eff 11-1-04 (emergency); Amended at 21 Ok Reg 2471, eff 7-11-05 ; Amended at 24 Ok Reg 675, eff 2-1-07 (emergency); Amended at 24 Ok Reg 2104, eff 6-25-07 ; Amended at 25 Ok Reg 2668, eff 7-25-08 ; Amended at 32 Ok Reg 1041, eff 8-27-15]

317:30-5-135. Intermediate care facility for the mentally retarded (ICF/MR) service fee [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 12 Ok Reg 3644, eff 9-8-95 (emergency); Amended at 13 Ok Reg 1645, eff 5-27-96 ; Revoked at 17 Ok Reg 3509, eff 9-1-00 (emergency); Revoked at 18 Ok Reg 1130, eff 5-11-01]

317:30-5-136. Nursing Facility Supplemental Payment Program [REVOKED]

[Source: Added at 34 Ok Reg 343, eff 12-29-16 (emergency); Added at 34 Ok Reg 666, eff 9-1-17 ; Amended at 35 Ok Reg 522, eff 2-27-18 (emergency); Amended at 35 Ok Reg 1440, eff 9-14-18 ; Amended at 36 Ok Reg 864, eff 9-1-19 ; Revoked at 37 Ok Reg 1602, eff 9-14-20]

317:30-5-136.1. Pay-for-Performance (PFP) program

317:30-5-136.1.¹ Pay-for-Performance (PFP) program

(a) **Purpose.** The PFP program was established through Oklahoma State Statute, Title 56, Section 56-1011.5 as amended. PFP's mission is to enhance the quality of life for target citizens by delivering effective programs and facilitating partnerships with providers and the community they serve. The program has a full commitment to the very best in quality, service and value which will lead to measurably improved quality outcomes, healthier lifestyles, greater satisfaction and confidence for our members.

(b) **Eligible providers.** Any Oklahoma long-term care nursing facility that is licensed and certified by the Oklahoma State Department of Health (OSDH) as defined in Oklahoma Administrative Code (OAC)

317:30-5-120.

(c) **Quality measure care criteria.** To maintain status in the PFP program, each nursing facility shall submit documentation as it relates to program metrics quarterly or upon the request of the Oklahoma Health Care Authority (OHCA). The program metrics can be found on the OHCA's PFP website or on PFP/Quality of Care (QOC) data collection portal. If any quality metric, listed below, is substituted or removed by Centers of Medicare and Medicaid Services (CMS), an alternative quality metric may be chosen with the support of participating partners. For the period beginning October 1, 2019 and until changed by amendment, qualifying facilities participating in the PFP program have the potential to earn an average of the five dollars (\$5.00) quality incentive per Medicaid patient per day. Facility(s) baseline is calculated annually and will remain the same for the twelve (12) month period. Facility(s) will meet or exceed five-percent (5%) relative improvement or the CMS' national average each quarter for the following metrics:

- (1) Decrease percent of high risk/unstageable pressure ulcers for long-stay residents.
- (2) Decrease percent of unnecessary weight loss for long-stay residents.
- (3) Decrease percent of use of anti-psychotic medications for long-stay residents.
- (4) Decrease percent of urinary tract infection for long-stay residents.

(d) **Payment.** Payment to long-term care facilities for meeting the metrics will be awarded quarterly. A facility may earn a minimum of one dollar and twenty-five cents (\$1.25) per Medicaid patient per day for each qualifying metric. A facility receiving a scope and severity tag deficiency of "I" or greater from the Oklahoma State Department of Health will forfeit the PFP incentive for the quarter out of compliance.

- (1) **Distribution of payment.** OHCA will notify the PFP facility of the quality reimbursement amount on a quarterly basis.
- (2) **Penalties.** Facilities shall have performance review(s) and provide documentation upon request from OHCA to maintain program compliance. Program payments will be withheld from facilities that fail to submit the requested documentation within fifteen (15) business days of the request.
- (3) **Timeframe.** To qualify for program reimbursement by meeting a specific quality measure, facilities are required to provide metric documentation within thirty (30) days after the end of each quarter to the OHCA.

(e) **Appeals.** Facilities can file an appeal with the Quality Review Committee and in accordance, with the grievance procedures found at OAC 317:2-1-2(c) and 317:2-1-17.

[Source: Added at 35 Ok Reg 1446, eff 9-14-18 ; Amended at 36 Ok Reg 864, eff 9-1-19 ; Amended at 37 Ok Reg 214, eff 10-25-19 (emergency); Amended at 37 Ok Reg 1506, eff 9-14-20 ; Amended at 38 Ok Reg 410, eff 1-1-21 (emergency); Amended at 38 Ok Reg 999, eff 9-1-21 ; Amended at 40 Ok Reg 2196, eff 9-11-23]

Editor's Note: ¹ Editorially renumbered from 317:30-5-137 to 317:30-5-136.1, to avoid a duplication in numbering.

PART 10. BARIATRIC SURGERY

317:30-5-137. Bariatric surgery

(a) **Bariatric surgery.** Gastric bypass and other types of weight-loss surgery, known as bariatric surgery, makes surgical changes to the stomach and digestive system, limits food intake and nutrient absorption, which leads to weight loss.

(b) **Eligible providers.** Bariatric surgery providers must be:

- (1) Certified by the American College of Surgeons (ACS) Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) as a Comprehensive Bariatric Surgery Center; or
- (2) Currently participating in a comprehensive multidisciplinary bariatric surgery quality assurance program and a clinical outcomes assessment review as a pathway to accreditation; and
- (3) Completed a fellowship training in bariatric surgery or be a fellow of the American Society of Metabolic and Bariatric Surgery (ASMBS) or a MBSAQIP verified surgeon; and
- (4) Contracted with the Oklahoma Health Care Authority (OHCA); and
- (5) Have a demonstrated record of quality assurance.

(c) **Documentation.** All documentation submitted to request services must demonstrate, through adequate objective medical records, evidence sufficient to justify the member's need for the service, in accordance with OAC 317:30-3-1(f). Documentation requirements include, but are not limited to:

- (1) Documents sufficient to show that member is between the ages of fifteen (15) to sixty-five (65);
- (2) Psychosocial evaluation;
- (3) Independent medical evaluation by a health care professional with dedicated expertise in the care of bariatric surgery patients;
- (4) Surgical evaluation by an OHCA-contracted surgeon who is credentialed to perform bariatric surgery;
- (5) Record on participation in a nutrition and lifestyle modification program under the supervision of an OHCA contracted medical provider; and
- (6) For full guidelines, please refer to www.okhca.org/mau.

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

- (1) Procedures considered experimental or investigational are not covered.
- (2) The OHCA may withdraw authorization of payment for the bariatric surgery at any time if the OHCA determines that the member, provider, or bariatric program is not in compliance with any of the requirements.

(e) Reimbursement.

(1) Reimbursement shall only be made for services that have been prior-authorized by OHCA or its designee.

(2) To be eligible for reimbursement, bariatric surgery providers must meet the requirements listed in (b) (1) through (5) of this Section.

(3) Payment shall be made at the lower of the provider's usual and customary charge or the OHCA fee schedule for Medicaid compensable services and in accordance with the Oklahoma Medicaid State Plan.

[**Source:** Added at 24 Ok Reg 141, eff 10-8-06 (emergency); Added at 24 Ok Reg 890, eff 5-11-07 ; Amended at 27 Ok Reg 450, eff 12-3-09 (emergency); Amended at 27 Ok Reg 939, eff 5-13-10 ; Amended at 38 Ok Reg 1004, eff 9-1-21]

Editor's Note: *In 2018, a new Section entitled "Focus on Excellence" was promulgated at this Section number 317:30-5-137, creating a duplication in numbering. The new Section was published at 35 Ok Reg 1446, and was editorially renumbered to 317:30-5-136.1 prior to being published in the 2018 OAC Supplement.*

317:30-5-137.1. Member candidacy [REVOKED]

[**Source:** Added at 27 Ok Reg 450, eff 12-3-09 (emergency); Added at 27 Ok Reg 939, eff 5-13-10 ; Revoked at 38 Ok Reg 1004, eff 9-1-21]

317:30-5-137.2. General coverage [REVOKED]

[**Source:** Added at 27 Ok Reg 450, eff 12-3-09 (emergency); Added at 27 Ok Reg 939, eff 5-13-10 ; Revoked at 38 Ok Reg 1004, eff 9-1-21]

317:30-5-138. General coverage [REVOKED]

[**Source:** Added at 24 Ok Reg 141, eff 10-8-06 (emergency); Added at 24 Ok Reg 890, eff 5-11-07 ; Revoked at 27 Ok Reg 450, eff 12-3-09 (emergency); Revoked at 27 Ok Reg 939, eff 5-13-10]

317:30-5-139. Member requirements [REVOKED]

[**Source:** Added at 24 Ok Reg 141, eff 10-8-06 (emergency); Added at 24 Ok Reg 890, eff 5-11-07 ; Revoked at 27 Ok Reg 450, eff 12-3-09 (emergency); Revoked at 27 Ok Reg 939, eff 5-13-10]

317:30-5-140. Coverage for children

Bariatric surgery services are currently allowed for members aged fifteen (15) to sixty-five (65), per OAC 317:30-5-137 (c) (1). Exceptions may be granted for member's younger than fifteen (15) if they are proven to be medically necessary and are prior authorized. State and Federal Medicaid law, including, but not limited to, Oklahoma's federally-approved State Medicaid Plan, require the State to make the determination as to whether services are medically necessary and does not allow for reimbursement of any items or services that the State determines are not safe and effective or which are considered

experimental. For more information regarding experimental or investigational including clinical trials, see OAC 317:30-3-57.1.

[Source: Added at 24 Ok Reg 141, eff 10-8-06 (emergency); Added at 24 Ok Reg 890, eff 5-11-07 ; Amended at 38 Ok Reg 1004, eff 9-1-21]

317:30-5-141. Reimbursement [REVOKED]

[Source: Added at 24 Ok Reg 141, eff 10-8-06 (emergency); Added at 24 Ok Reg 890, eff 5-11-07 ; Revoked at 38 Ok Reg 1004, eff 9-1-21]

PART 11. MATERNITY CLINIC SERVICES [REVOKED]

317:30-5-175. Eligible providers [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 24 Ok Reg 2070, eff 6-25-07]

317:30-5-176. Coverage by category [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 16 Ok Reg 141, eff 10-14-98 (emergency); Amended at 16 Ok Reg 1429, eff 5-27-99 ; Revoked at 24 Ok Reg 2070, eff 6-25-07]

317:30-5-177. Payment rates [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 19 Ok Reg 2134, eff 6-27-02]

317:30-5-178. Covered services [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 24 Ok Reg 2070, eff 6-25-07]

317:30-5-179. Billing [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 19 Ok Reg 2134, eff 6-27-02]

PART 12. THE OKLAHOMA PRESCRIPTION DRUG DISCOUNT PROGRAM

317:30-5-180. Purpose and general provisions

The purpose of this Part is to establish guidelines for the Oklahoma Prescription Drug Discount Program (OPDDP) under Title 59, O.S., Section 353.5 et seq. The Oklahoma Prescription Drug Discount Program (OPDDP) enables Oklahomans without prescription drug coverage to purchase prescription drugs at the lowest possible out-of-pocket cost through the OPDDP's pharmacy network. The Oklahoma Health Care

Authority (OHCA) contracts with a Pharmacy Benefit Manager (PBM) to administer the program. The OPDDP does not purchase drugs.

[Source: Added at 24 Ok Reg 303, eff 12-1-06 (emergency); Added at 24 Ok Reg 676, eff 2-1-07 (emergency); Added at 24 Ok Reg 2082, eff 6-25-07]

317:30-5-180.1. Definitions

The following words and terms, when used in this Part, have the following meaning, unless the context clearly indicates otherwise:

"Enrollment Fee" means the amount charged per individual to enroll in the OPDDP.

"Network" means a group of individual retail pharmacies that contract with the designated Pharmacy Benefit Manager to participate in the OPDDP and honor the discount offered through this program.

"Patient Assistance Programs (PAP)" means a program that some pharmaceutical companies use to offer medication assistance to low-income individuals and families. These programs typically require a doctor's consent and proof of financial status. They may also require the individual applying for their program either have no health insurance, or no prescription drug benefit through their health insurance. Each pharmaceutical company has specific eligibility requirements and application information. Neither OHCA nor the contracted PBM have any authority or responsibility for the structure of these private programs.

"Pharmacy Benefit Manager (PBM)" means the company contracted by OHCA to manage pharmacy networks, formularies, drug utilization reviews, pharmacotherapeutic outcomes, claims and/or other features of a pharmacy benefit.

"Prescription Drug" means a drug which can be dispensed only upon prescription by a health care professional authorized by his or her licensing authority and which is approved for safety and effectiveness as a prescription drug under Section 505 or 507 of the Federal Food, Drug and Cosmetic Act (52 Stat. 1040 (1938), 21 U.S.C.A., Section 301).

"Prescription Drug Coverage" means a payment or discount applied toward prescription drugs purchased by or for a consumer as part of a health insurance benefit.

[Source: Added at 24 Ok Reg 303, eff 12-1-06 (emergency); Added at 24 Ok Reg 676, eff 2-1-07 (emergency); Added at 24 Ok Reg 2082, eff 6-25-07]

317:30-5-180.2. Eligibility

In order to be eligible for the OPDDP, an individual must:

- (1) be an Oklahoma resident;
- (2) apply with the Pharmacy Benefit Manager (PBM);
- (3) not have insurance to cover all or part of prescriptions;
- (4) pay an enrollment fee when income is above 150% Federal Poverty Level (FPL); and
- (5) provide verification of income to determine enrollment fee, co-pay, and eligibility for the manufacturer's PAP.

[Source: Added at 24 Ok Reg 303, eff 12-1-06 (emergency); Added at 24 Ok Reg 676, eff 2-1-07 (emergency); Added at 24 Ok Reg 2082, eff 6-25-07]

317:30-5-180.3. Services

- (a) Services provided through the OPDDP include a discount negotiated by the PBM for prescription drugs. The member purchases these discounted drugs with their OPDDP drug card at a Network pharmacy.
- (b) The Patient Assistance Program (PAP) Application Assistance service provides a point of contact and applications to assist qualified members in applying for free or substantially reduced prices on prescription drugs through the manufacturer's Patient Assistance Programs.

[Source: Added at 24 Ok Reg 303, eff 12-1-06 (emergency); Added at 24 Ok Reg 676, eff 2-1-07 (emergency); Added at 24 Ok Reg 2082, eff 6-25-07]

317:30-5-180.4. Fraud

Applicants should be advised that the knowing misrepresentation of income or other information constitutes fraud and could lead to prosecution and recoupment of funds expended on their behalf.

[Source: Added at 24 Ok Reg 303, eff 12-1-06 (emergency); Added at 24 Ok Reg 676, eff 2-1-07 (emergency); Added at 24 Ok Reg 2082, eff 6-25-07]

317:30-5-180.5. Pharmacy Benefit Manager

- (a) The Oklahoma Health Care Authority (OHCA) will designate a PBM utilizing a competitive bidding process under state law.
- (b) The designated PBM administers the OPDDP subject to administrative rules regulating the program and contract requirements placed upon the PBM.
- (c) Per state law, all discounts must be passed through 100% to the member. No portion of any negotiated discount, rebate, or any other discount may be retained by the PBM to fund the OPDDP or for any other use.

[Source: Added at 24 Ok Reg 303, eff 12-1-06 (emergency); Added at 24 Ok Reg 676, eff 2-1-07 (emergency); Added at 24 Ok Reg 2082, eff 6-25-07]

PART 13. HIGH RISK PREGNANT WOMEN CASE MANAGEMENT SERVICES [REVOKED]

317:30-5-185. Eligible providers and services [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 24 Ok Reg 2070, eff 6-25-07]

317:30-5-186. Coverage [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 24 Ok Reg 2070, eff 6-25-07]

317:30-5-187. Payment rates [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 19 Ok Reg 2134, eff 6-27-02 ; Revoked at 24 Ok Reg 2070, eff 6-25-07]

317:30-5-188. Documentation of records [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 24 Ok Reg 2070, eff 6-25-07]

PART 14. TARGETED CASE MANAGEMENT SERVICES FOR FIRST TIME MOTHERS AND THEIR INFANTS/CHILDREN [REVOKED]

317:30-5-190. Eligible providers and services [REVOKED]

[Source: Added at 15 Ok Reg 1892, eff 3-17-98 (emergency); Added at 16 Ok Reg 1709, eff 3-9-99 (emergency); Added at 17 Ok Reg 1204, eff 5-11-00 ; Amended at 18 Ok Reg 2569, eff 6-25-01 ; Revoked at 24 Ok Reg 2070, eff 6-25-07]

317:30-5-191. Coverage [REVOKED]

[Source: Added at 15 Ok Reg 1892, eff 3-17-98 (emergency); Added at 16 Ok Reg 1429, eff 5-27-99 ; Amended at 18 Ok Reg 2569, eff 6-25-01 ; Revoked at 24 Ok Reg 2070, eff 6-25-07]

317:30-5-192. Payment rates [REVOKED]

[Source: Added at 15 Ok Reg 1892, eff 3-17-98 (emergency); Added at 16 Ok Reg 1429, eff 5-27-99 ; Amended at 18 Ok Reg 2569, eff 6-25-01 ; Amended at 19 Ok Reg 2134, eff 6-27-02 ; Revoked at 24 Ok Reg 2070, eff 6-25-07]

317:30-5-193. Documentation of records [REVOKED]

[Source: Added at 15 Ok Reg 1892, eff 3-17-98 (emergency); Added at 16 Ok Reg 1429, eff 5-27-99 ; Revoked at 24 Ok Reg 2070, eff 6-25-07]

PART 15. CHILD HEALTH CENTERS [REVOKED]

317:30-5-195. General provisions [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 19 Ok Reg 2134, eff 6-27-02 ; Amended at 23 Ok Reg 2463, eff 6-25-06 ; Revoked at 24 Ok Reg 2070, eff 6-25-07]

317:30-5-196. Eligible providers [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 23 Ok Reg 2463, eff 6-25-06 ; Revoked at 24 Ok Reg 2070, eff 6-25-07]

317:30-5-197. Periodicity schedule [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 23 Ok Reg 2463, eff 6-25-06 ; Revoked at 24 Ok Reg 2070, eff 6-25-07]

317:30-5-198. Coverage by category [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 14 Ok Reg 524, eff 12-24-96 (emergency); Amended at 14 Ok Reg 1785, eff 5-27-97 ; Amended at 16 Ok Reg 48, eff 9-11-98 (emergency); Amended at 16 Ok Reg 1429, eff 5-27-99 ; Amended at 16 Ok Reg 1927, eff 6-11-99 ; Amended at 21 Ok Reg 2201, eff 6-25-04 ; Amended at 23 Ok Reg 2463, eff 6-25-06 ; Revoked at 24 Ok Reg 2070, eff 6-25-07]

317:30-5-199. Periodic screening examination [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 23 Ok Reg 2463, eff 6-25-06 ; Revoked at 24 Ok Reg 2070, eff 6-25-07]

317:30-5-200. Interperiodic screening examination [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 19 Ok Reg 2134, eff 6-27-02 ; Revoked at 23 Ok Reg 2463, eff 6-25-06]

317:30-5-201. Reporting of suspected child abuse/neglect [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 23 Ok Reg 2463, eff 6-25-06 ; Revoked at 24 Ok Reg 2070, eff 6-25-07]

317:30-5-202. Payment rates and billing [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 19 Ok Reg 2134, eff 6-27-02]

317:30-5-203. Billing [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 19 Ok Reg 2134, eff 6-27-02]

PART 16. MATERNAL AND INFANT HEALTH LICENSED CLINICAL SOCIAL WORKERS

317:30-5-204. General information

The emphasis of maternal and infant health licensed clinical social work services is on providing psychosocial support, health and behavior assessment and intervention focused on biopsychosocial factors related to the member's perinatal health status. These services are intended for women who are at risk due to drug/alcohol use, domestic violence, lack of stable food/shelter, have high risk medical conditions, problems in the post partum environment that interfere with the infant health and

bonding and/or other psychosocial concerns.

[Source: Added at 25 Ok Reg 423, eff 11-1-07 (emergency); Added at 25 Ok Reg 1161, eff 5-25-08]

317:30-5-205. Eligible providers

Eligible providers are Licensed Clinical Social Workers (LCSWs) with a minimum of six hours of continuing education or technical assistance in the area of Maternal and Infant Health. LCSWs must have a current contract on file with the Oklahoma Health Care Authority and be licensed in the state in which the service is being provided. Services may also be provided through the Department of Health or other county health departments. Services provided through the health departments must be provided by a LCSW. In the event of a post-payment audit, LCSWs providing Maternal and Infant Health Clinical Social Work services must be able to demonstrate that they have completed at least six hours of continuing education or technical assistance for each calendar year of providing care to SoonerCare members. The continuing education or technical assistance must be in the area of Maternal and Infant Health relevant to the provision of Social Work Services.

[Source: Added at 25 Ok Reg 423, eff 11-1-07 (emergency); Added at 25 Ok Reg 1161, eff 5-25-08]

317:30-5-206. Coverage

Maternal and infant health social work services are covered for pregnant and postpartum women for whom a psychosocial condition exists that may negatively impact the pregnancy and/or well being of the newborn infant. SoonerCare members may self-refer or be referred by any provider. Identification of the condition may be based on a CH-16 or the Licensed Clinical Social Worker's initial assessment. Psychosocial assessment/counseling is appropriate in order to develop a social work care plan based upon the health risks due to psychosocial factors.

[Source: Added at 25 Ok Reg 423, eff 11-1-07 (emergency); Added at 25 Ok Reg 1161, eff 5-25-08]

317:30-5-207. Limitations

Coverage limitations for maternal and infant health social work services are as follows:

- (1) Services are only covered when performed in the LCSWs' office setting, patient's home or other confidential clinic setting.
- (2) No separate reimbursement will be made to a facility.
- (3) Services billed by a contracted LCSW must be provided face-to-face and in an individual setting.

[Source: Added at 25 Ok Reg 423, eff 11-1-07 (emergency); Added at 25 Ok Reg 1161, eff 5-25-08]

317:30-5-208. Reimbursement

- (a) Maternal and infant health social work services must be billed using appropriate CPT codes and guidelines.
- (b) SoonerCare does not allow more than thirty-two (32) units [fifteen (15) minutes = one (1) unit] during the pregnancy which includes twelve

(12) months postpartum.

(c) LCSWs that are employed by or remunerated by another provider may not bill the SoonerCare program directly for services if that billing would result in duplicate payment for the same service.

(d) Only the LCSW directly performing the care or a county health department may bill the SoonerCare Program.

(e) The time indicated on the claim form must be the time actually spent with the member.

[Source: Added at 25 Ok Reg 423, eff 11-1-07 (emergency); Added at 25 Ok Reg 1161, eff 5-25-08 ; Amended at 40 Ok Reg 652, eff 2-21-23 (emergency); Amended at 40 Ok Reg 2175, eff 9-11-23]

317:30-5-209. Documentation

All services must be reflected by documentation in the patient records. All assessment and treatment services must include the following:

- (1) date;
- (2) start and stop time for each timed treatment session;
- (3) signature of the service provider;
- (4) credentials of service provider;
- (5) documentation of the referral source;
- (6) problems(s), goals and/or objectives identified on the treatment plan;
- (7) methods used to address the problem(s), goals and objectives;
- (8) progress made toward goals and objectives;
- (9) patient response to the session or intervention; and
- (10) any new problem(s), goals and/or objectives identified during the session.

[Source: Added at 25 Ok Reg 423, eff 11-1-07 (emergency); Added at 25 Ok Reg 1161, eff 5-25-08]

PART 17. MEDICAL SUPPLIERS

317:30-5-210. Eligible providers

All eligible medical suppliers must have a current contract with the Oklahoma Health Care Authority (OHCA). The supplier must comply with all applicable state and federal laws. All suppliers of medical supplies, equipment, and appliances must be accredited by a Medicare deemed accreditation organization for quality standards for durable medical equipment (DME) suppliers in order to bill the SoonerCare program. OHCA may make exceptions to this standard based on the exemptions provided by the Centers for Medicare and Medicaid Services (CMS) for Medicare accreditation, if the provider is a government-owned entity, or at a provider's request and at the discretion of OHCA based on access issues and/or agency needs for SoonerCare members. Additionally, unless an exception is granted from the OHCA, all DME providers must meet the following criteria:

- (1) DME providers are required to have a physical location in the State of Oklahoma, or within a designated range of the Oklahoma

State border, as determined by the OHCA. The OHCA may make exceptions to this requirement if a DME provider provides a specialty item, product, or service, which is not otherwise available to SoonerCare members within the State of Oklahoma. Provider contracts for out-of-state DME providers will be reviewed on a case-by-case basis for specialty items only. The OHCA has discretion and the final authority to approve or deny any provider contract.

(2) DME providers are required to comply with Medicare DME Supplier Standards for medical supplies, equipment, and appliances provided to SoonerCare members, except the requirement to meet surety bond requirements, as specified in 42 Code of Federal Regulations (C.F.R.) 424.57(c).

(3) Complex rehabilitation technology (CRT) suppliers are considered DME providers. Only CRT suppliers may bill CRT procedure codes. A CRT supplier means a company or entity that:

(A) Is accredited by a recognized accrediting organization as a supplier of CRT;

(B) Is an enrolled Medicare supplier and meets the supplier and quality standards established for DME suppliers, including those for CRT, under the Medicare program;

(C) Employs as a W-2 employee at least one (1) qualified CRT professional, also known as assistive technology professional, for each location to:

(i) Analyze the needs and capacities of complex-needs patients in consultation with qualified health care professionals;

(ii) Participate in selecting appropriate CRT items for such needs and capacities; and

(iii) Provide the complex-needs patient technology related training in the proper use and maintenance of the CRT items.

(D) Requires a qualified CRT professional be physically present for the evaluation and determination of the appropriate CRT;

(E) Has the capability to provide service and repair by qualified technicians for all CRT items it sells; and

(F) Provides written information to the complex-needs patient prior to ordering CRT as to how to access service and repair.

(4) For additional requirements regarding DME providers of donor human breast milk, please refer to OAC 317:30-5-211.29.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 25 Ok Reg 424, eff 11-1-07 (emergency); Amended at 25 Ok Reg 1161, eff 5-25-08 ; Amended at 28 Ok Reg 1429, eff 6-25-11 ; Amended at 33 Ok Reg 802, eff 9-1-16 ; Amended at 39 Ok Reg 394, eff 12-21-21 (emergency); Amended at 39 Ok Reg 1430, eff 9-12-22 ; Amended at 40 Ok Reg 365, eff 11-4-22 (emergency); Amended at 40 Ok Reg 2206, eff 9-11-23]

317:30-5-210.1. Coverage for adults

Coverage of medical supplies, equipment, and appliances for adults complies with 42 Code of Federal Regulations (C.F.R.) § 440.70 and is specified in Oklahoma Administrative Code (OAC) 317:30-5-211.1 through OAC 317:30-5-211.19.

[Source: Added at 27 Ok Reg 453, eff 12-3-09 (emergency); Added at 27 Ok Reg 942, eff 5-13-10 ; Amended at 39 Ok Reg 394, eff 12-21-21 (emergency); Amended at 39 Ok Reg 1430, eff 9-12-22]

317:30-5-210.2. Coverage for children

(a) **Coverage.** Medical supplies, equipment, and appliances are covered for children.

(b) **Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services.** EPSDT services, supplies, or equipment that are determined to be medically necessary for a child, and which are included within the categories of mandatory and optional services in Section 1905(a) of Title XIX, are covered regardless of whether such services, supplies, or equipment are listed as covered in the Oklahoma Medicaid State Plan.

(c) **Medical necessity.** Federal regulations require the Oklahoma Health Care Authority (OHCA) 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 that are considered experimental. For more information regarding clinical trials, see Oklahoma Administrative Code 317:30-3-57.1.

[Source: Added at 27 Ok Reg 453, eff 12-3-09 (emergency); Added at 27 Ok Reg 942, eff 5-13-10 ; Amended at 32 Ok Reg 728, eff 7-1-15 (emergency); Amended at 33 Ok Reg 857, eff 9-1-16 ; Amended at 39 Ok Reg 394, eff 12-21-21 (emergency); Amended at 39 Ok Reg 1430, eff 9-12-22]

317:30-5-211. Coverage for adults [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 13 Ok Reg 2321, eff 4-30-96 (emergency); Amended at 14 Ok Reg 764, eff 11-25-96 (emergency); Amended at 14 Ok Reg 1780, eff 5-27-97 ; Amended at 16 Ok Reg 3413, eff 7-1-99 (emergency); Amended at 17 Ok Reg 1204, eff 5-11-00 ; Amended at 18 Ok Reg 477, eff 1-1-01 (emergency); Amended at 18 Ok Reg 1130, eff 5-11-01 ; Amended at 24 Ok Reg 655, eff 2-1-07 (emergency); Amended at 24 Ok Reg 2083, eff 6-25-07 ; Revoked at 24 Ok Reg 2890, eff 7-1-07 (emergency); Revoked at 25 Ok Reg 1161, eff 5-25-08]

317:30-5-211.1. Definitions

The following words and terms, when used in this Part, have the following meaning, unless the context clearly indicates otherwise.

"Activities of daily living-basic" means a series of activities performed on a day-to-day basis that are necessary to care for oneself (e.g., personal hygiene, dressing, eating, maintaining continence and transferring).

"Activities of daily living-instrumental" means activities that are not necessarily required on a daily basis but are important to being able to live independently (e.g., basic communication skills, transportation, meal preparation, shopping, housework, managing medication and managing personal finances).

"Capped rental" means monthly payments for the use of the medical supplies, equipment, and appliances for a limited period of time

not to exceed thirteen (13) months. Items are considered purchased and owned by the Oklahoma Health Care Authority (OHCA) after thirteen (13) months of continuous rental.

"Certificate of medical necessity (CMN)" means a certificate which is required to help document the medical necessity and other coverage criteria for selected items. Those items are defined in this Chapter. The CMN must include the member's diagnosis, the reason the equipment is required, and the physician's, non-physician provider's (NPP's), or dentist's estimate, in months, of the duration of its need.

"Complex rehabilitation technology" means medically necessary durable medical equipment and items that are individually configured to meet specific and unique medical, physical, and functional needs and capacities for basic activities of daily living and instrumental activities of daily living of a member with complex needs. Such equipment and items include, but are not limited to, individually configured power wheelchairs and accessories, individually configured manual wheelchairs and accessories, adaptive seating and positioning systems and accessories, and other specialized equipment such as standing frames and gait trainers.

"Customized equipment and/or appliances" means items of equipment and/or appliances which have been uniquely constructed or substantially modified for a specific member according to the description and orders of the member's treating physician or other qualified medical professional. For instance, a wheelchair would be considered "customized" if it has been:

- (A) Measured, fitted, or adapted in consideration of the member's body size, disability, period of need, or intended use;
- (B) Assembled by a supplier or ordered from a manufacturer who makes available customized features, modifications, or components for wheelchairs; and
- (C) Intended for an individual member's use in accordance with instructions from the member's physician.

"Equipment and/or appliances" means items that are primarily and customarily used to serve a medical purpose, generally are not useful to an individual in the absence of a disability, illness or injury, can withstand repeated use, can be reusable or removable, and are suitable for use in any setting in which normal life activities take place other than a hospital, long-term care facility, intermediate care facility for individuals with intellectual disabilities, or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board. Refer to 42 Code of Federal Regulations (C.F.R.) 440.70(b).

"Face-to-face encounter" means a patient visit in which a practitioner, as defined by 42 C.F.R. 440.70(f), completes a face-to-face assessment related to the primary reason the beneficiary requires durable medical equipment. The face-to-face encounter must occur no more than six (6) months prior to the start of services. The ordering physician must document the face-to-face encounter, including the practitioner who conducted the encounter and the date of the encounter. Clinical findings must be incorporated into a written or electronic

document included in the beneficiary's medical record. The face-to-face encounter may occur through telehealth.

"Invoice" means a document that provides the following information when applicable: the description of product, quantity, quantity in box, purchase price, NDC, strength, dosage, provider, seller's name and address, purchaser's name and address, and date of purchase. At times, visit notes will be required to determine how much of the supply was expended. When possible, the provider should identify the SoonerCare member receiving the equipment or supply on the invoice.

"Medical supplies" means health care related items that are consumable or disposable, or cannot withstand repeated use by more than one (1) individual, that are required to address an individual medical disability, illness, or injury. Medical supplies do not include skin care creams, cleansers, surgical supplies, or medical or surgical equipment.

"OHCA CMN" means a certificate required to help document the medical necessity and other coverage criteria for selected items. Those items are defined in this Chapter. The CMN must include the member's diagnosis, the reason equipment is required, and the physician's, NPP's, or dentist's estimate, in months, of the duration of its need. This certificate is used when the OHCA requires a CMN and one (1) has not been established by CMS.

"Orthotics" means a device used to support, align, prevent or correct deformities, protect a body function, improve the function of movable body parts or to assist a dysfunctional joint.

"Patient with complex needs" means an individual with a diagnosis or medical condition that results in significant loss of physical or functional needs and capacities.

"Prosthetics" means an artificial substitute which replaces all or part of a body organ or replaces all or part of the function of a permanently inoperative, absent, or malfunctioning body part.

"Provider" refers to the treating provider and must be a physician [Medical Doctor (MD), or Doctor of Osteopathy, (DO)], a NPP [Physician Assistant (PA), or Advanced Practice Registered Nurse (APRN)], or a dentist [Doctor of Dental Surgery (DDS), or Doctor of Medicine in Dentistry (DMD)].

[Source: Added at 24 Ok Reg 2890, eff 7-1-07 (emergency); Added at 25 Ok Reg 1161, eff 5-25-08 ; Amended at 27 Ok Reg 453, eff 12-3-09 (emergency); Amended at 27 Ok Reg 942, eff 5-13-10 ; Amended at 32 Ok Reg 1043, eff 8-27-15 ; Amended at 33 Ok Reg 802, eff 9-1-16 ; Amended at 39 Ok Reg 394, eff 12-21-21 (emergency); Amended at 39 Ok Reg 1430, eff 9-12-22]

317:30-5-211.10. Medical supplies, equipment, and appliances

(a) **Medical supplies, equipment, and appliances.** See the definition for medical supplies, equipment, and appliances at Oklahoma Administrative Code (OAC) 317:30-5-211.1.

(b) **Certificate of medical necessity (CMN).** Certain items of medical supplies, equipment, and appliances require a CMN/OHCA CMN which should be submitted with the request for prior authorization. These items include, but are not limited to:

- (1) Enteral and parenteral nutrition; and

(2) Support surfaces.

(c) **Rental.** Several medical supplies, equipment, and appliance products are classified as either a capped rental or a continuous rental. Payment for a capped rental is capped at thirteen (13) months and a continuous rental is paid monthly for as long as it is medically necessary. Both require documentation showing that the product is medically necessary.

(d) **Purchase.** Medical supplies, equipment, and appliances may be purchased when a member requires the product for an extended period of time. During the prior authorization review, the Oklahoma Health Care Authority (OHCA) may change the authorization from a rental to a purchase or a purchase to a rental based on the documentation submitted.

(e) **Backup equipment.** Backup equipment is considered part of the rental cost and is not a covered service without prior authorization.

(f) **Home modification.** Home modifications that require permanent installation are not covered services as they are not removable and therefore do not meet the definition of medical supplies, equipment, and appliances per 42 Code of Federal Regulations (C.F.R.) § 440.70. Refer to Title 317, Chapters 40 and 50 for home modifications covered under Home and Community Based Services Waivers, including the ADvantage Waiver.

[Source: Added at 24 Ok Reg 2890, eff 7-1-07 (emergency); Added at 25 Ok Reg 1161, eff 5-25-08 ; Amended at 27 Ok Reg 303, eff 1-10-10 (emergency); Amended at 27 Ok Reg 628, eff 4-13-10 (emergency); Amended at 27 Ok Reg 1451, eff 6-11-10 ; Amended at 29 Ok Reg 1103, eff 6-25-12 ; Amended at 32 Ok Reg 1043, eff 8-27-15 ; Amended at 39 Ok Reg 394, eff 12-21-21 (emergency); Amended at 39 Ok Reg 1430, eff 9-12-22 ; Amended at 40 Ok Reg 2209, eff 9-11-23]

317:30-5-211.11. Oxygen and oxygen equipment

(a) **Medical necessity.** Oxygen and oxygen supplies are covered when medically necessary. Medical necessity is determined from results of arterial blood gas analysis (ABG) or pulse oximetry (SaO₂) tests. ABG data are not required for children, but may be used if otherwise available. The test results to document Medical Necessity must be within thirty (30) days of the date of the qualified medical practitioner's order. Prior authorization is required after the initial three (3) months of billing whether qualifying tests were done at rest, during sleep, or during exercise. Appropriate documentation of ABG or SaO₂ data from the member's chart should be attached to the prior authorization request (PAR).

(1) The ABG or oximetry test used to determine medical necessity must be performed by a medical professional qualified to conduct such testing. The test may not be performed or paid for by a DMEPOS supplier, or a related corporation. A referring qualified medical practitioner may perform the test in his/her office as part of routine member care.

(2) In addition to ABG data, the following three (3) tests are acceptable for determining medical necessity for oxygen prescription:

(A) At rest and awake "spot oximetry."

(B) During sleep:

- (i) Overnight Sleep Oximetry done inpatient or at home.
- (ii) Polysomnogram, which may be used only if medically necessary for concurrent evaluation of another condition while in a chronic stable state.
- (C) During exercise with all three (3) of the following performed in the same testing session.
 - (i) At rest, off oxygen showing a non-qualifying result.
 - (ii) During exercise, off oxygen showing a qualifying event.
 - (iii) During exercise, on oxygen showing improvement over test (C) ii above.
- (3) Certification criteria:
 - (A) All qualifying testing must meet the following criteria:
 - (B) Adults. Initial requests for oxygen must include ABG or resting oximetry results. At rest and on room air, the arterial blood saturation (SaO₂) cannot exceed eighty-nine percent (89%) or the pO₂ cannot exceed 59mm Hg.
 - (C) Children. Members twenty (20) years of age or less must meet the following requirements:
 - (i) birth through three (3) years, SaO₂ equal to or less than ninety-four percent (94%); or
 - (ii) ages four (4) and above, SaO₂ level equal to or less than ninety percent (90%).
 - (iii) Requests from the qualified medical practitioner for oxygen for children who do not meet these requirements should include documentation of the medical necessity based on the child's clinical condition. These requests are considered on a case-by-case basis.

(b) **Guidelines.** For full guidelines, please refer to www.okhca.org/mau.

[Source: Added at 24 Ok Reg 2890, eff 7-1-07 (emergency); Added at 25 Ok Reg 1161, eff 5-25-08 ; Amended at 31 Ok Reg 663, eff 8-1-14 (emergency); Amended at 32 Ok Reg 1047, eff 8-27-15 ; Amended at 40 Ok Reg 2209, eff 9-11-23]

317:30-5-211.12. Oxygen rental

A monthly rental payment is made for rental of liquid oxygen systems, gaseous oxygen systems and oxygen concentrators. The rental payment for a stationary system includes all contents and supplies, such as, regulators, tubing, masks, etc., that are medically necessary. An additional monthly payment may be made for a portable liquid or gaseous oxygen system based on medical necessity.

- (1) Stationary oxygen systems and portable oxygen systems are covered items for members residing in their home and in any setting in which normal life activities take place except for a hospital, long-term care facility, intermediate care facility for individuals with intellectual disabilities, or any other setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

(2) For members who meet medical necessity criteria, SoonerCare covers portable liquid or gaseous oxygen systems. Payment for both oxygen contents used with stationary oxygen equipment and oxygen contents used with portable oxygen equipment is included in the monthly payments for oxygen and oxygen equipment. The need for a portable oxygen system must be stated on the CMN. A portable system that is used as a backup system only is not a covered item.

(3) When four (4) or more liters of oxygen are medically necessary, an additional payment will be paid up to one hundred and fifty percent (150%) of the allowable for a stationary system when billed with the appropriate modifier.

[Source: Added at 24 Ok Reg 2890, eff 7-1-07 (emergency); Added at 25 Ok Reg 1161, eff 5-25-08 ; Amended at 27 Ok Reg 628, eff 4-13-10 (emergency); Amended at 27 Ok Reg 1451, eff 6-11-10 ; Amended at 31 Ok Reg 663, eff 8-1-14 (emergency); Amended at 32 Ok Reg 1047, eff 8-27-15 ; Amended at 39 Ok Reg 394, eff 12-21-21 (emergency); Amended at 39 Ok Reg 1430, eff 9-12-22]

317:30-5-211.13. Orthotics and prosthetics

(a) Coverage of prosthetics for non-expansion adults is limited to (1) home dialysis equipment and supplies, (2) nerve stimulators, (3) external breast prosthesis and support accessories, and (4) implantable devices inserted during the course of a surgical procedure. Prosthetics prescribed by an appropriate qualified provider and as specified in this section are covered items for non-expansion adults. There is no coverage of orthotics for non-expansion adults.

(1) **Home dialysis.** Equipment and supplies are covered items for members receiving home dialysis treatments only.

(2) **Nerve stimulators.** Payment is made for transcutaneous nerve stimulators, implanted peripheral nerve stimulators, and neuromuscular stimulators.

(3) **Breast prosthesis, bras, and prosthetic garments.**

(A) Payment is limited to:

(i) One (1) prosthetic garment with mastectomy form every twelve (12) months for use in the postoperative period prior to a permanent breast prosthesis or as an alternative to a mastectomy bra and breast prosthesis;

(ii) Two (2) mastectomy bras per year; and

(iii) One (1) silicone or equal breast prosthetic per side every twenty-four (24) months; or

(iv) One (1) foam prosthetic per side every six (6) months.

(B) Payment will not be made for both a silicone and a foam prosthetic in the same twelve (12) month period.

(C) Breast prostheses, bras, and prosthetic garments must be purchased from a Board Certified Mastectomy Fitter.

(D) A breast prosthesis can be replaced if:

(i) Lost;

(ii) Irreparable damaged (other than ordinary wear and tear); or

(iii) The member's medical condition necessitates a different type of item and the physician provides a new prescription explaining the need for a different type of prosthesis.

(E) External breast prostheses are not covered after breast reconstruction is performed except in instances where a woman with breast cancer receives reconstructive surgery following a mastectomy, but the breast implant fails or ruptures and circumstances are such that an implant replacement is not recommended by the surgeon and/or desired by the member.

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

(b) Orthotics and prosthetics are covered for expansion adults services when:

(1) Orthotics are medically necessary when required to correct or prevent skeletal deformities, to support or align movable body parts, or to preserve or improve physical function.

(2) Prosthetics are medically necessary as a replacement for all or part of the function of a permanently inoperative, absent, or malfunctioning body part. The member shall require the prosthesis for mobility, daily care, or rehabilitation purposes.

(3) In addition, orthotics and prosthetics must be:

(A) A reasonable and medically necessary part of the member's treatment plan;

(B) Consistent with the member's diagnosis and medical condition, particularly the functional limitations and symptoms exhibited by the member; and

(C) Of high quality, with replacement parts available and obtainable.

(c) Refer to Oklahoma Administrative Code (OAC) 317:30-5-211.1 for definitions of orthotics and prosthetics.

[Source: Added at 24 Ok Reg 2890, eff 7-1-07 (emergency); Added at 25 Ok Reg 425, eff 12-1-07 (emergency); Added at 25 Ok Reg 1161, eff 5-25-08 ; Amended at 27 Ok Reg 942, eff 5-13-10 ; Amended at 39 Ok Reg 394, eff 12-21-21 (emergency); Amended at 39 Ok Reg 1430, eff 9-12-22]

317:30-5-211.14. Nutritional support

(a) **Enteral nutrition.** Enteral nutrition administered only via gravity, syringe, or pump is covered for children and adults at home. Refer to pharmacy policy related to coverage of food supplements at Oklahoma Administrative Code (OAC) 317:30-5-72.1(2)(C). For enteral nutrition authorization guidelines, see OAC 317:30-5-211.20.

(b) **Parenteral nutrition.** The member must require intravenous feedings to maintain weight and strength commensurate with the member's overall health status. Adequate nutrition must not be possible by dietary adjustment and/or oral supplements.

(1) The member must have a permanent impairment. Permanence does not require a determination that there is no possibility that the member's condition may improve sometime in the future. If the judgment of the attending physician, substantiated in the medical record, is that the condition is of long and indefinite duration (ordinarily at least three (3) months), the test of permanence is met. Parenteral nutrition will be denied as a non-covered service in situations involving temporary impairments.

(2) The member must have a condition involving the small intestine, exocrine glands, or other conditions that significantly impair the absorption of nutrients. Coverage is also provided for a disease of the stomach and/or intestine that is a motility disorder and impairs the ability of nutrients to be transported through the GI system, and other conditions as deemed medically necessary. There must be objective medical evidence supporting the clinical diagnosis.

(3) Re-certification of parenteral nutrition will be required as medically necessary and determined by the Oklahoma Health Care Authority (OHCA) medical staff.

(c) **Long-term care facility enteral and parenteral nutrition.** Enteral and parenteral nutrition products supplied to long-term care facility residents are included in the long-term care facility per diem rate.

(d) **Claim submission requirements.** A written signed and dated order must be received by the supplier before a claim is submitted to the OHCA. If the supplier bills an item addressed in this policy without first receiving the completed order, the item will be denied as not medically necessary. The ordering physician is expected to see the member within thirty (30) days prior to the initial certification or required re-certification. If the physician does not see the member within this time frame, the physician must document the reason why and describe what other monitoring methods were used to evaluate the member's parenteral nutrition needs.

[Source: Added at 24 Ok Reg 2890, eff 7-1-07 (emergency); Added at 25 Ok Reg 1161, eff 5-25-08 ; Amended at 27 Ok Reg 942, eff 5-13-10 ; Amended at 39 Ok Reg 394, eff 12-21-21 (emergency); Amended at 39 Ok Reg 1430, eff 9-12-22]

317:30-5-211.15. Medical Supplies

The Oklahoma Health Care Authority (OHCA) provides coverage for medically necessary supplies that are prescribed by the appropriate medical provider and meet the member's specific needs. Medical supplies include, but are not limited to, IV therapy supplies, diabetic supplies, catheters, colostomy and urostomy supplies, and incontinence supplies.

[Source: Added at 24 Ok Reg 2890, eff 7-1-07 (emergency); Added at 25 Ok Reg 1161, eff 5-25-08 ; Amended at 27 Ok Reg 628, eff 4-13-10 (emergency); Amended at 27 Ok Reg 1451, eff 6-11-10 ; Amended at 31 Ok Reg 1642, eff 9-12-14 ; Amended at 33 Ok Reg 857, eff 9-1-16 ; Amended at 39 Ok Reg 394, eff 12-21-21 (emergency); Amended at 39 Ok Reg 1430, eff 9-12-22]

317:30-5-211.16. Coverage for long-term care facility residents

For residents in a long-term care facility, medical supplies, equipment and appliances are included in the facility's per diem rate.

Orthotics and prosthetics are paid separately from the per diem rate in accordance with the Oklahoma Medicaid State Plan. Refer to Oklahoma Administrative Code (OAC) 317:30-5-211.13 for orthotics and prosthetics coverage.

[Source: Added at 24 Ok Reg 2890, eff 7-1-07 (emergency); Added at 25 Ok Reg 1161, eff 5-25-08 ; Amended at 39 Ok Reg 394, eff 12-21-21 (emergency); Amended at 39 Ok Reg 1430, eff 9-12-22]

317:30-5-211.17. Wheelchairs

(a) **Definitions.** The following words and terms, when used in this Section, have the following meaning, unless the context clearly indicates otherwise.

(1) **"Assistive technology professional" or "ATP"** means a for-service provider who is involved in analysis of the needs and training of a consumer in the use of a particular assistive technology device or is involved in the sale and service of rehabilitation equipment or commercially available assistive technology products and devices. All ATPs are required to be credentialed by Rehabilitation Engineering and Assistive Technology Society of North America (RESNA).

(2) **"Custom seating system"** means a wheelchair seating system which is individually made for a member using a plaster model of the member, a computer-generated model of the member (e.g., CAD-CAM technology), or the detailed measurements of the member to create either:

(A) A molded, contoured, or carved (foam or other suitable material) custom-fabricated seating system that is incorporated into the wheelchair base; or

(B) A custom seating system made from multiple pre-fabricated components or a combination of custom fabricated materials and pre-fabricated components which have been configured and attached to the wheelchair base or incorporated into a wheelchair seat and/or back in a manner that the wheelchair could not be easily re-adapted for use by another individual.

(3) **"Specialty evaluation"** means the determination and documentation of the consumer's pathology, history and prognosis, and the physiological, functional, and environmental factors that impact the selection of an appropriate wheeled mobility system.

(b) **Medical Necessity.** Medical necessity, pursuant to Oklahoma Administrative Code (OAC) 317:30-5-211.2, is required for a wheelchair to be covered and reimbursed by SoonerCare. Only one (1) wheelchair is covered as medically necessary during its reasonable useful lifetime, unless the member's documented medical condition indicates the current wheelchair no longer meets the member's medical need. Backup wheelchairs are not covered items.

(c) **Prior authorization.** Prior authorization, pursuant to OAC 317:30-5-211.3, is required for selected wheelchairs to be covered and reimbursed by SoonerCare. All prior authorization requests for the purchase of a wheelchair must indicate the length of the warranty period and what is

covered under the warranty.

(1) Wheelchairs, wheelchair parts and accessories, and wheelchair modifications that are beneficial primarily in allowing the member to perform leisure or recreational activities are not considered medically necessary and will not be authorized.

(2) Wheelchair parts, accessories, and/or modifications that are distinctly and separately requested and priced from the original wheelchair request may require prior authorization.

(3) The Oklahoma Health Care Authority will deny prior authorization requests when the required forms have not been fully completed or the member's medical record does not provide sufficient information to establish medical necessity or to determine that the criteria for coverage has been met.

(d) **Coverage and limitations.** For members who reside in a long-term care facility or intermediate care facility for individuals with intellectual disabilities, all standard manual and power wheelchairs are considered part of the facility's per diem rate. Repairs and maintenance for wheelchairs are considered part of the facility's per diem rate.

(e) **Rental, repairs, maintenance, and delivery.** Refer to OAC 317:30-5-211.4 through 317:30-5-211.5.

(f) **Documentation.**

(1) The specialty evaluation or wheelchair selection documentation must be submitted with the prior authorization request.

(2) The specialty evaluation or wheelchair selection must be performed no longer than ninety (90) days prior to the submission of the prior authorization request.

(3) The results of the specialty evaluation or wheelchair selection documentation must be supported by the information submitted on the member's medical record.

(4) A copy of the dated and signed written specialty evaluation or wheelchair selection document must be maintained by the wheelchair provider. The results of the specialty evaluation or wheelchair selection must be written, signed, and dated by the medical professional who evaluated the member or the ATP who was involved in the wheelchair selection for the member.

[Source: Added at 27 Ok Reg 303, eff 1-1-10 (emergency); Added at 27 Ok Reg 1455, eff 6-11-10 ; Amended at 32 Ok Reg 1043, eff 8-27-15 ; Amended at 39 Ok Reg 394, eff 12-21-21 (emergency); Amended at 39 Ok Reg 1430, eff 9-12-22]

317:30-5-211.18. Ownership of durable medical equipment

Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) purchased by SoonerCare are the property of the Oklahoma Health Care Authority (OHCA) to be used for the benefit of the requesting member until it is no longer medically necessary. At such time as the item is no longer medically necessary, OHCA or an OHCA contractor may retrieve the DMEPOS product if it is determined to be administratively and fiscally prudent.

[Source: Added at 27 Ok Reg 456, eff 12-3-09 (emergency); Added at 27 Ok Reg 946, eff 5-13-10]

317:30-5-211.19. Quality assurances and safeguards

All SoonerCare billed durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) must have the following quality assurances and safeguards:

(1) All DMEPOS items provided to SoonerCare members must meet manufacturer standards. The equipment must be provided by trained professionals in a manner that is both nationally recognized for safe and effective member care and that meets the member's needs and therapeutic goals, and that the member has received the appropriate education in order to minimize any hazard or safety risks.

(A) DMEPOS suppliers must only provide items that meet applicable state and federal regulations and medical device effectiveness and safety standards.

(B) DMEPOS suppliers must make available the manufacturer copies of the features, warranties, and instructions for each type of item.

(2) All DMEPOS supplier personnel who are educating SoonerCare members, or repairing SoonerCare DMEPOS items, must be working within the scope of their practice and meet all state and federal requirements.

(A) DMEPOS suppliers must have equipment delivery, set-up, and member education accomplished by competent technical and professional personnel who are licensed, certified, or registered, and who are functioning within their scope of practice as required by state and federal standards.

(B) DMEPOS suppliers must provide the appropriate information about equipment set-up features, routine use, troubleshooting, cleaning, and maintenance.

(C) DMEPOS suppliers must provide education and instructional material that is tailored to the member's needs, abilities, learning preferences, and language.

(D) DMEPOS suppliers must make repairs and maintenance available on all equipment and item(s) provided.

(3) DMEPOS suppliers must implement a program that promotes the safe use of equipment, and minimizes safety risks, infections, and hazards. Suppliers must investigate any incident, injury, or infection in which DMEPOS items were a contributor.

(A) DMEPOS suppliers must provide relevant information about infection control issues related to the use of the equipment and item(s) provided.

(B) DMEPOS suppliers must ensure that the member can use all equipment and item(s) provided safely and effectively in the settings of anticipated use.

(4) DMEPOS suppliers must make available their regular business hours and after-hour access telephone numbers for customer service, and for information about equipment repair, and emergency coverage.

(5) DMEPOS suppliers must provide follow-up services to members, consistent with the types of equipment and item(s) provided, and recommendations from the prescribing physician.

[Source: Added at 28 Ok Reg 1478, eff 6-25-11]

317:30-5-211.2. Medical necessity

(a) **Coverage.** Coverage is subject to the requirement that the equipment be necessary and reasonable for the treatment of an illness or injury, or to improve the functioning of a malformed body member, in accordance with state and federal Medicaid law, including, but not limited to, Oklahoma Administrative Code (OAC) 317:30-3-1(f). The member's diagnosis must warrant the type of equipment or supply being purchased or rented. Items that are used for the following are not a benefit to a member of any age:

- (1) Routine personal hygiene;
- (2) Education;
- (3) Exercise;
- (4) Convenience, safety, or restraint of the member, or his or her family or caregiver;
- (5) Participation in sports; and/or
- (6) Cosmetic purposes.

(b) **Ordering requirements.** All medical supplies, equipment, and appliances as defined by 42 Code of Federal Regulations (C.F.R.) § 440.70 (b)(3) and OAC 317:30-5-211.1, nursing services, and home health aide services provided by a home health agency, must be ordered by a physician, nurse practitioner, clinical nurse specialist or physician assistant, working in accordance with State law, as part of a written plan of care.

- (1) The plan of care must be reviewed in accordance with 42 C.F.R. § 440.70. Medical supplies, equipment, and appliances must be reviewed annually by the ordering provider. Nursing services and home health aide services provided by a home health agency must be reviewed every sixty (60) days by the ordering provider.
- (2) A face-to-face encounter must occur and be documented, in accordance with 42 C.F.R. § 440.70 and OAC 317:30-5-211.1.

(c) **Prescription requirements.** All medical supplies, equipment, and appliances, as those terms are defined by 42 C.F.R. § 440.120 and OAC 317:30-5-211.1, except for hearing aid batteries and equipment repairs with a cost per item of less than \$1,000.00 total parts and labor, require a prescription signed by a physician, a physician assistant, or an advanced practice registered nurse. Except as otherwise stated in state or federal law, the prescription must be in writing, or given orally and later reduced to writing by the provider filling the order. Prescriptions are valid for no more than one (1) year from the date written. The prescription must include the following information:

- (1) The member's name;
- (2) The prescribing practitioner's name;
- (3) The date of the prescription;

(4) All items, options, or additional features that are separately billed. The description can be either a narrative description (e.g., lightweight wheelchair base), a Healthcare Common Procedure Coding System (HCPCS) code, a HCPCS code narrative, or a brand name/model number; and

(5) The prescribing practitioner's signature and signature date.

(d) **Certificate of medical necessity (CMN).** For certain items or services, the supplier must receive a signed CMN/OHCA CMN from the treating physician, non-physician practitioner, or dentist. The supplier must have a signed CMN/OHCA CMN in their records before they submit a claim for payment. The CMN/OHCA CMN may be faxed copy, electronic copy, or the original hardcopy.

(e) **Place of service.**

(1) The Oklahoma Health Care Authority (OHCA) covers medical supplies, equipment, and appliances for use in the member's place of residence and in any setting in which normal life activities take place except for a hospital, long-term care facility, intermediate care facility for individuals with intellectual disabilities, or any other setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

(2) For members residing in a hospital, long-term care facility, intermediate care facility for individuals with intellectual disabilities, or any other setting in which payment is or could be made under Medicaid for inpatient services that include room and board, medical supplies, equipment, and appliances are considered part of the facility's per diem rate.

(f) **Contracting requirements.** Per 42 C.F.R. 455.410(b), medical supplies, equipment, and appliances may only be ordered or prescribed by a Soonercare contracted provider.

[Source: Added at 24 Ok Reg 2890, eff 7-1-07 (emergency); Added at 25 Ok Reg 1161, eff 5-25-08 ; Amended at 29 Ok Reg 473, eff 5-11-12 ; Amended at 39 Ok Reg 394, eff 12-21-21 (emergency); Amended at 39 Ok Reg 1430, eff 9-12-22]

317:30-5-211.20. Enteral nutrition

(a) **Enteral nutrition.** Enteral nutrition is the delivery of nutrients directly into the stomach, duodenum, or jejunum.

(b) **Medical necessity.** Enteral nutrition supplies must be determined by a provider to be medically necessary and documented in the member's plan of care as medically necessary and used for medical purposes. Requests by qualified providers for enteral nutrition supplies in and of itself shall not constitute medical necessity. The Oklahoma Health Care Authority (OHCA) shall serve as the final authority pertaining to all determinations of medical necessity. Refer to Oklahoma Administrative Code (OAC) 317:30-5-211.2 and 317:30-3-1(f) for policy on medical necessity.

(c) **Documentation.** All documentation submitted to request services must demonstrate, through adequate objective medical records, evidence sufficient to justify the member's need for the service, in accordance with OAC 317:30-3-1(f)(2). Documentation must include:

- (1) Diagnosis;
- (2) Certificate of medical necessity (CMN);
- (3) Ratio data;
- (4) Route;
- (5) Caloric intake; and
- (6) Prescription.
- (7) For full guidelines, please refer to www.okhca.org/mau.

(d) **Reimbursement.**

- (1) Extension sets and Farrell bags are not covered when requested separately from the supply kits;
- (2) Enteral nutrition for individuals in long-term care facilities is not separately reimbursed as this is included in the per diem rate.

(e) **Non-covered items.** The following are non-covered items:

- (1) Orally administered enteral products and/or related supplies;
- (2) Formulas that do not require a prescription unless administered by tube;
- (3) Food thickeners and infant formula;
- (4) Pudding and food bars; and
- (5) Nursing services to administer or monitor the feedings of enteral nutrition.

[Source: Added at 39 Ok Reg 394, eff 12-21-21 (emergency); Added at 39 Ok Reg 1430, eff 9-12-22 ; Amended at 40 Ok Reg 365, eff 11-4-22 (emergency); Amended at 40 Ok Reg 2206, eff 9-11-23]

317:30-5-211.21. Incontinence supplies

(a) **Incontinence supplies and services.** Incontinence supplies and services are those supplies that are used to alleviate or prevent skin breakdown or excoriation associated with incontinence.

(b) **Medical necessity.** Incontinence supplies must be determined by a provider to be medically necessary and documented in the member's plan of care as medically necessary and used for medical purposes. A request by a qualified provider for incontinence supplies in and of itself shall not constitute medical necessity. The Oklahoma Health Care Authority (OHCA) shall serve as the final authority pertaining to all determinations of medical necessity. Refer to Oklahoma Administrative Code (OAC) 317:30-5-211.2 and 317:30-3-1(f) for policy on medical necessity.

(c) **Documentation.** All documentation submitted to request services must demonstrate, through adequate objective medical records, evidence sufficient to justify the member's need for the service, in accordance with OAC 317:30-3-1(f)(2). Documentation must include:

- (1) A signed prescription by a provider specifying the requested item;
- (2) A documented diagnosis of an underlying chronic medical condition that involves loss of bladder or bowel control;
- (3) Documentation must include the height and weight of the member, the type of incontinence (bowel/bladder/combined), and expected length of need;
- (4) Requests submitted for underwear/pull-on(s) the member must be ambulatory or in toilet training;
- (5) The member may qualify for incontinence supplies for a short period of time when the member has documented full-skin

thickness injuries;

(6) When requesting wipes as incontinence supplies, documentation must be submitted specific to the supply being requested. Disposable wipes are only allowed when diapers have been approved;

(7) For full guidelines, please refer to www.okhca.org/mau.

(d) **Quantity limits.** There is a quantity limit to the products allowed as well as product combinations. For a listing of quantity limits on specific products, refer to the OHCA website, under the Durable Medical Equipment page, "Incontinence Supplies". Requests for quantities or combinations outside of the limits published will require additional medical review for approval.

(e) **Non-covered items.** The following are non-covered items:

- (1) Incontinence supplies for members under the age of four (4) years;
- (2) Reusable underwear and/or reusable pull-ons;
- (3) Reusable briefs and/or reusable diapers;
- (4) Diaper service for reusable diapers;
- (5) Feminine hygiene products;
- (6) Disposable penile wraps; and
- (7) Shipping costs.

[Source: Added at 39 Ok Reg 394, eff 12-21-21 (emergency); Added at 39 Ok Reg 1430, eff 9-12-22]

317:30-5-211.22. Pulse oximeter

(a) **Pulse oximeter.** Pulse oximeter is a device used for measuring blood oxygen levels in a non-invasive manner.

(b) **Medical necessity.** Pulse oximeters must be determined by a provider to be medically necessary and documented in the member's plan of care as medically necessary and used for medical purposes. A request by a qualified provider for pulse oximeters in and of itself shall not constitute medical necessity. The Oklahoma Health Care Authority (OHCA) shall serve as the final authority pertaining to all determinations of medical necessity. Refer to Oklahoma Administrative Code (OAC) 317:30-5-211.2 and OAC 317:30-3-1(f) for policy on medical necessity.

(c) **Documentation.** All documentation submitted to request services must demonstrate, through adequate objective medical records, evidence sufficient to justify the member's need for the service, in accordance with OAC 317:30-3-1(f)(2). Documentation must include:

- (1) A current oxygen order signed and dated by an OHCA-contracted provider;
 - (2) Pertinent information relating to the member's underlying diagnosis and condition which results in the need for the oximeter and supplies, including documentation of unstable airway events and documentation of current monitor readings if available; and
 - (3) Documentation of an available trained caregiver in the home who is able to intervene and address changes in the member's oxygen saturation levels in a medically safe and appropriate manner.
- (4) For full guidelines, please refer to www.okhca.org/mau.

(d) Reimbursement.

- (1) Temporary probe covers are not reimbursed separately for rented oximeters as they are included in the price of the rental.
- (2) Pulse oximeters are not reimbursed in conjunction with apnea monitors.

[Source: Added at 39 Ok Reg 394, eff 12-21-21 (emergency); Added at 39 Ok Reg 1430, eff 9-12-22 ; Amended at 40 Ok Reg 2209, eff 9-11-23]

317:30-5-211.23. Continuous passive motion device for the knee

(a) Continuous passive motion (CPM). CPM is a postoperative treatment method designed to aid recovery of joint range of motion after joint surgery. CPM provides for early post-operative motion and is considered a substitute for active physical therapy (PT).

(b) Medical necessity. CPM must be determined by a provider to be medically necessary and documented in the member's plan of care as medically necessary and used for medical purposes. A request by a qualified provider for CPM in and of itself shall not constitute medical necessity. The Oklahoma Health Care Authority (OHCA) shall serve as the final authority pertaining to all determinations of medical necessity. Refer to Oklahoma Administrative Code (OAC) 317:30-5-211.2 and 317:30-3-1(f) for policy on medical necessity.

(1) A knee CPM device is covered for up to twenty-one (21) days and does not require a prior authorization (PA) for a patient in an early phase of rehabilitation.

(2) A knee CPM device required for more than twenty-one (21) days does require a PA of the additional days. These cases will be individually reviewed for medical necessity.

(c) Documentation. All documentation submitted to request services must demonstrate, through adequate objective medical records, evidence sufficient to justify the member's need for the service, in accordance with OAC 317:30-3-1(f)(2).

(1) Documentation must include:

- (A) Type of surgery performed;
- (B) Date of surgery;
- (C) Date of application of CPM;
- (D) Date of discharge from the hospital; and
- (E) Written prescription issued by a licensed prescriber that is signed and dated no more than thirty (30) days prior to the first date of service and that defines the specific "from" and "to" dates that reflect the actual days the CPM device is to be utilized.

(2) For full guidelines, please refer to www.okhca.org/mau.

(d) Reimbursement.

- (1) Separate reimbursement will not be made for use of device while member is hospitalized or in a long-term care facility.
- (2) Billing for dates of service when the patient is no longer actively using the CPM device is not appropriate and is not reimbursable.

[Source: Added at 39 Ok Reg 394, eff 12-21-21 (emergency); Added at 39 Ok Reg 1430, eff 9-12-22]

317:30-5-211.24. Parenteral nutrition

(a) **Parenteral nutrition (PN).** PN is the provision of nutritional requirements intravenously.

(b) **Medical necessity.** PN must be determined by a provider to be medically necessary and documented in the member's plan of care as medically necessary and used for medical purposes. A request by a qualified provider for PN in and of itself shall not constitute medical necessity. The Oklahoma Health Care Authority (OHCA) shall serve as the final authority pertaining to all determinations of medical necessity. Refer to Oklahoma Administrative Code (OAC) 317:30-5-211.2 and 317:30-3-1(f) for policy on medical necessity.

(c) **Documentation.** All documentation submitted to request services must demonstrate, through adequate objective medical records, evidence sufficient to justify the member's need for the service, in accordance with OAC 317:30-3-1(f)(2).

(1) Hospital records that have objective medical evidence supporting the clinical diagnosis; if applicable;

(2) A certificate of medical necessity;

(3) A prescription; and

(4) Caloric Intake.

(5) For full guidelines, please refer to www.okhca.org/mau.

(d) **Reimbursement.**

(1) Supply kits are all inclusive, unbundled supplies (e.g., gloves, tubing, etc.) are not reimbursable for PN.

(2) Pumps are rented as a capped rental.

[Source: Added at 39 Ok Reg 394, eff 12-21-21 (emergency); Added at 39 Ok Reg 1430, eff 9-12-22]

317:30-5-211.25. Continuous glucose monitoring

(a) **Continuous glucose monitoring (CGM).** CGM means a minimally invasive system that measures glucose levels in subcutaneous or interstitial fluid. CGM provides blood glucose levels and can help members make more informed management decisions throughout the day.

(b) **Medical necessity.** CGM must be determined by a provider to be medically necessary and documented in the member's plan of care as medically necessary and used for medical purposes. A request by a qualified provider for CGM in and of itself shall not constitute medical necessity. The Oklahoma Health Care Authority (OHCA) shall serve as the final authority pertaining to all determinations of medical necessity. Refer to Oklahoma Administrative Code (OAC) 317:30-5-211.2 and 317:30-3-1(f) for policy on medical necessity. CGM devices must be approved by the U.S. Food and Drug Administration (FDA) as non-adjunctive and must be used for therapeutic purposes. Devices may only be used for members within the age range for which the devices have been FDA approved.

(c) **Documentation.** All documentation submitted to request services must demonstrate, through adequate objective medical records, evidence sufficient to justify the member's need for the service, in accordance with OAC 317:30-3-1(f)(2). Requests for CGM must include all of the following

documentation:

- (1) Prescription by a qualified provider;
- (2) Member diagnosis that correlates to the use of CGM;
- (3) Documentation of the member testing to include the frequency each day;
- (4) Documentation member is insulin-treated to include frequency of daily or is using insulin pump therapy;
- (5) Documentation member's insulin treatment regimen requires frequent adjustment;
- (6) The member and/or family member has participated in age appropriate diabetes education, training, and support prior to beginning CGM; and
- (7) In-person or telehealth visit [within the last six (6) months] between the treating provider, member and/or family to evaluate their diabetes control.
- (8) For full guidelines please refer to www.okhca.org/mau.

[Source: Added at 39 Ok Reg 394, eff 12-21-21 (emergency); Added at 39 Ok Reg 1430, eff 9-12-22]

317:30-5-211.26. Bathroom equipment

(a) **Bathroom equipment.** Bathroom equipment is used for bathing and toileting and may be considered primarily medical in nature if used in the presence of an illness and/or injury and if it is necessary for activities of daily living that are considered to be essential to health and personal hygiene.

(b) **Medical necessity.** Bathroom equipment must be determined by a provider to be medically necessary and documented in the member's plan of care as medically necessary and used for medical purposes. A request by a qualified provider for bathroom equipment in and of itself shall not constitute medical necessity. The Oklahoma Health Care Authority (OHCA) shall serve as the final authority pertaining to all determinations of medical necessity. Refer to Oklahoma Administrative Code (OAC) 317:30-5-211.2 and 317:30-3-1(f) for policy on medical necessity.

(c) **Documentation.** All documentation submitted to request services must demonstrate, through adequate objective medical records, evidence sufficient to justify the member's need for the service, in accordance with OAC 317:30-3-1(f)(2).

- (1) Current written prescription for specific medical supply, equipment, and appliance item;
- (2) Letter of medical necessity;
- (3) Product information;
- (4) Manufacturer's suggested retail price (MSRP) for each item requested
- (5) For full guidelines, please refer to www.okhca.org/mau.

[Source: Added at 39 Ok Reg 394, eff 12-21-21 (emergency); Added at 39 Ok Reg 1430, eff 9-12-22]

317:30-5-211.27. Positive airway pressure (PAP) devices

(a) **PAP devices.** PAP devices are both a single level continuous positive airway pressure device (CPAP), and/or a bi-level respiratory assist device

with or without back-up rate when it is used in the treatment of obstructive sleep apnea.

(b) **Medical Necessity.** PAP devices must be determined by a provider to be medically necessary and documented in the member's plan of care as medically necessary and used for medical purposes. A request by a qualified provider for PAP devices in and of itself shall not constitute medical necessity. The Oklahoma Health Care Authority (OHCA) shall serve as the final authority pertaining to all determinations of medical necessity. Refer to Oklahoma Administrative Code (OAC) 317:30-5-211.2 and 317:30-3-1(f) for policy on medical necessity.

(c) **Documentation.** All documentation submitted to request services must demonstrate, through adequate objective medical records, evidence sufficient to justify the member's need for the service, in accordance with OAC 317:30-3-1(f)(2).

- (1) A face-to-face clinical evaluation by the treating qualified medical professional within six (6) months prior to receiving device;
- (2) Qualifying polysomnogram that is dated within one (1) year of the prior authorization request submission;
- (3) The patient and/or his or her caretaker have received instruction from the supplier of the device in the proper use and care of the equipment; and
- (4) Medical records supporting the need for a PAP device.
- (5) For full guidelines, please refer to www.okhca.org/mau.

[Source: Added at 39 Ok Reg 394, eff 12-21-21 (emergency); Added at 39 Ok Reg 1430, eff 9-12-22]

317:30-5-211.28. Sleep studies

(a) **Sleep studies.** Sleep studies are the continuous and simultaneous monitoring and recording of specified physiological and pathophysiological parameters during a period of sleep for six (6) or more hours. The study is used to diagnose a variety of sleep disorders and to evaluate a patient's response to therapies such as continuous positive airway pressure (CPAP). A sleep study requires physician review, interpretation, and report.

(b) **Medical necessity.** Sleep studies must be determined by a provider to be medically necessary and documented in the member's plan of care as medically necessary and used for medical purposes. A request by a qualified provider for sleep studies in and of itself shall not constitute medical necessity. The Oklahoma Health Care Authority (OHCA) shall serve as the final authority pertaining to all determinations of medical necessity. Refer to Oklahoma Administrative Code (OAC) 317:30-5-211.2 and 317:30-3-1(f) for policy on medical necessity.

(c) **Documentation.** All documentation submitted to request services must demonstrate, through adequate objective medical records, evidence sufficient to justify the member's need for the service, in accordance with OAC 317:30-3-1(f)(2). Documentation requirements include:

- (1) Legible signature of the qualified provider or non-physician practitioner responsible for and providing the care to the patient;

- (2) All pages in the prior authorization request must be clear and legible;
- (3) Face-to-face evaluation by the ordering provider, the supervising physician, or the interpreting physician; and
- (4) Medical records to support the medical indication for the sleep study including results of sleep scale.
- (5) For full guidelines, please refer to www.okhca.org/mau.

(d) Reimbursement.

- (1) Sleep studies for children must be performed in a sleep diagnostic testing facility to be reimbursable.
- (2) Sleep studies for adults age twenty-one (21) and older must be performed in a sleep diagnostic testing facility or as a home sleep study to be reimbursable.
- (3) A split study beginning on a given date with the titration beginning after midnight on the subsequent date is one (1) study and may not be billed as two (2) consecutive studies.

[Source: Added at 39 Ok Reg 394, eff 12-21-21 (emergency); Added at 39 Ok Reg 1430, eff 9-12-22]

317:30-5-211.29. Donor human breast milk

(a) **Donor human breast milk.** Donor human breast milk is pasteurized donor human milk which has been donated to a Human Milk Banking Association of North America (HMBANA) milk bank. Upon donation, it is screened, pooled, and tested so that it can be dispensed. All donor mothers require screening and approval by a HMBANA milk bank, and additionally, all donor milk is logged, pasteurized, and monitored.

(b) **Provider qualifications.** Donor human breast milk must be obtained from a milk bank accredited by, and in good standing with, the HMBANA and be contracted with the Oklahoma Health Care Authority (OHCA) as a Durable Medical Equipment (DME) provider.

(c) **Medical necessity criteria.** To qualify to receive donor human breast milk the infant must meet medically necessary criteria, which can include but not limited to the following conditions:

- (1) Other feeding options have been exhausted or are contraindicated; and
- (2) Baby's biological mother's milk is contraindicated, unavailable due to medical or psychosocial condition, or mother's milk is available but is insufficient in quantity or quality to meet the infant's dietary needs, as reflected in medical records or by a physician (MD or DO), physician's assistant, or advanced practice nurse; and
- (3) Donor human breast milk must be procured through a HMBANA entity and delivered through a contracted provider, facility, or the supplier (HMBANA-accredited milk bank); and
 - (A) Requests for coverage over thirty-five (35) ounces per day, per infant, shall require review and approval by an OHCA Medical Director; and
 - (B) Coverage shall be extended for as long as medically necessary, but not to exceed an infant's twelve (12) months of age; and

(C) A new prior authorization will be required every ninety (90) days.

- (4) The infant has one (1) or more of the following conditions:
- (A) Infant born at Very Low Birth Weight (VLBW) (less than 1,500 grams) or lower; or
 - (B) Gastrointestinal anomaly, metabolic/digestive disorder, or recovery from intestinal surgery where digestive needs require additional support; or
 - (C) Diagnosed failure to thrive; or
 - (D) Formula intolerance with either documented feeding difficulty or weight loss; or
 - (E) Infant hypoglycemia; or
 - (F) Congenital heart disease; or
 - (G) Pre or post organ transplant; or
 - (H) Other serious health conditions where the use of donor human breast milk has been deemed medically necessary and will support the treatment and recovery of the infant as reflected in the medical records or by a physician (MD or DO), physician's assistant, or advanced practice nurse.
- (5) For full guidelines, including the medically necessary criteria, please refer to www.okhca.org/mau.

(d) **Documentation.** All documentation submitted to request services must demonstrate, through adequate objective medical records, evidence sufficient to justify the member's need for the service, in accordance with OAC 317:30-5-211.20(c). Documentation must include:

- (1) A prescription from a contracted provider [a physician (MD or DO), physician's assistant, or advanced practice nurse]. The prescription must include but not limited to:
- (A) Name of infant, address and diagnoses;
 - (B) Parent name and phone number or email;
 - (C) Donor human breast milk request form;
 - (D) Number of ounces per day, week, or month needed; and
 - (E) Prescriptions must be written on a prescription notepad and signed off by an authorized provider.
 - (F) For full guidelines, please refer to www.okhca.org/mau.

(2) Donor human breast milk is excluded from requiring a CMN.

(e) **Reimbursement.** Donor human breast milk is reimbursed as follows:

- (1) When donor human breast milk is provided in the inpatient setting, it will be reimbursed within the prospective Diagnosis Related Group (DRG) payment methodology for hospitals as authorized under the Oklahoma Medicaid State Plan.
- (2) When donor human breast milk is provided in an outpatient setting as a medical supply benefit, it will be reimbursed as a durable medical equipment, supplies, and appliances (DME) item in accordance with the OHCA fee schedule.

[Source: Added at 40 Ok Reg 365, eff 11-4-22 (emergency); Added at 40 Ok Reg 2206, eff 9-11-23]

317:30-5-211.3. Prior authorization (PA)

(a) **General.** PA is the electronic or written authorization issued by the Oklahoma Health Care Authority (OHCA) to a provider prior to the provision of a service. Providers should obtain a PA before providing services.

(b) **Requirements.** Billing must follow correct coding guidelines as promulgated by the Centers for Medicare and Medicaid Services (CMS) or per uniquely and publicly promulgated OHCA guidelines. Medical supplies, equipment, and appliances claims must include the most appropriate Healthcare Common Procedure Coding System (HCPCS) code as assigned by the Medicare Pricing, Data, Analysis, and Coding (PDAC) or its successor. Authorizations for services not properly coded will be denied. The following services require PA:

- (1) Services that exceed quantity/frequency limits;
- (2) Medical need for an item that is beyond OHCA's standards of coverage;
- (3) Use of a Not Otherwise Classified (NOC) code or miscellaneous codes;
- (4) Services for which a less costly alternative may exist; and
- (5) Procedures indicating that a PA is required on the OHCA fee schedule.

(c) **PA requests.**

(1) **PA 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 a PA. Also refer to OAC 317:30-3-31.

(A) **Required forms.** All required forms are available on the OHCA website.

(B) **Certificate of medical necessity (CMN).** The prescribing physician, non-physician practitioner (NPP), or dentist 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 physician, NPP, or dentist may sign the CMN. By signing the CMN, the physician, NPP, or dentist 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 PA request.

(2) **Submitting PA requests.** Contact information for submitting PA requests may be found in the OHCA Provider Billing and Procedures Manual. An electronic version of this manual is located on the OHCA website.

(3) **PA 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.

(4) **PA decisions.** After the PA request is processed, a notice will be issued regarding the outcome of the review.

(5) **PA 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.

(6) **PA of manually-priced items.** Manually-priced items must be prior authorized. For reimbursement of manually priced items, see OAC 317:30-5-218.

[Source: Added at 24 Ok Reg 2890, eff 7-1-07 (emergency); Added at 25 Ok Reg 1161, eff 5-25-08 ; Amended at 32 Ok Reg 1043, eff 8-27-15 ; Amended at 39 Ok Reg 394, eff 12-21-21 (emergency); Amended at 39 Ok Reg 1430, eff 9-12-22]

317:30-5-211.4. Rental and/or purchase

(a) **Purchase (New or Used).** Items may be purchased if they are inexpensive accessories for other DME or the equipment itself will be used for an extended period of time. The OHCA reserves the right to determine whether items of DMEPOS will be rented or purchased.

(b) **Rental.**

(1) **Continuous rental.** Items that require regular and ongoing servicing/maintenance are rented for the duration indicated by the physician's order and medical necessity. Examples include, but are not limited to, oxygen and volume ventilators. The rental payment includes routine servicing and all necessary repairs or replacements to make the rented item functional.

(2) **Capped rental.** Items are rented until the purchase price is reached. Capped rental items may be rented for a maximum of 13 months. If the member changes suppliers during or after the 13th continuous month rental period, this does not result in a new rental period. The supplier that provides the item to the member the 13th month of rental is responsible for supplying the equipment, as well as routine maintenance and servicing after the 13th month. If used equipment is issued to the member, the usual and customary charge reported to the OHCA must accurately reflect that the item is used.

(c) **Converting rental to purchase.** The majority of DME can be rented as a capped rental for up to a maximum of 13 continuous months. When an item is converted to a purchase during the rental period, the provider must subtract the amount already paid for the rental item from the total purchase price.

[Source: Added at 24 Ok Reg 2890, eff 7-1-07 (emergency); Added at 25 Ok Reg 1161, eff 5-25-08 ; Amended at 32 Ok Reg 1043, eff 8-27-15]

317:30-5-211.5. Repairs, maintenance, replacement and delivery

(a) **Repairs.** Repairs to equipment that either the Oklahoma Health Care Authority (OHCA) or a member owns are covered when they are necessary to make the equipment usable. The repair charge includes the use of "loaner" equipment as required. If the expense for repairs exceeds

the estimated expense of purchasing or renting another item of equipment for the remaining period of medical need, payment cannot be made for the amount in excess. Repairs of rented equipment are not covered.

(b) **Maintenance.** Routine periodic servicing, such as testing, cleaning, regulating, and checking the member's equipment is considered maintenance and not a separate covered service. DME suppliers must provide equipment-related services consistent with the manufacturer's specifications and in accordance with all federal, state, and local laws and regulations. Equipment-related services may include, but are not limited to, checking oxygen system purity levels and flow rates, changing and cleaning filters, and assuring the integrity of equipment alarms and back-up systems. However, more extensive maintenance, as recommended by the manufacturer and performed by authorized technicians, is considered repairs. This may include breaking down sealed components and performing tests that require specialized testing equipment not available to the member. The supplier of a capped rental item that supplied the item the thirteenth (13th) month must provide maintenance and service for the item. In very rare circumstances of malicious damage, culpable neglect, or wrongful disposition, the supplier may document the circumstances and be relieved of the obligation to provide maintenance and service.

(c) **Replacement.**

(1) If equipment that has met the capped rental period and has been in continued use by the member for the equipment's useful life or if the item is irreparably damaged, lost, or stolen, a prior authorization must be submitted to obtain new equipment. The reasonable useful lifetime for capped rental equipment cannot be less than five (5) years. Useful life is determined by the delivery of the equipment to the member, not the age of the equipment.

(2) Replacement parts must be billed with the appropriate Healthcare Common Procedure Coding System (HCPCS) code that represents the item or part being replaced along with a pricing modifier and replacement modifier. If a part that has not been assigned a HCPCS code is being replaced, the provider should use a miscellaneous HCPCS code to bill each part. Each claim that contains miscellaneous codes for replacement parts must include a narrative description of the item, the brand name, model name/number of the item, and an invoice.

(d) **Delivery.** Medical supplies, equipment, and appliance products are set with usual maximum quantities and frequency limits. Suppliers are not expected to provide these amounts routinely, nor are members required to accept medical supplies, equipment, and appliance products at frequencies or in quantities that exceed the amount the member would typically use. Suppliers must not dispense a quantity of any medical supplies, equipment, and appliance product exceeding a member's expected utilization. The reordering or refilling of medical supplies, equipment, and appliance products should always be based on actual member usage. Suppliers should stay attuned to atypical utilization patterns on behalf of their members and verify with the ordering

physician that the atypical utilization is warranted. Suppliers must exercise the following guidelines in regard to the delivery of medical supplies, equipment, and appliance products:

(1) For medical supplies, equipment, and appliance products that are supplied as refills to the original order, suppliers must contact the member prior to dispensing the refill. This shall be done to ensure that the refilled item is necessary and to confirm any changes/modifications to the order. Contact with the member regarding refills should take place no sooner than seven (7) days prior to the delivery/shipping date. For subsequent deliveries of refills, the supplier must deliver the medical supplies, equipment, and appliance product no sooner than five (5) days prior to the end of the usage for the current product. This is regardless of which delivery method is utilized. A member must specifically request the refill before a supplier dispenses the product.

Suppliers must not automatically dispense a quantity of supplies on a predetermined basis, even if the member has authorized this in advance. The supplier must have member contact documentation on file to substantiate that the medical supplies, equipment, and appliance product was refilled in accordance with this section.

(2) For medical supplies, equipment, and appliance products that are supplied via mail order, suppliers must bill using the appropriate modifier which indicates that the medical supplies, equipment, and appliance product was delivered via the mail. Reimbursement for medical supplies, equipment, and appliance products supplied and delivered via mail may be at a reduced rate.

(3) For medical supplies, equipment, and appliance products that are covered in the scope of the SoonerCare program, the cost of delivery is always included in the rate for the covered item(s).

[Source: Added at 24 Ok Reg 2890, eff 7-1-07 (emergency); Added at 25 Ok Reg 1161, eff 5-25-08 ; Amended at 28 Ok Reg 11, eff 8-13-10 (emergency); Amended at 28 Ok Reg 1437, eff 6-25-11 ; Amended at 32 Ok Reg 1043, eff 8-27-15 ; Amended at 39 Ok Reg 394, eff 12-21-21 (emergency); Amended at 39 Ok Reg 1430, eff 9-12-22]

317:30-5-211.6. General documentation requirements

(a) Section 1833(e) of the Social Security Act precludes payment to any provider of service unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider" [42 United States Code (U.S.C.) Section 1395l(e)]. The member's medical records will reflect the need for the care provided. The member's medical records should include the physician's office records, hospital records, nursing home records, home health agency records, records from other health care professionals and test reports. This documentation must be provided for prior authorization requests and available to the Oklahoma Health Care Authority (OHCA) or its designated agent upon request.

(b) Payment is made for durable medical equipment as set forth in this section when a face-to-face encounter has occurred in accordance with

provisions of 42 Code of Federal Regulations (C.F.R.) § 440.70 and Oklahoma Administrative Code (OAC) 317:30-5-211.1.

[Source: Added at 24 Ok Reg 2890, eff 7-1-07 (emergency); Added at 25 Ok Reg 1161, eff 5-25-08 ; Amended at 39 Ok Reg 394, eff 12-21-21 (emergency); Amended at 39 Ok Reg 1430, eff 9-12-22]

317:30-5-211.7. Free choice

A member has the choice of which provider will fill the prescription or order for a DMEPOS. All providers must inform the member they have a choice of provider when filling or ordering DMEPOS.

[Source: Added at 24 Ok Reg 2890, eff 7-1-07 (emergency); Added at 25 Ok Reg 1161, eff 5-25-08 ; Amended at 32 Ok Reg 1049, eff 8-27-15]

317:30-5-211.8. Coverage [REVOKED]

[Source: Added at 24 Ok Reg 2890, eff 7-1-07 (emergency); Added at 25 Ok Reg 1161, eff 5-25-08 ; Revoked at 27 Ok Reg 453, eff 12-3-09 (emergency); Revoked at 27 Ok Reg 942, eff 5-13-10]

317:30-5-211.9. Adaptive equipment [REVOKED]

[Source: Added at 24 Ok Reg 2890, eff 7-1-07 (emergency); Added at 25 Ok Reg 1161, eff 5-25-08 ; Amended at 32 Ok Reg 1043, eff 8-27-15 ; Revoked at 39 Ok Reg 394, eff 12-21-21 (emergency); Revoked at 39 Ok Reg 1430, eff 9-12-22]

317:30-5-212. Coverage for children [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 15 Ok Reg 4182, eff 8-5-98 (emergency); Amended at 16 Ok Reg 1429, eff 5-27-99 ; Amended at 18 Ok Reg 477, eff 1-1-01 (emergency); Amended at 18 Ok Reg 1130, eff 5-11-01 ; Amended at 24 Ok Reg 2890, eff 7-1-07 (emergency); Amended at 25 Ok Reg 1161, eff 5-25-08 ; Revoked at 27 Ok Reg 453, eff 12-3-09 (emergency); Revoked at 27 Ok Reg 942, eff 5-13-10]

317:30-5-213. Coverage for vocational rehabilitation [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 15 Ok Reg 4182, eff 8-5-98 (emergency); Revoked at 16 Ok Reg 1429, eff 5-27-99]

317:30-5-214. Coverage for individuals eligible for Part B of Medicare

Payment is made to medical suppliers utilizing the Medicaid allowable for comparable services.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 19 Ok Reg 2922, eff 7-1-02 (emergency); Amended at 20 Ok Reg 1193, eff 5-27-03]

317:30-5-215. Billing requirements [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 18 Ok Reg 477, eff 1-1-01 (emergency); Amended at 18 Ok Reg 1130, eff 5-11-01 ; Amended at 19 Ok Reg 2134, eff 6-27-02 ; Revoked at 24 Ok Reg 2890, eff 7-1-07 (emergency); Revoked at 25 Ok Reg 1161, eff 5-25-08]

317:30-5-216. Prior authorization requests [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 18 Ok Reg 477, eff 1-1-01 (emergency); Revoked at 18 Ok Reg 1130, eff 5-11-01 ; Added at 24 Ok Reg 2890, eff 7-1-07 (emergency); Added at 25 Ok Reg 1161, eff 5-25-08 ; Amended at 26 Ok Reg 256, eff 12-1-08 (emergency); Amended at 26 Ok Reg 1062, eff 5-11-09 ; Amended at 27 Ok Reg 453, eff 12-3-09 (emergency); Amended at 27 Ok Reg 942, eff 5-13-10 ; Amended at 31 Ok Reg 1644, eff 9-12-14 ; Revoked at 39 Ok Reg 394, eff 12-21-21 (emergency); Revoked at 39 Ok Reg 1430, eff 9-12-22]

317:30-5-217. Billing

- (a) **Procedure codes.** It is the supplier's responsibility to ensure that claims for the supply or equipment are submitted with the most appropriate HCPCS code as assigned by the Medicare PDAC or its successor. When the most appropriate procedure code is not used, the claim will be denied. When a specific procedure code has not been assigned to an item, an invoice is required which must contain a full description of the equipment or supply.
- (b) **Rental.** Claims for rental should indicate the first date of service and the inclusive dates of rental as part of the description of services. The appropriate modifier must be included. Only one month's rental should be entered on each detail line.
- (c) **Invoice.** For manually priced items, after the service has been provided, the supplier is required to include a copy of the invoice documenting the supplier's cost of the item with the claim.
- (d) **Place of service.** The appropriate indicator for the patient's place of residence must be entered.
- (e) **Prescribing provider.** The name of the prescribing provider must be included for claims processing and entered in the appropriate block.
- (f) **Proof of Delivery.** Items must be received by the member before billing OHCA. Proof of delivery must be retained by the provider in the member's file and provided to the OHCA upon request. In addition, for manually priced items, evidence of proof of delivery must be attached to the claim for adjudication.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 18 Ok Reg 477, eff 1-1-01 (emergency); Amended at 18 Ok Reg 1130, eff 5-11-01 ; Amended at 24 Ok Reg 2890, eff 7-1-07 (emergency); Amended at 25 Ok Reg 1161, eff 5-25-08 ; Amended at 32 Ok Reg 1043, eff 8-27-15]

317:30-5-218. Reimbursement

(a) Medical supplies, equipment and appliances.

(1) Reimbursement for medical supplies, equipment, and appliances will be made using an amount derived from the lesser of the Oklahoma Health Care Authority (OHCA) maximum allowable fee or the provider's usual and customary charge. The maximum allowable fee is the maximum amount that the OHCA will pay a provider for an allowable procedure. When a code is not assigned a maximum allowable fee for a unit of service, a fee will be established.

(2) The fee schedule will be reviewed annually. Adjustments to the fee schedule may be possible at any time based on efficiency,

budget considerations, federal regulations, and quality of care as determined by the OHCA.

(3) Payment for medical supplies, equipment, and appliances will be calculated using the rate methodologies found in the Oklahoma Medicaid State Plan.

(4) Payment is not made for medical supplies, equipment, and appliances that are not deemed as medically necessary or considered over-the-counter.

(5) OHCA does not reimburse medical supplies, equipment, and appliances providers separately for services that are included as part of the payment for another treatment program. For example, all items required during inpatient stays are paid through the inpatient payment structure.

(6) Medical supplies, equipment, and appliance products purchased at a pharmacy are paid the equivalent to Medicare Part B, average sales price (ASP) + six percent (6%). When ASP is not available, an equivalent price is calculated using wholesale acquisition cost (WAC). If no Medicare, ASP, or WAC pricing is available, then the price will be calculated based on invoice cost.

(b) **Manually-priced medical equipment and supplies.** There may be instances when manual pricing is required. When it is, the following pricing methods will be used:

(1) **Invoice pricing.** Reimbursement is at the provider's documented manufacturer's suggested retail price (MSRP) minus thirty percent (30%) or at the provider's invoice cost plus thirty percent (30%), whichever is the lesser of the two.

(2) **Fair market pricing.** OHCA may establish a fair market price through claims review and analysis. For a list of medical equipment and supplies that are fair market-priced, refer to the OHCA website at www.okhca.org for the fair market value list (Selected medical supplies, equipment, and appliance items priced at fair market price).

(c) **Oxygen equipment and supplies.**

(1) Payment for stationary oxygen systems (liquid oxygen systems, gaseous oxygen systems, and oxygen concentrators) is based on continuous rental, i.e., a continuous monthly payment that is made as long as it is medically necessary. The rental payment includes all contents and supplies, e.g., regulators, tubing, masks, etc. Portable oxygen systems are considered continuous rental. Ownership of the equipment remains with the supplier.

(2) Separate payment will not be made for maintenance, servicing, delivery, or for the supplier to pick up the equipment when it is no longer medically necessary. In addition, the provider/supplier will not be reimbursed for mileage.

(3) Payment for oxygen and oxygen equipment and supplies will not exceed the Medicare fee for the same procedure code.

(4) For residents in a long-term care facility, durable medical equipment products, including oxygen, are included in the facility's per diem rate.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 24 Ok Reg 2890, eff 7-1-07 (emergency); Amended at 25 Ok Reg 1161, eff 5-25-08 ; Amended at 27 Ok Reg 628, eff 4-13-10 (emergency); Amended at 27 Ok Reg 1451, eff 6-11-10 ; Amended at 32 Ok Reg 1043, eff 8-27-15 ; Amended at 39 Ok Reg 394, eff 12-21-21 (emergency); Amended at 39 Ok Reg 1430, eff 9-12-22 ; Amended at 41 Ok Reg, Number 14, effective 3-8-24 (emergency)]

PART 18. GENETIC COUNSELORS

317:30-5-219. General information

Genetic counseling gathers critical family history, patient history, and other factors to be analyzed and shared with the member to help them understand and adapt to the medical, psychosocial and familial contributions to potential or realized birth defects.

[Source: Added at 25 Ok Reg 428, eff 11-1-07 (emergency); Added at 25 Ok Reg 1161, eff 5-25-08]

317:30-5-220. Eligible providers

Eligible providers must be Licensed Genetic Counselors. Genetic Counselors must have a current contract on file with the Oklahoma Health Care Authority and be licensed in the state in which the service is being provided.

[Source: Added at 25 Ok Reg 428, eff 11-1-07 (emergency); Added at 25 Ok Reg 1161, eff 5-25-08]

317:30-5-221. Coverage

(a) Genetic counseling services are covered for SoonerCare members who meet the criteria for receiving medically necessary genetic testing as set forth in 317:30-5-2 (a)(1)(FF) and for pregnant/postpartum SoonerCare members as set forth in this section. Services for pregnant/postpartum SoonerCare members must be referred by a provider involved in the provision of obstetric or pediatric care. Members are eligible for genetic counseling during pregnancy which includes twelve (12) months postpartum. Reasons for genetic counseling include but are not limited to the following:

- (1) Advanced maternal age;
- (2) Abnormal maternal serum first or second screening;
- (3) Previous child or current fetus/infant with an abnormality;
- (4) Consanguinity/incest;
- (5) Parent is a known carrier or has a family history of a genetic condition;
- (6) Parent was exposed to a known or suspected reproductive hazard;
- (7) Previous fetal demise, stillbirth, or neonatal death involving known/suspected abnormalities;
- (8) History of recurrent pregnancy loss; or
- (9) Parent(s) are in an ethnic or racial group associated with an increased risk for specific genetic conditions.

(b) These services may be provided in an office or outpatient setting.

[Source: Added at 25 Ok Reg 428, eff 11-1-07 (emergency); Added at 25 Ok Reg 1161, eff 5-25-08 ; Amended at 27 Ok Reg 294, eff 11-3-09 (emergency); Amended at 27 Ok Reg 1439, eff 6-11-10 ; Amended at 30 Ok Reg 1143, eff 7-1-13 ; Amended at 38 Ok Reg 985, eff 9-1-21 ; Amended at 40 Ok Reg 652, eff 2-21-23 (emergency); Amended at 40 Ok Reg 2175, eff 9-11-23]

317:30-5-222. Reimbursement

(a) Counseling services must be billed using appropriate CPT codes and guidelines and must be medically necessary. SoonerCare does not allow more than six units [thirty (30) minutes = one (1) unit] per pregnancy including twelve (12) months postpartum care.

(b) Genetic Counselors who are employed by or remunerated by another provider may not bill the SoonerCare program directly for services if that billing would result in duplicate payment for the same service.

[Source: Added at 25 Ok Reg 428, eff 11-1-07 (emergency); Added at 25 Ok Reg 1161, eff 5-25-08 ; Amended at 40 Ok Reg 652, eff 2-21-23 (emergency); Amended at 40 Ok Reg 2175, eff 9-11-23]

317:30-5-223. Documentation

All services must be documented in the member's medical record. All genetic counseling sessions must, at a minimum, include the following:

- (1) date of service;
 - (2) start and stop time for each treatment session;
 - (3) practitioner's signature;
 - (4) pedigree, and/or review and interpretation of family history;
- and

(5) recommendation and plan of care.

[Source: Added at 25 Ok Reg 428, eff 11-1-07 (emergency); Added at 25 Ok Reg 1161, eff 5-25-08 ; Amended at 30 Ok Reg 1143, eff 7-1-13]

PART 19. CERTIFIED NURSE MIDWIVES

317:30-5-225. Eligible providers

The Certified Nurse-Midwife must be a qualified professional nurse registered with the Oklahoma Board of Nurse Registration and Nursing Education who possesses evidence of certification according to the requirement of the American College of Nurse-Midwives, and has the right to use the title Certified Nurse-Midwife and the abbreviation C.N.M. Nurse Midwives who practice in states other than Oklahoma must be appropriately licensed in the state in which they practice. The certified nurse midwife accepts responsibility, accountability, and obligation to practice in accordance with usual and customary advanced practice nursing standards and functions as defined by the scope of practice/role definition statements for the certified nurse midwife. In addition, all providers must have a current contract on file with the Oklahoma Health Care Authority.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 23 Ok Reg 264, eff 10-3-05 (emergency); Added at 23 Ok Reg 1359, eff 5-25-06 ; Amended at 30 Ok Reg 1143, eff 7-1-13]

317:30-5-226. Coverage by category

(a) **Adults.** Payment is made for certified nurse midwife services within the scope of practice as defined by state law including obstetrical care such as antepartum care, delivery, postpartum care, and care of the normal newborn during the first 28 days of life.

(1) Obstetrical care should be billed using the appropriate CPT codes for Maternity Care and Delivery. The date of delivery should be 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. The date the patient was first seen must be on the claim form. Payment for total obstetrical care includes all routine care. Ultrasounds and other procedures reimbursed separately from total obstetrical care are paid in accordance with provisions found at OAC 317:30-5-22(b).

(2) For payment of total OB care, the provider 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 provider outside of antepartum visits. The antepartum care during the prenatal care period includes all care by the OB provider except major illness distinctly unrelated to the pregnancy.

(b) **Newborn.** Payment to certified nurse midwives for services to newborn is the same as for adults. A newborn is an infant during the first

28 days following birth.

(1) Providers must use OKDHS Form FSS-NB-1, or the eNB1 application on the Secure Website to notify the county DHS office of the child's birth. A claim may then be filed for charges for the baby under the case number and the baby's name and assigned person code.

(2) Charges billed on the mother's person code for services rendered to the child will be denied.

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

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 18 Ok Reg 109, eff 10-7-00 (emergency); Amended at 18 Ok Reg 1130, eff 5-11-01 ; Amended at 19 Ok Reg 2134, eff 6-27-02 ; Amended at 19 Ok Reg 2922, eff 7-1-02 (emergency); Amended at 20 Ok Reg 1193, eff 5-27-03 ; Amended at 24 Ok Reg 303, eff 12-1-06 (emergency); Amended at 24 Ok Reg 895, eff 5-11-07 ; Amended at 30 Ok Reg 1143, eff 7-1-13 ; Amended at 33 Ok Reg 846, eff 9-1-16 ; Amended at 34 Ok Reg 192, eff 11-22-16 (emergency); Amended at 34 Ok Reg 657, eff 9-1-17]

317:30-5-227. Procedure codes [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 14 Ok Reg 2397, eff 2-5-97 (emergency); Amended at 14 Ok Reg 2928, eff 7-11-97 ; Amended at 16 Ok Reg 151, eff 10-14-98 (emergency); Amended at 16 Ok Reg 1429, eff 5-27-99 ; Amended at 16 Ok Reg 3413, eff 7-1-99 (emergency); Amended at 17 Ok Reg 1204, eff 5-11-00 ; Revoked at 18 Ok Reg 109, eff 10-7-00 ; Revoked at 18 Ok Reg 1130, eff 5-11-01]

317:30-5-228. Billing [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 19 Ok Reg 2134, eff 6-27-02]

317:30-5-229. Reimbursement

In accordance with the Omnibus Budget Reconciliation Act of 1993, effective October 1, 1993, certified nurse midwife services include maternity services, as well as services outside the maternity cycle within the scope of their practice under state law.

(1) Medical verification of pregnancy is required. A written statement from the physician or certified nurse midwife verifying the applicant is pregnant and the expected date of delivery is acceptable. Pregnancy may also be verified by submission of a copy of a laboratory report indicating the individual is pregnant.

(2) Newborn charges billed on the mother's person code will be denied.

(3) Providers must use OKDHS Form FSS-NB-1 or the eNB1 application on the Secure Website to notify the county DHS office of the child's birth.

(4) Obstetrical care should be billed using the appropriate CPT codes for Maternity Care and Delivery. The date of delivery should be 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. The date the patient was first seen must be on the claim form. Payment for total obstetrical care

includes all routine care performed by the attending provider. For payment of total OB care, the provider 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 provider outside of antepartum visits. The antepartum care during the prenatal care period includes all care by the OB provider except major illness distinctly unrelated to the pregnancy.

[Source: Added at 30 Ok Reg 1143, eff 7-1-13 ; Amended at 33 Ok Reg 846, eff 9-1-16 ; Amended at 34 Ok Reg 192, eff 11-22-16 (emergency); Amended at 34 Ok Reg 657, eff 9-1-17]

PART 20. LACTATION CONSULTANTS

317:30-5-230. General information

The primary focus of this service is member-specific support and education regarding breastfeeding, addressing particular issues, and/or managing lactation crisis.

[Source: Added at 25 Ok Reg 429, eff 12-1-07 through 7-14-08 (emergency)¹; Added at 25 Ok Reg 2639, eff 7-25-08]

Editor's Note: ¹*This emergency action expired before being superseded by a permanent action. Upon expiration of an emergency action enacting a new Section, the Section is no longer effective. Therefore, on 7-15-08 (after the 7-14-08 expiration of this emergency action), Section 317:30-5-230 was no longer effective, and remained as such until added again by permanent action on 7-25-08.*

317:30-5-231. Eligible providers

Eligible providers must be licensed by the state as a nurse or dietician and be an International Board Certified Lactation Consultants (IBCLCs). Providers must have a current contract on file with the Oklahoma Health Care Authority.

[Source: Added at 25 Ok Reg 429, eff 12-1-07 through 7-14-08 (emergency)¹; Added at 25 Ok Reg 2639, eff 7-25-08]

Editor's Note: ¹*This emergency action expired before being superseded by a permanent action. Upon expiration of an emergency action enacting a new Section, the Section is no longer effective. Therefore, on 7-15-08 (after the 7-14-08 expiration of this emergency action), Section 317:30-5-231 was no longer effective, and remained as such until added again by permanent action on 7-25-08.*

317:30-5-232. Coverage

Lactation Consultant services are covered for pregnant women and women up to twelve (12) months postpartum. SoonerCare members may self-refer or be referred by any provider. Reasons for lactation services include but are not limited to the following:

- (1) Prenatal education/training for first-time mothers;
- (2) Women who have not previously breastfed, have a history of breastfeeding difficulty, have identified risk factors for breastfeeding difficulty or lactation insufficiency (e.g., history of breast surgery, infertility, hormonal imbalance, diabetes, obesity);
- (3) Women expecting an infant with risk factors for ineffective breastfeeding (e.g., preterm, multiples, congenital birth defects);
- (4) Latch-on difficulties;
- (5) Low milk supply;
- (6) Breastfeeding a premature baby (thirty-six (36) weeks or less gestation);
- (7) Breastfeeding multiples; and
- (8) A baby with special needs (e.g., Down Syndrome, cleft lip/or palate).

[Source: Added at 25 Ok Reg 429, eff 12-1-07 through 7-14-08 (emergency)¹; Added at 25 Ok Reg 2639, eff 7-25-08 ; Amended at 40 Ok Reg 652, eff 2-21-23 (emergency); Amended at 40 Ok Reg 2175, eff 9-11-23]

Editor's Note: ¹*This emergency action expired before being superseded by a permanent action. Upon expiration of an emergency action enacting a new Section, the Section is no longer effective. Therefore, on 7-15-08 (after the 7-14-08 expiration of this emergency action), Section 317:30-5-232 was no longer effective, and remained as such until added again by permanent action on 7-25-08.*

317:30-5-233. Limitations

- (a) Services billed by a contracted IBCLC are only covered when performed in the IBCLC's office setting, patient's home, or other confidential outpatient setting. Payment for inpatient services provided by a Lactation Consultant is included in the hospital's per diem rate.
- (b) No separate reimbursement will be made to a facility.
- (c) Services are not to duplicate any basic breastfeeding education/training a member may have received through another program such as WIC or the Children's First Program and services must be problem focused.
- (d) Services provided by a contracted IBCLC must be provided face-to-face and in an individual setting.
- (e) Reimbursement is limited to not more than 6 sessions per pregnancy and must be objectively documented as medically necessary.

[Source: Added at 25 Ok Reg 429, eff 12-1-07 through 7-14-08 (emergency)¹; Added at 25 Ok Reg 2639, eff 7-25-08]

Editor's Note: ¹*This emergency action expired before being superseded by a permanent action. Upon expiration of an emergency action enacting*

a new Section, the Section is no longer effective. Therefore, on 7-15-08 (after the 7-14-08 expiration of this emergency action), Section 317:30-5-233 was no longer effective, and remained as such until added again by permanent action on 7-25-08.

317:30-5-234. Reimbursement

IBCLCs who are employed by or remunerated by another provider may not bill the SoonerCare program directly for services if that billing would result in duplicate payment for the same service.

[Source: Added at 25 Ok Reg 429, eff 12-1-07 through 7-14-08 (emergency)¹; Added at 25 Ok Reg 2639, eff 7-25-08]

Editor's Note: *¹This emergency action expired before being superseded by a permanent action. Upon expiration of an emergency action enacting a new Section, the Section is no longer effective. Therefore, on 7-15-08 (after the 7-14-08 expiration of this emergency action), Section 317:30-5-234 was no longer effective, and remained as such until added again by permanent action on 7-25-08.*

317:30-5-235. Documentation

All services must be documented in the member's medical record. All prenatal and postpartum lactation sessions must, at a minimum, include the following:

- (1) date of service;
- (2) start and stop time for each session;
- (3) documentation of services provided;
- (4) practitioner's signature; and
- (5) recommendation and plan of care.

[Source: Added at 25 Ok Reg 429, eff 12-1-07 through 7-14-08 (emergency)¹; Added at 25 Ok Reg 2639, eff 7-25-08]

Editor's Note: *¹This emergency action expired before being superseded by a permanent action. Upon expiration of an emergency action enacting a new Section, the Section is no longer effective. Therefore, on 7-15-08 (after the 7-14-08 expiration of this emergency action), Section 317:30-5-235 was no longer effective, and remained as such until added again by permanent action on 7-25-08.*

PART 21. OUTPATIENT BEHAVIORAL HEALTH AGENCY SERVICES

317:30-5-240. Eligible providers

All outpatient behavioral health providers eligible for reimbursement under OAC 317:30-5-240 et seq. must be an accredited or Oklahoma Department of Mental Health and Substance Abuse Services

(ODMHSAS) certified organization/agency in accordance with Section(s) 3-317, 3-323A, 3-306.1 or 3-415 of Title 43A of the Oklahoma Statutes and have a current contract on file with the Oklahoma Health Care Authority. Eligibility requirements for independent professionals (e.g., physicians and Licensed Behavioral Health Professionals), who provide outpatient behavioral health services and bill under their own national provider identification (NPI) number are covered under OAC 317:30-5-1 and OAC 317:30-5-275. Other outpatient ambulatory clinics (e.g. Federally Qualified Health Centers, Indian Health Clinics, school-based clinics) that offer outpatient behavioral health services are covered elsewhere in the agency rules.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 14 Ok Reg 1221, eff 8-7-96 (emergency); Amended at 14 Ok Reg 158, eff 10-24-96 (emergency); Amended at 14 Ok Reg 2125, eff 4-4-97 (emergency); Amended at 15 Ok Reg 1528, eff 5-11-98 ; Amended at 16 Ok Reg 2839, eff 7-12-99 ; Amended at 18 Ok Reg 3459, eff 6-28-01 (emergency); Amended at 19 Ok Reg 1067, eff 5-13-02 ; Amended at 22 Ok Reg 156, eff 10-6-04 (emergency); Amended at 21 Ok Reg 2473, eff 7-11-05 ; Amended at 23 Ok Reg 2540, eff 6-25-06 ; Amended at 24 Ok Reg 2830, eff 7-1-07 (emergency); Amended at 25 Ok Reg 1200, eff 5-25-08 ; Amended at 26 Ok Reg 734, eff 4-1-09 (emergency); Amended at 26 Ok Reg 2090, eff 6-25-09 ; Amended at 27 Ok Reg 2753, eff 7-20-10 (emergency); Amended at 28 Ok Reg 1469, eff 6-25-11 ; Amended at 29 Ok Reg 413, eff 3-7-12 (emergency); Amended at 29 Ok Reg 1125, eff 6-25-12 ; Amended at 30 Ok Reg 1146, eff 7-1-13]

317:30-5-240.1. Definitions

The following words or terms, when used in this Part, shall have the following meaning, unless the context clearly indicates otherwise:

"Accrediting body" means one (1) of the following:

- (A) Accreditation Association for Ambulatory Health Care (AAAHC);
- (B) American Osteopathic Association (AOA);
- (C) Commission on Accreditation of Rehabilitation Facilities (CARF);
- (D) Council on Accreditation of Services for Families and Children, Inc. (COA);
- (E) The Joint Commission (TJC) formerly known as Joint Commission on Accreditation of Healthcare Organizations;
- (F) Accreditation Commission for Health Care (ACHC); or
- (G) Other OHCA approved accreditation.

"Adult" means an individual twenty-one (21) and over, unless otherwise specified.

"AOD" means alcohol and other drug.

"AODTP" means alcohol and other drug treatment professional.

"ASAM" means the American Society of Addiction Medicine.

"ASAM patient placement criteria (ASAM PPC)" means the most current edition of the American Society of Addiction Medicine's published criteria for admission to treatment, continued services, and discharge.

"Behavioral health (BH) services" means a wide range of diagnostic, therapeutic, and rehabilitative services used in the treatment of mental illness, substance abuse, and co-occurring disorders.

"BHAs" means behavioral health aides.

"Certifying agency" means the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS).

"C.F.R." means Code of Federal Regulations.

"Child" means an individual younger than twenty-one (21), unless otherwise specified.

"Client Assessment Record (CAR)" means the standardized tool recognized by OHCA and ODMHSAS to evaluate the functioning of the member as per the OHCA prior authorization manual on the OHCA'S website at www.oklahoma.gov/ohca.

"CM" means case management.

"Cultural competency" means the ability to recognize, respect, and address the unique needs, worth, thoughts, communications, actions, customs, beliefs and values that reflect an individual's racial, ethnic, age group, religious, sexual orientation, and/or social group.

"DSM" means the most current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

"EBP" means an evidence-based practice per the Substance Abuse & Mental Health Services Administration (SAMHSA).

"EPSDT" means the Early and Periodic Screening, Diagnostic and Treatment benefit for children. In addition to screening services, EPSDT also covers the diagnostic and treatment services necessary to ameliorate acute and chronic physical and mental health conditions.

"FBCS" means facility-based crisis stabilization.

"FSPs" means family support providers.

"ICF/IID" means intermediate care facility for individuals with intellectual disabilities.

"Institution" means an inpatient hospital facility or institution for mental disease (IMD).

"IMD" means institution for mental disease as per 42 C.F.R. § 435.1009 as a hospital, nursing facility, or other institution of more than sixteen (16) beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care and related services. The regulations indicate that an institution is an IMD if its overall character is that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases. Title XIX of the Social Security Act provides that, except for individuals under age twenty-one (21) receiving inpatient psychiatric care, Medicaid (Title XIX) does not cover services to IMD patients under sixty-five (65) years of age [Section 1905(a)(24)(B) of the Social Security Act].

"Level of functioning rating" means a standardized mechanism to determine the intensity or level of services needed based upon the severity of the member's condition. The CAR level of function rating scale is the tool that links the clinical assessment to the appropriate level of Mental Health treatment. Either the Addiction Severity Index (ASI) or the TeenAddiction Severity Index (TASI), based on age, is the tool that links the clinical assessment to the appropriate level of Substance Abuse (SA) treatment.

"LBHP" means a licensed behavioral health professional.

"MST" means the EBP Multi-Systemic Therapy.

"**OAC**" means the publication authorized by 75 Oklahoma Statutes, Sec. 256 known as The Oklahoma Administrative Code, or, prior to its publication, the compilation of codified rules authorized by 75 O.S. § 256(A)(1)(a) and maintained in the Office of Administrative Rules.

"**Objectives**" means a specific statement of planned accomplishments or results that are specific, measurable, attainable, realistic, and time limited.

"**ODMHSAS**" means the Oklahoma Department of Mental Health and Substance Abuse Services.

"**ODMHSAS contracted facilities**" means those providers that have a contract with the ODMHSAS to provide mental health or substance use disorder treatment services, and contract directly with the Oklahoma Health Care Authority to provide outpatient behavioral health services.

"**OHCA**" means the Oklahoma Health Care Authority.

"**OJA**" means the Office of Juvenile Affairs.

"**O.S.**" means Oklahoma Statutes.

"**RBMS**" means residential behavioral management services within a group home or therapeutic foster home.

"**Recovery**" means an ongoing process of discovery and/or rediscovery that must be self defined, individualized and may contain some, if not all, of the ten fundamental components of recovery as outlined by SAMHSA.

"**PRSS**" means peer recovery support specialist.

"**SAMHSA**" means the Substance Abuse and Mental Health Services Administration.

"**Serious emotional disturbance (SED)**" means a condition experienced by persons from birth to eighteen (18) that show evidence of points of (A), (B) and (C) below:

(A) The disability must have persisted for six (6) months and be expected to persist for a year or longer.

(B) A condition or serious emotional disturbance as defined by the most recently published version of the DSM or the International Classification of Disease (ICD) equivalent with the exception of DSM "V" codes, substance abuse, and developmental disorders which are excluded, unless they co-occur with another diagnosable serious emotional disturbance.

(C) The child must exhibit either (i) or (ii) below:

(i) Psychotic symptoms of a serious mental illness (e.g., Schizophrenia characterized by defective or lost contact with reality, often hallucinations or delusions); or

(ii) Experience difficulties that substantially interfere with or limit a child or adolescent from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills. There is functional impairment in at least two (2) of the following capacities (compared with expected developmental level):

(I) Impairment in self-care manifested by a person's consistent inability to take care of personal grooming, hygiene, clothes and meeting of nutritional needs.

(II) Impairment in community function manifested by a consistent lack of age-appropriate behavioral controls, decision-making, judgment and value systems which result in potential involvement or involvement with the juvenile justice system.

(III) Impairment of social relationships manifested by the consistent inability to develop and maintain satisfactory relationships with peers and adults.

(IV) Impairment in family function manifested by a pattern of disruptive behavior exemplified by repeated and/or unprovoked violence to siblings and/or parents, disregard for safety and welfare or self or others (e.g., fire setting, serious and chronic destructiveness, inability to conform to reasonable limitations and expectations which may result in removal from the family or its equivalent).

(V) Impairment in functioning at school manifested by the inability to pursue educational goals in a normal time frame (e.g., consistently failing grades, repeated truancy, expulsion, property damage or violence toward others).

"Serious mental illness (SMI)" means a condition experienced by persons age eighteen (18) and over that show evidence of points of (A), (B) and (C) below:

(A) The disability must have persisted for six (6) months and be expected to persist for a year or longer.

(B) A condition or serious mental illness as defined by the most recently published version of the DSM or the International Classification of Disease (ICD) equivalent with the exception of DSM "V" codes, substance abuse, and developmental disorders which are excluded, unless they co-occur with another diagnosable serious mental illness.

(C) The adult must exhibit either (i) or (ii) below:

(i) Psychotic symptoms of a serious mental illness (e.g., Schizophrenia characterized by defective or lost contact with reality, often hallucinations or delusions); or

(ii) Experience difficulties that substantially interfere with or limit an adult from achieving or maintaining one or more developmentally

appropriate social, behavioral, cognitive, communicative, or adaptive skills. There is functional impairment in at least two (2) of the following capacities (compared with expected developmental level):

(I) Impairment in self-care manifested by a person's consistent inability to take care of personal grooming, hygiene, clothes and meeting of nutritional needs.

(II) Impairment in community function manifested by a consistent lack of appropriate behavioral controls, decision-making, judgment and value systems which result in potential involvement or involvement with the criminal justice system.

(III) Impairment of social relationships manifested by the consistent inability to develop and maintain satisfactory relationships with peers.

(IV) Impairment in family function manifested by a pattern of disruptive behavior exemplified by repeated and/or unprovoked violence, disregard for safety and welfare of self or others (e.g., fire setting, serious and chronic destructiveness, inability to conform to reasonable limitations and expectations).

(V) Impairment in functioning at school or work manifested by the inability to pursue educational or career goals.

"Trauma informed" means the recognition and responsiveness to the presence of the effects of past and current traumatic experiences in the lives of members.

[Source: Added at 26 Ok Reg 734, eff 4-1-09 (emergency); Added at 26 Ok Reg 2090, eff 6-25-09 ; Added at 27 Ok Reg 2753, eff 7-20-10 (emergency); Added at 28 Ok Reg 1469, eff 6-25-11 ; Amended at 29 Ok Reg 413, eff 3-7-12 (emergency); Amended at 29 Ok Reg 1125, eff 6-25-12 ; Amended at 30 Ok Reg 331, eff 1-14-13 (emergency); Amended at 30 Ok Reg 1146, eff 7-1-13 ; Amended at 31 Ok Reg 1645, eff 9-12-14 ; Amended at 35 Ok Reg 1415, eff 9-14-18 ; Amended at 39 Ok Reg 1498, eff 9-12-22]

317:30-5-240.2. Provider participation standards

(a) **Accreditation and certification status.** Any agency may participate as an Outpatient Behavioral Health (OPBH) provider if the agency is qualified to render a covered service and meets the OHCA requirements for provider participation.

(1) Private, Community-based Organizations must be accredited as a provider of outpatient behavioral health services from one of the accrediting bodies listed in (c)(1) below and be an incorporated organization governed by a board of directors or be certified by the certifying agency in accordance with 43A O.S. §§ 3-317, 3-323A, 3-306.1, or 3-415;

- (2) State-operated programs under the direction of ODMHSAS must be accredited by one of the accrediting bodies or be certified by the certifying agency in accordance with 43A O.S. §§ 3-317, 3-323A, 3-306.1 or 3-415;
- (3) Freestanding Psychiatric Hospitals must be licensed and certified by the State Survey Agency as meeting Medicare psychiatric hospital standards and JCAHO accreditation;
- (4) General Medical Surgical Hospitals must be appropriately licensed and certified by the State Survey Agency as meeting Medicare standards, including a JCAHO or AOA accreditation;
- (5) Federally Qualified Health Centers/Community Health Centers facilities that qualify under OAC 317:30-5-660;
- (6) Indian Health Services/Tribal Clinics/Urban Tribal Clinics facilities that qualify under federal regulation;
- (7) Rural Health Clinics facilities that qualify under OAC 317:30-5-355;
- (8) Public Health Clinics and County Health Departments;
- (9) Public School Systems.

(b) **Certifications.** In addition to the accreditation in paragraph (a) above or ODMHSAS certification in accordance with 43A O.S. §§ 3-317, 3-323A, 3-306.1 or 3-415, provider specific credentials are required for the following:

- (1) Substance Abuse agencies (OAC 450:18-1-1);
- (2) Evidence Based Best Practices but not limited to:
 - (A) Assertive Community Treatment (OAC 450:55-1-1);
 - (B) Multi-Systemic Therapy (Office of Juvenile Affairs); and
 - (C) Peer Support/Community Recovery Support;
- (3) Systems of Care (OAC 340:75-16-46);
- (4) Mobile and Facility-based Crisis Intervention (OAC 450:23-1-1);
- (5) Case Management (OAC 450:50-1-1);
- (6) RBMS in group homes (OAC 377:10-7) or therapeutic foster care settings (OAC 340:75-8-4);
- (7) Day Treatment - CARF, JCAHO, ACHC or COA for Day Treatment Services; and
- (8) Partial Hospitalization/Intensive Outpatient CARF, JCAHO, ACHC or COA for Partial Hospitalization services.

(c) **Provider enrollment and contracting.**

- (1) Organizations who have JCAHO, CARF, COA, ACHC or AOA accreditation or ODMHSAS certification in accordance with 43A O.S. §§ 3-317, 3-323A, 3-306.1 or 3-415 will supply the documentation from the accrediting body or certifying agency, along with other information as required for contracting purposes to the OHCA. The contract must include copies of all required state licenses, accreditation and certifications.
- (2) If the contract is approved, a separate provider identification number for each outpatient behavioral health service site will be assigned. Each site operated by an outpatient behavioral health facility must have a separate provider contract and site-specific accreditation and/or certification as applicable. A site is defined as an office, clinic, or other business setting where outpatient

behavioral health services are routinely performed. When services are rendered at the member's residence, a school, or when provided occasionally at an appropriate community based setting, a site is determined according to where the professional staff perform administrative duties and where the member's chart and other records are kept. Failure to obtain and utilize site specific provider numbers will result in disallowance of services.

(3) All behavioral health providers are required to have an individual contract with OHCA in order to receive SoonerCare reimbursement. This requirement includes outpatient behavioral health agencies and all individual rendering providers who work within an agency setting. Individual contracting rendering provider qualification requirements are set forth in OAC 317:30-3-2 and 317:30-5-240.3.

(d) **Standards and criteria.** Eligible organizations must meet each of the following:

(1) Have a well-developed plan for rehabilitation services designed to meet the recovery needs of the individuals served.

(2) Have a multi-disciplinary, professional team. This team must include all of the following:

(A) One of the LBHPs;

(B) A Certified Behavioral Health Case Manager II (CM II) or CADC, if individual or group rehabilitative services for behavioral health disorders are provided, and the designated LBHP(s) or licensure candidate(s) on the team will not be providing rehabilitative services;

(C) An AODIP, if treatment of substance use disorders is provided;

(D) A registered nurse, advanced practice nurse, or physician assistant, with a current license to practice in the state in which the services are delivered if Medication Training and Support Service is provided;

(E) The member for whom the services will be provided, and parent/guardian for those under eighteen (18) years of age.

(F) A member treatment advocate if desired and signed off on by the member.

(3) Demonstrate the ability to provide each of the following outpatient behavioral health treatment services as described in OAC 317:30-5-241 et seq., as applicable to their program. Providers must provide proper referral and linkage to providers of needed services if their agency does not have appropriate services.

(A) Assessments and Service Plans;

(B) Psychotherapies;

(C) Behavioral Health Rehabilitation services;

(D) Crisis Intervention services;

(E) Support Services; and

(F) Day Treatment/Intensive Outpatient.

(4) Be available twenty-four (24) hours a day, seven (7) days a week, for Crisis Intervention services.

- (5) Provide or have a plan for referral to physician and other behavioral health services necessary for the treatment of the behavioral disorders of the population served.
- (6) Comply with all applicable federal and state regulations.
- (7) Have appropriate written policy and procedures regarding confidentiality and protection of information and records, member grievances, member rights and responsibilities, and admission and discharge criteria, which shall be posted publicly and conspicuously.
- (8) Demonstrate the ability to keep appropriate records and documentation of services performed.
- (9) Maintain and furnish, upon request, a current report of fire and safety inspections of facilities clear of any deficiencies.
- (10) Maintain and furnish, upon request, all required staff credentials including certified transcripts documenting required degrees.

[Source: Added at 26 Ok Reg 734, eff 4-1-09 (emergency); Added at 26 Ok Reg 2090, eff 6-25-09 ; Amended at 27 Ok Reg 2753, eff 7-20-10 (emergency); Amended at 28 Ok Reg 1469, eff 6-25-11 ; Amended at 29 Ok Reg 413, eff 3-7-12 (emergency); Amended at 29 Ok Reg 1125, eff 6-25-12 ; Amended at 30 Ok Reg 1146, eff 7-1-13 ; Amended at 31 Ok Reg 1645, eff 9-12-14 ; Amended at 32 Ok Reg 1109, eff 8-27-15 ; Amended at 35 Ok Reg 1415, eff 9-14-18]

317:30-5-240.3. Staff credentials

(a) **Licensed behavioral health professional (LBHPs).** LBHPs are defined as any of the following practitioners:

- (1) An allopathic or osteopathic physician with a current license and board certification in psychiatry or board eligible in the state in which services are provided, or a current resident in psychiatry practicing as described in OAC 317:30-5-2.
- (2) A practitioner with a current license to practice in the state in which services are provided, within one (1) of the areas of practice listed in (A) through (F). The exemptions from licensure under 59 O.S. § 1353(4) and (5), 59 O.S. § 1903(C) and (D), 59 O.S. § 1925.3(B) and (C), and 59 O.S. § 1932(C) and (D) do not apply to outpatient behavioral health services.
 - (A) Psychology;
 - (B) Social work (clinical specialty only);
 - (C) Professional counselor;
 - (D) Marriage and family therapist;
 - (E) Behavioral practitioner; or
 - (F) Alcohol and drug counselor.
- (3) An advanced practice registered nurse (APRN) certified in a psychiatric mental health specialty, and licensed as a registered nurse (RN) with a current certification of recognition from the board of nursing in the state in which services are provided.
- (4) A physician assistant who is licensed and in good standing in the state in which services are provided and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or counseling functions.

(b) **Licensure candidates.** Licensure candidates are practitioners actively and regularly receiving board-approved supervision, and

extended supervision by a fully licensed clinician if board's supervision requirement is met but the individual is not yet licensed, to become licensed by one (1) of the areas of practice listed in (2)(A) through (F) above. The supervising LBHP responsible for the member's care must:

- (1) Staff the member's case with the candidate;
- (2) Be personally available, or ensure the availability of an LBHP to the licensure candidate for consultation while they are providing services;
- (3) Agree with the current plan for the member;
- (4) Confirm that the service provided by the candidate was appropriate; and
- (5) The member's medical record must show that the requirements for reimbursement were met and the LBHP responsible for the member's care has reviewed, countersigned, and dated the service plan and any updates thereto so that it is documented that the licensed professional is responsible for the member's care.

(c) **Certified alcohol and drug counselors (CADCs).** CADCs are defined as having a current certification as a CADC in the state in which services are provided.

(d) **Multi-systemic therapy (MST) provider.** Master's level therapist who works on a team established by the Oklahoma Juvenile Affairs Office (OJA) which may include bachelor's level staff.

(e) **Peer recovery support specialist (PRSS).** The PRSS must be certified by ODMHSAS pursuant to requirements found in OAC 450:53.

(f) **Family support and training provider (FSP).** FSPs must:

- (1) Have a high school diploma or equivalent;
- (2) Be twenty-one (21) years of age and have a successful experience as a family member of a child/adolescent with serious emotional disturbance, or a minimum of have lived experience as the primary caregiver of a child/adolescent who has received services for substance use disorder and/or co-occurring substance use and mental health, or have lived experience being the caregiver for a child/adolescent with Child Welfare/Child Protective Services involvement;
- (3) Successfully complete family support training according to a curriculum approved by ODMHSAS and pass the examination with a score of eighty percent (80%) or better;
- (4) Pass Oklahoma State Bureau of Investigation (OSBI) background check;
- (5) Have treatment plans be overseen and approved by a licensed behavioral health professional (LBHP) or licensure candidate; and
- (6) Function under the general direction of an LBHP, licensure candidate or systems of care team, with an LBHP or licensure candidate available at all times to provide back up, support, and/or consultation.

(g) **Qualified behavioral health aide (QBHA).** QBHAs must:

- (1) Have completed sixty (60) hours or equivalent of college credit; or may substitute one (1) year of relevant employment and/or responsibility in the care of children with complex emotional needs for up to two (2) years of college experience; and

- (2) Have successfully completed the specialized training and education curriculum provided by the ODMHSAS; and
- (3) Be supervised by a bachelor's level individual with a minimum of two (2) years case management or care coordination experience; and
- (4) Have service plans be overseen and approved by an LBHP or licensure candidate; and
- (5) Function under the general direction of an LBHP, or licensure candidate and/or systems of care team, with an LBHP or licensure candidate available at all times to provide back up, support, and/or consultation.

(h) **Behavioral health case manager.** For behavioral health case management services to be compensable by SoonerCare, the provider performing the services must be an LBHP, licensure candidate, CADC or have and maintain a current certification as a case manager II (CM II) or case manager I (CM I) from ODMHSAS. The requirements for obtaining these certifications are as follows:

- (1) The CM II must meet the requirements in (A), (B), (C) or (D) below:

- (A) Possess a bachelor's or master's degree in a behavioral health related field earned from a regionally accredited college or university recognized by the United States Department of Education (USDE) or a bachelor's or master's degree in education; and complete web-based training for behavioral health case management and behavioral health rehabilitation as specified by ODMHSAS; and complete one (1) day of face-to-face behavioral health case management training and two (2) days of face-to-face behavioral health rehabilitation training as specified by ODMHSAS; and pass web-based competency exams in behavioral health case management and behavioral health rehabilitation.

- (B) Be licensed and in good standing as a registered nurse in the state in which services are provided, with experience in behavioral health care; complete web-based training for behavioral health case management and behavioral health rehabilitation as specified by ODMHSAS; complete one (1) day of face-to-face behavioral health case management training and two (2) days of face-to-face behavioral health rehabilitation training as specified by ODMHSAS; and pass web-based competency exams for behavioral health case management and behavioral health rehabilitation.

- (C) Possess a bachelor's or master's degree in any field earned from a regionally accredited college or university recognized by the USDE and a current certification or Children's Certificate in Psychiatric Rehabilitation from the US Psychiatric Rehabilitation Association (USPRA); complete the behavioral health case management web-based training as specified by ODMHSAS; complete one (1) day of face-to-face behavioral health case management

training; and pass web-based competency exams for behavioral health case management. Applicants who have not received a certificate in children's psychiatric rehabilitation from the USpra must also complete the behavioral health rehabilitation web-based training as specified by ODMHSAS.

(D) Possess a bachelor's or master's degree in any field and proof of active progression toward obtaining a clinical licensure master's or doctoral degree at a regionally accredited college or university recognized by the USDE and complete web-based training for behavioral health case management and behavioral health rehabilitation as specified by ODMHSAS; complete one (1) day of face-to-face behavioral health case management training and two (2) days of face-to-face behavioral health rehabilitation training as specified by ODMHSAS; and pass web-based competency exams in behavioral health case management and behavioral health rehabilitation.

- (2) The CM I meets the requirements in either (A) or (B) and (C):
- (A) Completed sixty (60) college credit hours; or
 - (B) Possesses a high school diploma with thirty-six (36) total months of experience working with persons who have a mental illness and/or substance abuse. Documentation of experience on file with ODMHSAS; and
 - (C) Completes two (2) days of ODMHSAS specified behavioral health case management training and passes a web-based competency exam for behavioral health case management.

(3) Wraparound facilitator case manager is an LBHP, licensure candidate or CADC that meets the qualifications for CM II and has the following:

- (A) Successful completion of the ODMHSAS training for wraparound facilitation within six (6) months of employment; and
- (B) Participate in ongoing coaching provided by ODMHSAS and employing agency; and
- (C) Successfully complete wraparound credentialing process within nine (9) months of beginning process; and
- (D) Direct supervision or immediate access and a minimum of one (1) hour weekly clinical consultation with a qualified mental health professional, as required by ODMHSAS.

(4) Intensive case manager is an LBHP, licensure candidate, or CADC that meets the provider qualifications of a CM II and has the following:

- (A) A minimum of two (2) years behavioral health case management experience, crisis diversion experience, and
- (B) Must have attended the ODMHSAS six (6) hours intensive case management training.

[Source: Added at 26 Ok Reg 734, eff 4-1-09 (emergency); Added at 26 Ok Reg 2090, eff 6-25-09 ; Amended at 27 Ok Reg 2753, eff 7-20-10 (emergency); Amended at 28 Ok Reg 1469, eff 6-25-11 ; Amended at 30 Ok Reg 1146, eff 7-1-13 ; Amended at 31 Ok Reg 1645, eff 9-12-14 ; Amended at 32 Ok Reg 1109, eff 8-27-15 ; Amended at 33 Ok Reg 804, eff 9-1-16 ; Amended at 37 Ok Reg 1512, eff 9-14-20]

317:30-5-241. Covered Services

(a) Outpatient behavioral health services are covered for adults and children as set forth in this Section when provided in accordance with a documented individualized service plan, developed to treat the identified behavioral health and/or substance use disorder(s), unless specified otherwise.

(b) All services are to be for the goal of improvement of functioning, independence, or well-being of the member. The services and service plans are to be recovery focused, trauma and co-occurring specific. The member must be able to actively participate in the treatment. Active participation means that the member must have sufficient cognitive abilities, communication skills, and short-term memory to derive a reasonable benefit from the treatment.

(c) In order to be reimbursed for services, providers must submit a completed Customer Data Core (CDC) to OHCA or its designated agent. The CDC must be reviewed, updated and resubmitted by the provider every six months. Reimbursement is made only for services provided while a current CDC is on file with OHCA or its designated agent. For further information and instructions regarding the CDC, refer to the Prior Authorization Manual.

(d) All outpatient BH services must be provided following established medical necessity criteria. Some outpatient behavioral health services may require authorization. For information regarding services requiring authorization and the process for obtaining them, refer to the Prior Authorization Manual. Authorization of services is not a guarantee of payment. The provider is responsible for ensuring that the eligibility, medical necessity, procedural, coding, claims submission, and all other state and federal requirements are met. OHCA does retain the final administrative review over both authorization and review of services as required by 42 CFR 431.10.

(e) Services to nursing facility residents. Reimbursement is not allowed for outpatient behavioral health services provided to members residing in a nursing facility. Provision of these services is the responsibility of the nursing facility and reimbursement is included within the rate paid to the nursing facility for the member's care.

(f) Services to members during an inpatient stay. Unless otherwise specified in rules, reimbursement is not allowed for outpatient behavioral health services provided to members who are considered to be in "inpatient status" as defined in OAC 317:30-5-41.

(g) In addition to individual service limitations, reimbursement for outpatient behavioral health services is limited to 35 hours per rendering provider per week. Service hours will be calculated using a rolling four week average. Services not included in this limitation are:

- (1) Assessments;
- (2) Testing;

- (3) Service plan development; and
- (4) Crisis intervention services.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 14 Ok Reg 1221, eff 8-7-96 (emergency); Amended at 14 Ok Reg 275, eff 10-24-96 (emergency); Amended at 14 Ok Reg 2125, eff 4-4-97 (emergency); Amended at 15 Ok Reg 139, eff 11-1-97 (emergency); Amended at 15 Ok Reg 1528, eff 5-11-98 ; Amended at 16 Ok Reg 2839, eff 7-12-99 ; Amended at 18 Ok Reg 3459, eff 6-28-01 (emergency); Amended at 19 Ok Reg 1067, eff 5-13-02 ; Amended at 20 Ok Reg 2767, eff 7-1-03 (emergency); Amended at 21 Ok Reg 407, eff 1-1-04 (emergency); Amended at 21 Ok Reg 2210, eff 6-25-04 ; Amended at 22 Ok Reg 156, eff 10-6-04 (emergency); Amended at 21 Ok Reg 2473, eff 7-11-05 ; Amended at 23 Ok Reg 771, eff 3-9-06 (emergency); Amended at 23 Ok Reg 2540, eff 6-25-06 ; Amended at 24 Ok Reg 2830, eff 7-1-07 (emergency); Amended at 25 Ok Reg 2640, eff 7-25-08 ; Amended at 26 Ok Reg 102, eff 10-1-08 (emergency); Amended at 26 Ok Reg 734, eff 4-1-09 (emergency); Amended at 26 Ok Reg 2090, eff 6-25-09 ; Amended at 27 Ok Reg 2753, eff 7-20-10 (emergency); Amended at 28 Ok Reg 1469, eff 6-25-11 ; Amended at 29 Ok Reg 413, eff 3-7-12 (emergency); Amended at 29 Ok Reg 1125, eff 6-25-12 ; Amended at 30 Ok Reg 331, eff 1-14-13 (emergency); Amended at 30 Ok Reg 1146, eff 7-1-13 ; Amended at 31 Ok Reg 1645, eff 9-12-14 ; Amended at 32 Ok Reg 225, eff 11-3-14 (emergency); Amended at 32 Ok Reg 1056, eff 8-27-15 ; Amended at 34 Ok Reg 649, eff 9-1-17]

317:30-5-241.1. Screening, assessment and service plan

All providers must comply with the requirements as set forth in this Section.

(1) Screening.

(A) **Definition.** Screening is for the purpose of determining whether the member meets basic medical necessity and need for further behavioral health (BH) assessment and possible treatment services.

(B) **Qualified professional.** Screenings can be performed by any credentialed staff members as listed under OAC 317:30-5-240.3.

(C) **Target population and limitations.** Screening is compensable on behalf of a member who is seeking services for the first time from the contracted agency. This service is not compensable if the member has previously received or is currently receiving services from the agency, unless there has been a gap in service of more than six (6) months. To qualify for reimbursement, the screening tools used must be evidence-based or otherwise approved by Oklahoma Health Care Authority (OHCA) and Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) and appropriate for the age and/or developmental stage of the member.

(2) Assessment.

(A) **Definition.** Gathering and assessment of historical and current bio-psycho-social information which includes face-to-face contact with the person and/or the person's family or other person(s) resulting in a written summary report, diagnosis and recommendations. All agencies must assess the medical necessity of each individual to determine the appropriate level of care.

(B) **Qualified practitioners.** This service is performed by a licensed behavioral health professional (LBHP) or licensure candidate.

(C) **Target population and limitations.** The BH assessment is compensable on behalf of a member who is seeking services for the first time from the contracted agency. This service is not compensable if the member has previously received or is currently receiving services from the agency, unless there has been a gap in service of more than six (6) months and it has been more than one (1) year since the previous assessment.

(D) **Documentation requirements.** The assessment must include all elements and tools required by the OHCA. In the case of children under the age of eighteen (18), it is performed with the direct, active face-to-face participation of the parent or guardian. The child's level of participation is based on age, developmental and clinical appropriateness. The assessment must include at least one DSM diagnosis from the most recent DSM edition or diagnostic impression. The information in the assessment must contain but is not limited to the following:

- (i) Behavioral, including substance use, abuse, and dependence;
- (ii) Emotional, including issues related to past or current trauma;
- (iii) Physical;
- (iv) Social and recreational;
- (v) Vocational;
- (vi) Date of the assessment sessions as well as start and stop times; and
- (vii) Signature of parent or guardian participating in face-to-face assessment. Signatures are required for members over the age of fourteen (14). Signature and credentials of the practitioner who performed the face-to-face behavioral assessment. The signatures may be included in a signature page applicable to both the assessment and treatment plan if the signature page clearly indicates that the signatories consent and approve of both.

(3) **Behavioral Health Services Plan Development.**

(A) **Definition.** The Behavioral Health Service Plan is developed based on information obtained in the assessment and includes the evaluation of all pertinent information by the practitioners and the member, including a discharge plan. It is a process whereby an individualized plan is developed that addresses the member's strengths, functional assets, weaknesses or liabilities, treatment goals, objectives and methodologies that are specific and time limited, and defines the services to be performed by the practitioners and others who comprise the treatment team. Behavioral Health Service Plan Development is performed with the direct active participation of the member and a member support person or advocate if requested by the member. In the case of

children under the age of eighteen (18), it is performed with the participation of the parent or guardian and the child as age and developmentally appropriate, and must address school and educational concerns and assisting the family in caring for the child in the least restrictive level of care. For adults, it is focused on recovery and achieving maximum community interaction and involvement including goals for employment, independent living, volunteer work, or training. A Service Plan Development, Low Complexity is required every six (6) months and must include an update to the bio-psychosocial assessment and re-evaluation of diagnosis.

(B) **Qualified practitioners.** This service is performed by an LBHP or licensure candidate.

(C) **Time requirements.** Service Plan updates must be conducted face-to-face and are required every six (6) months during active treatment. However, updates can be conducted whenever it is clinically needed as determined by the qualified practitioner and member, but are only compensable twice in one (1) year.

(D) **Documentation requirements.** Comprehensive and integrated service plan content must address the following:

- (i) member strengths, needs, abilities, and preferences (SNAP);
- (ii) identified presenting challenges, problems, needs and diagnosis;
- (iii) specific goals for the member;
- (iv) objectives that are specific, attainable, realistic, and time-limited;
- (v) each type of service and estimated frequency to be received;
- (vi) the practitioner(s) name and credentials that will be providing and responsible for each service;
- (vii) any needed referrals for service;
- (viii) specific discharge criteria;
- (ix) description of the member's involvement in, and responses to, the service plan, and his/her signature and date;
- (x) service plans are not valid until all signatures are present [signatures are required from the member, if fourteen (14) or over], the parent/guardian [if younger than eighteen (18) or otherwise applicable], and the primary LBHP or licensure candidate. The signatures may be included in a signature page applicable to both the assessment and treatment plan if the signature page clearly indicates that the signatories consent and approve of both; and
- (xi) all changes in a service plan must be documented in either a scheduled six (6) month

service plan update (low complexity) or within the existing service plan through an amendment until time for the update (low complexity). Any changes to the existing service plan must, prior to implementation, be signed and dated by the member [if fourteen (14) or over], the parent/guardian [if younger than eighteen (18) or otherwise applicable], and the lead LBHP or licensure candidate.

(xii) Amendment of an existing service plan to revise or add goals, objectives, service provider, service type, and service frequency, may be completed prior to the scheduled six (6) month review/update. A plan amendment must be documented through an addendum to the service plan, dated and signed prior to the implementation, by the member [if fourteen (14) or over], the parent/guardian [if younger than eighteen (18) or otherwise applicable], and the lead LBHP or licensure candidate. A temporary change of service provider may be documented in the progress note for the service provided, rather than an amendment.

(xiii) Behavioral health service plan development, low complexity, must address the following:

- (I) update to the bio-psychosocial assessment, re-evaluation of diagnosis service plan goals and/ or objectives;
- (II) progress, or lack of, on previous service plan goals and/or objectives;
- (III) a statement documenting a review of the current service plan and an explanation if no changes are to be made to the service plan;
- (IV) change in goals and/or objectives (including target dates) based upon member's progress or identification of new need, challenges and problems;
- (V) change in frequency and/or type of services provided;
- (VI) change in practitioner(s) who will be responsible for providing services on the plan;
- (VII) change in discharge criteria;
- (VIII) description of the member's involvement in, and responses to, the service plan, and his/her signature and date; and
- (IX) service plan updates (low complexity) are not valid until all signatures are present. The required signatures are: from

the member [if fourteen (14) or over], the parent/guardian [if younger than eighteen (18) or otherwise applicable], and the primary LBHP or licensure candidate.

(E) Service limitations:

(i) Behavioral Health Service Plan Development, Moderate Complexity (i.e., pre-admission procedure code group) is limited to one (1) per member, per provider, unless more than one (1) year has passed between services, in which case, one can be requested and performed, if authorized by OHCA or its designated agent.

(ii) Behavioral Health Service Plan Development, Low Complexity: Service Plan updates are required every six (6) months during active treatment. Updates, however, can be conducted whenever clinically needed as determined by the provider and member, but are only reimbursable twice in one (1) year. The date of service is when the service plan is complete and the date the last required signature is obtained. Services should always be age, developmentally, and clinically appropriate.

(4) Assessment/Evaluation testing.

(A) **Definition.** Assessment/Evaluation testing is provided by a clinician utilizing tests selected from currently accepted assessment test batteries. Test results must be reflected in the Service Plan. The medical record must clearly document the need for the testing and what the testing is expected to achieve.

(B) **Qualified practitioners.** Assessment/Evaluation testing will be provided by a psychologist, certified psychometrist, psychological technician of a psychologist, an LBHP or licensure candidate. For assessments conducted in a school setting, the Oklahoma State Department of Education (OSDE) requires that a licensed supervisor sign the assessment. Each qualified professional must have a current contract with the OHCA.

(C) **Documentation requirements.** All psychological services must be documented in the member's record. All assessment, testing, and treatment services/units billed must include the following:

- (i) date;
- (ii) start and stop time for each session/unit billed and physical location where service was provided;
- (iii) signature of the provider;
- (iv) credentials of provider;
- (v) specific problem(s), goals and/or objectives addressed;
- (vi) methods used to address problem(s), goals and objectives;

- (vii) progress made toward goals and objectives;
- (viii) patient response to the session or intervention; and
- (ix) any new problem(s), goals and/or objectives identified during the session.

(D) **Service Limitations.** Testing for a child younger than three (3) must be medically necessary and meet established child [zero (0) to thirty-six (36) months of age] criteria as set forth in the Prior Authorization Manual. Evaluation and testing is clinically appropriate and allowable when an accurate diagnosis and determination of treatment needs is needed. Eight (8) hours/units of testing per patient over the age of three (3), per provider is allowed every twelve (12) months. There may be instances when further testing is appropriate based on established medical necessity criteria found in the Prior Authorization Manual. Justification for additional testing beyond allowed amount as specified in this Section must be clearly explained and documented in the medical record. Testing units must be billed on the date the actual testing, interpretation, scoring, and reporting are performed. A maximum of twelve (12) hours of therapy and testing, per day per rendering provider are allowed. A child who is being treated in an acute inpatient setting can receive separate psychological services by a physician or psychologist as the inpatient per diem is for "non-physician" services only. A child receiving residential level treatment in either a therapeutic foster care home, or group home may not receive additional individual, group or family counseling or psychological testing unless allowed by the OHCA or its designated agent. Psychologists employed in state and federal agencies, who are not permitted to engage in private practice, cannot be reimbursed for services as an individually contracted provider. For assessment conducted in a school setting the OSDE requires that a licensed supervisor sign the assessment. For individuals who qualify for Part B of Medicare, payment is made utilizing the SoonerCare allowable for comparable services. Payment is made to physicians, LBHPs or psychologists with a license to practice in the state where the services is performed or to practitioners who have completed education requirements and are under current board approved supervision to become licensed.

[Source: Added at 26 Ok Reg 734, eff 4-1-09 (emergency); Added at 26 Ok Reg 2090, eff 6-25-09 ; Amended at 27 Ok Reg 2386, eff 7-10-10 (emergency); Amended at 28 Ok Reg 1480, eff 6-25-11 ; Amended at 29 Ok Reg 413, eff 3-7-12 (emergency); Amended at 29 Ok Reg 1125, eff 6-25-12 ; Amended at 31 Ok Reg 1645, eff 9-12-14 ; Amended at 32 Ok Reg 1056, eff 8-27-15 ; Amended at 33 Ok Reg 541, eff 5-1-16 (emergency); Amended at 33 Ok Reg 818, eff 9-1-16 ; Amended at 34 Ok Reg 53, eff 9-22-16 (emergency); Amended at 34 Ok Reg 649, eff 9-1-17 ; Amended at 35 Ok Reg 1422, eff 9-14-18]

317:30-5-241.10. Partial hospitalization program (PHP) - Adults

(a) **Definition.** PHP is an intensive nonresidential, structured therapeutic treatment for individuals with substance use disorder, mental health diagnoses, and/or co-occurring disorders. It can be used as an alternative to and/or a step-down from inpatient or residential treatment, or to stabilize a deteriorating condition that may result in a need for inpatient or residential care. PHP services are:

- (1) Reasonable and necessary for the diagnosis or active treatment of the individual's condition; and
- (2) Reasonably expected to improve the individual's condition and functional level and to prevent relapse or hospitalization/residential care.

(b) **Eligibility criteria.** This service must be prior authorized by OHCA or its designated agent, and individuals must meet ongoing medical necessity criteria. Treatment is time limited, and length of participation is based on the individual's needs.

(c) **Eligible providers.** Provider agencies for PHP must be accredited to provide partial hospitalization services by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Accreditation Commission for Health Care (ACHC) or The Council on Accreditation (COA) and enrolled in SoonerCare. The staff providing PHP services are employees or contractors of the enrolled agency. The agency is responsible for ensuring that all services are provided by properly credentialed clinicians.

(d) **Qualified practitioners.** Program services are overseen by a psychiatrist. The number of professionals and paraprofessionals required on the clinical team is dependent on the size of the program. The clinical team includes the following required professionals:

- (1) A licensed physician, physician's assistant, or advanced practice registered nurse [any of whom meet the requirements of an LBHP as described at OAC 317:30-5-240.3(a)];
- (2) A registered nurse; and
- (3) One (1) or more LBHPs or licensure candidates listed in OAC 317:30-5-240.3(a) and (b).
- (4) The clinical team may also include a certified behavioral health case manager.

(e) **Service components.** PHP service components include the following, provided by qualified professionals:

- (1) Behavioral health/alcohol and drug assessment;
- (2) Behavioral health/alcohol and drug service plan development;
- (3) Individual/family/group therapy for behavioral health and/or substance abuse;
- (4) Psychosocial rehabilitation services/substance abuse skills development (individual and group);
- (5) Medication training and support;
- (6) Case management;
- (7) Crisis intervention services must be available twenty-four (24) hours a day, seven (7) days a week.

(f) **Limitations.** Treatment is time limited, based on medical necessity, and must offered at a minimum of three (3) hours per day, five (5) days a

week. PHP cannot be billed in conjunction with the following services:

- (1) Inpatient/residential psychiatric or residential substance use disorder services;
- (2) Individual/family/group therapy for behavioral health; and/or substance abuse;
- (3) Psychosocial rehabilitation services/substance abuse skills development (individual and group);
- (4) Targeted case management (TCM);
- (5) Mobile crisis intervention provided within the PHP setting;
- (6) Peer recovery support;
- (7) Program of Assertive Community Treatment (PACT);
- (8) Certified Community Behavioral Health (CCBH) services.

(g) **Non-covered services.** The following services are not considered PHP and are not reimbursable:

- (1) Room and board;
- (2) Educational costs;
- (3) Services to inmates of public institutions;
- (4) Routine supervision and non-medical support services in school settings;
- (5) Child care;
- (6) Respite;
- (7) Personal care.

(h) **Documentation requirements.** Documentation needs to specify active involvement of the member. A nursing health assessment must be completed within twenty-four (24) hours of admission. Service plan updates are required every three (3) months or more frequently based on clinical need. Records must be documented according to OAC 317:30-5-248.

(i) **Staffing requirements.** Staffing must consist of the following:

- (1) A registered nurse (RN) trained and competent in the delivery of behavioral health services as evidenced by education and/or experience that is available on-site during program hours to provide necessary nursing care and/or psychiatric nursing care [one (1) RN at a minimum can be backed up by a licensed practical nurse (LPN) but an RN must always be on site];
- (2) Medical director must be a licensed psychiatrist;
- (3) A psychiatrist/physician must be available twenty-four (24) hours a day, seven (7) days a week; and
- (4) One (1) or more LBHPs or licensure candidates listed in OAC 317:30-5-240.3(a) and (b).

(j) **Reimbursement.** PHP services are reimbursed pursuant to the methodology described in the Oklahoma Medicaid State Plan. PHP reimbursement is all-inclusive of the service components, except for the following:

- (1) Physician services;
- (2) Medications;
- (3) Psychological testing by a licensed psychologist.

317:30-5-241.11. Day treatment program

Day treatment programs are for the stabilization of children and adolescents with severe emotional and/or behavioral disturbances. Treatment is designed for children who have difficulty functioning in mainstream community settings such as classrooms, and who need a higher intensity of services than outpatient counseling provides. Treatment is time limited and includes therapeutically intensive clinical services geared towards reintegration to the home, school, and community.

(1) **Qualified practitioners.** All services in day treatment are provided by a team, which must be composed of one (1) or more of the following participants: physician, registered nurse, licensed behavioral health professional (LBHP) or licensure candidate, a case manager, or other certified behavioral health/substance abuse paraprofessional staff. Services are directed by an LBHP.

(2) **Qualified providers.** Provider agencies for day treatment must be accredited to provide day treatment services by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Accreditation Commission for Health Care (ACHC) or The Council on Accreditation (COA).

(3) **Limitations.** Services must be offered at a minimum of four (4) days per week at least three (3) hours per day. Behavioral health rehabilitation group size is limited to a maximum of eight (8) individuals as clinically appropriate given diagnostic and developmental functioning. Children under age six (6) are not eligible for behavioral health rehabilitation services unless a prior authorization for children ages four (4) and five (5) has been granted by OHCA or its designated agent based on a finding of medical necessity.

(4) **Service requirements.** On-call crisis intervention services must be available twenty-four (24) hours a day, seven (7) days a week (When members served have psychiatric needs, psychiatric services are available which include the availability of a psychiatrist twenty-four (24) hours a day, seven (7) days a week. A psychiatrist can be available either on site or on call but must be available at all times). Day treatment program will provide assessment and diagnostic services and/or medication monitoring, when necessary.

(A) Treatment activities are to include the following every week:

- (i) Family therapy at least one (1) hour per week (additional hours of family therapy may be substituted for other day treatment services);
- (ii) Group therapy at least two (2) hours per week; and
- (iii) Individual therapy at least one (1) hour per week.

(B) Additional services are to include at least one (1) of the following services per day:

- (i) Medication training and support (nursing) once monthly if on medications;
- (ii) Behavioral health rehabilitation services to include alcohol and other drug education if the child meets the criteria established in OAC 317:30-5-241.3 and is clinically necessary and appropriate except for children under age six (6), unless a prior authorization has been granted for children ages four (4) and five (5);
- (iii) Behavioral health case management as needed and part of weekly hours for member;
- (iv) Occupational therapy as needed and part of weekly hours for member; and
- (v) Expressive therapy as needed and part of weekly hours for the member.

(5) **Documentation requirements.** Service plans are required every three (3) months. Records must be documented according to OAC 317:30-5-248.

(6) **Reimbursement.** Day treatment program services are reimbursed pursuant to the OHCA fee schedule based on the type and level of practitioner employed by the agency. All rates are published on the Agency's website www.oklahoma.gov/ohca.

[Source: Added at 39 Ok Reg 1506, eff 9-12-22]

317:30-5-241.2. Psychotherapy

(a) Individual psychotherapy.

(1) **Definition.** Psychotherapy is a face-to-face treatment for mental illnesses and behavioral disturbances, in which the clinician, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse, or change maladaptive patterns of behavior, and encourage growth and development. Insight oriented, behavior modifying and/or supportive psychotherapy refers to the development of insight of affective understanding, the use of behavior modification techniques, the use of supportive interactions, the use of cognitive discussion of reality, or any combination of these items to provide therapeutic change. Ongoing assessment of the member's status and response to treatment as well as psycho-educational intervention are appropriate components of individual therapy. The therapy must be goal directed, utilizing techniques appropriate to the service plan and the member's developmental and cognitive abilities.

(2) **Interactive complexity.** Psychotherapy is considered to involve "interactive complexity" when there are communication factors during a visit that complicate delivery of the psychotherapy by the qualified practitioner. Sessions typically involve members who have other individuals legally responsible for their care (i.e., minors or adults with guardians); members who request others to be involved in their care during the session

(i.e., adults accompanied by one or more participating family members or interpreter or language translator); or members that require involvement of other third parties (i.e., child welfare, juvenile justice, parole/probation officers, schools, etc.).

Psychotherapy should only be reported as involving interactive complexity when at least one (1) of the following communication factors is present:

(A) The need to manage maladaptive communication (i.e., related to high anxiety, high reactivity, repeated questions, or disagreement) among participants that complicate delivery of care.

(B) Caregiver emotions/behavior that interfere with implementation of the service plan.

(C) Evidence/disclosure of a sentinel event and mandated report to a third party (i.e., abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other visit participants.

(D) Use of play equipment, physical devices, interpreter, or translator to overcome barriers to therapeutic interaction with a patient who is not fluent in the same language or who has not developed or lost expressive or receptive language skills to use or understand typical language.

(3) **Qualified practitioners.** Psychotherapy must be provided by an LBHP or licensure candidate in a setting that protects and assures confidentiality.

(4) **Documentation requirements.** Providers must comply with documentation requirements in OAC 317:30-5-248.

(5) **Limitations.** A maximum of four (4) units per day per member is compensable. A cumulative maximum of eight (8) units of individual psychotherapy and family psychotherapy per week per member is compensable. Except for psychotherapy involving interactive complexity as described in this Section, only the member and the qualified practitioner should be present during the session. Individual psychotherapy is not reimbursable for a child younger than the age of thirty-six (36) months. Limitations exclude outpatient behavioral health services provided in a foster care setting.

(b) **Group psychotherapy.**

(1) **Definition.** Group psychotherapy is a method of treating behavioral disorders using the interaction between the qualified practitioner and two (2) or more individuals to promote positive emotional or behavioral change. The focus of the group must be directly related to the goals and objectives in the individual member's current service plan. This service does not include social or daily living skills development as described under behavioral health rehabilitation services.

(2) **Group sizes.** Group psychotherapy is limited to a total of eight (8) adult [eighteen (18) and over] individuals except when the individuals are residents of an ICF/IID where the maximum group size is six (6). For all children under the age of eighteen

(18), the total group size is limited to six (6).

(3) **Multi-family and conjoint family therapy.** Sessions are limited to a maximum of eight (8) families/units. Billing is allowed once per family unit, though units may be divided amongst family members.

(4) **Qualified practitioners.** Group psychotherapy must be provided by an LBHP or licensure candidate. Group psychotherapy must take place in a confidential setting limited to the qualified practitioner, an assistant or co-therapist, if desired, and the group psychotherapy participants.

(5) **Documentation requirements.** Providers must comply with documentation requirements in OAC 317:30-5-248.

(6) **Limitations.** A maximum of six (6) units per day per member is compensable, not to exceed twelve (12) units per week. Group psychotherapy is not reimbursable for a child younger than the age of thirty-six (36) months. Limitations exclude outpatient behavioral health services provided in a foster care setting.

(c) **Family psychotherapy.**

(1) **Definition.** Family psychotherapy is a face-to-face psychotherapeutic interaction between a qualified practitioner and the member's family, guardian, and/or support system. It is typically inclusive of the identified member but may be performed if indicated without the member's presence. When the member is an adult, his/her permission must be obtained in writing. Family psychotherapy must be provided for the direct benefit of the SoonerCare member to assist him/her in achieving his/her established treatment goals and objectives and it must take place in a confidential setting. This service may include the evidence-based practice "Family Psychoeducation". For children under the age of thirty-six (36) months, family psychotherapy is focused on the infant/young child and parent (or primary caregiver) interactions and the relationship needs of the infant/young child.

(2) **Qualified practitioners.** Family psychotherapy must be provided by an LBHP or licensure candidate.

(3) **Documentation requirements.** Providers must comply with documentation requirements in OAC 317:30-5-248.

(4) **Limitations.** A maximum of four (4) units per day per member/family unit is compensable. A cumulative maximum of eight (8) units of individual psychotherapy and family psychotherapy per week per member is compensable. Family psychotherapy for a child younger than thirty-six (36) months must be medically necessary and meet established child [zero (0) through thirty-six (36) months of age] criteria as set forth in the Prior Authorization Manual. Limitations exclude outpatient behavioral health services provided in a foster care setting.

[Source: Added at 26 Ok Reg 734, eff 4-1-09 (emergency); Added at 26 Ok Reg 2090, eff 6-25-09 ; Amended at 27 Ok Reg 2753, eff 7-20-10 (emergency); Amended at 28 Ok Reg 459, eff 12-27-10 (emergency); Amended at 28 Ok Reg 1481, eff 6-25-11 ; Amended at 29 Ok Reg 413, eff 3-7-12 (emergency); Amended at 29 Ok Reg 1125, eff 6-25-12 ; Amended at 30 Ok Reg 1146, eff 7-1-13 ; Amended at 31 Ok Reg 651, eff 8-1-14 (emergency); Amended at 31 Ok Reg 1645, eff 9-12-14 ; Amended at 31 Ok Reg 651, eff 9-12-14 (emergency); Amended at 32 Ok Reg 1059, eff 8-27-15 ; Amended at 33 Ok

317:30-5-241.3. Behavioral Health Rehabilitation (BHR) services

(a) **Definition.** Behavioral Health Rehabilitation (BHR) services are goal oriented outpatient interventions that target the maximum reduction of mental and/or behavioral health impairments and strive to restore the members to their best possible mental and/or behavioral health functioning. BHR services must be coordinated in a manner that is in the best interest of the member and may be provided in a variety of community and/or professional settings that protect and assure confidentiality. For purposes of this Section, BHR includes Psychosocial Rehabilitation, Outpatient Substance Abuse Rehabilitation, and Medication Training and Support.

(b) **Psychosocial Rehabilitation (PSR).**

(1) **Definition.** PSR services are face-to-face Behavioral Health Rehabilitation services which are necessary to improve the member's ability to function in the community. They are performed to improve the skills and abilities of members to live interdependently in the community, improve self-care and social skills, and promote lifestyle change and recovery practices. Rehabilitation services may be provided individually or in group sessions, and they take the format of curriculum based education and skills training.

(2) **Clinical restrictions.** This service is generally performed with only the members and the qualified provider, but may include a member and the member's family/support system when providing educational services from a curriculum that focuses on the member's diagnosis, symptom management, and recovery. A member who at the time of service is not able to cognitively benefit from the treatment due to active hallucinations, substance abuse, or other impairments is not suitable for this service. Family involvement is allowed for support of the member and education regarding his/her recovery, but does not constitute family therapy, which requires a licensed provider.

(3) **Qualified practitioners.** A Certified Behavioral Health Case Manager II (CM II), CADC, LBHP, or Licensure Candidate may perform PSR, following development of a service plan and treatment curriculum approved by an LBHP or Licensure Candidate. The CM II and CADC must have immediate access to a LBHP who can provide clinical oversight and collaborate with the qualified PSR provider in the provision of services. A minimum of one monthly face-to-face consultation with a LBHP is required for PSR providers. In addition, a minimum of one face-to-face consultation per week with a LBHP or Licensure Candidate is required for PSR providers regularly rendering services away from the outpatient behavioral health agency site.

(4) **Group sizes.** The maximum staffing ratio is fourteen members for each qualified provider for adults and eight to one for children under the age of eighteen.

(5) **Limitations.**

(A) **Transportation.** Travel time to and from PSR treatment is not compensable. Group PSR services do not qualify for the OHCA transportation program, but OHCA will arrange for transportation for those who require specialized transportation equipment.

(B) **Time.** Breaks, lunchtime and times when the member is unable or unwilling to participate are not compensable and must be deducted from the overall billed time.

(C) **Location.** In order to develop and improve the member's community and interpersonal functioning and self care abilities, PSR services may take place in settings away from the outpatient behavioral health agency site as long as the setting protects and assures confidentiality. When this occurs, the qualified provider must be present and interacting, teaching, or supporting the defined learning objectives of the member for the entire claimed time.

(D) **Eligibility for PSR services.** All PSR services require prior authorization and must meet established medical necessity criteria.

(i) **Adults.** PSR services for adults are limited to members who have a history of psychiatric hospitalization or admissions to crisis centers, have been determined disabled by the SSA for mental health reasons, are residing in residential care facilities or are receiving services through a specialty court program.

(ii) **Children.** PSR services for children are limited to members who have a history of psychiatric hospitalization or admissions to crisis centers; have been determined disabled by the SSA for mental health reasons; have a current Individual Education Plan (IEP) or 504 Plan for emotional disturbance; or have been evaluated by a school psychologist, licensed psychologist or psychiatrist and determined to be "at risk" as outlined in the Prior Authorization Manual.

(iii) The following members are not eligible for PSR services:

(I) Residents of ICF/IID facilities, unless authorized by OHCA or its designated agent;

(II) children under age 6, unless a prior authorization for children ages 4 and 5 has been granted by OHCA or its designated agent based on the criteria in (5)(D)(ii) above as well as a finding of medical necessity;

(III) children receiving RBMS in a group home or therapeutic foster home, unless authorized by OHCA or its designated

- agent;
- (IV) inmates of public institutions;
- (V) members residing in inpatient hospitals or IMDs; and
- (VI) members residing in nursing facilities.

(E) **Billing limits.** PSR services are time-limited services designed to be provided over the briefest and most effective period possible and as adjunct (enhancing) interventions to compliment more intensive behavioral health therapies. Service limits are based on the member's needs according to the CAR or other approved tool, the requested placement based on the level of functioning rating, medical necessity, and best practice. Service limitations are designed to help prevent rehabilitation diminishing return by remaining within reasonable age and developmentally appropriate daily limits. PSR services authorized under this Section are separate and distinct from, but should not duplicate the structured services required for children residing in group home or therapeutic foster care settings, or receiving services in Day Treatment or Partial Hospitalization Programs. Children under an ODMHSAS Systems of Care program and adults residing in residential care facilities may be prior authorized additional units as part of an intensive transition period. PSR is billed in unit increments of 15 minutes with the following limits:

(i) **Group PSR.** The maximum is 24 units per day for adults and 16 units per day for children.

(ii) **Individual PSR.** The maximum is six units per day.

(iii) **Per-Member service levels and limits.**

Unless otherwise specified, group and/or individual PSR services provided in combination may not exceed the monthly limits established in the individual's prior authorization. Limits on PSR services are established based on the level for which the member has been approved.

(iv) **EPSDT.** Pursuant to OAC 317:30-3-65 et seq., billing limits may be exceeded or may not apply if documentation demonstrates that the requested services are medically necessary and are needed to correct or ameliorate defects, physical or behavioral illnesses or conditions discovered through a screening tool approved by OHCA or its designated agent. The OHCA has produced forms for documenting an EPSDT child health checkup screening which the provider can access on the OHCA website.

(F) **Progress Notes.** In accordance with OAC 317:30-5-241.1, the behavioral health service plan developed by the LBHP or Licensure Candidate must include the member's

strengths, functional assets, weaknesses or liabilities, treatment goals, objectives and methodologies that are specific and time-limited, and defines the services to be performed by the practitioners and others who comprise the treatment team. When PSR services are prescribed, the plan must address objectives that are specific, attainable, realistic, and time-limited. The plan must include the appropriate treatment coordination to achieve the maximum reduction of the mental and/or behavioral health disability and to restore the member to their best possible functional level. Progress notes for PSR day programs must be documented in accordance with the requirements found in 317:30-5-248(5). Progress notes for all other Behavioral Health Rehabilitation services must be documented in accordance with the requirements found in 317:30-5-248(3).

(G) Additional documentation requirements.

- (i) a list/log/sign in sheet of participants for each Group rehabilitative session and facilitating qualified provider must be maintained; and
- (ii) Documentation of ongoing consultation and/or collaboration with an LBHP or Licensure Candidate related to the provision of PSR services.

(H) Non-Covered Services. The following services are not considered BHR and are not reimbursable:

- (i) Room and board;
- (ii) educational costs;
- (iii) supported employment; and
- (iv) respite.

(c) Outpatient Substance Abuse Rehabilitation Services.

(1) **Definition.** Covered outpatient substance abuse rehabilitation services are provided in non-residential settings in regularly scheduled sessions intended for individuals not requiring a more intensive level of care or those who require continuing services following more intensive treatment regimes. The purpose of substance abuse rehabilitation services is to begin, maintain, and/or enhance recovery from alcoholism, problem drinking, drug abuse, drug dependency addiction or nicotine use and addiction. Rehabilitation services may be provided individually or in group sessions, and they take the format of curriculum based education and skills training.

(2) **Limitations.** Group sessions may not be provided in the home.

(3) **Eligibility.** Members eligible for substance abuse rehabilitation services must meet the criteria for ASAM PCC Treatment Level 1, Outpatient Treatment.

(4) **Qualified practitioners.** CM II, CADC, LBHP or Licensure Candidate.

(5) **Billing limits.** Group rehabilitation is limited to two (2) hours per session. Group and/or individual outpatient substance abuse rehabilitation services provided in combination may not exceed

the monthly limits established in the individual's prior authorization. Limits on services are established based on the level for which the member has been approved. There are no limits on substance abuse rehabilitation services for individuals determined to be Level 4.

(6) **Documentation requirements.** Documentation requirements are the same as for PSR services as set forth in 30-5-241.3(b)(5)(F).

(d) **Medication training and support.**

(1) **Definition.** Medication Training and Support is a documented review and educational session by a registered nurse, advanced practice nurse, or physician assistant focusing on a member's response to medication and compliance with the medication regimen. The review must include an assessment of medication compliance and medication side effects. Vital signs must be taken including pulse, blood pressure and respiration and documented within the medical or clinical record. A physician is not required to be present, but must be available for consult. Medication Training and Support is designed to maintain the member on the appropriate level of the least intrusive medications, encourage normalization and prevent hospitalization.

(2) **Limitations.**

(A) Medication Training and Support may not be billed for SoonerCare members who reside in ICF/IID facilities.

(B) Two units are allowed per month per patient.

(C) Medication Training & Support is not allowed to be billed on the same day as an evaluation and management (E/M) service provided by a psychiatrist.

(3) **Qualified professionals.** Must be provided by a licensed registered nurse, an advanced practice nurse, or a physician assistant as a direct service under the supervision of a physician.

(4) **Documentation requirements.** Medication Training and Support documented review must focus on:

(A) a member's response to medication;

(B) compliance with the medication regimen;

(C) medication benefits and side effects;

(D) vital signs, which include pulse, blood pressure and respiration; and

(E) documented within the progress notes/medication record.

[Source: Added at 26 Ok Reg 734, eff 4-1-09 (emergency); Added at 26 Ok Reg 2090, eff 6-25-09 ; Amended at 27 Ok Reg 305, eff 11-3-09 (emergency); Amended at 27 Ok Reg 966, eff 5-13-10 ; Added at 27 Ok Reg 2753, eff 7-20-10 (emergency); Added at 28 Ok Reg 1469, eff 6-25-11 ; Amended at 29 Ok Reg 413, eff 3-7-12 (emergency); Amended at 29 Ok Reg 1125, eff 6-25-12 ; Amended at 30 Ok Reg 331, eff 1-14-13 (emergency); Amended at 30 Ok Reg 1146, eff 7-1-13 ; Amended at 31 Ok Reg 651, eff 8-1-14 (emergency); Amended at 31 Ok Reg 1645, eff 9-12-14 ; Amended at 31 Ok Reg 651, eff 9-12-14 (emergency); Amended at 32 Ok Reg 1059, eff 8-27-15]

317:30-5-241.4. Crisis Intervention

(a) **Onsite and Mobile Crisis Intervention Services (CIS).**

(1) **Definition.** CIS are face-to-face services for the purpose of responding to acute behavioral or emotional dysfunction as evidenced by psychotic, suicidal, homicidal severe psychiatric distress, and/or danger of AOD relapse. The crisis situation including the symptoms exhibited and the resulting intervention or recommendations must be clearly documented.

(A) Onsite CIS is the provision of CIS to the member at the treatment facility, either in-person or via telehealth.

(B) Mobile CIS is the provision of CIS by at least one (1) professional at the location of a member who is not at the treatment facility (e.g., services provided at the member's home).

(2) **Limitations.** CIS are not compensable for SoonerCare members who reside in ICF/IID facilities, or who receive RBMS in a group home or therapeutic foster home. CIS is also not compensable for members who experience acute behavioral or emotional dysfunction while in attendance for other behavioral health services unless there is a documented attempt of placement in a higher level of care. The maximum is eight (8) units per month; established mobile crisis response teams can bill a maximum of four (4) hours per month, and ten (10) hours each twelve (12) months per member.

(3) **Qualified professionals.** Services must be provided by an LBHP or licensure candidate.

(b) **Facility Based Crisis Stabilization (FBCS).** FBCS services are emergency psychiatric and substance abuse services aimed at resolving crisis situations. The services provided are emergency stabilization, which includes a protected environment, chemotherapy, detoxification, individual and group treatment, and medical assessment.

(1) **Qualified practitioners.** FBCS services are provided under the supervision of a physician aided by a licensed nurse, and also include LBHPs and licensure candidates for the provision of group and individual treatments. A physician must be available. This service is limited to providers who contract with or are operated by the ODMHSAS to provide this service within the overall behavioral health service delivery system.

(2) **Limitations.** The unit of service is per hour. Providers of this service must meet the requirements delineated in the OAC 450:23. Documentation of records must comply with OAC 317:30-5-248.

[Source: Added at 26 Ok Reg 734, eff 4-1-09 (emergency); Added at 26 Ok Reg 2090, eff 6-25-09 ; Amended at 29 Ok Reg 413, eff 3-7-12 (emergency); Amended at 29 Ok Reg 1125, eff 6-25-12 ; Amended at 32 Ok Reg 1109, eff 8-27-15 ; Amended at 40 Ok Reg 2211, eff 9-11-23]

317:30-5-241.5. Support services

(a) Program of Assertive Community Treatment (PACT) Services.

(1) **Definition.** PACT is provided by an interdisciplinary team that ensures service availability 24 hours a day, seven days a week and is prepared to carry out a full range of treatment functions wherever and whenever needed. An individual is referred to the

PACT team service when it has been determined that his/her needs are so pervasive and/or unpredictable that it is unlikely that they can be met effectively by other combinations of available community services, or in circumstances where other levels of outpatient care have not been successful to sustain stability in the community.

(2) **Target population.** Individuals 18 years of age or older with serious and persistent mental illness and co-occurring disorders. PACT services are those services delivered within an assertive community-based approach to provide treatment, rehabilitation, and essential behavioral health supports on a continuous basis to individuals 18 years of age or older with serious mental illness with a self-contained multi-disciplinary team. The team must use an integrated service approach to merge essential clinical and rehabilitative functions and staff expertise. This level of service is to be provided only for persons most clearly in need of intensive ongoing services.

(3) **Qualified practitioners.** Providers of PACT services are specific teams within an established organization and must be operated by or contracted with and certified by the ODMHSAS in accordance with 43A O.S. 319 and OAC 450:55. The team leader must be an LBHP or Licensure Candidate.

(4) **Limitations.** PACT services are billable in 15 minute units. A maximum of 105 hours per member per year in the aggregate is allowed. All PACT compensable SoonerCare services are required to be face-to-face. The following services are separately billable: Case management, facility-based crisis stabilization, physician and medical services.

(5) **Service requirements.** PACT services must include the following:

- (A) PACT assessments (initial and comprehensive);
 - (i) Initial assessment- is the initial evaluation of the member based upon available information, including self-reports, reports of family members and other significant parties, and written summaries from other agencies, including police, court, and outpatient and inpatient facilities, where applicable, culminating in a comprehensive initial assessment. Member assessment information for admitted members shall be completed on the day of admission to the PACT. The start and stop times for this service should be recorded in the chart.
 - (ii) Comprehensive assessment- is the organized process of gathering and analyzing current and past information with each member and the family and/or support system and other significant people to evaluate: 1) mental and functional status; 2) effectiveness of past treatment; 3) current treatment, rehabilitation and support needs to achieve individual goals and support recovery; and 4) the range of individual strengths (e.g.,

knowledge gained from dealing with adversity or personal/professional roles, talents, personal traits) that can act as resources to the member and his/her recovery planning team in pursuing goals. Providers must bill only the face-to-face service time with the member. Non-face to face time is not compensable. The start and stop times for this service should be recorded in the chart.

(B) Behavioral health service plan (moderate and low complexity by a non-physician treatment planning and review) is a process by which the information obtained in the comprehensive assessment, course of treatment, the member, and/or treatment team meetings is evaluated and used to develop a service plan that has individualized goals, objectives, activities and services that will enable a member to improve. The initial assessment serves as a guide until the comprehensive assessment is completed. It is to focus on recovery and must include a discharge plan. It is performed with the direct active participation by the member. SoonerCare compensation for this service includes only the face to face time with the member. The start and stop times for this service should be recorded in the chart.

(C) Treatment team meetings (team conferences with the member present) is a billable service. This service is conducted by the treatment team, which includes the member and all involved practitioners. For a complete description of this service, see OAC 450:55-5-6 Treatment Team Meetings. This service can be billed to SoonerCare only when the member is present and participating in the treatment team meeting. The conference starts at the beginning of the review of an individual member and ends at the conclusion of the review. Time related to record keeping and report generation is not reported. The start and stop times should be recorded in the member's chart. The participating psychiatrist/physician should bill the appropriate CPT code; and the agency is allowed to bill one treatment team meeting per member as medically necessary.

(D) Individual and family psychotherapy;

(E) Individual rehabilitation;

(F) Recovery support services;

(G) Group rehabilitation;

(H) Group psychotherapy;

(I) Crisis Intervention;

(J) Medication training and support services;

(K) Blood draws and /or other lab sample collection services performed by the nurse.

(b) Therapeutic Behavioral Services.

(1) **Definition.** Therapeutic behavioral services include behavior management and redirection and behavioral and life skills

remedial training provided by qualified behavioral health aides. The behavioral health aide also provides monitoring and observation of the child's emotional/behavioral status and responses, providing interventions, support and social skills redirection when needed. Training is generally focused on behavioral, interpersonal, communication, self help, safety and daily living skills.

(2) **Target population.** This service is limited to children with serious emotional disturbance who are in an ODMHSAS contracted systems of care community based treatment program, or are under OKDHS or OJA custody residing within a RBMS level of care, who need intervention and support in their living environment to achieve or maintain stable successful treatment outcomes.

(3) **Qualified practitioners.** Behavioral Health Aides must be trained/credentialed through ODMHSAS.

(4) **Limitations.** The Behavioral Health Aide cannot bill for more than one individual during the same time period. Therapeutic behavioral services by a BHA, Treatment Parent Specialist (TPS) or Behavioral Health School Aide (BHSA) cannot be delivered during the same clock time.

(5) **Documentation requirements.** Providers must follow requirements listed in OAC 317:30-5-248.

(c) **Family Support and Training.**

(1) **Definition.** This service provides the training and support necessary to ensure engagement and active participation of the family in the service plan development process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. Child Training is provided to family members to increase their ability to provide a safe and supportive environment in the home and community for the child. Parent Support ensures the engagement and active participation of the family in the service plan development process and guides families toward taking a proactive role in their child's treatment. Parent Training is assisting the family with the acquisition of the skills and knowledge necessary to facilitate an awareness of their child's needs and the development and enhancement of the family's specific problem-solving skills, coping mechanisms, and strategies for the child's symptom/behavior management.

(2) **Target population.** Family Support and Training is designed to benefit the SoonerCare eligible child experiencing a serious emotional disturbance who is in an ODMHSAS contracted systems of care community based treatment program, are diagnosed with a pervasive developmental disorder, or are under OKDHS or OJA custody, are residing within a RBMS level of care or are at risk for out of home placement, and who without these services would require psychiatric hospitalization.

(3) **Qualified practitioners.** Family Support Providers (FSPs) must be trained/credentialed through ODMHSAS.

(4) **Limitations.** The FSP cannot bill for more than one individual during the same time period.

(5) **Documentation requirements.** Providers must comply with requirements listed in OAC 317:30-5-248.

(d) **Peer Recovery Support Services (PRSS).**

(1) **Definition.** Peer recovery support services are an EBP model of care which consists of a qualified peer recovery support specialist provider (PRSS) who assists individuals with their recovery from behavioral health disorders. Recovery Support is a service delivery role in the ODMHSAS public and contracted provider system throughout the behavioral health care system where the provider understands what creates recovery and how to support environments conducive of recovery. The role is not interchangeable with traditional staff members who usually work from the perspective of their training and/or their status as a licensed behavioral health provider; rather, this provider works from the perspective of their experiential expertise and specialized credential training. They lend unique insight into mental illness and what makes recovery possible because they are in recovery.

(2) **Target population.** Children 16 and over with SED and/or substance use disorders and adults 18 and over with SMI and/or substance use disorder(s).

(3) **Qualified professionals.** Peer Recovery Support Specialists (PRSS) must be certified through ODMHSAS pursuant to OAC 450:53.

(4) **Limitations.** The PRSS cannot bill for more than one individual during the same time period. This service can be an individual or group service. Groups have no restriction on size.

(5) **Documentation requirements.** Providers must comply with requirements listed in OAC 317:30-5-248.

(6) **Service requirements.**

(A) PRSS staff utilizing their knowledge, skills and abilities will:

- (i) teach and mentor the value of every individual's recovery experience;
- (ii) model effective coping techniques and self-help strategies;
- (iii) assist members in articulating personal goals for recovery; and
- (iv) assist members in determining the objectives needed to reach his/her recovery goals.

(B) PRSS staff utilizing ongoing training must:

- (i) proactively engage members and possess communication skills/ability to transfer new concepts, ideas, and insight to others;
- (ii) facilitate peer support groups;
- (iii) assist in setting up and sustaining self-help (mutual support) groups;
- (iv) support members in using a Wellness Recovery Action Plan (WRAP);
- (v) assist in creating a crisis plan/Psychiatric Advanced Directive;

- (vi) utilize and teach problem solving techniques with members;
- (vii) teach members how to identify and combat negative self-talk and fears;
- (viii) support the vocational choices of members and assist him/her in overcoming job-related anxiety;
- (ix) assist in building social skills in the community that will enhance quality of life. Support the development of natural support systems;
- (x) assist other staff in identifying program and service environments that are conducive to recovery; and
- (xi) attend treatment team and program development meetings to ensure the presence of the member's voice and to promote the use of self-directed recovery tools.

[Source: Added at 26 Ok Reg 734, eff 4-1-09 (emergency); Added at 26 Ok Reg 2090, eff 6-25-09 ; Added at 27 Ok Reg 2753, eff 7-20-10 (emergency); Added at 28 Ok Reg 1469, eff 6-25-11 ; Amended at 29 Ok Reg 413, eff 3-7-12 (emergency); Amended at 29 Ok Reg 1125, eff 6-25-12 ; Amended at 31 Ok Reg 1645, eff 9-12-14 ; Amended at 32 Ok Reg 1109, eff 8-27-15]

317:30-5-241.6. Behavioral health targeted case management

Payment is made for behavioral health targeted case management services as set forth in this Section. The limitations set forth in this Section do not apply to case management provided in programs and service delivery models which are not reimbursed for case management on a fee-for-service basis.

(1) Description of behavioral health case management services. Behavioral health case management services are provided to assist eligible individuals in gaining access to needed medical, social, educational and other services essential to meeting basic human needs. Services under behavioral health targeted case management are not comparable in amount, duration and scope. The target groups for behavioral health case management services are persons under age twenty-one (21) who are in imminent risk of out-of-home placement for psychiatric or substance abuse reasons or are in out-of-home placement due to psychiatric or substance abuse reasons, and chronically and/or severely mentally ill adults who are institutionalized or are at risk of institutionalization. All behavioral health case management services will be authorized based on established medical necessity criteria.

(A) The behavioral health case manager provides assessment of case management needs, development of a case management care plan, referral, linkage, monitoring and advocacy on behalf of the member to gain access to appropriate community resources. The behavioral health case manager must monitor the progress in gaining access to services and continued appropriate utilization of

necessary community resources. Behavioral case management is designed to promote recovery, maintain community tenure, and to assist individuals in accessing services for themselves following the case management guidelines established by ODMHSAS. In order to be compensable, the service must be performed utilizing the Strengths Based model of case management. This model of case management assists individuals in identifying and securing the range of resources, both environmental and personal, needed to live in a normally interdependent way in the community. The focus for the helping process is on strengths, interests, abilities, knowledge and capacities of each person, not on their diagnosis, weakness or deficits. The relationship between the service member and the behavioral health case manager is characterized by mutuality, collaboration, and partnership. Assistive activities are designed to occur primarily in the community, but may take place in the behavioral health case manager's office, if more appropriate.

(B) The provider will coordinate transition services with the member and family (if applicable) by phone or face to face, to identify immediate needs for return to home/community no more than seventy-two (72) hours after notification that the member/family requests case management services. For members discharging from a higher level of care than outpatient, the higher level of care facility is responsible for scheduling an appointment with a case management agency for transition and post discharge services. The case manager will make contact with the member and family (if applicable) for transition from the higher level of care other than outpatient back to the community, within seventy-two (72) hours of discharge, and then conduct a follow-up appointment/contact within seven (7) days. The case manager will provide linkage/referral to physicians/medication services, psychotherapy services, rehabilitation and/or support services as described in the case management service plan.

(C) Case managers may also provide crisis diversion (unanticipated, unscheduled situation requiring supportive assistance, face to face or telephone, to resolve immediate problems before they become overwhelming and severely impair the individual's ability to function or maintain in the community) to assist member(s) from progression to a higher level of care. During the follow-up phase of these referrals or links, the behavioral health case manager will provide aggressive outreach if appointments or contacts are missed within two (2) business days of the missed appointments. Community/home based case management to assess the needs for services will be scheduled as reflected in the case management service plan, but not

less than one (1) time per month. The member/parent/guardian has the right to refuse behavioral health case management and cannot be restricted from other services because of a refusal of behavioral health case management services.

(D) An eligible member/parent/guardian will not be restricted and will have the freedom to choose a behavioral health case management provider as well as providers of other medical care.

(E) In order to ensure that behavioral health case management services appropriately meet the needs of the member and family and are not duplicated, behavioral health case management activities will be provided in accordance with an individualized plan of care.

(F) The individual plan of care must include general goals and objectives pertinent to the overall recovery of the member's (and family, if applicable) needs. Progress notes must relate to the individual plan of care and describe the specific activities to be performed. The individual plan of care must be developed with participation by, as well as, reviewed and signed by the member, the parent or guardian [if the member is under eighteen (18)], the behavioral health case manager, and an LBHP or licensure candidate as defined in OAC 317:30-5-240.3(a) and (b).

(G) SoonerCare reimbursable behavioral health case management services include the following:

(i) Gathering necessary psychological, educational, medical, and social information for the purpose of individual plan of care development.

(ii) Face-to-face meetings with the member and/or the parent/guardian/family member for the implementation of activities delineated in the individual plan of care.

(iii) Face-to-face meetings with treatment or service providers, necessary for the implementation of activities delineated in the individual plan of care.

(iv) Supportive activities such as non-face-to-face communication with the member and/or parent/guardian/family member.

(v) Non face-to-face communication with treatment or service providers necessary for the implementation of activities delineated in the individual plan of care.

(vi) Monitoring of the individual plan of care to reassess goals and objectives and assess progress and or barriers to progress.

(vii) Crisis diversion (unanticipated, unscheduled situation requiring supportive assistance, face to face or telephone, to resolve immediate problems before they become overwhelming and severely

impair the individual's ability to function or maintain in the community) to assist member(s) from progression to a higher level of care.

(viii) Behavioral health targeted case management is available to individuals transitioning from institutions to the community [except individuals who are inmates of public institutions]. Individuals are considered to be transitioning to the community during the last thirty (30) consecutive days of a covered institutional stay. This time is to distinguish case management services that are not within the scope of the institution's discharge planning activities from case management required for transitioning individuals with complex, chronic, medical needs to the community. Transition services provided while the individual is in the institution are to be claimed as delivered on the day of discharge from the institution.

(2) Levels of case management.

(A) Standard case management/resource coordination services are targeted to adults with serious mental illness or children with serious emotional disturbance, or who have or are at-risk for mental disorders, including substance use disorders (SUD), and their families, who need assistance in accessing, coordination, and monitoring of resources and services. Services are provided to assess an individual's strengths and meet needs in order to achieve stability in the community. Standard case managers have caseloads of thirty (30) to thirty-five (35) members. Standard case management/resource coordination is limited to twelve (12) units per member per month. Additional units may be authorized up to twenty-five (25) units per member per month if medical necessity criteria for transitional case management are met.

(B) Intensive case management (ICM) is targeted to adults with serious and persistent mental illness in PACT programs. To ensure that these intense needs are met, caseloads are limited to between ten (10) to fifteen (15) members. The ICM shall: be a certified behavioral health case manager II; have a minimum of two (2) years' behavioral health case management experience; have crisis diversion experience; have attended the ODMHSAS six (6) hour ICM training and be available twenty-four (24) hours a day. ICM is limited to fifty-four (54) units per member per month.

(C) Wraparound facilitation case management (WFCM) is targeted to children with significant mental health conditions being treated in a System of Care (SOC) Network who are deemed at imminent risk of out-of-home placement due to psychiatric or SUD reasons and in need

of more intensive case management services. It is designed to ensure access to community agencies, services, and people whose functions are to provide the support, training and assistance required for a stable, safe, and healthy community life, and decreased need for higher levels of care. To produce a high fidelity wraparound process, a facilitator can facilitate between eight (8) and ten (10) families. Staff providing WFCM must meet the requirements for the SOC/WFCM. WFCM is limited to fifty-four (54) units per member per month.

(3) **Excluded services.** SoonerCare reimbursable behavioral health case management does not include the following activities:

- (A) Physically escorting or transporting a member or family to scheduled appointments or staying with the member during an appointment;
- (B) Managing finances;
- (C) Providing specific services such as shopping or paying bills;
- (D) Delivering bus tickets, food stamps, money, etc.;
- (E) Counseling, rehabilitative services, psychiatric assessment, or discharge planning;
- (F) Filling out forms, applications, etc., on behalf of the member when the member is not present;
- (G) Filling out SoonerCare forms, applications, etc.;
- (H) Mentoring or tutoring;
- (I) Provision of behavioral health case management services to the same family by two (2) separate behavioral health case management agencies;
- (J) Non-face-to-face time spent preparing the assessment document and the service plan paperwork;
- (K) Monitoring financial goals;
- (L) Leaving voice or text messages for clients and other failed communication attempts.

(4) **Excluded individuals.** The following SoonerCare members who are receiving similar services through another method are not eligible for behavioral health case management services without special arrangements with the Oklahoma Department of Human Services (OKDHS), OJA, OHCA or ODMHSAS as applicable, in order to avoid duplication in payment.

Services/programs include, but may not be limited to:

- (A) Members/families (when applicable) for whom at-risk case management services are available through OKDHS and OJA staff;
- (B) Members in out-of-home placement and receiving targeted case management services through staff in a foster care or group home setting, unless transitioning into the community;
- (C) Residents of ICF/IIDs and nursing facilities unless transitioning into the community;
- (D) Members receiving targeted case management services under a Home and Community Based Services

- (HCBS) waiver program;
- (E) Members receiving case management through the ADvantage waiver program;
- (F) Members receiving targeted case management available through a Certified Community Behavioral Health Center (CCBHC);
- (G) Members receiving case management services through Programs of All-Inclusive Care for the Elderly (PACE);
- (H) Members receiving Early Intervention case management (EICM);
- (I) Members receiving case management services through certified school-based targeted case management (SBTCM) providers;
- (J) Members receiving partial hospitalization services; or
- (K) Members receiving MST.

(5) **Filing requirements.** Case management services provided to Medicare eligible members should be filed directly with the fiscal agent.

(6) **Documentation requirements.** The service plan must include general goals and objectives pertinent to the overall recovery needs of the member. Progress notes must relate to the service plan and describe the specific activities performed. Behavioral health case management service plan development is compensable time if the time is spent communicating with the member and it must be reviewed and signed by the member, the behavioral health case manager, and an LBHP or licensure candidate as defined at OAC 317:30-5-240.3(a) and (b). All behavioral health case management services rendered must be reflected by documentation in the records. In addition to a complete behavioral health case management service, plan documentation of each session must include but is not limited to:

- (A) Date;
- (B) Person(s) to whom services are rendered;
- (C) Start and stop times for each service;
- (D) Original signature or the service provider [original signatures for faxed items must be added to the clinical file within thirty (30) days];
- (E) Credentials of the service provider;
- (F) Specific service plan needs, goals, and/or objectives addressed;
- (G) Specific activities performed by the behavioral health case manager on behalf of the member related to advocacy, linkage, referral, or monitoring used to address needs, goals, and/or objectives;
- (H) Progress and barriers made towards goals, and/or objectives;
- (I) Member/family (when applicable) response to the service;
- (J) Any new service plan needs, goals, and/or objectives identified during the service; and
- (K) Member satisfaction with staff intervention.

(7) **Case management travel time.** The rate for case management services assumes that the case manager will spend some amount of time traveling to the member for the face-to-face service. The case manager must only bill for the actual face-to-face time that they spend with the member and not bill for travel time. This would be considered duplicative billing since the rate assumes the travel component already.

[Source: Added at 33 Ok Reg 804, eff 9-1-16 ; Amended at 34 Ok Reg 649, eff 9-1-17 ; Amended at 35 Ok Reg 24, eff 8-28-17 (emergency); Amended at 35 Ok Reg 1422, eff 9-14-18 ; Amended at 37 Ok Reg 217, eff 10-25-19 (emergency); Amended at 37 Ok Reg 1532, eff 9-14-20 ; Amended at 38 Ok Reg 428, eff 12-18-20 (emergency); Amended at 38 Ok Reg 1023, eff 9-1-21]

317:30-5-241.7. Medication-assisted treatment (MAT) services for eligible individuals with opioid use disorder (OUD)

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

(1) **"Medication-assisted treatment (MAT)"** means an evidence-based practice approved by the Food and Drug Administration (FDA) to treat opioid use disorder, including methadone and all biological products licensed under federal law for such purpose. MAT also includes the provision of counseling and behavioral therapy.

(2) **"Office-based opioid treatment (OBOT)"** means a fully contracted SoonerCare provider that renders MAT services in OBOT settings. OBOT providers must have capacity to provide all drugs approved by the FDA for the treatment of opioid use disorder, directly or by referral, including for maintenance, detoxification, overdose reversal, and relapse prevention, and appropriate counseling and other appropriate ancillary services.

(3) **"Opioid treatment program (OTP)"** means a program or provider:

- (A) Registered under federal law;
- (B) Certified by the Substance Abuse and Mental Health Services Administration (SAMHSA);
- (C) Certified by ODMHSAS, unless deemed an exempted entity as defined by federal law;
- (D) Registered by the Drug Enforcement Agency (DEA);
- (E) Registered by the Oklahoma Bureau of Narcotics and Dangerous Drugs (OBNDD); and
- (F) Engaged in opioid treatment of individuals by use of an opioid agonist treatment medication, including methadone.

(4) **"Opioid use disorder (OUD)"** means a cluster of cognitive, behavioral, and physiological symptoms in which the individual continues use of opioids despite significant opioid-induced problems.

(5) **"Phase I"** means the first ninety (90) days of treatment.

(6) **"Phase II"** means the second ninety (90) days of treatment.

(7) **"Phase III"** means the third ninety (90) days of treatment.

(8) "**Phase IV**" means the last ninety (90) days of the first year of treatment.

(9) "**Phase V**" means the phase of treatment for members who have been receiving continuous treatment for more than one (1) year.

(10) "**Phase VI**" means the phase of treatment for members who have been receiving continuous treatment for more than two (2) years.

(b) **Coverage.** The SoonerCare program provides coverage of medically necessary MAT services in OTPs, including but not limited to, methadone treatment, to eligible individuals with OUD. An OTP must have the capacity to provide the full range of services included in the definition of MAT and must document both medication dosing and supporting behavioral health services, including but not limited to, individual, family and group therapy and rehabilitation services. MAT services and/or medications may also be provided in OBOT settings per OAC 317:30-5-9(b)(16).

(c) **OTP requirements.** Every OTP provider shall:

- (1) Have a current contract with the OHCA as an OTP provider;
- (2) Hold a certification as an OTP from ODMHSAS, unless deemed an exempted entity as defined by federal law;
- (3) Hold a certification from the Substance Abuse and Mental Health Services Administration (SAMHSA);
- (4) Be appropriately accredited by a SAMHSA-approved accreditation organization;
- (5) Be registered with the DEA and the OBNDD; and
- (6) Meet all state and federal opioid treatment standards, including all requirements within OAC 450:70.

(d) **Individual OTP providers.** OTP providers include a:

- (1) MAT provider who is a physician, physician's assistant (PA), or advanced practice registered nurse (APRN) who may prescribe, dispense, and administer medications in accordance with state and federal law and the Oklahoma Medicaid State Plan.
- (2) OTP behavioral health services practitioner who is a practitioner that meets the qualifications in OAC 317:30-5-240.3, except for family support and training providers, qualified behavioral therapy aide providers, multi-systemic therapy providers, and case manager I providers, for the provision of outpatient behavioral health services.

(e) **Intake and assessment.** OTPs shall conduct intake and assessment procedures in accordance with OAC 450:70-3-5 through OAC 450:70-3-7.

(f) **Service phases.** In accordance with OAC 450:70-6-17.2 through OAC 450:70-6-17.8, the OTP shall have structured phases of treatment and rehabilitation to support member progress and to establish requirements regarding member attendance and service participation. The OTP shall utilize ASAM criteria to determine the appropriate level of care during each phase of treatment. Treatment requirements for each phase shall include, but not limited to, the following:

- (1) During phase I, the member shall participate in a minimum of four (4) treatment sessions per month. Available services shall include, but not be limited to, therapy, rehabilitation, case

management, and peer recovery support services.

(2) During phase II, the member shall participate in at least two (2) treatment sessions per month . Available services shall include, but not be limited to, therapy, rehabilitation, case management, and peer recovery support services.

(3) During phase III, phase IV and phase V, the member shall participate in at least one (1) treatment session per month. Available services shall include, but not be limited to, therapy, rehabilitation, case management, and peer recovery support services.

(4) During phase VI, the LBHP, licensure candidate or certified alcohol and drug counselor (CADC) determines the frequency of therapy or rehabilitation service sessions with input from the member.

(5) If an OTP is providing MAT medications to members receiving residential substance use disorder services, the required minimum services for the OTP may be delivered by the residential substance use disorder provider. The OTP provider shall document the provision of these services and the provider delivering such services in the member's service plan.

(g) **Service plans.** In accordance with OAC 450:70-3-8, a service plan shall be completed for each member upon completion of the admission evaluation. The service plan shall be based on the patient's presenting problems or diagnosis, intake assessment, biopsychosocial assessment, and expectations of their recovery.

(1) **Service plan development.** Service plans shall be completed by an LBHP or licensure candidate. Service plans, including updates, must include dated signatures of the person served [if age fourteen (14) or older], the parent/guardian (if required by law), and the LBHP or licensure candidate. If a minor is eligible to self-consent to treatment pursuant to state law, a parent/guardian signature is not required. Service plans completed by a licensure candidate must be co-signed and dated by a fully-licensed LBHP. Signatures must be obtained after the service plan is completed.

(2) **Service plan content.** Service plans shall address, but not limited to, the following:

- (A) Presenting problems or diagnosis;
- (B) Strengths, needs, abilities, and preferences of the member;
- (C) Goals for treatment with specific, measurable, attainable, realistic and time-limited;
- (D) Type and frequency of services to be provided;
- (E) Dated signature of primary service provider;
- (F) Description of member's involvement in, and responses to, the service plan and his or her signature and date;
- (G) Individualized discharge criteria or maintenance;
- (H) Projected length of treatment;
- (I) Measurable long and short term treatment goals;
- (J) Primary and supportive services to be utilized with the patient;

- (K) Type and frequency of therapeutic activities in which patient will participate;
- (L) Documentation of the member's participation in the development of the plan; and
- (M) Staff who will be responsible for the member's treatment.

(3) **Service plan updates.** Service plan updates shall be completed by an LBHP or licensure candidate. Service updates completed by a licensure candidate must be co-signed and dated by a fully-licensed LBHP. Service plan review and updates shall occur no less than every six (6) months and shall occur more frequently if required based upon the service phase or certain circumstances:

- (A) Change in goals and objectives based upon member's documented progress, or identification of any new problem(s);
- (B) Change in primary therapist or rehabilitation service provider assignment;
- (C) Change in frequency and types of services provided;
- (D) Critical incident reports; and/or
- (E) Sentinel events.

(4) **Service plan timeframes.** Service plans shall be completed by the fourth visit after admission.

(h) **Progress notes.** Progress notes shall be completed in accordance with OAC 317:30-5-248(3).

(i) **Discharge planning.** All members shall be assessed for biopsychosocial appropriateness of discharge from each level of care using ASAM criteria that includes a list of symptoms for all six (6) dimensions and each of the levels of care, to determine a clinically appropriate placement in the least restrictive level of care. This organized process involves a professional determination by an LBHP or licensure candidate for appropriate placement to a specific level of care based on the following symptoms and situations:

- (1) Acute intoxication and/or withdrawal potential;
- (2) Biomedical conditions and complications;
- (3) Emotional, behavioral or cognitive conditions and complications;
- (4) Readiness to change;
- (5) Relapse, continued use or continued problem potential; and
- (6) Recovery/living environment.

(j) **Service exclusions.** The following services are excluded from coverage:

- (1) Components that are not provided to or exclusively for the treatment of the eligible individual;
- (2) Services or components of services of which the basic nature is to supplant housekeeping or basic services for the convenience of a person receiving covered services;
- (3) Telephone calls or other electronic contacts (not inclusive of telehealth);
- (4) Field trips, social, or physical exercise activity groups;

(k) **Reimbursement.** To be eligible for payment, OTPs shall:

(1) Have an approved provider agreement on file with the OHCA. Through this agreement, the OTP assures that they are in compliance with all applicable federal and state Medicaid law and regulations, including, but not limited to, OHCA administrative rules, ODMHSAS administrative rules, and the Oklahoma Medicaid State Plan.

(2) Obtain prior authorization for applicable drugs and services by the OHCA or its designated agent before the service is rendered by an eligible provider. Without prior authorization for applicable drugs and services, payment is not authorized.

(3) Record the National Drug Code (NDC) number for each drug used in every encounter at the time of billing.

(4) Be reimbursed pursuant to the methodology described in the Oklahoma Medicaid State Plan.

[Source: Added at 38 Ok Reg 424, eff 1-1-21 (emergency); Added at 38 Ok Reg 1020, eff 9-1-21 ; Amended at 39 Ok Reg 1503, eff 9-12-22 ; Amended at 40 Ok Reg 2212, eff 9-11-23]

317:30-5-241.8. Multi-systemic therapy (MST)

MST intensive outpatient program services are limited to children within an Office of Juvenile Affairs (OJA) MST treatment program which provides an intensive, family and community-based treatment targeting specific BH disorders in children with SED who exhibit chronic, aggressive, antisocial, and/or substance abusing behaviors, and are at risk for out of home placement. Caseloads are kept low due to the intensity of the services provided.

(1) **Qualified professionals.** All MST services are provided by LBHPs or licensure candidates. Licensure candidate signatures must be co-signed by a fully-licensed LBHP in good standing. Additional team support services may be provided by a behavioral health case manager II (CM II) and/or peer recovery support specialist (PRSS) per OAC 317:30-5-240.3.

(2) **Documentation requirements.** Providers must comply with documentation requirements in OAC 317:30-5-248.

(3) **Limitations.** Services are subject to the following:

(A) Partial billing is not allowed. When only one (1) service is provided in a day, providers should not bill for services performed for less than eight (8) minutes.

(B) MST cannot be billed in conjunction with the following:

- (i) Children's psychosocial rehabilitation;
- (ii) Partial hospitalization/intensive outpatient treatment;
- (iii) Targeted case management;
- (iv) Individual, family, and group therapy;
- (v) Mobile crisis intervention;
- (vi) Peer-to-peer services.

(C) Duration of MST services is between three (3) to six (6) months. Weekly interventions may range from three (3) to twenty (20) hours per week. Weekly hours may be lessened as case nears closure.

(4) **Reimbursement.** MST services are reimbursed pursuant to the methodology described in the Oklahoma Medicaid State Plan.

[Source: Added at 39 Ok Reg 1506, eff 9-12-22]

317:30-5-241.9. Partial hospitalization program (PHP) - Children/Adolescent

(a) **Definition.** Partial hospitalization is an intermediary, stabilizing step for children and adolescents who have had inpatient psychiatric hospitalization prior to returning to school and community supports or as a less restrictive alternative when inpatient treatment may not be indicated. PHP services are:

- (1) Reasonable and necessary for the diagnosis or active treatment of the member's condition; and
- (2) Reasonably expected to improve the member's condition and functional level and to prevent relapse or hospitalization.

(b) **Eligibility criteria.** This service must be prior authorized by OHCA or its designated agent, and individuals must meet ongoing medical necessity criteria. Treatment is time limited, and length of participation is based on the individual's needs.

(c) **Eligible providers.** Provider agencies for PHP must be accredited to provide partial hospitalization services by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Accreditation Commission for Health Care (ACHC) or The Council on Accreditation (COA) for partial hospitalization and enrolled in SoonerCare. Staff providing these services are employees or contractors of the enrolled agency. The agency is responsible for ensuring that all services are provided by properly credentialed clinicians.

(d) **Qualified practitioners.** Program services are overseen by a psychiatrist. The number of professionals and paraprofessionals required on the clinical team is dependent on the size of the program. The clinical team includes the following required professionals:

- (1) A licensed physician, physician's assistant, or advanced practice registered nurse [any of whom meet the requirements of an LBHP as described at OAC 317:30-5-240.3(a)];
- (2) Registered nurse; and
- (3) One (1) or more LBHPs or licensure candidates listed in OAC 317:30-5-240.3(a) and (b).
- (4) The clinical team may also include a certified behavioral health case manager.

(e) **Service components.** PHP includes the following services:

- (1) Assessment, diagnostic and service plan services for mental illness and/or substance use disorders provided by LBHPs or licensure candidates;
- (2) Individual/group/family (primary purpose is treatment of the member's condition) psychotherapies provided by LBHPs or licensure candidates;
- (3) Substance use disorder specific services are provided by LBHPs or licensure candidates qualified to provide these services;
- (4) Drugs and biologicals furnished for therapeutic purposes;

(5) Family counseling, the primary purpose of which is treatment of the member's condition;

(6) Behavioral health rehabilitation services to the extent the activities are closely and clearly related to the member's care and treatment, provided by a certified behavioral health case manager II, certified alcohol and drug counselor (CADC), LBHP, or licensure candidate who meets the professional requirements listed in OAC 317:30-5-240.3; and

(7) Care coordination of behavioral health services provided by certified behavioral health case managers.

(f) **Limitations.** Services are subject to the following:

(1) Children under age six (6) are not eligible for behavioral health rehabilitation services unless a prior authorization for children ages four (4) and five (5) has been granted by OHCA or its designated agent based on a finding of medical necessity.

(2) Services must be offered at a minimum of three (3) hours per day, five (5) days per week.

(3) Therapeutic services are limited to four (4) billable hours per day.

(4) Group size is limited to a maximum of eight (8) individuals as clinically appropriate given diagnostic and developmental functioning.

(5) Occupational, physical and speech therapy will be provided by the Independent School District (ISD). Academic instruction, meals, and transportation are not covered.

(6) PHP services cannot be billed in conjunction with the following:

(A) Children's psychosocial rehabilitation services;

(B) Residential services [psychiatric residential treatment facility (PRTF) or residential behavior management services (RBMS)];

(C) Targeted case management (TCM);

(D) Individual, family, or group therapy;

(E) Mobile crisis intervention within the PHP setting;

(F) Peer-to-peer services;

(G) Certified Community Behavioral Health (CCBH) services;

(H) Day treatment;

(I) Multi-systemic therapy (MST);

(J) Program of Assertive Community Treatment (PACT) [Applicable for individuals eighteen (18) to twenty-one (21) years of age].

(g) **Service requirements.** This service includes:

(1) Therapeutic services that include the following:

(A) Psychiatrist/physician face-to-face visit two (2) times per month; and

(B) Crisis management services available twenty-four (24) hours a day, seven (7) days a week.

(2) Psychotherapies that are provided at a minimum of four (4) hours per week and include the following:

- (A) Individual therapy - a minimum of one (1) session per week;
- (B) Family therapy - a minimum of one (1) session per week; and
- (C) Group therapy - a minimum of two (2) sessions per week.

(3) Interchangeable services that include the following:

- (A) Behavioral health case management (face-to-face);
- (B) Behavioral health rehabilitation services/alcohol and other drug abuse education, except for children under age six (6), unless a prior authorization has been granted for children ages four (4) and five (5);
- (C) Medication training and support; and
- (D) Expressive therapy.

(h) **Documentation requirements.** Documentation needs to specify active involvement of the member's family, caretakers, or significant others involved in the individual's treatment. A nursing health assessment must be completed within twenty-four (24) hours of admission. A physical examination and medical history must be coordinated with the primary care physician. Service plan updates are required every three (3) months or more frequently based on clinical need. Records must be documented according to OAC 317:30-5-248.

(i) **Staffing requirements.** Staffing must consist of the following:

- (1) A registered nurse (RN) trained and competent in the delivery of behavioral health services as evidenced by education and/or experience that is available on-site during program hours to provide necessary nursing care and/or psychiatric nursing care [one (1) RN at a minimum can be backed up by a licensed practical nurse (LPN) but an RN must always be on site]. Nursing staff administers medications, follows up with families on medication compliance, and completes restraint assessments;
- (2) Medical director must be a licensed psychiatrist;
- (3) A psychiatrist/physician must be available twenty-four (24) hours a day, seven (7) days a week.
- (4) One (1) or more LBHPs or licensure candidates listed in OAC 317:30-5-240.3(a) and (b).

(A) Physician services;

(B) Medications;

(C) Psychological testing by a licensed psychologist.

(j) **Reimbursement.** PHP services are reimbursed pursuant to the methodology described in the Oklahoma Medicaid State Plan. PHP reimbursement is all-inclusive of the service components, except for the following:

[Source: Added at 39 Ok Reg 1506, eff 9-12-22]

317:30-5-242. Coverage for children [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 14 Ok Reg 1221, eff 8-7-96 (emergency); Amended at 14 Ok Reg 2125, eff 4-4-97 (emergency); Amended at 15 Ok Reg 1528, eff 5-11-98 ; Revoked at 16 Ok Reg 2839, eff 7-12-99]

317:30-5-243. Vocational rehabilitation coverage [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 14 Ok Reg 2125, eff 4-4-97 (emergency); Amended at 15 Ok Reg 1528, eff 5-11-98 ; Revoked at 22 Ok Reg 156, eff 10-6-04 (emergency); Revoked at 21 Ok Reg 2473, eff 7-11-05]

317:30-5-244. Individuals eligible for Part B of Medicare

Outpatient Behavioral Health services provided to Medicare eligible members are filed directly with the fiscal agent.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 14 Ok Reg 2125, eff 4-4-97 (emergency); Amended at 15 Ok Reg 1528, eff 5-11-98 ; Amended at 26 Ok Reg 734, eff 4-1-09 (emergency); Amended at 26 Ok Reg 2090, eff 6-25-09]

317:30-5-245. Reimbursement

Payment is made for Outpatient Behavioral Health services at the lower of the provider's usual and customary charge or the OHCA fee schedule for SoonerCare compensable services.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 14 Ok Reg 1221, eff 8-7-96 (emergency); Amended at 14 Ok Reg 2125, eff 4-4-97 (emergency); Amended at 15 Ok Reg 1528, eff 5-11-98 ; Amended at 16 Ok Reg 2839, eff 7-12-99 ; Amended at 25 Ok Reg 2674, eff 7-25-08]

317:30-5-246. Covered services [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 14 Ok Reg 1221, eff 8-7-96 (emergency); Amended at 14 Ok Reg 2125, eff 4-4-97 (emergency); Amended at 15 Ok Reg 139, eff 11-1-97 (emergency); Amended at 15 Ok Reg 1528, eff 5-11-98 ; Amended at 16 Ok Reg 2839, eff 7-12-9 ; Revoked at 19 Ok Reg 2134, eff 6-27-02]

317:30-5-247. Billing [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 14 Ok Reg 1221, eff 8-7-96 (emergency); Amended at 14 Ok Reg 2125, eff 4-4-97 (emergency); Amended at 15 Ok Reg 1528, eff 5-11-98 ; Revoked at 22 Ok Reg 156, eff 10-6-04 (emergency); Revoked at 22 Ok Reg 2473, eff 7-11-05]

317:30-5-248. Documentation of records

All outpatient behavioral health services must be reflected by documentation in the member's records.

- (1) For Behavioral Health Assessments (see OAC 317:30-5-241), no progress notes are required.
- (2) For Behavioral Health Services Plan (see OAC 317:30-5-241), no progress notes are required.
- (3) Treatment Services must be documented by progress notes.
 - (A) Progress notes shall chronologically describe the services provided, the member's response to the services provided and the member's progress, or lack of, in treatment and must include the following:
 - (i) Date;
 - (ii) Person(s) to whom services were rendered;

- (iii) Start and stop time for each timed treatment session or service;
- (iv) Original signature of the therapist/service provider; in circumstances where it is necessary to fax a service plan to someone for review and then have them fax back their signature, this is acceptable; however, the provider must obtain the original signature for the clinical file within 30 days and no stamped or photocopied signatures are allowed. Electronic signatures are acceptable following OAC 317:30-3-4.1 and 317:30-3-15;
- (v) Credentials of therapist/service provider;
- (vi) Specific service plan need(s), goals and/or objectives addressed;
- (vii) Services provided to address need(s), goals and/or objectives;
- (viii) Progress or barriers to progress made in treatment as it relates to the goals and/or objectives;
- (ix) Member (and family, when applicable) response to the session or intervention;
- (x) Any new need(s), goals and/or objectives identified during the session or service.

(4) In addition to the items listed above in this subsection:

- (A) Crisis Intervention Service notes must also include a detailed description of the crisis and level of functioning assessment;
- (B) a list/log/sign in sheet of participants for each Group rehabilitative or psychotherapy session and facilitating qualified provider must be maintained; and
- (C) for medication training and support, vital signs must be recorded in the medical record, but are not required on the behavioral health services plan;

(5) Progress notes for PSR day programs may be in the form of daily or weekly summary notes and must include the following:

- (A) Curriculum sessions attended each day and/or dates attended during the week;
- (B) Start and stop times for each day attended;
- (C) Specific goal(s) and/or objectives addressed during the week;
- (D) Type of Skills Training provided each day and/or during the week including the specific curriculum used with the member;
- (E) Member satisfaction with staff intervention(s);
- (F) Progress or barriers made toward goals, objectives;
- (G) New goal(s) or objective(s) identified;
- (H) Signature of the lead qualified provider; and
- (I) Credentials of the lead qualified provider.

(6) Concurrent documentation between the clinician and member can be billed as part of the treatment session time, but must be documented clearly in the progress notes.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 14 Ok Reg 1221, eff 8-7-96 (emergency); Amended at 14 Ok Reg 2125, eff 4-4-97 (emergency); Amended at 15 Ok Reg 1528, eff 5-11-98 ; Amended at 16 Ok Reg 2839, eff 7-12-99 ; Amended at 22 Ok Reg 156, eff 10-6-04 (emergency); Amended at 21 Ok Reg 2473, eff 7-11-05 ; Amended at 23 Ok Reg 2540, eff 6-25-06 ; Amended at 24 Ok Reg 2830, eff 7-1-07 (emergency); Amended at 25 Ok Reg 1200, eff 5-25-08 ; Amended at 26 Ok Reg 734, eff 4-1-09 (emergency); Amended at 26 Ok Reg 2090, eff 6-25-09 ; Amended at 27 Ok Reg 2753, eff 7-20-10 (emergency); Amended at 28 Ok Reg 1469, eff 6-25-11 ; Amended at 30 Ok Reg 1146, eff 7-1-13 ; Amended at 31 Ok Reg 1645, eff 9-12-14]

317:30-5-249. Non-covered services

In addition to the general program exclusions [OAC 317:30-5-2(a)(2)] the following are excluded from coverage. Work and education services:

- (1) Talking about the past and current and future employment goals, going to various work sites to explore the world of work, and assisting client in identifying the pros and cons of working.
- (2) Development of an ongoing educational and employment rehabilitation plan to help each individual establish job specific skills and credentials necessary to achieve ongoing employment. Psycho-social skills training however would be covered.
- (3) Work/school specific supportive services, such as assistance with securing of appropriate clothing, wake-up calls, addressing transportation issues, etc. These would be billed as Case Management following 317:30-5-241.6.
- (4) Job specific supports such as teaching/coaching a job task.

[Source: Added at 26 Ok Reg 734, eff 4-1-09 (emergency); Added at 26 Ok Reg 2090, eff 6-25-09 ; Amended at 31 Ok Reg 1645, eff 9-12-14 ; Amended at 33 Ok Reg 804, eff 9-1-16]

PART 22. HEALTH HOMES [REVOKED]

317:30-5-250. Purpose [REVOKED]

[Source: Added at 32 Ok Reg 229, eff 1-1-15 (emergency); Added at 32 Ok Reg 1065, eff 8-27-15 ; Revoked at 38 Ok Reg 1039, eff 10-1-21]

317:30-5-251. Eligible providers [REVOKED]

[Source: Added at 32 Ok Reg 229, eff 1-1-15 (emergency); Added at 32 Ok Reg 1065, eff 8-27-15 ; Amended at 33 Ok Reg 821, eff 9-1-16 ; Revoked at 38 Ok Reg 1039, eff 10-1-21]

317:30-5-252. Covered Services [REVOKED]

[Source: Added at 32 Ok Reg 229, eff 1-1-15 (emergency); Added at 32 Ok Reg 1065, eff 8-27-15 ; Amended at 33 Ok Reg 821, eff 9-1-16 ; Revoked at 38 Ok Reg 1039, eff 10-1-21]

317:30-5-253. Reimbursement [REVOKED]

[Source: Added at 32 Ok Reg 229, eff 1-1-15 (emergency); Added at 32 Ok Reg 1065, eff 8-27-15 ; Revoked at 38 Ok Reg 1039, eff 10-1-21]

317:30-5-254. Limitations [REVOKED]

[Source: Added at 32 Ok Reg 229, eff 1-1-15 (emergency); Added at 32 Ok Reg 1065, eff 8-27-15 ; Revoked at 38 Ok Reg 1039, eff 10-1-21]

PART 23. PODIATRISTS

317:30-5-260. Eligible providers

Payment can be made to a podiatrist licensed in the state where they practice, who has a current contract on file with the Oklahoma Health Care Authority.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 16 Ok Reg 3449, eff 7-1-99 (emergency); Amended at 17 Ok Reg 1204, eff 5-11-00 ; Amended at 34 Ok Reg 664, eff 9-1-17]

317:30-5-261. Coverage by category

Payment is made to podiatrists as set forth in this Section:

(1) **Adults.** Payment is made for medically necessary surgical procedures, x-rays, and outpatient visits. Procedures which are generally considered as preventative foot care, i.e. cutting or removal of corns, warts, callouses, or nails, are not covered unless the diagnoses on the claim, i.e. diabetes, multiple sclerosis, cerebral vascular accident, peripheral vascular disease establishes the medical necessity for the service. The patient must be under the active care of a doctor of medicine or osteopathy who documents the condition. All services must be medically appropriate and related to systemic disease for which foot care is viewed as preventative in nature. Nursing home visits must be ordered by the attending physician. The nursing home record must contain appropriate documentation that the visit was not performed for screening purposes. A specific foot ailment, symptom or complaint must be documented. In instances where the examination is performed in response to specific symptoms or complaints which suggests the need for care, the visit is compensable regardless of the resulting diagnosis. All outpatient visits are subject to existing visit limitations.

(2) **Children.** Coverage of podiatric services for children is the same as for adults. Refer to OAC 317:30-3-57 (13) for additional coverage under the Early and Periodic Screening, Diagnosis and Treatment Program.

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

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 16 Ok Reg 3449, eff 7-1-99 (emergency); Amended at 17 Ok Reg 1204, eff 5-11-00 ; Amended at 19 Ok Reg 2922, eff 7-1-02 (emergency); Amended at 20 Ok Reg 1193, eff 5-27-03 ; Amended at 38 Ok Reg 985, eff 9-1-21]

317:30-5-262. Claim form [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 19 Ok Reg 2134, eff 6-27-02]

PART 24. CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS

317:30-5-263. Definitions

The following words or terms, when used in this Part, shall have the following meaning, unless the context clearly indicates otherwise:

"Advanced practice registered nurse (APRN)" means a registered nurse in good standing with the board of nursing in the state in which services are provided, who has completed an accredited graduate level advanced practice registered nursing education program approved by the board of nursing in the state in which services are provided, and possesses a current national certification by a national certifying body recognized by the board of nursing in the state in which services are provided. APRN services are limited to the scope of their practice as defined in Title 59 of the Oklahoma Statutes (O.S.) § 567.3a and corresponding rules and regulations at Oklahoma Administrative Code (OAC) 485:10-5-1 through 485:10-16-9.

"Behavioral health rehabilitation (BHR) services" means goal-oriented outpatient interventions that target the maximum reduction of mental and/or behavioral health impairments and strive to restore the members to their best possible mental and/or behavioral health functioning.

"Centers for Medicare and Medicaid Services (CMS)" means the federal agency within the United States Department of Health and Human Services (HHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid.

"Certified alcohol and drug counselor (CADC)" means an individual with an Oklahoma certification as an alcohol and drug counselor.

"Certified behavioral health case manager (CM)" means an individual who is certified by the ODMHSAS as a behavioral health case manager pursuant to OAC, Title 450, Chapter 50. Refer to OAC 317:30-5-240.3(h).

"Certified community behavioral health clinics (CCBHC)" means a service delivery model designed to provide a comprehensive range of mental health and/or substance abuse rehabilitative services. Services are furnished by an interdisciplinary and mobile mental health team that functions interchangeably.

"C.F.R." means the Code of Federal Regulations.

"Facility-based crisis stabilization (FBCS)" means emergency psychiatric and substance abuse services aimed at resolving crisis situations. The services provided are emergency stabilization, which includes a protected environment, chemotherapy, detoxification,

individual and group treatment, and medical assessment.

"Family support and training provider (FSP)" means an individual who provides a system of care that is child-centered with the needs of the child and family dictating the types and mix of services provided, to assist in keeping the family together and preventing an out-of-home placement. FSP providers must:

- (A) Have a high school diploma or equivalent;
- (B) Be twenty-one (21) years of age and have a successful experience as a family member of a child or youth with serious emotional disturbance, or have lived experience as the primary caregiver of a child or youth who has received services for substance use disorder and/or co-occurring substance use and mental health, or have lived experience being the caregiver for a child with Child Welfare/Child Protective Services involvement;
- (C) Successfully complete family support training according to a curriculum approved by the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) and pass the examination with a score of eighty percent (80%) or better;
- (D) Pass Oklahoma State Bureau of Investigation (OSBI) background check;
- (E) Have treatment plans be overseen and approved by a licensed behavioral health professional (LBHP) or licensure candidate; and
- (F) Function under the general direction of an LBHP, licensure candidate or systems of care team, with an LBHP or licensure candidate available at all times to provide back up, support, and/or consultation.

"Illness/wellness management and recovery

(IMR/WMR)" means evidence-based practice models designed to help people who have experienced psychiatric symptoms. Elements include: developing personalized strategies for managing their mental illness and moving forward with their lives; setting and pursuing personal goals; learning information and skills to develop a sense of mastery over their psychiatric illness; and helping clients put strategies into action in their everyday lives.

"Institution for mental disease (IMD)" means a hospital, nursing facility, or other institution of more than sixteen (16) beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services, as defined by 42 C.F.R. § 435.1010.

"Intermediate care facility for individuals with intellectual disabilities (ICF/IID)" means a facility which primarily provides health-related care and services above the level of custodial care to intellectually disabled individuals but does not provide the level of care available in a hospital or skilled nursing facility.

"Licensed behavioral health professional (LBHP)" means any of the following practitioners:

- (A) An allopathic or osteopathic physician with a current license and board certification in psychiatry or board

eligible in the state in which services are provided, or a current medical resident in psychiatry;
(B) A practitioner with a current license to practice in the state in which services are provided, within one (1) of the following areas of practice:

- (i) Psychology;
- (ii) Social work (clinical specialty only);
- (iii) Professional counselor;
- (iv) Marriage and family therapist;
- (v) Behavioral practitioner; or
- (vi) Alcohol and drug counselor.

(C) An APRN, certified in a psychiatric mental health specialty, and licensed as a registered nurse with a current certification of recognition from the board of nursing in the state in which services are provided; or

(D) A physician assistant (PA) with a current license to practice and in good standing in the state in which services are provided and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or counseling functions.

"Licensure candidate" means a practitioner who is actively and regularly receiving board approved supervision, and extended supervision by a fully licensed clinician if the board's supervision requirement is met but the individual is not yet licensed, to become licensed in a specific area of practice as outlined in (B)(i) through (vi) above. The supervising LBHP responsible for the member's care must:

- (A) Staff the member's case with the candidate;
- (B) Be personally available, or ensure the availability of an LBHP to the candidate for consultation while they are providing services;
- (C) Agree with the current plan for the member;
- (D) Confirm that the service provided by the candidate was appropriate; and
- (E) Show that the member's medical record meet the requirements for reimbursement and the LBHP responsible for the member's care has reviewed, countersigned, and dated the service plan and any updates thereto so that it is documented that the licensed professional is responsible for the member's care.

"OAC" means Oklahoma Administrative Code, the publication authorized by Section 256 of Title 75 of the Oklahoma Statutes known as The Oklahoma Administrative Code, or, prior to its publication, the compilation of codified rules authorized by 75 O.S. § 256(A)(1)(a) and maintained in the Office of Administrative Rules.

"ODMHSAS" means the Oklahoma Department of Mental Health and Substance Abuse Services.

"OHCA" means the Oklahoma Health Care Authority.

"O.S." means Oklahoma Statutes.

"Peer recovery support specialist (PRSS)" means an individual certified by ODMHSAS as a peer recovery support specialist pursuant to requirements found in OAC 450:53.

"Program of All-Inclusive Care for the Elderly (PACE)" means a home and community based acute and long-term care services program for eligible individuals who meet the medical requirements for nursing facility care and can be served safely and appropriately in the community.

"Psychiatric residential treatment facility (PRTF)" means a non-hospital facility contracted with the OHCA to provide inpatient psychiatric services to SoonerCare-eligible members under the age of twenty-one (21), as defined by 42 C.F.R. § 483.352.

"Psychosocial rehabilitation services (PSR)" means face-to-face Behavioral Health Rehabilitation services which are necessary to improve the member's ability to function in the community. They are performed to improve the skills and abilities of members to live independently in the community, improve self-care and social skills, and promote lifestyle change and recovery practices.

"Qualified behavioral health aide (QBHA)" means a behavioral health aide who must meet requirements described in OAC 317:30-5-240.3.

"Registered nurse (RN)" means an individual who is a graduate of an approved school of nursing and is appropriately licensed in the state in which he or she practices.

"Serious emotional disturbance (SED)" means a condition experienced by persons from birth to eighteen (18) who have a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria outlined in OAC 317:30-5-240.1.

"Serious mental illness (SMI)" means a condition experienced by persons age eighteen (18) and over that have a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities. Specific diagnostic criteria is outlined in OAC 317:30-5-240.1.

"System of care values" means a philosophy, which embraces a family-driven, child-centered model of care that integrates and coordinates the efforts of different agencies and providers to individualize care in the least restrictive setting that is clinically appropriate.

"Wellness recovery action plans (WRAP)" means a self-management and recovery system designed to:

- (A) Decrease intrusive or troubling feelings and behaviors;
- (B) Increase personal empowerment;
- (C) Improve quality of life; and
- (D) Assist people in achieving their own life goals and dreams.

"Wraparound approach" means a team-based planning and implementation process to improve the lives of children with complex needs and their families by developing individualized plans of care. The key characteristics of the process are that the plan is developed by a family centered team, is individualized based on the strengths and culture of the child and his or her family, and is driven by needs rather than services.

317:30-5-264. Purpose

Certified community behavioral health clinic is a service delivery model designed to provide a comprehensive range of mental health and substance use disorder services. Services are furnished by an interdisciplinary and mobile mental health team that functions interchangeably to provide the rehabilitation and treatment designed to enable the member to live successfully in the community.

[Source: Added at 36 Ok Reg 1107, eff 7-1-19 (emergency); Added at 37 Ok Reg 1536, eff 9-14-20]

317:30-5-265. Eligible providers

(a) **Agency requirements.** CCBHCs are responsible for providing services to qualifying individuals within the provider's specified service area. Qualifying providers must:

- (1) Be certified by the ODMHSAS as a community mental health center under OAC 450:17 and have provider specific credentials from ODMHSAS for CCBHCs (OAC 450:17-5-170 et seq.);
- (2) Be under the direction of a licensed physician;
- (3) Provide mobile crisis care twenty-four (24) hours, seven (7) days a week and have a twenty-four (24) hours, seven (7) days a week walk-in crisis clinic or a psychiatric urgent care, or have an agreement in place with a State-sanctioned alternative;
- (4) Actively use an Office of National Coordinator (ONC) certified Electronic Health Record (EHR) as demonstrated on the ONC Certified Health IT Product List;
- (5) Have a contract with a Health Information Exchange (HIE) and demonstrate staff use of obtaining and sending data through the HIE as well as policy stating frequency of use and security protocols; and
- (6) Report on encounter, clinical outcomes, and quality improvement. This includes meeting all federal and State specifications of the required CMS quality measure reporting, as well as performance improvement reports outlining activities taken to improve outcomes.

(b) **Interdisciplinary team.** CCBHCs will utilize an interdisciplinary team of professionals and paraprofessionals to identify an individual's strengths and needs, create a unified plan to empower a person toward self-management, and coordinate the individual's varied healthcare needs. CCBHC teams will vary in size depending on the size of the member panel and acuity of the member. The treatment team includes the member, the family/caregiver of child members, the adult member's family to the extent the member does not object, and any other person the member chooses. Each CCBHC shall maintain a core staff comprised of employed and, if needed, contracted staff, as appropriate to the needs of the member as stated in the member's individual service plan.

- (1) Teams shall at a minimum, include the following positions:
 - (A) Licensed psychiatrist;
 - (B) Licensed nurse care manager (RN or licensed practical nurse);

- (C) Consulting primary care physician, APRN, or physician assistant (PA);
 - (D) At least one (1) LBHP and may include additional LBHPs and licensure candidates (see OAC 317:30-5-263);
 - (E) Peer recovery support specialist (see OAC 317:30-5-263);
 - (F) Family support provider for child members (see OAC 317:30-5-263);
 - (G) Certified behavioral health case manager II or certified alcohol and drug counselor (see OAC 317:30-5-263); and
 - (H) Qualified behavioral health aide.
- (2) Optional team members may include the following:
- (A) Certified behavioral health case manager I (see OAC 317:30-5-263);
 - (B) Licensed nutritionist;
 - (C) Occupational therapist; and/or
 - (D) Occupational therapist assistant under the supervision of a licensed occupational therapist.

[Source: Added at 36 Ok Reg 1107, eff 7-1-19 (emergency); Added at 37 Ok Reg 1536, eff 9-14-20]

317:30-5-266. Covered services

CCBHCs provide a comprehensive array of services that create access, stabilize people in crisis, and provide the needed treatment and recovery support services for those with the most serious and complex mental health and substance use disorders. CCBHCs integrate additional services to ensure an approach to health care that emphasizes recovery, wellness, trauma-informed care, and physical-behavioral health integration. Initial screening, assessment, and diagnosis must be completed in order to receive a covered service. Services must be medically necessary and recommended by an LBHP or licensure candidate (see OAC 317:30-5-263). Services are covered when provided in accordance with a person-centered and family-centered service plan. Coverage includes the following services:

- (1) **Crisis assessment and intervention services.**
- (A) **Service requirements.** This service is an immediately available service designed to meet the psychological, physiological, and environmental needs of individuals who are experiencing mental health and/or substance use disorder crises. Services include the following:
 - (i) Twenty-four (24) hours mobile crisis teams [see OAC 317:30-5-241.4(a) for service definition]. Reimbursement is triggered by the LBHP/licensure candidate crisis assessment;
 - (ii) Emergency crisis intervention service [see OAC 317:30-5-241.4(a) for service definition];
 - (iii) Facility-based crisis stabilization [see OAC 317:30-5-241.4(b) for service definition], provided directly by the CCBHC or by a State-sanctioned alternative; and

(iv) Urgent recovery clinic (URC) services provided in accordance with OAC 450:23-3-20 through 450:23-3-24.

(B) **Qualified professionals.** Twenty-four (24) hours mobile crisis intervention is provided by either a team consisting of an LBHP/licensure candidate and a CM II or CADC, or just an LBHP/licensure candidate. Emergency crisis intervention is provided by an LBHP/licensure candidate. Facility-based crisis stabilization is provided by a team, directed by a physician, and consisting of an LBHP/licensure candidate, licensed nurses, CM II or CADC, and PRSS staff. URC services are provided by an LBHP/licensure candidate with supervision from a physician or APRN with prescribing authority.

(2) **Behavioral health integrated (BHI) services.**

(A) **Service requirements.** This service includes activities provided that have the purpose of coordinating and managing the care and services furnished to each member, assuring a fixed point of responsibility for providing treatment, rehabilitation, and support services. This service includes, but is not limited to:

- (i) Care coordination for primary health care, specialty health care, and transitional care from emergency departments, hospitals, and PRTFs;
- (ii) Ensuring integration and compatibility of mental health and physical health activities;
- (iii) Providing on-going service coordination and linking members to resources;
- (iv) Tracking completion of mental and physical health goals in member's comprehensive care plan;
- (v) Coordinating with all team members to ensure all objectives of the comprehensive care plan are progressing;
- (vi) Appointment scheduling;
- (vii) Conducting referrals and follow-up monitoring;
- (viii) Participating in hospital discharge processes; and
- (ix) Communicating with other providers and members/family.

(B) **Qualified professionals.** This service is performed by an LBHP/licensure candidate, nurse, CM II or CADC, and/or PRSS staff.

(3) **Person-centered and family-centered treatment planning.**

(A) **Service requirements.** This service is a process in which the information obtained in the initial screenings and assessments are used to develop a treatment plan that has individualized goals, objectives, activities, and services that will enable the member to improve. For children assessed as SED with significant behavioral needs,

treatment planning is a wraparound process consistent with System of Care values. A wraparound planning process supports children and youth in returning to or remaining in the community.

(B) **Qualified professionals.** This service is conducted by LBHPs/licensure candidates, nurses, CM II or CADC, and/or PRSS staff. Treatment planning must include the member and involved practitioners.

(4) **Psychotherapy (individual / group / family).**

(A) **Service requirements.** See OAC 317:30-5-241.2 for service definitions and requirements. Fee-for-service billing limitations do not apply.

(B) **Qualified professionals.** This service is conducted by an LBHP/licensure candidate.

(5) **Medication training and support.**

(A) **Service requirements.** This service includes:

(i) A review and educational session focused on the member's response to medication and compliance with the medication regimen and/or medication administration;

(ii) Prescription administration and ordering of medication by appropriate medical staff;

(iii) Assisting the member in accessing medications;

(iv) Monitoring medication response and side effects; and

(v) Assisting members with developing the ability to take medications with greater independence.

(B) **Qualified professionals.** This service is performed by an RN, APRN, or a physician assistant (PA) as a direct service under the supervision of a physician.

(6) **Psychosocial rehabilitation services (PSR).**

(A) **Service requirements.**

(i) **Adult.** PSR services are face-to-face behavioral health rehabilitation (BHR) services which are necessary to improve the member's ability to function in the community. They are performed to improve the skills and abilities of members to live independently in the community, improve self-care and social skills, and promote lifestyle change and recovery practices. Rehabilitation services may be provided individually or in group sessions through the format of curriculum-based education and skills training. This service is generally performed with only the member and the qualified provider, but may include a member and the member's family/support system when providing educational services from a curriculum that focuses on the member's diagnosis, symptom management, and recovery. A member who, at the time of service, is not able to cognitively benefit from the treatment

due to active hallucinations, substance abuse, or other impairments, is not suitable for this service. Family involvement is allowed for support of the member and education regarding his/her recovery but does not constitute family therapy, which requires a licensed provider. Eligibility requirements and billing limits found in OAC 317:30-5-241.3 do not apply.

(ii) **Children.** PSR services are an array of services that are provided in the child's home, in the location where behavioral challenges are most likely to occur such as school, or in community settings for all children, youth, and young adults ages zero (0) to twenty (20). PSR services must be provided in a context that is child-centered, family-focused, strength-based, culturally competent, and responsive to each child's psychosocial, developmental, and treatment care needs. PSR service array includes:

- (I) Intensive in-home services;
- (II) Therapeutic behavioral services;
- (III) Intensive family intervention; and
- (IV) Intensive outpatient substance abuse rehabilitation.

(B) **Qualified professionals.** This service is solely restorative in nature and may be performed by a behavioral health CM II, CADC, LBHP, or licensure candidate, following development of a service plan and treatment curriculum approved by an LBHP or licensure candidate. For children, services are typically provided by a team that can offer a combination of therapy from a LBHP or licensure candidate and skills training and support from a paraprofessional [CM II, behavioral health aide (BHA)]. The behavioral health CM II, CADC, and BHA must have immediate access to an LBHP who can provide clinical oversight and collaborate with the qualified PSR provider in the provision of services.

(7) **Psychoeducation and counseling.**

(A) **Service requirements.** This service is designed to restore, rehabilitate, and support the individual's overall health and wellness. Services are intended for members to provide purposeful and ongoing psychoeducation and counseling that are specified in the individual's person-centered, individualized plan of care. For children and their families, treatment services are an array of therapeutic strategies and services designed to ameliorate or reduce the risk of social, emotional, and behavioral disorders and disruptions in the relationship between an infant and parent/caregiver. Such disorders and disruptions may be due to infant/toddler and/or parent/caregiver vulnerabilities and/or negative

environmental factors that are significantly impacting the infant and/or parent/caregiver-infant relationship.

Treatment services are grounded in attachment theory and are relationship focused. Components include:

- (i) Delivery of manualized wellness management interventions via group and individual work such as WRAP or IMR/WMR; and
- (ii) Emotional support, education, resources during periods of crisis, and problem-solving skills.

(B) **Qualified professionals.** For children, zero (0) to five (5) years old, this service is provided by an LBHP or licensure candidate. For all other ages, this service is provided by a licensed nurse, licensed nutritionist, or CM II or CADC within the scope of their licensure, certification, and/or training.

(8) **Peer recovery support services.**

(A) **Service requirements.** See OAC 317:30-5-241.5(d) for service requirements.

(B) **Qualified professionals.** PRSS must be certified through ODMHSAS pursuant to OAC 450:53.

(9) **Family support and training.**

(A) **Service requirements.** See OAC 317:30-5-241.5(c) for service requirements.

(B) **Qualified professionals.** Family support providers must be trained/credentialed through ODMHSAS.

(10) **Screening, assessment, and service planning.**

(A) **Service requirements.** See OAC 317:30-5-241.1 for service requirements. Service billing limitations found in OAC 317:30-5-241.1 do not apply.

(B) **Qualified professionals.** Screenings can be performed by any qualified team member as listed in OAC 317:30-5-265(b). Assessment and service planning can only be performed by an LBHP or licensure candidate.

(11) **Occupational therapy.**

(A) **Service requirements.** This service includes the therapeutic use of everyday life activities (occupations) with an individual or groups for the purpose of participation in roles and situations in home, school, workplace, community, and other settings for the purpose of promoting health and wellness. Occupational therapy services are provided to those who have developed an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restrictions. Occupational therapy addresses the physical, cognitive, psychosocial, sensory, and other aspects of performance in a variety of contexts to support engagement in everyday life activities that affect health, well-being, and quality of life.

(B) **Qualified professionals.** This service is solely restorative in nature and provided by a qualified occupational therapist who is contracted with the OHCA

or an occupational therapist assistant who is working under the supervision of a licensed occupational therapist (see OAC 317:30-5-295).

(C) **Coverage limitations.** In order to be eligible for SoonerCare reimbursement, occupational therapy services must be prior authorized and/or prescribed by a physician or other licensed practitioner of the healing arts, in accordance with State and federal law, including, but not limited to, OAC 317:30-5-296, OAC 317:30-5-1020, and 42 C.F.R. § 440.110.

(12) **Behavioral health targeted case management.**

(A) **Service requirements.** See OAC 317:30-5-241.6 for service requirements.

(B) **Qualified professionals.** This service is provided by a CM II certified in accordance with OAC 450:50.

(C) **Coverage limitations.** Services are provided to individuals of all ages who meet medical necessity criteria.

(13) **Outpatient substance abuse prevention counseling.**

(A) **Service requirements.** This service provides counseling to enable individuals to successfully resist social and other pressures to engage in destructive activities.

(B) **Qualified professionals.** This service must be recommended by a physician or licensed practitioner and provided by LBHP/licensure candidate.

(C) **Coverage limitations.** Services are provided to individuals under age twenty-one (21) who meet medical necessity criteria.

[Source: Added at 36 Ok Reg 1107, eff 7-1-19 (emergency); Added at 37 Ok Reg 1536, eff 9-14-20 ; Amended at 39 Ok Reg 1498, eff 9-12-22]

317:30-5-267. Reimbursement

(a) In order to be eligible for payment, CCBHCs must have an approved provider agreement on file with the OHCA. Through this agreement, the CCBHC assures that OHCA's requirements are met and assures compliance with all applicable federal and state Medicaid law, including, but not limited to, OHCA administrative rules, ODMHSAS administrative rules, the Code of Federal Regulations, and the Oklahoma State Medicaid Plan. These agreements are renewed annually with each provider.

(b) Reimbursement is made using a provider-specific prospective payment system (PPS) rate developed based on provider-specific cost report data. The PPS rate varies by category and level of service intensity and is paid when a CCBH program delivers at least one (1) CCBHC covered service, and when a valid individual procedure code is reported for the calendar month. For reimbursement purposes, members are categorized as follows, and are assigned to special populations by the State:

(1) Standard population;

(2) Special population 1. This population includes individuals eighteen (18) years of age and over with SMI and complex needs

including those with co-occurring substance use disorder (SUD). Individuals between eighteen (18) and twenty-one (21) years of age can be served in either special population 1 or 2 depending on the member's individualized needs; and

(3) Special population 2. This population includes children and youth [ages six (6) through twenty-one (21)] with SED and complex needs, including those with co-occurring mental health and SUD.

(c) Preliminary screening, risk assessment, and care coordination services are required activities to establish CCBHC members but do not trigger a PPS payment. An additional, qualifying service must be provided in the calendar month for the CCBHC to receive the PPS payment.

(d) Payments for services provided to non-established CCBHC members will be separately billable. Non-established CCBHC members are those who receive crisis services directly from the CCBHC without receiving a preliminary screening and risk assessment by the CCBHC and who are not established at another CCBHC, and those referred to the CCBHC directly from other outpatient behavioral health agencies for pharmacologic management.

(e) Additional reimbursement may be made to the CCBHC once in the same calendar month as the PPS payment for care coordination provided by CCBHC staff to members who are involved in a drug court or other specialty court program. Physician services provided to these members by the CCBHC are reimbursable using the SoonerCare fee schedule.

(f) Initial provider-specific rates are rebased after one (1) year based on actual cost and visit data. All other provider-specific rates are rebased once every two (2) years. Provider-specific rates are updated between rebasing periods based on the Medicare Economic Index (MEI).

(g) Providers may receive a provider-specific rate adjustment for changes in scope expected to change payment rates by two point five percent (2.5%) or more, once per year, subject to State approval in accordance with the Oklahoma Medicaid State Plan.

[Source: Added at 36 Ok Reg 1107, eff 7-1-19 (emergency); Added at 37 Ok Reg 1536, eff 9-14-20 ; Amended at 39 Ok Reg 1498, eff 9-12-22]

317:30-5-268. Limitations

(a) The following are non-billable opportunities for CCBHCs serving eligible members:

- (1) Employment services;
- (2) Personal care services;
- (3) Childcare
- (4) Respite services; and
- (5) Care coordination.

(b) The following SoonerCare members are not eligible for CCBHC services:

- (1) Members residing in a nursing facility or ICF/IID;
- (2) Inmates of a public correctional institution; and
- (3) SoonerCare members being served by a PACE provider.

[Source: Added at 36 Ok Reg 1107, eff 7-1-19 (emergency); Added at 37 Ok Reg 1536, eff 9-14-20 ; Amended at 38 Ok Reg 428, eff 12-18-20 (emergency); Amended at 38 Ok Reg 1023, eff 9-1-21]

PART 25. PSYCHOLOGISTS

317:30-5-275. Eligible providers

(a) Licensed Psychologist must be licensed to practice in the state in which services are provided. Payment is made for compensable services to psychologists licensed in the state in which face-to-face services are delivered.

(b) 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.

(c) Services provided by 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, are eligible for reimbursement. Each supervising psychologist must have a current contract with the Oklahoma Health Care Authority (OHCA).

(d) For those licensure candidates who are actively and regularly receiving board approved supervision, or extended supervision by a fully licensed clinician and if the board's supervision requirement is met but the individual is not yet licensed, each supervising psychologist must have a current contract with the Oklahoma Health Care Authority (OHCA).

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

- (1) The licensed 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 who is responsible for the member's care;

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

- (A) Staff the member's case with the intern or fellow,
- (B) Actively direct the services;
- (C) Be available to the intern or fellow for in-person consultation while they are providing services;
- (D) Agree with the current plan for the member; and
- (E) Confirm that the service provided by the intern or fellow was appropriate.

(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.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 23 Ok Reg 2554, eff 6-25-06 ; Amended at 26 Ok Reg 257, eff 12-1-08 (emergency); Amended at 26 Ok Reg 1064, eff 5-11-09 ; Amended at 27 Ok Reg 1676, eff 7-10-10 (emergency); Amended at 28 Ok Reg 1483, eff 6-25-11 ; Amended at 40 Ok Reg 2185, eff 9-11-23]

317:30-5-276. Coverage by category

(a) **Outpatient Behavioral Health Services.** Outpatient behavioral health services are covered as set forth in this Section, when provided in accordance with a documented individualized service plan medical record, developed to treat the identified behavioral health and/or substance use disorder(s), unless specified otherwise.

(1) All services are to be for the goal of improvement of functioning, independence, or wellbeing of the member. The services and treatment plans are to be recovery focused, trauma and co-occurring specific. The member must be able to actively participate in the treatment. Active participation means that the member must have sufficient cognitive abilities, communication skills, and short-term memory to derive a reasonable benefit from the treatment.

(2) In order to be reimbursed for services, providers must submit a completed Customer Data Core (CDC) to OHCA or its designated agent. The CDC must be reviewed, updated and resubmitted by the provider every six months. Reimbursement is made only for services provided while a current CDC is on file with OHCA or its designated agent. For further information and instructions regarding the CDC, refer to the Prior Authorization Manual.

(3) Some outpatient behavioral health services may require authorization. For information regarding services requiring authorization and the process for obtaining them, refer to the Prior Authorization Manual. Authorization of services is not a guarantee of payment. The provider is responsible for ensuring that the eligibility, medical necessity, procedural, coding, claims submission, and all other state and federal requirements are met. OHCA does retain the final administrative review over both

authorization and review of services as required by 42 Code of Federal Regulations 431.10.

(b) **Children.** Coverage for children includes the following services:

(1) Bio-Psycho-Social Assessments. Psychiatric Diagnostic Interview Examination (PDIE) initial assessment or Level of Care Assessment. The interview and assessment is defined as a face-to-face interaction with the member. Psychiatric diagnostic interview examination includes a history, mental status, and a disposition, and may include communication with family or other sources, ordering and medical interpretation of laboratory or other medical diagnostic studies. Only one (1) PDIE is allowable per provider per member. If there has been a break in service over a six (6) month period, then an additional unit of PDIE can be prior authorized by OHCA, or their designated agent.

(2) Psychotherapy in an outpatient setting including an office, clinic, or other confidential setting. The services may be performed at the residence of the member if it is demonstrated that it is clinically beneficial, or if the member is unable to go to a clinic or office. Psychotherapy is defined as a one to one treatment using a widely accepted modality or treatment framework suited to the individual's age, developmental abilities and diagnosis. It may include specialized techniques such as biofeedback or hypnosis. Psychotherapy is considered to involve "interactive complexity" when there are communication factors during a visit that complicate delivery of the psychotherapy by the psychologist. Sessions typically involve members who have other individuals legally responsible for their care (i.e. minors or adults with guardians); members who request others to be involved in their care during the session (i.e. adults accompanied by one or more participating family members or interpreter or language translator); or members that require involvement of other third parties (i.e. child welfare, juvenile justice, parole/probation officers, schools, etc.). Psychotherapy should only be reported as involving interactive complexity when at least one (1) of the following communication factors is present:

(A) The need to manage maladaptive communication (i.e. related to high anxiety, high reactivity, repeated questions, or disagreement) among participants that complicate delivery of care.

(B) Caregiver emotions/behavior that interfere with implementation of the treatment plan.

(C) Evidence/disclosure of a sentinel event and mandated report to a third party (i.e. abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other visit participants.

(D) Use of play equipment, physical devices, interpreter or translator to overcome barriers to therapeutic interaction with a patient who is not fluent in the same language or who has not developed or lost expressive or receptive language skills to use or understand typical language.

(3) Family Psychotherapy is performed in an outpatient setting limited to an office, clinic, or other confidential setting. Family therapy is a face-to-face interaction between a therapist and the patient/family to facilitate emotional, psychological or behavioral changes and promote communication and understanding. Family therapy must be provided for the benefit of the member as a specifically identified component of an individual treatment plan.

(4) Group and/or Interactive Group psychotherapy in an outpatient setting must be performed in the psychologist's office, clinic, or other confidential setting. Group therapy is a face to face interaction between a therapist and two or more unrelated patients (though there may be siblings in the same group, just not siblings only) to facilitate emotional, psychological, or behavioral changes. All group therapy records must indicate group size. Maximum total group size is six (6) patients for children four years of age up to the age of 18. Groups can include up to eight (8) individuals for members 18-20 years of age. Group therapy must be provided for the benefit of the member four years of age or older as a specifically identified component of an individual treatment plan. Multi-family group therapy size is limited to eight family units.

(5) Assessment/Evaluation and testing is provided by a psychological technician of a psychologist or a LBHP utilizing tests selected from currently accepted assessment test batteries. For assessments conducted in a school setting, the Oklahoma State Department of Education requires that a licensed supervisor sign the assessment. Eight hours/units of testing per patient (over the age of three), per provider is allowed every 12 months. There may be instances when further testing is appropriate based on established medical necessity criteria found in the Prior Authorization Manual. Test results must be reflected in the service plan or medical record. The service must clearly document the need for the testing and what the testing is expected to achieve. Testing for a child younger than three must be medically necessary and meet established criteria as set forth in the Prior Authorization Manual. Justification for additional testing beyond allowed amount as specified in this section must be clearly explained and documented in the medical record. Testing units must be billed on the date the testing, interpretation, scoring, and/or reporting was performed and supported by documentation.

(6) Health and Behavior codes - behavioral health services are available only to chronically and severely medically ill members.

(7) Crisis intervention services for the purpose of stabilization and hospital diversion as clinically appropriate.

(8) Payment for therapy services provided by a psychologist to any one member is limited to eight sessions/units per month. A maximum of twelve (12) sessions/units of therapy and testing services per day per provider are allowed. A maximum of thirty five (35) hours of therapy per week per provider are allowed. The weekly service hour limitation will be calculated using a rolling

four (4) week average.

(9) A child may receive psychological testing and evaluation services as separately reimbursable services.

(10) A child receiving Residential Behavioral Management in a foster home, also known as therapeutic foster care, or a child receiving Residential Behavioral Management in a group home, also known as therapeutic group home, may not receive individual, group or family counseling unless allowed by the OHCA or its designated agent.

(c) **Adults.** Coverage for adults is the same as for children. For group therapy, groups can include up to eight individuals for adult members 18 years of age and older.

(d) **Home and Community Based Waiver Services for the Intellectually Disabled.** All providers participating in the Home and Community Based Waiver Services program for people with intellectual and developmental disabilities must have a separate contract with this Authority to provide services under this program. All services are specified in the individual's plan of care.

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

(f) **Nursing Facilities.** Services provided to members residing in nursing facilities may not be billed to SoonerCare.

[**Source:** Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 14 Ok Reg 768, eff 11-25-96 (emergency); Amended at 14 Ok Reg 1780, eff 5-27-97 ; Amended at 18 Ok Reg 2959, eff 5-17-01 (emergency); Amended at 19 Ok Reg 1067, eff 5-13-02 ; Amended at 19 Ok Reg 2922, eff 7-1-02 (emergency); Amended at 20 Ok Reg 1193, eff 5-27-03 ; Amended at 23 Ok Reg 2554, eff 6-25-06 ; Amended at 26 Ok Reg 2111, eff 6-25-09 ; Amended at 27 Ok Reg 1676, eff 7-10-10 (emergency); Amended at 28 Ok Reg 1483, eff 6-25-11 ; Amended at 29 Ok Reg 413, eff 3-7-12 (emergency); Amended at 29 Ok Reg 1125, eff 6-25-12 ; Amended at 30 Ok Reg 1146, eff 7-1-13 ; Amended at 31 Ok Reg 1665, eff 9-12-14 ; Amended at 32 Ok Reg 225, eff 11-3-14 (emergency); Amended at 32 Ok Reg 1056, eff 8-27-15 ; Amended at 40 Ok Reg 2185, eff 9-11-23]

317:30-5-277. Procedure codes [REVOKED]

[**Source:** Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 14 Ok Reg 768, eff 11-25-96 (emergency); Amended at 14 Ok Reg 1780, eff 5-27-97 ; Amended at 18 Ok Reg 2959, eff 5-17-01 (emergency); Amended at 19 Ok Reg 1067, eff 5-13-02 ; Revoked at 19 Ok Reg 2134, eff 6-27-02]

317:30-5-278. Non-covered procedures

The following procedures by psychologists are not covered:

- (1) sensitivity training
- (2) encounter
- (3) workshops
- (4) sexual competency training
- (5) marathons or retreats for mental disorders
- (6) strictly education training
- (7) psychotherapy to persons under three years of age unless specifically approved by OHCA, or its designated agent.

[**Source:** Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 14 Ok Reg 768, eff 11-25-96 (emergency); Amended at 14 Ok Reg 1780, eff 5-27-97 ; Amended at 27 Ok Reg 1676, eff 7-10-10 (emergency); Amended at 28 Ok Reg 1483, eff 6-25-11]

317:30-5-278.1. Documentation of records

All psychological services will be reflected by documentation in the patient records.

- (1) All assessment, testing, and treatment services/units billed must include the following:
 - (A) date;
 - (B) start and stop time for each session/unit billed;
 - (C) signature of the provider;
 - (D) credentials of provider;
 - (E) specific problem(s), goals and/or objectives addressed;
 - (F) methods used to address problem(s), goals and objectives;
 - (G) progress made toward goals and objectives;
 - (H) patient response to the session or intervention; and
 - (I) any new problem(s), goals and/or objectives identified during the session.
- (2) For each Group psychotherapy session, a separate list of participants must be maintained.
- (3) Psychological testing will be documented for each date of service performed which should include at a minimum, the objectives for testing, the tests administered, the results/conclusions and interpretation of the tests, and recommendations for treatment and/or care based on testing results and analysis.

[Source: Added at 18 Ok Reg 2959, eff 5-17-01 (emergency); Added at 19 Ok Reg 1067, eff 5-13-02 ; Amended at 23 Ok Reg 2554, eff 6-25-06 ; Amended at 26 Ok Reg 2111, eff 6-25-09]

317:30-5-279. Claim form [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 19 Ok Reg 2134, eff 6-27-02]

PART 26. LICENSED BEHAVIORAL HEALTH PROVIDERS

317:30-5-280. Eligible Providers

Licensed Behavioral Health Professionals (LBHP) are defined as follows:

- (1) Allopathic or Osteopathic Physicians with a current license and board certification in psychiatry or board eligible in the state in which services are provided, or a current resident in psychiatry practicing as described in OAC 317:30-5-2.
- (2) Practitioners with a license to practice in the state in which services are provided.
 - (A) Social Worker (clinical specialty only),
 - (B) Professional Counselor,
 - (C) Marriage and Family Therapist,
 - (D) Behavioral Practitioner, or

(E) Alcohol and Drug Counselor.

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

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

[Source: Added at 27 Ok Reg 1676, eff 7-10-10 (emergency); Added at 28 Ok Reg 1483, eff 6-25-11 ; Amended at 31 Ok Reg 1669, eff 9-12-14]

317:30-5-281. Coverage by Category

(a) **Outpatient Behavioral Health Services.** Outpatient behavioral health services are covered as set forth in this Section, and when provided in accordance with a documented individualized service plan and/or medical record, developed to treat the identified behavioral health and/or substance use disorder(s), unless specified otherwise.

(1) All services are to be for the goal of improvement of functioning, independence, or wellbeing of the member. The services and treatment plans are to be recovery focused, trauma and co-occurring specific. The member must be able to actively participate in the treatment. Active participation means that the member must have sufficient cognitive abilities, communication skills, and short-term memory to derive a reasonable benefit from the treatment.

(2) In order to be reimbursed for services, providers must submit a completed Customer Data Core (CDC) to OHCA or its designated agent. The CDC must be reviewed, updated and resubmitted by the provider every six (6) months. Reimbursement is made only for services provided while a current CDC is on file with OHCA or its designated agent. For further information and instructions regarding the CDC, refer to the Prior Authorization Manual.

(3) Some outpatient behavioral health services may require authorization. For information regarding services requiring authorization and the process for obtaining them, refer to the Prior Authorization Manual. Authorization of services is not a guarantee of payment. The provider is responsible for ensuring that the eligibility, medical necessity, procedural, coding, claims submission, and all other state and federal requirements are met. OHCA does retain the final administrative review over both authorization and review of services as required by 42 CFR 431.10.

(b) **Adults.** Outpatient behavioral health coverage for adults rendered by a LBHP is limited to bio-psycho-social assessments when required by OHCA as part of a preoperative prior authorization protocol for organ transplant or bariatric surgical procedures.

(1) The interview and assessment is defined as a face-to-face interaction with the member. Assessment includes a history,

mental status, full bio-psycho-social evaluation, a disposition, communications with family or other sources, review of laboratory or other pertinent medical information, and medical/clinical consultations as necessary. The pre-op evaluation should aim to assess the member's psychological well-being, ability to make informed decisions, and willingness to participate actively in postoperative treatment.

(2) For bariatric preoperative assessments, issues to address include, but are not limited to: depression, self-esteem, stress management, coping skills, binge eating, change in eating habits, other eating disorders, change in social roles, changes associated with return to work/school, body image, sexual function, lifestyle issues, personality factors that may affect treatment and recovery, alcohol or substance use disorders, ability to make lasting behavior changes, and need for further support and counseling.

(c) **Children.** Coverage for children includes the following services:

(1) Bio-psycho-social and level of care assessments.

(A) The interview and assessment is defined as a face-to-face interaction with the member. Assessment includes a history, mental status, full bio-psycho-social evaluation, a disposition, communications with family or other sources, review of laboratory or other pertinent medical information, and medical/clinical consultations as necessary.

(B) Assessments for children's level of care determination of medical necessity must follow a specified assessment process through OHCA or their designated agent. Only one assessment is allowable per provider per member. If there has been a break in service over a six (6) month period, or the assessment is conducted for the purpose of determining a child's need for inpatient psychiatric admission, then an additional unit can be authorized by OHCA, or their designated agent.

(2) Psychotherapy in an outpatient setting including an office, clinic, or other confidential setting. The services may be performed at the residence of the member if it is demonstrated that it is clinically beneficial, or if the member is unable to go to a clinic or office. Individual psychotherapy is defined as a one to one treatment using a widely accepted modality or treatment framework suited to the individual's age, developmental abilities and diagnosis. It may include specialized techniques such as biofeedback or hypnosis. Psychotherapy is considered to involve "interactive complexity" when there are communication factors during a visit that complicate delivery of the psychotherapy by the LBHP. Sessions typically involve members who have other individuals legally responsible for their care (i.e. minors or adults with guardians); members who request others to be involved in their care during the session (i.e. adults accompanied by one or more participating family members or interpreter or language translator); or members that require involvement of other third parties (i.e. child welfare, juvenile justice, parole/probation

officers, schools, etc.). Psychotherapy should only be reported as involving interactive complexity when at least one of the following communication factors is present:

(A) The need to manage maladaptive communication (i.e. related to high anxiety, high reactivity, repeated questions, or disagreement) among participants that complicate delivery of care.

(B) Caregiver emotions/behavior that interfere with implementation of the treatment plan.

(C) Evidence/disclosure of a sentinel event and mandated report to a third party (i.e. abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other visit participants.

(D) Use of play equipment, physical devices, interpreter or translator to overcome barriers to therapeutic interaction with a patient who is not fluent in the same language or who has not developed or lost expressive or receptive language skills to use or understand typical language.

(3) Family Psychotherapy is performed in an outpatient setting limited to an office, clinic, or other confidential setting. Family therapy is a face-to-face interaction between a therapist and the patient/family to facilitate emotional, psychological or behavioral changes and promote communication and understanding. Family therapy must be provided for the benefit of the member as a specifically identified component of an individual treatment plan.

(4) Group and/or Interactive Group psychotherapy in an outpatient setting must be performed in an office, clinic, or other confidential setting. Group therapy is a face-to-face interaction between a therapist and two or more unrelated patients (though there may be siblings in the same group, just not siblings only) to facilitate emotional, psychological, or behavioral changes. All group therapy records must indicate group size. Maximum total group size is six (6) for ages four (4) up to eighteen (18). Groups 18-20 year olds can include eight (8) individuals. Group therapy must be provided for the benefit of the member as a specifically identified component of an individual treatment plan. Multi-family group therapy size is limited to eight (8) family units.

(5) Assessment/evaluation and testing is provided by a psychologist, certified psychometrist, psychological technician of a psychologist or a LBHP utilizing tests selected from currently accepted assessment test batteries. For assessments conducted in a school setting, the Oklahoma State Department of Education requires that a licensed supervisor sign the assessment. Eight (8) hours/units of testing per patient over the age of three (3), per provider is allowed every twelve (12) months. There may be instances when further testing is appropriate based on established medical necessity criteria found in the Prior Authorization Manual. Justification for additional testing beyond allowed amount as specified in this section must be clearly explained and documented in the medical record. Test results

must be reflected in the service plan or medical record. The service plan must clearly document the need for the testing and what the testing is expected to achieve. Testing units must be billed on the date the testing, interpretation, scoring, and/or reporting was performed and supported by documentation.

(6) Crisis intervention services for the purpose of stabilization and hospitalization diversion as clinically appropriate.

(7) Payment for therapy services provided by a LBHP to any one member is limited to four (4) sessions/units per month. A maximum of twelve (12) sessions/units of therapy and testing services per day per provider are allowed. A maximum of thirty-five (35) hours of therapy per week per provider are allowed. The weekly service hour limitation will be calculated using a rolling four (4) week average. Case Management services are considered an integral component of the behavioral health services listed above.

(8) A child receiving residential behavioral management in a foster home, also known as therapeutic foster care, or a child receiving residential behavioral management in a group home, also known as therapeutic group home, may not receive individual, group or family counseling or testing unless allowed by the OHCA or their designated agent.

(d) Home and Community Based Waiver Services for the Intellectually Disabled. All providers participating in the Home and Community Based Waiver Services for the intellectually disabled program must have a separate contract with this Authority to provide services under this program. All services are specified in the individual's plan of care.

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

(f) Nursing Facilities. Services provided to members residing in nursing facilities may not be billed to SoonerCare.

[Source: Added at 27 Ok Reg 1676, eff 7-10-10 (emergency); Added at 28 Ok Reg 1483, eff 6-25-11 ; Amended at 29 Ok Reg 413, eff 3-7-12 (emergency); Amended at 29 Ok Reg 1125, eff 6-25-12 ; Amended at 30 Ok Reg 1146, eff 7-1-13 ; Amended at 31 Ok Reg 1665, eff 9-12-14 ; Amended at 32 Ok Reg 225, eff 11-3-14 (emergency); Amended at 32 Ok Reg 1056, eff 8-27-15 ; Amended at 33 Ok Reg 548, eff 5-31-16 (emergency); Amended at 34 Ok Reg 670, eff 9-1-17]

317:30-5-282. Non-covered procedures

The following procedures by LBHPs are not covered:

- (1) sensitivity training
- (2) encounter
- (3) workshops
- (4) sexual competency training
- (5) marathons or retreats for mental disorders
- (6) strictly education training
- (7) psychotherapy to persons under three years of age unless specifically approved by OHCA, or its designated agent.

[Source: Added at 27 Ok Reg 1676, eff 7-10-10 (emergency); Added at 28 Ok Reg 1483, eff 6-25-11]

317:30-5-283. Documentation of records

All behavioral health services will be reflected by documentation in the patient records.

- (1) All assessment, testing, and treatment services/units billed must include the following:
 - (A) date;
 - (B) start and stop time for each session/unit billed;
 - (C) signature of the provider;
 - (D) credentials of provider;
 - (E) specific problem(s), goals, and/or objectives addressed;
 - (F) methods used to address problem(s), goals and objectives;
 - (G) progress made toward goals and objectives;
 - (H) patient response to the session or intervention; and
 - (I) any new problem(s), goals and/or objectives identified during the session.
- (2) For each Group psychotherapy session, a separate list of participants must be maintained.
- (3) Testing will be documented for each date of service performed which should include at a minimum, the objectives for testing, the test administered, the results/conclusions and interpretation of the tests, and recommendations for treatment and/or care based on testing and analysis.

[Source: Added at 27 Ok Reg 1676, eff 7-10-10 (emergency); Added at 28 Ok Reg 1483, eff 6-25-11]

PART 27. INDEPENDENT PHYSICAL THERAPISTS AND PHYSICAL THERAPIST ASSISTANTS

317:30-5-290. Payment for outpatient services [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 25 Ok Reg 123, eff 8-1-07 (emergency); Revoked at 25 Ok Reg 112, eff 10-1-07 (emergency); Revoked at 25 Ok Reg 1192, eff 5-25-08]

317:30-5-290.1. Eligible providers

(a) Physical therapists.

- (1) Must be appropriately licensed in good standing in the state in which they practice and working in accordance with the Oklahoma Physical Therapy Practice Act or other applicable statute(s); and
- (2) Entered into a provider agreement with the Oklahoma Health Care Authority (OHCA) to provide physical therapy services.

(b) Physical therapist assistants.

- (1) Must be working under the supervision of a fully licensed physical therapist;
- (2) Must be appropriately licensed in good standing in the state in which they practice and working in accordance with the Oklahoma Physical Therapy Practice Act or other applicable

statute(s);

(3) Entered into a provider agreement with the OHCA to provide physical therapy services; and

(4) Provided the name of their OHCA-contracted supervising physical therapist upon enrollment.

[Source: Added at 25 Ok Reg 123, eff 8-1-07 (emergency); Added at 25 Ok Reg 1192, eff 5-25-08 ; Amended at 38 Ok Reg 411, eff 2-1-21 (emergency); Amended at 38 Ok Reg 1006, eff 9-1-21]

317:30-5-291. Coverage by category; payment rates and procedure codes

(a) **Coverage.** Payment is made to registered physical therapists as set forth in this Section.

(1) **Children.** Initial therapy evaluations do not require prior authorization and must be provided by a fully licensed physical therapist. All therapy services following the initial evaluation must be prior authorized for continuation of service. Prior to the initial evaluation, the therapist must have on file a signed and dated prescription or referral for the therapy services from the member's physician or other licensed practitioner of the healing arts. The prescribing or referring provider must be able to provide, if requested, clinical documentation from the member's medical record that supports the medical necessity for the evaluation and referral.

(2) **Adults.** There is no coverage for adults for services rendered by individually contracted providers. Coverage for adults is permitted in an outpatient hospital setting as described in Oklahoma Administrative Code (OAC) 317:30-5-42.1.

(3) **Individuals eligible for Part B of Medicare.** Services provided to Medicare eligible recipients are filed directly with the fiscal agent.

(b) **Payment rates.** All physical therapy services are reimbursed per the methodology described in the Oklahoma Medicaid State Plan.

(c) **Procedure codes.** The appropriate procedure codes used for billing physical therapy services are found in the Physicians' Current Procedural Terminology (CPT) Coding Manual.

317:30-5-291v2. Coverage by category¹

Payment is made to registered physical therapists as set forth in this Section.

(1) **Children.** Initial therapy evaluations do not require prior authorization and must be provided by a fully licensed physical therapist. All therapy services following the initial evaluation must be prior authorized for continuation of service. Prior to the initial evaluation, the therapist must have on file a signed and dated prescription or referral for the therapy services from the member's physician or other licensed practitioner of the healing arts. The prescribing or referring provider must be able to provide, if requested, clinical documentation from the member's medical record that supports the medical necessity for the evaluation and referral.

(2) **Adults.** There is no coverage for adults for services rendered by individually contracted providers. Coverage for adults is permitted in an outpatient hospital setting as described in Oklahoma Administrative Code (OAC) 317:30-5-42.1.

(3) **Individuals eligible for Part B of Medicare.** Services provided to Medicare eligible recipients are filed directly with the fiscal agent.

(4) **Alternative treatments for pain management.** Refer to OAC 317:30-5-728.

Editor's Note: ¹*In 2022, the agency promulgated two permanent amended versions of this Section (317:30-5-291) with the same effective date (9-12-22). Therefore, both versions are published herein until the agency reconciles the two versions.*

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 19 Ok Reg 2922, eff 7-1-02 (emergency); Amended at 20 Ok Reg 1193, eff 5-27-03 ; Amended at 25 Ok Reg 123, eff 8-1-07 (emergency); Amended at 25 Ok Reg 1192, eff 5-25-08 ; Amended at 29 Ok Reg 477, eff 5-11-12 ; Amended at 30 Ok Reg 336, eff 1-14-13 (emergency); Amended at 30 Ok Reg 1163, eff 7-1-13 ; Amended at 38 Ok Reg 411, eff 2-1-21 (emergency); Amended at 38 Ok Reg 1006, eff 9-1-21 ; Amended at 39 Ok Reg 419, eff 1-1-22 (emergency); Amended at 39 Ok Reg 1425, eff 9-12-22]

317:30-5-291.1. Payment rates [REVOKED]

[Source: Added at 25 Ok Reg 123, eff 8-1-07 (emergency); Added at 25 Ok Reg 1192, eff 5-25-08 ; Amended at 38 Ok Reg 411, eff 2-1-21 (emergency); Amended at 38 Ok Reg 1006, eff 9-1-21 ; Revoked at 39 Ok Reg 1425, eff 9-12-22]

317:30-5-291.2. Procedure codes [REVOKED]

[Source: Added at 25 Ok Reg 123, eff 8-1-07 (emergency); Added at 25 Ok Reg 1192, eff 5-25-08 ; Revoked at 39 Ok Reg 1425, eff 9-12-22]

317:30-5-292. Claim form [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 19 Ok Reg 2134, eff 6-27-02]

317:30-5-293. Team therapy (Co-treatment)

Therapists, or therapy assistants, working together as a team to treat one (1) or more members cannot bill separately for the same or different service provided at the same time to the same member.

(1) Current Procedural Terminology (CPT) codes are used for billing the services of one (1) therapist or therapy assistant. The therapist cannot bill for his/her services and those of another therapist or a therapy assistant, when both provide the same or different services, at the same time, to the same member.

(2) If multiple therapies (physical therapy, occupational therapy, and/or speech therapy) are provided to one (1) member at the same time, only one (1) therapist can bill for the entire service, or each therapist can divide the service units.

(3) Providers must report the CPT code for the time actually spent in the delivery of the modality requiring constant attendance and therapy services. Pre- and post-delivery services are not to be counted in determining the treatment service time. The time counted must begin when the therapist is directly working with the member to deliver treatment services.

(4) The time counted is the time the member is being treated. If the member requires both a therapist and an assistant, or even two (2) therapists, each service unit of time the member is being treated can count as only one (1) unit of each code. The service units billed must equal the total time the member was receiving actual therapy services. It is not allowable for each therapist or therapy assistant to bill for the entire therapy session. The time the member spends not being treated, for any reason, must not be billed.

[Source: Added at 28 Ok Reg 12, eff 8-13-10 (emergency); Added at 28 Ok Reg 1475, eff 6-25-11 ; Amended at 38 Ok Reg 411, eff 2-1-21 (emergency); Amended at 38 Ok Reg 1006, eff 9-1-21]

PART 28. OCCUPATIONAL THERAPISTS AND OCCUPATIONAL THERAPY ASSISTANTS

317:30-5-295. Eligible providers

(a) Occupational therapists.

(1) Must be appropriately licensed in good standing in the state in which they practice and working in accordance with the Oklahoma Occupational Therapy Practice Act or other applicable statute(s); and

(2) Entered into a provider agreement with the Oklahoma Health Care Authority (OHCA) to provide occupational therapy services.

(b) Occupational therapy assistants.

(1) Must be working under the supervision of a fully licensed occupational therapist;

(2) Must be appropriately licensed in good standing in the state in which they practice and working in accordance with the Oklahoma Occupational Therapy Practice Act or other applicable statute(s);

(3) Entered into a provider agreement with the OHCA to provide occupational therapy services; and

(4) Provided the name of their OHCA-contracted supervising occupational therapist upon enrollment.

[Source: Added at 25 Ok Reg 123, eff 8-1-07 (emergency); Added at 25 Ok Reg 1192, eff 5-25-08 ; Amended at 38 Ok Reg 411, eff 2-1-21 (emergency); Amended at 38 Ok Reg 1006, eff 9-1-21]

317:30-5-296. Coverage by category; payment rates and procedure codes

(a) **Coverage.** Payment is made for occupational therapy services as set forth in this Section.

(1) **Children.** Initial therapy evaluations do not require prior authorization and must be provided by a fully licensed occupational therapist. All therapy services following the initial evaluation must be prior authorized for continuation of service. Prior to the initial evaluation, the therapist must have on file a signed and dated prescription or referral for the therapy services from the member's physician or other licensed practitioner of the healing arts. The prescribing or referring provider must be able to provide, if requested, clinical documentation from the member's medical record that supports the medical necessity for the evaluation and referral.

(2) **Adults.** There is no coverage for adults for services rendered by individually contracted providers. Coverage for adults is permitted in an outpatient hospital setting as described in Oklahoma Administrative Code (OAC) 317:30-5-42.1.

(3) **Individuals eligible for Part B of Medicare.** Services provided to Medicare eligible recipients are filed directly with the fiscal agent.

(b) **Payment rates.** All occupational therapy services are reimbursed per the methodology described in the Oklahoma Medicaid State Plan.

(c) **Procedure codes.** The appropriate procedure codes used for billing occupational therapy services are found in the Physicians' Current Procedural Terminology (CPT) Coding Manual.

[Source: Added at 25 Ok Reg 123, eff 8-1-07 (emergency); Added at 25 Ok Reg 1192, eff 5-25-08 ; Amended at 29 Ok Reg 477, eff 5-11-12 ; Amended at 30 Ok Reg 336, eff 1-14-13 (emergency); Amended at 30 Ok Reg 1163, eff 7-1-13 ; Amended at 38 Ok Reg 411, eff 2-1-21 (emergency); Amended at 38 Ok Reg 1006, eff 9-1-21 ; Amended at 39 Ok Reg 1425, eff 9-12-22]

317:30-5-297. Payment rates [REVOKED]

[Source: Added at 25 Ok Reg 123, eff 8-1-07 (emergency); Added at 25 Ok Reg 1192, eff 5-25-08 ; Amended at 38 Ok Reg 411, eff 2-1-21 (emergency); Amended at 38 Ok Reg 1006, eff 9-1-21 ; Revoked at 39 Ok Reg 1425, eff 9-12-22]

317:30-5-298. Procedure codes [REVOKED]

[Source: Added at 25 Ok Reg 123, eff 8-1-07 (emergency); Added at 25 Ok Reg 1192, eff 5-25-08 ; Revoked at 39 Ok Reg 1425, eff 9-12-22]

317:30-5-299. Team therapy (Co-treatment)

Therapists, or therapy assistants, working together as a team to treat one (1) or more members cannot bill separately for the same or different service provided at the same time to the same member.

(1) Current Procedural Terminology (CPT) codes are used for billing the services of one (1) therapist or therapy assistant. The therapist cannot bill for his/her services and those of another therapist or a therapy assistant, when both provide the same or different services, at the same time, to the same member.

(2) If multiple therapies (physical therapy, occupational therapy, and/or speech therapy) are provided to one (1) member at the same time, only one (1) therapist can bill for the entire service, or

each therapist can divide the service units.

(3) Providers must report the CPT code for the time actually spent in the delivery of the modality requiring constant attendance and therapy services. Pre- and post-delivery services are not to be counted in determining the treatment service time. The time counted must begin when the therapist is directly working with the member to deliver treatment services.

(4) The time counted is the time the member is being treated. If the member requires both a therapist and an assistant, or even two (2) therapists, each service unit of time the member is being treated can count as only one (1) unit of each code. The service units billed must equal the total time the member was receiving actual therapy services. It is not allowable for each therapist or therapy assistant to bill for the entire therapy session. The time the member spends not being treated, for any reason, must not be billed.

[Source: Added at 28 Ok Reg 12, eff 8-13-10 (emergency); Added at 28 Ok Reg 1475, eff 6-25-11 ; Amended at 38 Ok Reg 411, eff 2-1-21 (emergency); Amended at 38 Ok Reg 1006, eff 9-1-21]

PART 29. RENAL DIALYSIS FACILITIES

317:30-5-305. Eligible providers

Payment can be made to a Medicare certified Renal Dialysis Center when its clinical services are under the medical direction of a physician licensed by the Oklahoma State Board of Medical Licensure and Supervision, the Oklahoma Board of Osteopathic Examiners, or the appropriate licensing body of the state where the provider is located. Renal Dialysis Centers must also have a current contract on file with the Oklahoma Health Care Authority.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 34 Ok Reg 664, eff 9-1-17]

317:30-5-306. Coverage by category

Payment is made to renal dialysis facilities as set forth in this Section.

(1) **Adults.** Payment is made for outpatient renal dialysis for adults at the PPS rate.

(2) **Children.** Coverage for children is the same as for adults.

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

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 19 Ok Reg 2922, eff 7-1-02 (emergency); Amended at 20 Ok Reg 1193, eff 5-27-03 ; Amended at 29 Ok Reg 1106, eff 6-25-12]

317:30-5-307. Payment methodology

Payment of in-facility dialysis treatments and home dialysis treatment is made under the PPS rate reimbursement system.

(1) All items and services included under the PPS rate must be furnished by the facility, either directly or under arrangements, to all of its dialysis patients. If the facility fails to furnish (either directly or under arrangements) any part of the items and services covered under the rate, then the facility cannot be paid any amount for the part of the items and services that the facility does furnish. These items and services include:

- (A) medically necessary dialysis equipment and dialysis support equipment;
- (B) home dialysis support services including the delivery, installation, maintenance, repair, and testing of home dialysis equipment, and home support equipment;
- (C) purchase and delivery of all necessary dialysis supplies;
- (D) routine ESRD related laboratory tests; and
- (E) all dialysis services furnished by the facility's staff.

(2) Some examples (but not an all-inclusive list) of items and services that are included in the PPS rate and may not be billed separately when furnished by a dialysis facility are:

- (A) staff time used to administer blood;
- (B) dec clotting of shunts and any supplies used to dec clot shunts;
- (C) oxygen and the administration of oxygen; and
- (D) staff time used to administer nonroutine peritoneal items.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 29 Ok Reg 1106, eff 6-25-12]

PART 30. APPLIED BEHAVIOR ANALYSIS (ABA) SERVICES

317:30-5-310. Purpose

The purpose of this Section is to establish guidelines for the provision of ABA services under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit.

(1) ABA focuses on the analysis, design, implementation, and evaluation of instructional and other environmental modifications to produce meaningful changes in human behavior. ABA services include the use of direct observation, measurement, and functional analysis of the relations between the environment and behavior. Common ABA-based techniques include but are not limited to; discrete trial training (DTT); naturalistic developmental behavioral intervention (NDBI); and verbal behavioral intervention.

(2) ABA may be provided in a variety of settings, including home, community, or clinical. It involves development of an individualized treatment plan that includes transition and aftercare planning, and family/caregiver involvement.

(3) At an initial assessment, target symptoms are identified. A treatment plan is developed to identify core deficits and aberrant behaviors, and includes designated interventions intended to address these deficits and behaviors and that are functional, meaningful, and connected to the member's daily activities routines.

(4) ABA services require prior authorization [refer to Oklahoma Administrative Code (OAC) 317:30-3-31 and 317:30-5-314].

[Source: Added at 39 Ok Reg 1455, eff 9-12-22]

317:30-5-311. Eligible providers and requirements

(a) **Eligible providers.** Eligible ABA provider types include:

(1) Board certified behavior analyst® (BCBA®) - A master's or doctoral level independent practitioner who is certified by the national-accrediting Behavior Analyst Certification Board, Inc.® (BACB®) and licensed by the Oklahoma Human Services' (OKDHS) Developmental Disabilities Services Division (DDS) to provide behavior analysis services. A BCBA may supervise the work of board-certified assistant behavior analysts and registered behavior technicians implementing behavior analytic interventions;

(2) Board-certified assistant behavior analyst® (BCaBA®) - A bachelor's level practitioner who is certified by the national-accrediting BACB and certified by OKDHS DDS to provide behavior analysis services under the supervision of a BCBA;

(3) Registered behavior technician™ (RBT®) - A high school level or higher paraprofessional who is certified by the national-accrediting BACB and practices under the close and ongoing supervision of a BCBA. The RBT works under the license number of a BCBA and is primarily responsible for the direct implementation of BCBA designed and prescribed behavior-analytic services;

(4) Licensed psychologist - An individual who is licensed and in good standing with the Oklahoma State Board of Examiners of Psychologists and has professional experience in the use of ABA therapy may render behavior analysis services. Refer to OAC 317:30-5-275; and

(5) Human services professional - A practitioner who is licensed by the State of Oklahoma pursuant to (A) - (G), and certified by the national-accrediting BACB, and who is working within the scope of his or her practice, to include:

(A) A licensed physical therapist;

(B) A licensed occupational therapist;

(C) A licensed clinical social worker or social worker candidate under the supervision of a licensed clinical social worker;

(D) A licensed speech-language pathologist or licensed audiologist;

- (E) A licensed professional counselor or professional counselor candidate under the supervision of a licensed professional counselor;
- (F) A licensed marital and family therapist or marital and family therapist candidate under the supervision of a licensed marital and family therapist; or
- (G) A licensed behavioral practitioner or behavioral practitioner candidate under the supervision of a licensed behavioral practitioner.

(b) **Provider criteria.** To direct, supervise, and/or render ABA services, the following conditions shall be met.

- (1) A BCBA shall:
 - (A) Be currently licensed by OKDHS DDS as a BCBA;
 - (B) Have no sanctions or disciplinary actions by OKDHS DDS or the BACB;
 - (C) Have no current overpayment(s) due to SoonerCare, and no Medicare or Medicaid sanctions or exclusions from participation in federally funded programs; and
 - (D) Be fully contracted with SoonerCare as a provider.
- (2) A BCaBA shall:
 - (A) Be currently certified by OKDHS DDS as a BCaBA;
 - (B) Work under the supervision of a SoonerCare-contracted BCBA provider;
 - (C) Have no current overpayment(s) due to SoonerCare, and no Medicare or Medicaid sanctions or exclusions from participation in federally funded programs; and
 - (D) Be fully contracted with SoonerCare as a provider.
- (3) An RBT shall:
 - (A) Be currently certified by the national-accrediting BACB as an RBT;
 - (B) Work under the supervision of a SoonerCare-contracted BCBA provider;
 - (C) Have no current overpayment(s) due to SoonerCare, and no Medicare or Medicaid sanctions or exclusions from participation in federally funded programs; and
 - (D) Be fully contracted with SoonerCare as a provider.
- (4) A human services professional shall:
 - (A) Be currently licensed or certified by the State of Oklahoma, in accordance with Section 1928 of Title 59 of the Oklahoma Statutes;
 - (B) Be currently certified by the national-accrediting BACB;
 - (C) Have no sanctions or disciplinary actions by the applicable state licensing board or the BACB;
 - (D) If working under supervision within the scope of his or her practice, have a documented relationship with a fully-licensed human service professional working in a supervisory capacity;
 - (E) Have no current overpayment(s) due to SoonerCare, and no Medicare or Medicaid sanctions or exclusions from participation in federally funded programs; and

(F) Be fully contracted with SoonerCare as a provider.

[Source: Added at 39 Ok Reg 1455, eff 9-12-22]

317:30-5-312. Treatment plan components and documentation requirements

(a) **Treatment plan.** The treatment plan is developed by a BCBA or a licensed psychologist from the FBA. The treatment plan shall:

- (1) Be person-centered and individualized;
- (2) Delineate the baseline levels of target behaviors;
- (3) Specify long-term and short-term objectives that are defined in observable, measurable behavioral terms;
- (4) Specify criteria that will be used to determine achievement of objectives;
- (5) Include assessment(s) and treatment protocols for addressing each of the target behaviors such as including antecedent and consequence interventions, and teaching of replacement skills specific to the function of the identified maladaptive behaviors;
- (6) Clearly identify the schedule of services planned and the individuals responsible for delivering the services, including frequent review of data on target behaviors and adjustments in the treatment plan and/or protocols by the BCBA or licensed psychologist as needed;
- (7) Include training and supervision to enable board certified assistant behavior analysts (BCaBAs) and registered behavior technicians (RBTs) to implement assessment and treatment protocols;
- (8) Include training and support to enable parents and other caregivers to participate in treatment planning and successfully reinforce the established treatment plan in the home and community settings;
- (9) Include care coordination involving the parents or caregiver(s), school, state disability programs, and others as applicable; and
- (10) Ensure that services are consistent with applicable professional standards and guidelines relating to the practice of applied behavior analysis as well as state Medicaid laws and regulations.

(b) **Assessments.** Initial assessments allow ABA providers to develop a treatment plan that is unique to the member and include all treatment recommendations and goals.

- (1) The functional behavior assessment (FBA) serves as a critical component of the treatment plan and is conducted by a board-certified behavior analyst (BCBA) to identify the specific behavioral needs of the member. The FBA consists of:
 - (A) Description of the problematic behavior (topography, onset/offset, cycle, intensity, and severity);
 - (B) History of the problematic behavior (long-term and recent);

- (C) Antecedent analysis (setting, people, time of day, and events);
- (D) Consequence analysis; and
- (E) Impression and analysis of the function of the problematic behavior.

(2) Other relevant assessments may be submitted in addition to the FBA for review by an OHCA reviewer and/or physician to support medical necessity criteria.

(c) **Documentation requirements.** ABA providers must:

(1) Document all ABA services in the member's record. Refer to OAC 317:30-5-248;

(2) Retain the member's records necessary to disclose the extent of services. Refer to OAC 317:30-3-15; and

(3) Release the medical information necessary for payment of a claim upon request. Refer to OAC 317:30-3-16.

(4) All assessment and treatment services must include the following:

(A) Date;

(B) Start and stop time for each session/unit billed and physical location where service was provided;

(C) Signature of the provider;

(D) Credentials of provider;

(E) Specific problem(s), goals and/or objectives addressed;

(F) Methods used to address problem(s), goals and objectives;

(G) Progress made toward goals and objectives;

(H) Patient response to the session or intervention; and

(I) Any new problem(s), goals and/or objectives identified during the session.

(J) Treatment plans are not valid until all signatures are present. As used in this subsection, all signatures mean:

(i) The signature of acknowledgement of the supervising BCBA or licensed psychologist; and

(ii) The signature of assent of any minor who is age fourteen (14) or older; and

(iii) The signature of consent of:

(I) A parent or legal guardian of any minor; or

(II) If the minor documents a legal exception to parent or legal guardian consent, the excepted minor.

(iv) All signatures:

(I) Must clearly indicate that the signatories approve of and consent, assent, or acknowledge the treatment plan; and

(II) May be provided on a signature page applicable to both the assessment and the treatment plan, if the signed page clearly indicates approval of and consent, assent, or acknowledgment of both the assessment and the treatment plan.

[Source: Added at 39 Ok Reg 1455, eff 9-12-22]

317:30-5-313. Medical necessity criteria for members under twenty-one (21) years of age

ABA services are considered medically necessary when all the following conditions are met:

(1) The member is under twenty-one (21) years of age with a definitive diagnosis of an Autism Spectrum Disorder (ASD) from the following providers:

- (A) Pediatric neurologist or neurologist;
- (B) Developmental pediatrician;
- (C) Licensed psychologist;
- (D) Psychiatrist or neuropsychiatrist; or
- (E) Other licensed physician experienced in the diagnosis and treatment of ASD.

(2) A comprehensive diagnostic evaluation or thorough clinical assessment completed by one (1) of the above identified professionals must:

- (A) Include a complete pertinent medical and social history, including pre-and perinatal, medical, developmental, family, and social elements; and
- (B) Be based on criteria outlined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) or the most current version of the DSM for ASD and/or may also include scores from the use of formal diagnostic tests such as the Autism Diagnostic Interview-Revised (ADI-R), Autism Diagnostic Observation Schedule-2 (ADOS-2), Childhood Autism Rating Scale (CARS) or other tools with acceptable psychometric properties. Screening scales are not sufficient to make a diagnosis and will not be accepted as the only formal scale.

(3) There must be a reasonable expectation that the member will benefit from ABA. The member must exhibit:

- (A) The ability/capacity to learn and develop generalized skills to assist with his or her independence; and
- (B) The ability to develop generalized skills to assist in addressing maladaptive behaviors associated with ASD.

(4) The member is medically stable and does not require twenty-four (24) hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for individuals with intellectual disabilities (ICF/IID).

(5) The member exhibits atypical or disruptive behavior within the most recent thirty (30) calendar days that significantly interferes with daily functioning and activities. Such atypical or disruptive behavior may include, but is not limited to:

- (A) Impulsive aggression toward others;
- (B) Self-injury behaviors;
- (C) Intentional property destruction; or

(D) Severe disruption in daily functioning (e.g., the individual's inability to maintain in school, child care settings, social settings, etc.) due to changes in routine activities that have not been helped by other treatments such as occupational therapy, speech therapy, additional psychotherapy and/or school/ daycare interventions.

(6) The focus of treatment is not custodial in nature (which is defined as care provided when the member "has reached maximum level of physical or mental function and such person is not likely to make further significant improvement" or "any type of care where the primary purpose of the type of care provided is to attend to the member's daily living activities which do not entail or require the continuing attention of trained medical or paramedical personnel.") Interventions are intended to strengthen the individual's/parent's/legal guardian's capacity for self care and self sufficiency to decrease interventions in the home by those other than the parent(s)/legal guardian(s).

(7) It has been determined that there is no less intensive or more appropriate level of service which can be safely and effectively provided.

[Source: Added at 39 Ok Reg 1455, eff 9-12-22]

317:30-5-314. Prior authorization

Eligible providers must submit an initial prior authorization request to the Oklahoma Health Care Authority (OHCA) or its designated agent. Prior authorization requests shall be granted up to six (6) months of ABA treatment services at one (1) time unless a longer duration of treatment is clinically indicated. The number of hours authorized may differ from the hours requested on the prior authorization request based on the review by an OHCA reviewer and/or physician. If the member's condition necessitates a change in the treatment plan, the provider must request a new prior authorization. The prior authorization request must meet the following SoonerCare criteria for ABA services.

(1) The criteria include a comprehensive behavioral assessment, FBA, and other supporting assessment(s) outlining the maladaptive behaviors consistent with the diagnosis of ASD and its associated comorbidities. In addition to completing the initial request form, providers will be required to submit documentation that will consist of the following:

(A) Information about relevant medical status, prior assessment results, response to prior treatment, and other relevant information gathered from review of records and past assessments.

(B) Information gathered from interview of family and/or caregivers, rating scales, and social validity measures to assess perceptions of the client's skill deficits and behavioral excesses, and the extent to which these deficits impede the daily life of the member and the family.

(C) Direct assessment and observation, including any data related to the identified problem behavior. The analysis of such data serves as the primary basis for identifying pretreatment levels of functioning, developing, and adapting treatment protocols, and evaluating response to treatment and progress towards goals.

(D) Functional assessment of problem behavior that includes antecedent factors, skill deficits, and consequences contributing to the problem behavior. The treatment plan should address all three (3) areas, including antecedent interventions, teaching replacement skills, and modification of consequences. Other supporting assessments may be additionally submitted for review.

(2) The prior authorization for ABA treatment will be time limited for up to thirty (30) hours per week unless other hours are deemed medically necessary and authorized through a prior authorization request and must:

(A) Be a one-on-one encounter (face to face between the member and ABA provider) except in the case of family adaptive treatment guidance;

(B) Be child-centered and based upon individualized goals that are strengths-specific, family focused, and community based;

(C) Be culturally competent and the least intrusive as possible;

(D) Clearly define in measurable and objective terms the intervention plan so it can address specific target behaviors. The intervention plan should be clearly linked to the function of the maladaptive behavior and include antecedent interventions, replacement skills to be taught, and modification of consequences. Additional goals may be identified that are related to the core deficits of ASD and are prioritized based on current research and social significance for the individual.

(E) Record the frequency, rate, symptom intensity/duration, or other objective measures of baseline levels;

(F) Set quantifiable criteria for progress;

(G) Establish and record behavioral intervention techniques that are appropriate to target behaviors. The detailed treatment plan utilizes reinforcement and other behavioral principles and excludes the use of methods or techniques that lack consensus about their effectiveness based on evidence in peer-reviewed publications;

(H) Specify strategies for generalization of learned skills beyond the clinical settings such as in the home or other community settings;

(I) Document planning for transition through the continuum of interventions, services, and settings, as well as discharge criteria. Treatment (behavioral training) will be individualized, and documentation will support the

identified atypical or disruptive behavior.

(J) Include parent(s)/legal guardian(s) in behavioral training techniques so that they can practice additional hours of intervention on their own. The treatment plan is expected to achieve the parent(s)/legal guardian(s) ability to successfully reinforce the established plan of care and support generalization of skills in the home and community settings. Frequency of parental involvement will be determined by the treatment provider and listed on the treatment plan;

(K) Document parent(s)/legal guardian(s) participation in the training of behavioral techniques in the member's medical record. Parent(s)/legal guardian(s)' participation is critical to the generalization of treatment goals to the member's environment; and

(L) Ensure that recommended ABA services do not duplicate, or replicate services received in a member's primary academic education setting or provided within an Individualized Education Plan (IEP), Individualized Service Plan (ISP), or any other individual plan of care.

Documentation may be requested by the OHCA to support coordination of services with other providers and to prevent overlap and duplication of services including those in school settings.

[Source: Added at 39 Ok Reg 1455, eff 9-12-22]

317:30-5-315. ABA extension requests

Extension requests for ABA services must be submitted to the OHCA or its designated agent. Extension requests must contain the appropriate documentation validating the need for continued treatment and establish the following:

- (1) Eligibility criteria in OAC 317:30-5-313;
- (2) The frequency of the target behavior has diminished since last review, or if not, there has been modification of the treatment or additional assessments have been conducted;
- (3) A functional analysis shall be completed by the provider when no measurable progress has occurred, or it may be requested by the OHCA. The functional analysis should record the member's serious maladaptive target behavioral symptom(s) and precipitants, and document the modifications of the current treatment plan to address progress, as well as make a determination of the function a particular maladaptive behavior serves for the member in the environmental context;
- (4) Appropriate consultations from other staff or experts have occurred (to optimize psychiatric medications and medical treatments to include but not limited to psychiatric consults, pediatric evaluation for other conditions, etc.) and interventions have been changed, including the number of hours per week of service or setting (higher level of care);

- (5) The OHCA may suggest appropriate consultation from other staff or experts during the process of prior authorization;
- (6) Parent(s)/legal guardian(s) have received re-training on these changed approaches; and
- (7) The treatment plan documents a gradual tapering of higher intensities of intervention and transitioning to supports from other sources (i.e., schools) as progress allows.

[Source: Added at 39 Ok Reg 1455, eff 9-12-22]

317:30-5-316. Reimbursement methodology

SoonerCare shall provide reimbursement for ABA services in accordance with the Medicaid State Plan.

(1) Payment shall only be made to SoonerCare-contracted groups or qualified individual providers who are currently licensed and in good standing. Payment is not made to under supervision ABA practitioners/paraprofessionals, including but not limited to, BCaBAs and RBTs.

(2) Reimbursement for ABA services is only made on a fee-for-services basis. The maximum allowable fee for a unit of service has been determined by OHCA to be a reasonable fee, consistent with efficiency, economy, and quality of care. Payment for covered services is the lower of the provider's actual billed charges, consistent with the provider's usual and customary charge to the general public for the service, or the maximum allowable per unit of service.

(3) Reimbursement shall only be made for services that have been prior authorized by OHCA or its designee; and performed on an individualized basis and not in a group setting except for family adaptive behavior treatment guidance by a qualified ABA provider (OAC 317:30-5-311).

(4) Providers may only concurrently bill current Procedural Terminology (CPT) codes when they outline in the prior authorization the following criteria:

- (A) The BCBA or licensed psychologist met with the member and/or parent or guardian and directed the RBT through one (1) or more of the following:
 - (i) Monitoring treatment integrity to ensure satisfactory implementation of treatment protocols;
 - (ii) Directing RBT staff and/or caregivers in the implementation of new or revised treatment protocols;
 - (iii) Selection and development of treatment goals, protocols, and data collection systems;
 - (iv) Collaboration with family members and other stakeholders;
 - (v) Creating materials, gathering materials;
 - (vi) Reviewing data to make adjustments to treatment protocols; and/or

(vii) Development and oversight of transition and discharge planning.

(B) The BCBA or licensed psychologist used behavior training in session as appropriate in supervision of the RBT staff and/or caregivers. Behavioral skills training consists of providing instructions, modeling, rehearsal, and feedback between provider and member.

(5) Reimbursement for ABA services shall not be made to or for services rendered by a parent, legal guardian, or other legally responsible person.

[Source: Added at 39 Ok Reg 1455, eff 9-12-22]

PART 31. ROOM AND BOARD PROVIDERS

317:30-5-320. Eligible providers

All providers of accommodations for overnight lodging, which may include meals, for clients to obtain medical services must have entered into a contract to provide services to eligible individuals. Each provider must agree to accept the payment made by this Authority as full and complete reimbursement for such services.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95]

317:30-5-321. Coverage by category

Payment is made to Room and Board Providers as set forth in this Section.

(1) **Adults.** Payment is made to Room and Board Providers for room and board of an eligible adult and an escort, if necessary, when authorized by the Oklahoma Health Care Authority (OHCA). Room and Board is authorized by, Room and Board Order form, for Adults and Children. A copy of the authorization must be attached to each claim along with the dates of stay and signature of authorized escort.

(2) **Children.** Coverage for children is the same as for adults.

(A) Services, deemed medically necessary and allowable under Federal Medicaid regulations, may be covered by the EPSDT/OHCA Child Health program even though the services may not be part of the OHCA SoonerCare program. Such services must be prior authorized.

(B) 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. For more information regarding experimental or investigational including clinical trials see, Oklahoma Administrative Code 317:30-3-57.1.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 19 Ok Reg 2134, eff 6-27-02 ; Amended at 24 Ok Reg 2086, eff 6-25-07 ; Amended at 38 Ok Reg 970, eff 9-1-21]

**317:30-5-322. Procedure codes and allowable amounts
[REVOKED]**

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 24 Ok Reg 2086, eff 6-25-07]

317:30-5-323. Claim form [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 19 Ok Reg 2134, eff 6-27-02]

**PART 32. SOONERRIDE NON-EMERGENCY
TRANSPORTATION (NEMT)**

317:30-5-325. [RESERVED]

[Source: Reserved at 18 Ok Reg 258, eff 11-21-00 (emergency); Reserved at 18 Ok Reg 1130, eff 5-11-01]

317:30-5-326. Provider eligibility

The Oklahoma Health Care Authority (OHCA) is responsible for assuring that necessary transportation is available to all eligible SoonerCare members who are in need of SoonerCare medical services in accordance with Section 431.53 of Title 42 of the Code of Federal Regulations.

(1) The agency contracts with a broker to provide the most appropriate, and least costly mode of transportation necessary to meet the individual needs of SoonerCare members statewide.

(2) All SoonerRide contracted providers must meet the standards and requirements outlined in the Oklahoma Medicaid State Plan, the SoonerRide provider manual and contract, as well as all applicable federal and state laws/regulations.

(3) Payment for covered services to the broker is made pursuant to the methodology described in the Oklahoma Medicaid State Plan.

[Source: Reserved at 18 Ok Reg 258, eff 11-21-00 (emergency); Reserved at 18 Ok Reg 1130, eff 5-11-01 ; Added at 24 Ok Reg 2095, eff 6-25-07 ; Amended at 25 Ok Reg 526, eff 1-2-09 (emergency); Amended at 26 Ok Reg 1066, eff 5-11-09 ; Amended at 26 Ok Reg 526, eff 1-2-09 (emergency); Amended at 26 Ok Reg 2113, eff 6-25-09 ; Amended at 38 Ok Reg 992, eff 9-1-21 ; Amended at 40 Ok Reg 2188, eff 9-11-23]

317:30-5-326.1. Definitions

The following words and terms, when used in this Part shall have the following meaning, unless context clearly indicates otherwise.

"Attendant" means one (1) of the following:

"Emergency/Emergent" means a serious situation or occurrence that happens unexpectedly and demands immediate action such as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected, by a reasonable and prudent layperson, to result in placing the members' health in serious jeopardy, serious impairment to bodily function, or serious dysfunction of any bodily organ or part.

"Medical escort" means a family member, legal guardian, or volunteer whose presence is required and medically necessary to assist a member during transport and while at the place of treatment. A medical escort voluntarily accompanies the member during transport and leaves the vehicle at its destination and remains with the member. A medical escort must be of an age of legal majority recognized under Oklahoma State law, an emancipated minor, or a minor who is escorting his or her child to treatment.

"Medically necessary" means services that meet the criteria described in Oklahoma Administrative Code 317:30-3-1 (f) (1) - (6), and are not primarily for the convenience of the member.

"Member/eligible member" means any person eligible for SoonerCare and individuals considered to be Medicare/SoonerCare dual eligible.

"Nearest appropriate facility" means a medical facility that is generally equipped and legally permitted to provide the needed care for the illness or injury involved that is the closest in geographical proximity to the members' residence with exceptions. In the case of approved

hospital services, it also means that a physician or physician specialist is available to provide the necessary care required to treat the member's condition. The fact that a particular physician does or does not have staff privileges in a hospital is not a consideration in determining whether the hospital has appropriate facilities.

"Non-ambulance" means a carrier that is not an ambulance.

"Non-emergency" means all reasons for transportation that are not an emergency as defined above.

"Service animal" means an animal individually trained to work or perform tasks for an individual with a disability. The work or task an animal has been trained to provide must be directly related to the individual's disability.

"SoonerRide Non-Emergency Transportation (NEMT)" means non-emergency non-ambulance transportation provided statewide within the geographical boundaries of the State of Oklahoma.

"Standing appointments" means recurring appointments that are scheduled over a significant period of time. Examples include, but are not limited to, dialysis and chemotherapy.

[Source: Added at 24 Ok Reg 2095, eff 6-25-07 ; Amended at 29 Ok Reg 1104, eff 6-25-12 ; Amended at 38 Ok Reg 992, eff 9-1-21]

317:30-5-327. Eligibility for SoonerRide NET

Transportation is provided when medically necessary in connection with examination and treatment to the nearest appropriate facility in accordance with 42 CFR 440.170. As the Medicaid Agency, the Oklahoma Health Care Authority (OHCA) is the payer of last resort, with few exceptions. When other resources are available, those resources must first be utilized. Exceptions to this policy are those receiving medical treatment through Indian Health Services and those eligible for the Crime Victims Compensation Act. Individuals considered fully dual eligible qualify for SoonerRide. However, SoonerRide excludes those individuals who are categorized as:

- (1) Qualified Medicare Beneficiaries(QMB);
- (2) Specified Low Income Medicare Beneficiaries (SLMB) only;
- (3) Qualifying Individuals-1 and individuals who are in an institution for mental disease (IMD);
- (4) inpatient;
- (5) institutionalized;
- (6) Home and Community Based Waiver members, with the exception of the In-home Supports Waiver for Children, the Advantage Waiver, the Living Choice demonstration, and the Medically Fragile Waiver.

[Source: Added at 18 Ok Reg 258, eff 11-21-00 (emergency); Added at 18 Ok Reg 1130, eff 5-11-01 ; Amended at 23 Ok Reg 771, eff 3-9-06 (emergency); Amended at 23 Ok Reg 2440, eff 6-25-06 ; Amended at 24 Ok Reg 2095, eff 6-25-07 ; Amended at 29 Ok Reg 1104, eff 6-25-12 ; Amended at 30 Ok Reg 1129, eff 7-1-13 ; Amended at 32 Ok Reg 1035, eff 8-27-15]

317:30-5-327.1. SoonerRide NEMT coverage and exclusions

(a) **SoonerRide NEMT coverage.** SoonerRide NEMT is available for SoonerCare compensable services under the following conditions:

(1) **Nearest appropriate facility.**

(A) Transportation is to the nearest appropriate facility or medical provider that is capable of providing the necessary services.

(B) SoonerRide NEMT services to a more distant hospital, clinic, practitioner or physicians' office solely to avail a member of the service of a specific physician or physician assistant does not make the institution in which the physician has staff privileges the nearest institution with appropriate facilities.

(C) The nearest facility is not considered appropriate if:

(i) The member's condition requires a higher level of care or specialized services available at a more distant facility; or

(ii) There are no beds or providers available.

Medical records must be properly documented in this circumstance.

(2) **Radius.** Primary care and specialty SoonerCare compensable services should be available within forty-five (45) miles of the member's residence. The Oklahoma Health Care Authority (OHCA) has the final authority to approve or deny travel greater than forty-five (45) miles to access these services.

(A) **Residency change.** Should a member change residence then care will be established within forty-five (45) miles of the new residence.

(B) **American Indians/Alaska Natives (AI/AN).** AI/AN members that are seeking services at a Tribal or Indian Health Services (I.H.S.) facility may be transported to any Tribal or I.H.S. facility equipped for their medical needs. All trips to out-of-state facilities require prior authorization and approval.

(3) **Services requiring prior authorization.**

(A) Travel that exceeds the forty-five (45) mile radius, as mentioned in Oklahoma Administrative Code (OAC) 317:30-5-327.1 (a) (2), must be authorized and approved; and

(B) Out-of-state travel for prior authorized out-of-state medically necessary services, must also be authorized and approved.

(b) **Discharge coverage.** SoonerRide NEMT is available if a member is being discharged from a facility to their home. The facility is responsible for scheduling the transportation. SoonerRide NEMT is only responsible for transporting the member.

(1) Personal belongings and/or durable medical equipment (with the exception of portable oxygen or a wheelchair that is medically necessary for transportation) will not be transported through SoonerRide NEMT.

(2) Wheelchairs must be provided by the medical escort/member. This item is not provided by the SoonerRide NEMT transport.

(c) **Medical escorts/service animals/additional passengers.** In instances where there is documented medical necessity, a medical escort or service animal may accompany the member.

(1) **Medical escort.** A medical escort is not eligible for direct compensation by the SoonerRide NEMT broker or SoonerCare.

(2) **Service animal.** The SoonerRide NEMT broker may request additional information regarding the service animal, including but not limited to, if the animal is required because of a disability and what work or task the animal has been trained to perform.

(3) **Removal of the service animal.** The SoonerRide NEMT broker may ask for the service animal to be removed if it is not under the control of the handler or if it is not housebroken/trained. Additionally, the SoonerRide NEMT broker and the OHCA are not responsible for the care and supervision of the service animal.

(4) **Additional passengers.** SoonerRide NEMT is not required to transport any additional individuals other than the one (1) approved individual providing the escort services.

(A) **Additional passengers request.** In the event that additional individuals request transportation, it is the responsibility of the member to contact the transportation provider directly to request allotment of additional passengers. The SoonerRide NEMT broker will not facilitate this request.

(B) **Exceptions for urgent appointments.** Exceptions may be granted if the medical appointment is urgent in nature and meets the criteria outlined in Oklahoma Administrative Code (OAC) 317:30-5-327.1 (d) (1)- (3).

(d) **Urgent appointments and additional passengers.** An urgent appointment can be for either a sick child or sick parent/guardian. The member must make the request for additional child passengers when making the trip reservation. A maximum of three (3) children can ride with the parent/guardian. The total number of passengers, including the driver, cannot exceed more than five (5) persons for any vehicle. In addition, the following conditions must be met:

(1) **Urgent medical appointment.** The medical appointment must be urgent (for a sick child or sick parent) as determined by the member's doctor. The SoonerRide NEMT broker will confirm that the medical appointment is urgent with the member's doctor;

(2) **Children.** All children must be the member's by birth, marriage, legal adoption, foster child, or legal guardianship. Further, the additional children passengers must be younger than thirteen (13) years of age. Exception will be granted if a child has complex, medical, intellectual, or physical disabilities that requires constant care and supervision; and

(3) **Car seats for children.** Each child must have his or her own car seat, provided by the member, if required by Oklahoma state law.

(e) **Forms of transportation.** SoonerRide NEMT can include one (1) of the following forms of transportation:

(1) **Authorization for transportation by private vehicle or bus.** Transportation by private vehicle or bus is administered through the broker when it is necessary for an eligible member to receive medical services.

(2) **Authorization for transportation by taxi.** Taxi service may be authorized at the discretion of the broker.

(3) **Transportation by ambulance.** Transportation by ambulance is only provided for non-emergency scheduled stretcher service.

(4) **Transportation by airplane.** When an individual's medical condition is such that transportation out-of-state by a commercial airline is required, approval for airfare must be secured by telephoning the OHCA who will make the necessary flight arrangements.

(f) **Exclusions for SoonerRide NEMT.** SoonerRide NEMT coverage excludes the following:

(1) **Emergency services.** Transportation of members to access emergency services;

(2) **Ambulance.** Transportation of members by ambulance for any reason, except for non-emergency scheduled stretcher service per OAC 317:30-5-327.1 (e) (3);

(3) **Non-compensable services.** Transportation of members to services that are not covered by SoonerCare; and

(4) **Non-medically necessary services.** Transportation of members to services that are not medically necessary.

[Source: Added at 24 Ok Reg 2095, eff 6-25-07 ; Amended at 29 Ok Reg 1104, eff 6-25-12 ; Amended at 32 Ok Reg 1035, eff 8-27-15 ; Amended at 38 Ok Reg 992, eff 9-1-21]

317:30-5-327.2. Service availability [REVOKED]

[Source: Added at 24 Ok Reg 2095, eff 6-25-07 ; Revoked at 29 Ok Reg 1104, eff 6-25-12]

317:30-5-327.3. Coverage for residents of long-term care facilities

(a) An attendant must accompany members during SoonerRide NEMT. An attendant must be at least at the level of a nurse's aide, and must have the appropriate training necessary to provide any and all assistance to the member, including physical assistance needed to seat the member in the vehicle. The attendant must have the ability to interface with health care providers as appropriate. An attendant must be of an age of legal majority recognized under Oklahoma State law.

(1) The long-term care facility must provide an attendant to accompany members receiving NEMT services.

(2) The attendant will be responsible for any care needed by the member(s) during transport and any assistance needed by the member(s) to assure the safety of all passengers and the driver of the vehicle. An attendant leaves the vehicle at its destination and remains with the member(s).

(3) When multiple members residing in the same long-term care facility are being transported to the same provider for health care

services, the long-term care facility may provide one (1) qualified attendant for three (3) members unless other circumstances indicate the need for additional attendants. Such circumstances might include, but are not limited to:

- (A) The physical and/or mental status of the member(s);
- (B) Difficulty in getting the member(s) in and out of the vehicle;
- (C) The amount of time that a member(s) would have to wait unattended, etc.

(4) SoonerRide NEMT is not responsible for arranging for an attendant. The services of the attendant are not directly reimbursable by the SoonerRide program or SoonerCare. The cost for the attendant is included in the SoonerCare long-term care facility per diem rate.

(5) In certain instances, a family member or legal guardian may wish to accompany the member for health care services. In such instances, the family member or legal guardian may accompany the member in place of the attendant. Only one (1) medical escort may accompany a member and it must be declared, upon reservation, that the medical escort is accompanying the member. The medical escort must be able to provide any services and assistance necessary to assure the safety of the member in the vehicle.

(A) When a medical escort wishes to accompany the member in place of an attendant provided by the long-term care facility, the medical escort and the long-term care facility must sign a release form stating that a medical escort will be traveling with the member and performing the services which would normally be performed by the attendant. This release must be faxed to the SoonerRide broker's business office prior to the date of the transport.

(B) If a medical escort is used in place of an attendant provided by the long-term care facility, that medical escort cannot be counted as a medical escort for any other member who is traveling in the same vehicle.

(C) In the event that additional individuals request transportation, it is the responsibility of the member to contact the transportation provider directly to request allotment of additional passengers. The SoonerRide NEMT broker will not facilitate this request.

(D) A medical escort or attendant is not eligible for direct compensation by the SoonerRide NEMT broker or SoonerCare.

(b) For members who require SoonerRide NEMT for dialysis, one (1) attendant is required to accompany a group of up to three (3) dialysis patients when they are being transported for dialysis services. The attendant must remain with the patient(s) unless the provider of the dialysis treatment and the long-term care facility sign a release form stating that the presence of the attendant is not necessary during the dialysis treatment. The release must be faxed to the SoonerRide NEMT

broker's business office prior to the date of the dialysis service.

(1) In instances when an attendant does not remain with the member(s) during dialysis treatment, SoonerRide NEMT is not responsible for transporting the attendant back to the long-term care facility.

(2) In instances when an attendant does not remain with the member(s) during dialysis treatment, the long-term care facility is responsible for providing an attendant to accompany the member(s) on the return trip from the dialysis center. The long-term care facility is also responsible for transporting that attendant to the dialysis center in order to accompany the member(s) on the return trip.

(c) In the event that a member is voluntarily moving from one (1) long-term care facility to another, SoonerRide will provide NEMT to the new facility. The long-term care facility that the member is moving from will be responsible for scheduling the transportation and providing an attendant for the member.

(d) In the event that a long-term care facility's license is terminated, SoonerRide will provide NEMT to a new long-term care facility. The long-term care facility that the member is moving from will be responsible for scheduling the NEMT through SoonerRide and providing an attendant to accompany the member. SoonerRide is only responsible for transporting the member. Personal belongings and/or durable medical equipment (with the exception of portable oxygen or a wheelchair that is medically necessary for transportation) will not be transported through SoonerRide NEMT.

(e) The long-term care facility is responsible for providing a wheelchair when needed. This item is not provided by the SoonerRide NEMT transport.

[Source: Added at 24 Ok Reg 2095, eff 6-25-07 ; Amended at 38 Ok Reg 992, eff 9-1-21]

317:30-5-327.4. Coverage for children

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

(b) 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. For more information regarding experimental or investigational including clinical trials, see Oklahoma Administrative Code 317:30-3-57.1.

[Source: Added at 24 Ok Reg 2095, eff 6-25-07 ; Amended at 38 Ok Reg 970, eff 9-1-21]

317:30-5-327.5. Exclusions from SoonerRide NET [REVOKED]

[Source: Added at 24 Ok Reg 2095, eff 6-25-07 ; Amended at 25 Ok Reg 659, eff 1-18-08 through 7-14-08 (emergency)¹; Amended at 25 Ok Reg 2674, eff 7-25-08 ; Revoked at 38 Ok Reg 992, eff 9-1-21]

Editor's Note: ¹*This emergency action expired on 7-14-08 before being superseded by a permanent action. Upon expiration of an emergency amendatory action, the last effective permanent text is reinstated. Therefore, on 7-15-08 (after the 7-14-08 expiration of the emergency action), the text of 317:30-5-327.5 reverted back to the permanent text that became effective 6-25-07, as was last published in the 2007 OAC Supplement, and remained as such until amended again by permanent action on 7-25-08.*

317:30-5-327.6. Denial of SoonerRide NEMT services by the SoonerRide broker

(a) In addition to the exclusions listed in Oklahoma Administrative Code (OAC) 317:30-5-327.1 (f) (1) - (4) of this Part, the SoonerRide NEMT broker may deny NEMT services if:

- (1) The long-term care facility/member refuses to cooperate in determining the member's eligibility;
- (2) The long-term care facility/member refuses to provide the documentation required to determine the medical necessity for NEMT services;
- (3) The member, medical escort, attendant, or service animal exhibits uncooperative behavior or misuses/abuses NEMT services;
- (4) The member is not ready to board the NEMT transport at the scheduled time or within fifteen (15) minutes after the scheduled pick up time;
- (5) The member has not shown or cancelled previous appointments less than twenty-four (24) hours prior to the appointment, or has cancelled three (3) times within a ninety (90) day period, upon the SoonerRide NEMT transport's arrival at the member's residence; or
- (6) The long-term care facility/member fails to request a reservation at least three (3) days in advance of a health care appointment without good cause. Good cause is created by factors such as, but not limited to, any of the following:
 - (A) Urgent care;
 - (B) Post-surgical and/or medical follow up care specified by a health care provider to occur in fewer than three (3) days;
 - (C) Imminent availability of an appointment with a specialist when the next available appointment would require a delay of two (2) weeks or more; and
 - (D) The result of administrative or technical delay caused by SoonerRide and requiring that an appointment be rescheduled.
- (7) All requests, provided with or without good cause, are subject to availability and resources.

(b) Pursuant to Federal law, SoonerRide will provide notification in writing to long-term care facilities/members when services have been denied. This notification must include the specific reason for the denial and the member's right to appeal.

(1) An appeal must be filed with the Oklahoma Health Care Authority (OHCA) in accordance with OAC 317:2-1-2.

(2) The appropriateness of transportation may be appealed only to the extent that the transportation does not meet the medical needs of the member. Dissatisfaction with the use of public transportation, shared rides, type of vehicle, etc., is not appropriate grounds for appeal.

(3) The OHCA's decision is final. This decision may be appealed to the chief executive officer of the OHCA pursuant to OAC 317:2-1-13.

(c) The agency contracts directly with ambulance and air providers for all other transportation needs for eligible members not approved by SoonerRide NEMT. Please refer to Subchapter 5, Part 33, Transportation by Ambulance, of this Chapter.

[Source: Added at 24 Ok Reg 2095, eff 6-25-07 ; Amended at 38 Ok Reg 992, eff 9-1-21]

317:30-5-327.7. SoonerRide provider network

(a) The SoonerRide broker will maintain an adequate number of appropriate network providers to provide non-emergency, non-ambulance transportation services for eligible members.

(b) If a nursing facility has the capability to provide non-emergency, non-ambulance transportation, the SoonerRide broker may contract with the nursing facility as a NET network provider. The nursing facility must meet the same standards as any other SoonerRide contracted provider for vehicle and driver licensing, safety, training, liability, and ADA regulations. Additionally, when a nursing facility is contracted as a NET provider, the nursing facility cannot limit transportation services to members of a specific nursing facility, but must have the same availability as any other contracted network provider except for the transportation of members for dialysis services.

(c) SoonerRide may contract with other transportation providers solely for the non-emergency, non-ambulance transportation of members for dialysis services.

[Source: Added at 24 Ok Reg 2095, eff 6-25-07]

317:30-5-327.8. Type of services provided and duties of the SoonerRide NEMT driver

(a) The SoonerRide NEMT program shall not exceed curb-to-curb services. This service will be determined by the SoonerRide NEMT broker.

(1) Curb-to-curb services are defined as services for which the vehicle picks up and discharges the passengers at the curb or driveway in front of their place of residence or destination.

- (A) The SoonerRide NEMT driver will open and close the vehicle doors, load or provide assistance with loading adaptive equipment.
 - (B) The SoonerRide NEMT driver may fasten and unfasten safety restraints when that service is requested by the rider or on behalf of the rider.
- (2) Curb-to-curb services are limited to the first thirty (30) days of NEMT eligibility. After thirty (30) days, the member may be required to utilize public transportation. Exceptions to this include:
- (A) The member's residence is outside of three-fourths (3/4) of a mile from the public transportation stop; or
 - (B) The medical appointment is outside of three-fourths (3/4) of a mile from the transportation stop.
- (3) If a letter of medical necessity is provided by the member's medical provider as to the need of curb-to-curb services, when the exceptions listed in Oklahoma Administrative Code 317:30-5-327.8 (a) (2) (A) and (B) are applicable, the approval must be confirmed by the Oklahoma Health Care Authority (OHCA).
- (b) If the member is traveling by lift van, the SoonerRide NEMT driver will load and unload the member according to established protocols for such procedures approved by the OHCA.
- (c) The SoonerRide NEMT driver will deliver the member to the scheduled destination, and is not required to remain with the member.
- (d) The SoonerRide NEMT driver does not provide assistance to passengers along walkways or steps to the door of the residence or other destination.

[Source: Added at 24 Ok Reg 2095, eff 6-25-07 ; Amended at 38 Ok Reg 992, eff 9-1-21]

317:30-5-327.9. Scheduling NEMT services through SoonerRide

- (a) The long-term care facility/member will schedule SoonerRide NEMT services for transportation to covered services. SoonerRide NEMT services may be scheduled by calling the toll free SoonerRide number or by faxing a request to SoonerRide.
- (b) All SoonerRide NEMT routine services must be scheduled by advance appointment. Appointments must be made at least three (3) business days in advance of the health care appointment, but may be scheduled up to fourteen (14) business days in advance. Scheduling for members with standing appointments may be scheduled for those appointments beyond the fourteen (14) days.
- (c) NEMT services for eligible members will be scheduled and obtained through the SoonerRide NEMT program. The long-term care facility/member will be financially responsible for NEMT services which are not scheduled for eligible members through the SoonerRide program. The long-term care facility may not charge the member or member's family for NEMT services which were not paid for by SoonerRide because they were not scheduled through SoonerRide in the appropriate manner.
- (d) The long-term care facility/member must provide wheelchairs or car seats when needed. These items will not be provided by the SoonerRide

NEMT transport.

(e) Whenever possible SoonerRide will give consideration for members who request NEMT for routine care and the request is made less than three (3) business days in advance of the appointment. However, such requests for service are not guaranteed and will depend on the availability of space and resources, as well as, the distance to the medical appointment.

(f) If SoonerRide cannot provide NEMT for urgent care, the long-term care facility/member may provide the NEMT transportation and submit proper documentation to SoonerRide for reimbursement. In such cases the long-term care facility/member must attempt to schedule the service through SoonerRide first, and obtain a reference number or the service must have become necessary during a time that SoonerRide scheduling was unavailable, such as after hours or weekends. For NEMT for urgent services provided after hours or on weekends, the long-term care facility/member must notify SoonerRide within two (2) business days of the date of service.

[Source: Added at 24 Ok Reg 2095, eff 6-25-07 ; Amended at 38 Ok Reg 992, eff 9-1-21]

317:30-5-328. Subsistence (sleeping accommodations and meals) [REVOKED]

[Source: Revoked at 30 Ok Reg 1129, eff 7-1-13]

PART 33. TRANSPORTATION BY AMBULANCE

317:30-5-335. Eligible providers

To be eligible for reimbursement, all ambulance service suppliers that operate air, water or ground services (including stretcher service) must be licensed by the State Department of Health (OSDH) consistent with the level of care they provide, in accordance with the Oklahoma Emergency Response System Development Act of 2005, 63 OS 1-2503. Ambulance suppliers that do not provide services in Oklahoma must be licensed by the appropriate agency in the state in which they provide services. Ambulance companies and all other transportation providers must have a current contract on file with the Oklahoma Health Care Authority (OHCA). Air Ambulance providers must indicate on the application for enrollment that they are requesting fixed wing or rotary wing ambulance status and provide a copy of their license with their enrollment application.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 23 Ok Reg 265, eff 10-3-05 (emergency); Added at 23 Ok Reg 1360, eff 5-25-06 ; Amended at 24 Ok Reg 601, eff 12-21-06 (emergency); Amended at 24 Ok Reg 920, eff 5-11-07]

317:30-5-335.1. Definitions

The following words and terms, when used in this subchapter shall have the following meaning, unless the context clearly indicates otherwise.

"Ambulance" means a motor vehicle, watercraft, or aircraft that is primarily used or designated as available to provide transportation and basic life support or advanced life support.

"Bed confined" means that the member is unable to get up from bed without assistance, unable to ambulate, and unable to sit in a chair or wheelchair. The term bed confined is not synonymous with bed rest or non-ambulatory.

"Continuous or round trip" means an ambulance service in which the member is transported to the hospital, the physician deems it medically necessary for the ambulance to wait, and the member is then transported to a more appropriate facility for care or back to the place of origin.

"Emergency/ Emergent" means a serious situation or occurrence that happens unexpectedly and demands immediate action such as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected, by a reasonable and prudent layperson, to result in placing the member's health in serious jeopardy, serious impairment to bodily function, or serious dysfunction of any bodily organ or part.

"Emergency transfer" means the movement of an acutely ill or injured member from the scene to a health care facility (pre-hospital), or the movement of an acutely ill or injured member from one health care facility to another health care facility (inter-facility).

"Loaded mileage" means the number of miles for which the member is transported in the ambulance.

"Locality" means the service area surrounding the facility from which individuals normally travel or are expected to travel to seek medical care.

"Medically necessary transport" means an ambulance transport that is required because no other effective and less costly mode of transportation can be used due to the member's medical condition. The transport is required to transfer the member to and/or from a medically necessary service not available at the primary location.

"Nearest appropriate facility" means that the receiving institution is generally equipped to provide the needed hospital or skilled nursing care for the illness or injury involved. In the case of a hospital, it also means that a physician or physician specialist is available to provide the necessary care required to treat the member's condition. The fact that a particular physician does or does not have staff privileges in a hospital is not a consideration in determining whether the hospital has appropriate facilities. Thus, ambulance service to a more distant hospital solely to avail a member of the service of a specific physician or physician specialist does not make the hospital in which the physician has staff privileges the nearest hospital with appropriate facilities.

"Non-emergency transfer" means the movement of any member in an ambulance other than an emergency transfer.

"Stretcher service" means a non-emergency transport by a ground vehicle that is approved by the OSDH which is designed and equipped to transport individuals on a stretcher or gurney type apparatus that is operated to accommodate an incapacitated or disabled

person who does not require medical monitoring, aid, care or treatment during transport.

[Source: Added at 24 Ok Reg 303, eff 12-1-06 (emergency); Added at 24 Ok Reg 601, eff 12-21-06 (emergency); Added at 24 Ok Reg 920, eff 5-11-07 ; Amended at 30 Ok Reg 1164, eff 7-1-13]

317:30-5-336. General coverage

(a) OHCA covers ground and air ambulance transportation services, within certain limitations.

(1) Ambulance and stretcher transportation is covered only when medically necessary and when due to the member's condition any other method of transportation is contraindicated.

(2) As a general rule ambulance transportation to the nearest appropriate facility in the locality is covered. OHCA utilizes the locality areas as defined by Medicare.

(b) OHCA recognizes different levels of ambulance medical services by qualified ambulance staff according to the standards established by law and regulation through the Oklahoma Emergency Response System Development Act of 2005, '63 OS 1-2503.

(c) Ambulance medical services are divided into different levels for payment purposes. Payment is made according to the medically necessary services actually furnished. That is, payment is based on the level of service furnished, not simply on the vehicle used.

(d) Ambulance providers must maintain documentation of the medical necessity and appropriateness of service in the member's file.

(e) Clinical decisions can be made without delay if documentation to support coverage and medical necessity is submitted as part of the initial claim form. This may be accomplished by submitting supporting detailed documentation regarding the member's condition and need for ambulance/stretcher transport.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 23 Ok Reg 265, eff 10-3-05 (emergency); Added at 23 Ok Reg 1360, eff 5-25-06 ; Amended at 24 Ok Reg 601, eff 12-21-06 (emergency); Amended at 24 Ok Reg 920, eff 5-11-07]

317:30-5-336.1. Medical necessity

(a) The member's condition must require the ambulance/stretcher transportation itself and the level of service provided, in order for the billed service to be considered medically necessary. Medical necessity is established when the member's condition is such that the use of any other method of transportation is contraindicated.

(b) The medical personnel in attendance, including the Emergency Medical Technician (EMT) at the scene of an emergency, determine medical necessity and appropriateness of service within the scope of accepted medical practice and SoonerCare guidelines.

(c) Non-emergency transports are not covered unless the member is bed confined or has a medical condition that requires medical expertise not available with a less specialized method of transportation. Medical necessity for non-emergency transports must be substantiated with a physician's written order.

[Source: Added at 24 Ok Reg 601, eff 12-21-06 (emergency); Added at 24 Ok Reg 920, eff 5-11-07]

317:30-5-336.10. Fixed wing air ambulance services

(a) Fixed wing air ambulance transports must be approved by OHCA.

This approval is contingent upon medical necessity.

(b) Ambulance transport in a fixed wing aircraft is a covered service if the following requirements are met:

- (1) The transport, including ancillary services (e.g. flight nurse), is ordered by a physician.
- (2) The written physician order is maintained in the member's file.
- (3) Transport by ground vehicle would endanger the member's life due to time and distance from the hospital.
- (4) Medically necessary care or services for the member's medical condition cannot be provided by a local facility.

[Source: Added at 24 Ok Reg 601, eff 12-21-06 (emergency); Added at 24 Ok Reg 920, eff 5-11-07 ; Amended at 28 Ok Reg 1489, eff 6-25-11]

317:30-5-336.11. Rotary wing air ambulance

Rotary wing air ambulance services are covered by the OHCA only under the following circumstances:

- (1) Time and distance in a ground ambulance would be a hazard to the life of the member;
- (2) The medically necessary care and services for the member's need are not available at the local hospital, and;
- (3) The transfer is for medical or surgical procedures, not solely for diagnostic services only.

[Source: Added at 24 Ok Reg 601, eff 12-21-06 (emergency); Added at 24 Ok Reg 920, eff 5-11-07]

317:30-5-336.12. Non-emergency ambulance and stretcher service transportation

(a) OHCA covers non-emergency ground, stretcher and air transportation to and from a medically necessary service. To be covered, the member must be either:

- (1) bed confined and unable to use another means of transportation, or
- (2) the member's condition must warrant ambulance transportation.

(b) OHCA's Non-emergency Transportation (NET) program, known as SoonerRide, is the first choice for non-emergency transportation for scheduled medical services. SoonerRide provides non-emergency transportation in accordance with all applicable criteria set forth in the American's with Disabilities Act (ADA).

(c) Regularly scheduled non-emergency medical services, such as outpatient dialysis, must be scheduled through SoonerRide unless the member's condition requires transport by stretcher or ambulance. All claims for scheduled trips for outpatient services that cannot be provided by SoonerRide must be accompanied by the medical documentation to

substantiate the need for the higher level of transportation and will be reviewed prior to payment by OHCA.

(d) Ambulance or stretcher transport for unscheduled emergent medical care is covered if the trip meets all applicable criteria.

[Source: Added at 24 Ok Reg 601, eff 12-21-06 (emergency); Added at 24 Ok Reg 920, eff 5-11-07]

317:30-5-336.13. Non-covered services

(a) Ambulance transportation from residence to residence is not covered except for transfers from nursing home to nursing home when the transferring facility is not certified.

(b) Payment will not be made for ambulance transportation determined not to be medically necessary.

(c) Transportation to a funeral home, mortuary, or morgue is not covered.

[Source: Added at 24 Ok Reg 601, eff 12-21-06 (emergency); Added at 24 Ok Reg 920, eff 5-11-07 ; Amended at 30 Ok Reg 1164, eff 7-1-13]

317:30-5-336.2. Nearest appropriate facility

(a) OHCA covers transportation to the nearest facility that can appropriately treat the member.

(b) An institution is not considered an appropriate facility if the member's condition requires a higher level of care or specialized services available at the more distant hospital. However, a legal impediment barring a member's admission would mean that the institution did not have "appropriate facilities". For example, the nearest transplant center may be in another state and that state's law precludes admission of nonresidents.

(c) An institution is not considered an appropriate facility if no bed is available. However, the medical records must be properly documented.

[Source: Added at 24 Ok Reg 601, eff 12-21-06 (emergency); Added at 24 Ok Reg 920, eff 5-11-07]

317:30-5-336.3. Destination and transport outside of locality

(a) Transportation is covered from the point of origin to the Hospital, Critical Access Hospital or Nursing Facility that is capable of providing the required level and type of care for the member.

(b) Ambulance transportation from a hospital with a higher level of care to a hospital with a lower level of care in the locality is covered, provided all other criteria are met and approved by the OHCA.

(c) Non-emergency transportation to the outpatient facilities of a Hospital, free-standing Ambulatory Surgery Center (ASC), Independent Diagnostic Testing Facility (IDTF), Physician's office or other outpatient facility is compensable if the member's condition necessitates ambulance or stretcher transportation and all other conditions are met.

(d) Ambulance Transportation to a Veteran's Administration (VA) Hospital is covered when the trip has not been authorized by the VA.

(e) If ambulance transportation is provided out of the transport locality, the claim must be documented with the reason for the transport outside of the service area.

(f) If it is determined the member was transported out of locality and the closest facility could have cared for the member, payment will be made only for the distance to the nearest medical institution with the appropriate facilities.

(g) Any transportation which begins or ends outside of the Oklahoma geographic border requires prior authorization. The exception to this rule is if transportation begins or ends within one hundred (100) miles of Oklahoma's geographic border, no prior authorization is required.

[Source: Added at 24 Ok Reg 601, eff 12-21-06 (emergency); Added at 24 Ok Reg 920, eff 5-11-07 ; Amended at 40 Ok Reg 2172, eff 9-11-23]

317:30-5-336.4. Transport outside of locality [REVOKED]

[Source: Added at 24 Ok Reg 601, eff 12-21-06 (emergency); Added at 24 Ok Reg 920, eff 5-11-07 ; Amended at 30 Ok Reg 1164, eff 7-1-13 ; Revoked at 40 Ok Reg 2172, eff 9-11-23]

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) 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.

[Source: Added at 24 Ok Reg 601, eff 12-21-06 (emergency); Added at 24 Ok Reg 920, eff 5-11-07 ; Amended at 26 Ok Reg 261, eff 12-1-08 (emergency); Amended at 26 Ok Reg 1065, eff 5-11-09 ; Amended at 30 Ok Reg 1164, eff 7-1-13]

317:30-5-336.6. Mileage

(a) Charges for mileage must be based on loaded mileage only, i.e., from the pickup of a member to his/her arrival at the destination.

(b) Coverage is allowed only to the nearest appropriate facility.

[Source: Added at 24 Ok Reg 601, eff 12-21-06 (emergency); Added at 24 Ok Reg 920, eff 5-11-07]

317:30-5-336.7. Waiting time

(a) Waiting time is reimbursable after the first 30 minutes when a physician deems it medically necessary for the ambulance provider to wait at a hospital while the member is being stabilized, with the intent of continuing the member's transport to an appropriate hospital for care or back to the point of origin.

(b) The maximum number of hours allowed for waiting time is four hours.

[Source: Added at 24 Ok Reg 601, eff 12-21-06 (emergency); Added at 24 Ok Reg 920, eff 5-11-07]

317:30-5-336.8. Special situations

(a) Continuous or round trip transport.

(1) If a member is transported to a destination and returned to their original point of pickup, coverage includes payment for the primary transport and the return transport.

(2) If the provider is required to remain and attend the member between transports, the provider may claim waiting time.

(b) Nursing facility.

(1) Ambulance or stretcher transportation from nursing home to nursing home (skilled or intermediate care) is covered if the discharging institution is not certified and the admitting nursing home is certified.

(2) Nursing home to nursing home transports are covered if the member requires care not available at the discharging facility, and the member's medical status requires ambulance transport.

(c) Multiple members per transport.

(1) When more than one eligible member is transported at the same time, the only acceptable duplication of charges is half the base rate.

(2) Separate claims must be submitted for each member.

(3) No mileage or waiting time is to be charged for additional members. These services are included in the reimbursement of the first claim.

(d) **Multiple transports per member.** More than one transport per member on the same date of service is covered when the member received a different level of service on each transport (e.g., Advanced Life Support 1 and Basic Life Support). When more than one transport with the same level of care occurs on the same day medical necessity must be documented.

(e) **Multiple arrivals.** When multiple units respond to a call for services, only the entity that actually provides services for the member may bill and be paid for the services by the OHCA. The entity that rendered service/care bills for all services furnished.

(f) **No transport.** If member refuses treatment after immediate aid has been provided the ambulance may bill the base rate for the level of service and waiting time.

(g) Pronouncement of death.

(1) If the member dies before dispatch, no payment is available.

(2) If the member dies after dispatch, but before the member is loaded, payment is allowed for the base rate but no mileage.

(3) If the member dies after pickup, payment is available for the base rate and mileage.

(4) Time of death is the point at which the member is pronounced dead by an individual authorized by the state to make such pronouncements.

(h) Out of state transports.

(1) Out of state, non-emergency transports require prior authorization.

(2) The ambulance provider, home health agency, hospital, nursing facility, physician, case manager or social worker may

request this authorization. The ambulance provider must retain the physician's order of medical necessity in the member's file to support the need for ambulance transportation.

(3) When a member is transported by ground ambulance to or from an air ambulance for out-of-state services, the ground and air ambulance providers providing the transports must bill OHCA independently. When the OHCA is unable to contract for the out-of-state ground transport, the ground and air ambulance charges (air service, medical team, ground transportation) may be consolidated and billed when the following conditions apply.

(A) The air ambulance provider furnishing air transportation (hereafter referred to as "the entity") arranges for ground transportation services and has a contract on file with the OHCA to subcontract for ground ambulance;

(B) The contract includes the requirement that the entity certifies that the ground transportation provider meets the minimum state licensure requirements in the state in which the service is provided;

(C) The entity certifies that the payment will be made to the ground provider;

(i) Neonatal transports.

(1) Coverage of neonatal transport includes neonatal base rate, loaded mileage, transfer isolette, and waiting time.

(2) The intensive care transport of critically ill neonate(s) (i.e. newborns to approved, designated neonatal intensive care units) is a covered service.

(3) When a trained hospital medical team from the receiving or transferring hospital accompanies a newborn on the transport ambulance services, the primary care of the newborn is the hospital team's responsibility, reimbursement for the hospital team is made to the hospital as part of the hospital rate.

[Source: Added at 24 Ok Reg 601, eff 12-21-06 (emergency); Added at 24 Ok Reg 920, eff 5-11-07]

317:30-5-336.9. Air ambulance

(a) Air Ambulance service, which includes fixed and rotary wing transportation, are covered only when:

(1) The point of pickup is inaccessible by land vehicle; or,

(2) Great distances or other obstacles are involved in getting the member to the nearest hospital with appropriate facilities and timely admission is essential; i.e., in cases where transportation by land ambulance is contraindicated; or

(3) The member's medical condition and other circumstances of the case necessitated the use of this type of transportation.

However, where land ambulance service would have sufficed, payment is based on the amount payable for land ambulance, if this is less costly.

(b) Only one base rate is allowed per trip. Base rate includes the lift off, professional intensive care, transport isolate, ventilator setup,

respiratory setup, and all other medical services provided during the flight. No additional payment is made to the air service provider for bedside to bedside service.

(c) If the accident scene is inaccessible by air and a land ambulance must pick up the member to transport to a site where the air ambulance can land, the land ambulance trip is covered. Air transportation is covered only to a hospital in this situation.

[Source: Added at 24 Ok Reg 601, eff 12-21-06 (emergency); Added at 24 Ok Reg 920, eff 5-11-07]

317:30-5-337. Coverage for children

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

(b) 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. For more information regarding experimental or investigational including clinical trials, see Oklahoma Administrative Code 317:30-3-57.1.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 24 Ok Reg 601, eff 12-21-06 (emergency); Amended at 24 Ok Reg 920, eff 5-11-07 ; Amended at 38 Ok Reg 970, eff 9-1-21]

317:30-5-338. Vocational rehabilitation coverage [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 19 Ok Reg 2134, eff 6-27-02]

317:30-5-339. Individuals eligible for Part B of Medicare

Payment for ambulance transportation is made using current Medicare methodology.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 19 Ok Reg 2922, eff 7-1-02 (emergency); Amended at 20 Ok Reg 1193, eff 5-27-03 ; Amended at 24 Ok Reg 601, eff 12-21-06 (emergency); Amended at 24 Ok Reg 920, eff 5-11-07]

317:30-5-340. Procedure codes [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 19 Ok Reg 2134, eff 6-27-02]

317:30-5-341. Claim form [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 19 Ok Reg 2134, eff 6-27-02]

317:30-5-342. Public transportation [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 23 Ok Reg 265, eff 10-3-05 (emergency); Revoked at 23 Ok Reg 1360, eff 5-25-06]

317:30-5-343. Reimbursement

Payment is made at the lower of the provider's usual and customary charge or the OHCA's fee schedule.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 23 Ok Reg 265, eff 10-3-05 (emergency); Added at 23 Ok Reg 1360, eff 5-25-06]

317:30-5-344. Ground Emergency Medical Transportation (GEMT) supplemental payment program

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

(1) **"Advanced life support"** means emergency medical care and services which are provided by a licensed ground ambulance services provider in accordance with Oklahoma Administrative Code (OAC) 310:641, to include, but not limited to, advanced airway management, intravenous therapy, administration of drugs and other medicinal preparations, and other invasive medical procedures and specified techniques that are limited to the Intermediate, Advanced EMT, and Paramedic scope of practice in accordance with OAC 310:641, Subchapter 5.

(2) **"Allowable costs"** means an expenditure that complies with the regulatory principles as listed in Title 2 of the Code of Federal Regulations (C.F.R.), Section 200.

(3) **"Basic life support"** means emergency medical care and services which are provided by a licensed ground ambulance service in accordance with OAC 310:641 to include, but not limited to, cardiopulmonary resuscitation procedures (CPR), hemorrhage control, stabilization of actual or possible skeletal injuries, spinal immobilization, extrication, transportation, and other non-invasive medical care.

(4) **"Contracts with a local government"** means contracts pursuant to a county plan for ambulance and emergency medical services with a:

(A) City, county, or an Indian tribe as defined in Section 4 of the Indian Self-Determination and Education Assistance Act; or

(B) Local service district, including, but not limited to, a rural fire protection district, or all administrative subdivisions of such city, county, or local service district.

(5) **"Eligible GEMT provider"** means a GEMT provider that meets all eligibility requirements in OAC 317:30-5-344 and the Oklahoma Medicaid State Plan (State Plan).

(6) "**Federal financial participation (FFP)**" means the portion of medical assistance expenditures for emergency medical services that are paid or reimbursed by the Centers for Medicare and Medicaid Services (CMS) in accordance with the State Plan.

(7) "**GEMT services**" means the act of transporting an individual by ground from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient, as well as the advanced, limited-advanced, and basic life support services provided to an individual by eligible GEMT providers before or during the act of transportation.

(8) "**Governmental unit**" means the entire state, local, or federally-recognized Indian tribal government, including any component thereof.

(9) "**Publicly owned or operated**" means a unit of government that is a state, a city, a county, a special purpose district, or other governmental unit in a state that has taxing authority, has direct access to tax revenues, or is an Indian tribe as defined in Section 4 of the Indian Self-Determination and Education Assistance Act.

(b) **Purpose.** In accordance with 63 Oklahoma Statutes (O.S.) § 3242, the GEMT Supplemental Payment Program is a voluntary program which makes supplemental payments above the Medicaid fee schedule reimbursement rate to eligible GEMT providers for specific allowable, certified, and uncompensated costs incurred for providing GEMT Services to SoonerCare members.

(c) **Provider eligibility.** To be eligible for supplemental payments, a GEMT provider must meet all of the following requirements:

- (1) Be enrolled as an Oklahoma SoonerCare provider for the time period claimed on its annual cost report;
- (2) Provide ground ambulance transportation services to SoonerCare members;
- (3) Be classified as a governmental unit provider in accordance with 2 C.F.R. 200;
- (4) Comply with all applicable state and federal law;
- (5) Be an organization that:
 - (A) Is publicly owned or operated; or
 - (B) Is under contract with a local government unit. A copy of any such contract must be submitted to the Oklahoma Health Care Authority (OHCA) simultaneous with the submission of the GEMT provider's annual cost report; and
- (6) Timely submit all relevant information requested by the OHCA, in the format as prescribed by the OHCA, including, but not limited to, a certification that conforms with 42 C.F.R. § 433.51 that certifies that the claimed expenditures for GEMT Services are eligible for FFP.

(d) **Allowable costs.**

- (1) Supplemental payments provided by this program are available only for the specific allowable costs per medical transport of a SoonerCare member that are in excess of the reimbursement paid by Medicaid and all other insurers and/or third-party resources.

(2) Total reimbursement from SoonerCare, including the supplemental payment, when combined with all other sources of reimbursement, must not exceed one-hundred percent (100%) of actual costs of providing services to SoonerCare members.

(e) Payments and recoupment.

(1) The OHCA will make annual supplemental payments after the conclusion of each state fiscal year (SFY) and in accordance with the methodology outlined in the State Plan. The payments will be made in the form of an interim payment and a later reconciliation payment (i.e., settle-up payment). The payments are not an increase to current fee-for-service (FFS) reimbursement rates.

(2) The interim supplemental payment will be equal to seventy-five percent (75%) of the total allowable costs as indicated on the annual approved cost report.

(3) The reconciliation payment will be computed by the OHCA based on the difference between the interim supplemental payment and total allowable costs from the approved cost report.

(4) Any excess payments determined in the reconciliation process are recouped and the federal share is returned to CMS.

(5) Cost reconciliation and cost settlement processes will be completed within twelve (12) months of the end of the cost reporting period.

(f) Reporting requirements.

(1) Eligible GEMT providers will:

(A) Submit a CMS-approved cost report annually, no later than ninety (90) days after the close of the SFY, on a form approved by the OHCA, unless a provider has made a written request for an extension and such request is granted by the OHCA;

(i) After the ninety (90) day deadline, an extension of no more than fifteen (15) calendar days can be granted; and

(ii) Extensions of time shall be requested by a letter addressed to the Finance Division. Any such request must be received by October 1, and must explain the good faith reason for the extension.

OHCA shall provide a written notice of any denial of a request for an extension, which shall become effective on the date it is mailed.

(B) Provide supporting documentation simultaneous with the cost report, as required by the OHCA;

(C) Keep, maintain, and have readily retrievable, such records as specified by the OHCA to fully disclose reimbursement amounts to which the eligible governmental entity is entitled, and any other records required by CMS; and

(D) Comply with the allowable cost requirements provided in 42 C.F.R. Part 413, 2 C.F.R. Part 200, and federal Medicaid non-institutional reimbursement policy.

(2) Penalties for false statements or misrepresentations made by or on behalf of the provider are established by 42 U.S.C. Section

1320a-7b which states, in part, "Whoever... (2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment...shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be under the program, be guilty of a felony and upon conviction thereof fined not more than \$100,000 or imprisoned for not more than 10 years or both, or (ii) in the case of such a statement, representation, concealment, failure, conversion, or provision of counsel or assistance by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than \$20,000 or imprisoned for not more than one (1) year, or both."

(g) **Agency responsibilities.** The OHCA will:

- (1) Submit claims to CMS based on total computable certified expenditures for GEMT services provided, that are allowable and in compliance with federal laws and regulations and Medicaid non-institutional reimbursement policy;
- (2) Submit on an annual basis, any necessary materials to the federal government to provide assurances that claims will include only those expenditures that are allowable under federal law; and
- (3) Complete the audit and final reconciliation process of the interim cost settlement payments for the services provided within twelve (12) months of the postmark date of the cost report and conduct on-site audits as necessary.

[Source: Added at 37 Ok Reg 1547, eff 9-14-20]

317:30-5-345. Ambulance Service Provider Access Payment Program (ASPAPP)

(a) **Purpose.** The Ambulance Service Provider Access Payment Program (ASPAPP) is an ambulance service provider (ASP) assessment fee that is eligible for federal matching funds when used to reimburse SoonerCare services in accordance with Section 3242.1 through 3242.6 of Title 63 of the Oklahoma Statutes (O.S.).

(b) **Definitions.** The following words and terms, when used in this Section shall have the following meaning, unless the context clearly indicates otherwise:

- (1) **"Air ambulance"** means ambulance services provided by fixed or rotor wing ambulance services.
- (2) **"Alliance"** means the Oklahoma Ambulance Alliance or its successor association.
- (3) **"Ambulance"** means a motor vehicle that is primarily used or designated as available to provide transportation and basic life support or advanced life support.
- (4) **"Ambulance service" or "ambulance service provider (ASP)"** means any private firm or governmental agency licensed by the Oklahoma State Department of Health (OSDH) to provide levels of medical care based on certification rules or standards

promulgated by the Oklahoma state Commissioner of Health.

(5) "**Emergency**" or "**emergent**" means a serious situation or occurrence that happens unexpectedly and demands immediate action, such as a medical condition manifesting itself by acute symptoms of sufficient severity including severe pain such that the absence of immediate medical attention could reasonably be expected, by a reasonable and prudent layperson, to result in placing the patient's health in serious jeopardy, serious impairment to bodily function or serious dysfunction of any bodily organ or part.

(6) "**Emergency transport**" means the movement of an acutely ill or injured patient from the scene to a health care facility or the movement of an acutely ill or injured patient from one health care facility to another health care facility.

(7) "**Medicaid**" means the medical assistance program established in Title XIX of the Social Security Act and administered in Oklahoma by the Oklahoma Health Care Authority (OHCA).

(8) "**Net operating revenue**" means the gross revenues earned for providing emergency transports in Oklahoma excluding revenues earned for providing air ambulance services, non-emergency transports, and amounts refunded to or recouped, offset, or otherwise deducted by a patient or payer for ground medical transportation.

(9) "**Non-emergency transport**" means the movement of any patient in an ambulance other than an emergency transport as defined in Part 33, 317:30-5-335.1.

(10) "**Upper payment limit**" means the lesser of the customary charges of the ASP or the prevailing charges in the locality of the ASP for comparable services under comparable circumstances, calculated according to methodology in an approved state plan amendment for the state Medicaid program.

(11) "**Upper payment limit gap**" means the difference between the upper payment limit of the ASP and the Medicaid payments not financed using the ASP assessments made to all ASPs, provided that the upper payment limit gap shall not include air ambulance services.

(c) **ASPAPP exemptions.**

(1) Pursuant to 63 O.S. §§ 3242.1 through 3242.6 the OHCA is mandated to assess ASPs licensed in Oklahoma pursuant to rules and standards promulgated by the Oklahoma state Commissioner of Health, unless exempted under (c) (2) of this Section, an ASP access payment program fee.

(2) The following ASPs are exempt from the ASPAPP fee:

(A) Owned or operated by the state or a state agency, the federal government, a federally recognized Indian tribe, or the Indian Health Service.

(B) Eligible for Supplemental Hospital Offset Payment Program (SHOPP) Medicaid reimbursement;

(C) Provides air ambulance services only; or

(D) Provides non-emergency transports only.

(d) The ASPAPP assessment.

(1) The ASPAPP assessment is imposed on each ambulance service provider, except those exempted under (c)(2) of this Section, for each calendar year in an amount calculated as a percentage of each ambulance service provider's net operating revenue.

(2) The assessment rate shall be determined annually based upon the percentage of net operating revenue needed to generate an amount up to the non-federal portion of the upper payment limit gap, plus the annual fee paid to OHCA for administrative expenses incurred in performing the activities, not to exceed \$200,000 each year, plus the state share of ASP access payments for ASPs that participate in the assessment. At no time will the assessment rate exceed the maximum rate allowed by federal law or regulation.

(3) OHCA will review and determine the amount of annual assessment in December of each year in consultation with the Oklahoma Ambulance Alliance.

(4) The annual assessment is due and payable quarterly. However, a payment of the assessment will not be due and payable until:

(A) OHCA issues written notice stating that the payment methodologies to the ASPs under 63 O.S. §§ 3242.1 through 3242.6 have been approved by the Centers for Medicare and Medicaid Services (CMS) and the waiver under 42 C.F.R. § 433.68 for the assessment, if necessary, has been granted by CMS.

(B) OHCA has made all quarterly installments of the ASP access payments that were otherwise due, consistent with the effective date of the approved state plan.

(5) The method of collection of net operating revenue is as follows:

(A) Annually, no later than January 31, OHCA will send all licensed ASPs the net operating revenue form. ASPs shall complete the forms and deliver them to OHCA or its contractor no later than March 31 of that year. ASPs that fail to return the net operating revenue form will have their assessment calculated based on the state per capita average assessment for that year. OHCA will send a notice of assessment to each ASP informing the provider of the assessment rate and the estimated annual amount owed by the ASP for the applicable calendar year.

(B) The first notice of assessment will be sent within forty-five (45) days of receipt by OHCA of notice from the Centers for Medicare and Medicaid Services that the payments under 63 O.S. §§ 3242.1 through 3242.6, and if necessary, the waiver granted under 42 C.F.R. § 433.68 have been approved.

(C) Annual notices of assessment will be sent at least forty-five (45) days before the due date for the first quarterly assessment payment of each calendar year. The ASP shall have thirty (30) days from the date of its receipt

of a notice of assessment to review and verify the assessment rate and the estimated assessment amount.
(D) If an ASP operates, conducts, or maintains more than one (1) ASP in the state, the ASP will pay the assessment for each ASP separately. However, if the ASP operates more than one (1) ASP under one (1) Medicaid provider number, the ASP provider may pay the assessment for all such ASPs in the aggregate.

- (6) The method of collection of the assessment fee is as follows:
- (A) After the initial installment has been paid, each subsequent quarterly payment of an assessment will be due and payable by the 15th day on the first month of the applicable quarter (i.e., January 15th, April 15th, etc.).
 - (B) Failure to pay the amount by the 15th or failure to have the payment mailing postmarked by the 13th will result in a debt to the State of Oklahoma and is subject to penalties of five percent (5%) of the amount and interest of one and one-quarter percent (1.25%) per month.

(e) Penalties and adjustments.

- (1) If an ASP fails to timely pay the full amount of a quarterly assessment, OHCA will add to the assessment:
 - (A) A penalty equal to five percent (5%) of the quarterly amount not paid on or before the due date, and
 - (B) An additional five percent (5%) penalty on any unpaid quarterly and unpaid penalty amounts on the last day of each quarter after the due date until the assessed amount and the penalty imposed under subpart (A) of this paragraph are paid in full.
- (2) The quarterly assessment including applicable penalties and interest must be paid regardless of any appeals action requested by the facility. If an ASP fails to pay the OHCA the assessment within the timeframes noted on the invoice to the provider, the assessment, applicable penalty, and interest will be deducted from the ASP's payment.
- (3) Any change in payment amount resulting from an appeals decision will be adjusted in future payments.
- (4) If Medicaid reimbursement rates are adjusted, ASP rates may not be adjusted less favorably than the average percentage-rate reduction or increase applicable to the majority of other provider groups.

(f) Closure, merger, and new Ambulance Service Providers (ASPs).

- (1) If an ASP ceases to operate as an ASP for any reason or ceases to be subject to the fee, the assessment for the year in which the cessation occurs is adjusted by multiplying the annual assessment by a fraction, the numerator of which is the number of days in the year during which the ASP is subject to the assessment and the denominator of which is three hundred sixty-five (365). Within thirty (30) days of ceasing to operate as an ASP, or otherwise ceasing to be subject to the assessment, the ASP will pay the assessment for the year as so adjusted, to the extent not

previously paid.

(2) The ASP also shall receive payments under 63 O.S. §§ 3242.1 through 3242.6, for the calendar year in which the cessation occurs, which will be adjusted by the same fraction as its annual assessment.

(3) For new ASPs, the OHCA will calculate revenue to be assessed based on the population of the county for which the ASP is licensed. The per capita amount will be assigned and calculated based on the average net operating revenue per capita for all other ASPs in the state that are currently being assessed. Average revenue per capita will be used in this way through the end of the second calendar year.

(4) Any assessment paid by a provider on revenue subject to another health care related tax as defined in 42 CFR § 433.68 shall be a credit against any assessment due under these rules.

(g) Disbursement of payment to ASPs.

(1) To preserve and improve access to ambulance services, for ambulance services rendered on or after the approval of the ASPAPP by CMS, OHCA shall make ASP payments as set forth in this section. These payments are considered supplemental payments and do not replace any currently authorized Medicaid payments for ambulance services.

(2) OHCA shall pay all quarterly ASP access payments within ten (10) calendar days of the due date for the quarterly assessment payments established in subsection (d) of this section.

(3) OHCA shall calculate the ASP access payment amount as the balance of the ASPAPP Fund plus any federal matching funds earned on the balance up to but not to exceed the upper payment limit gap for all ASPs.

(4) All ASPs shall be eligible for ASP access payments each year as set forth in this subsection except ambulance services excluded or exempted in subsection (c)(2) of this section.

(5) Access payments shall be made on a quarterly basis.

(6) ASPs eligible to receive ASP access payments are those providers:

(A) Subject to this assessment; and

(B) That apply to receive the ASP access payment as provided in Section 317:30-5-345.

(7) An application by the ASP shall be submitted to OHCA to be eligible to receive payments.

(A) Not less than one-hundred eighty (180) days prior to the beginning of each state fiscal year, OHCA will send all qualified licensed ASPs an application for ASP access payments.

(B) The application will:

(i) Allow the ASP to submit all information needed to calculate that ASP's average commercial rate;

(ii) Provide that the application must be received by OHCA on a date which will be no less than one-hundred twenty (120) days prior to the beginning of the calendar year;

- (iii) Explain that unless exempt from payment by law, the ASP will be required to pay the ASP assessment even if the provider fails to apply for the ASP access payments;
 - (iv) Explain that if the ASP fails to supply the Net Operating Revenue Survey, the assessment will be calculated based on the state per capita average assessment for that year; and
 - (v) Explain that the ASP will not be eligible to receive ASP access payments in the next calendar year if the application is not timely filed but will still be assessed based on the average assessment.
- (C) An ASP that has previously received ASP access payments is required to make an application for such payments and provide the revenue survey no less than every three (3) years.
- (8) The Average Commercial Rate will be calculated as follows:
- (A) The ASP access payment shall be determined in a manner to bring the payments for these services up to the average commercial rate level as described in Section 317:30-5-345. The average commercial rate level is defined as the average amount payable by the commercial payers for the same service.
 - (B) OHCA shall align the paid Medicaid claims with the Medicare fees for each healthcare common procedure coding system (HCPCS) or current procedure terminology (CPT) code for the ASP and calculate the Medicare payment for those claims.
 - (C) OHCA shall calculate an overall Medicare to commercial conversion factor for each qualifying ASP that submits an ASP access payment application by dividing the total amount of the average commercial payments for the claims by the total Medicare payments for the claims.
 - (D) The commercial to Medicare ratio for each provider will be redetermined every three (3) years.

[Source: Added at 40 Ok Reg 367, eff 11-4-22 (emergency); Added at 40 Ok Reg 2189, eff 9-11-23]

PART 34. SECURE BEHAVIORAL HEALTH TRANSPORTATION

317:30-5-347. Definitions

[Source: Added at 41 Ok Reg, Number 14, effective 3-8-24 (emergency)]

317:30-5-347. Definitions

[Source: Added at 41 Ok Reg, Number 14, effective 3-8-24 (emergency)]

317:30-5-348. Program overview

[Source: Added at 41 Ok Reg, Number 14, effective 3-8-24 (emergency)]

317:30-5-349. Program eligibility and covered services

[Source: Added at 41 Ok Reg, Number 14, effective 3-8-24 (emergency)]

317:30-5-350. Service requirements

[Source: Added at 41 Ok Reg, Number 14, effective 3-8-24 (emergency)]

317:30-5-351. Authorization and reimbursement

[Source: Added at 41 Ok Reg, Number 14, effective 3-8-24 (emergency)]

PART 35. RURAL HEALTH CLINICS

317:30-5-354. Definitions

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

"**APRN**" means advanced practice registered nurse.

"**C.F.R.**" means the U.S. Code of Federal Regulations.

"**CLIA**" means the Clinical Laboratory Improvement Amendments.

"**CMS**" means the Centers for Medicare and Medicaid Services.

"**CNM**" means certified nurse midwife.

"**Core services**" means outpatient services that may be covered when furnished to a patient at the rural health clinic (RHC) or other location, including the patient's place of residence.

"**CP**" means clinical psychologist.

"**CPT**" means current procedural terminology.

"**CSW**" means clinical social worker.

"**EPSDT**" means the Early and Periodic Screening, Diagnostic and Treatment program for members under twenty-one (21).

"**FFS**" means the current OHCA's fee-for-service reimbursement rate.

"**HCPCS**" means Healthcare Common Procedure Coding System.

"**OAC**" means the Oklahoma Administrative Code.

"**OHCA**" means the Oklahoma Health Care Authority.

"**Other ambulatory services**" means other outpatient health services covered under the Oklahoma Medicaid State Plan other than core services.

"**PA**" means physician assistant.

"**Physician**" means:

(A) A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which the function is performed or who is a licensed physician employed by the Public Health Service;

(B) Within limitations as to the specific services furnished, a doctor of dentistry or dental, a doctor of optometry, or a doctor of podiatry.

"Physicians' services" means professional services that are performed by a physician at the RHC (or are performed away from the Center, excluding inpatient hospital services) whose agreement with the RHC provides that he or she will be paid by the RHC for such services.

"PPS" means prospective payment system all-inclusive per visit rate method specified in the Oklahoma Medicaid State Plan.

"RHC" means rural health clinic.

"Visit" means a face-to-face encounter between a clinic patient and a physician, PA, APRN, CNM, CP or CSW whose services are reimbursed under the RHC payment method. Encounters with more than one (1) health care professional and multiple encounters with the same health care professional that take place on the same day and at a single location constitute a single visit, except when the patient, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

[Source: Added at 38 Ok Reg 1043, eff 9-1-21]

317:30-5-355. Eligible providers and staffing requirements

(a) **Eligible providers.** RHCs certified for participation in the Medicare Program are considered eligible for participation in the Medicaid Program. RHC conditions for certification are found in 42 C.F.R. Part 491. RHCs may be provider-based (i.e., clinics that are an integral part of a hospital, skilled nursing facility, or home health agency that participates in Medicare) or independent (freestanding) and may include Indian Health Clinics. To participate, an RHC must have a current contract on file with the OHCA.

(b) **Staffing requirements.** Eligible providers must follow all staffing and staff responsibilities in accordance with 42 C.F.R. § 491.8. Additional requirements for mid-level practitioners at the clinic include:

(1) A nurse practitioner, a physician assistant, or certified nurse-midwife must be available to furnish patient care services at least fifty percent (50%) of the time the clinic operates.

(2) An existing clinic may request a temporary waiver of these staffing requirements for a one (1) year period, if it demonstrates that it has been unable to hire a physician assistant, nurse-practitioner, or a certified nurse-midwife in the previous ninety (90) day period.

(3) A subsequent request for a waiver cannot be made less than six (6) months after the expiration date of any previous waiver of the mid-level staffing requirements for the clinic.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 13 Ok Reg 397, eff 11-14-95 (emergency); Amended at 13 Ok Reg 1645, eff 5-27-96 ; Amended at 1043 Ok Reg 9,]

317:30-5-355.1. RHC professional staff

(a) RHCs must either directly employ or contract the services of professional staff who is licensed or certified and in good standing in the state in which services are provided. Services must be within the scope of the professional's license or certification for which claims are submitted to OHCA or its designated agent.

(b) Professional staff contracted or employed by the RHC recognized by the OHCA for direct reimbursement are required to individually enroll with the OHCA and will be affiliated with the organization which contracts or employs them. Participating RHCs are required to submit a list of names upon request of all practitioners working within the RHC and a list of all individual OHCA provider numbers. Reimbursement for services rendered at or on behalf of the RHC is made to the organization. Practitioners eligible for direct reimbursement for providing services to a clinic patient outside of the clinic may bill with their individual assigned number if they are not compensated under agreement by the RHC.

(c) Other providers who are not eligible for direct reimbursement may be recognized by the OHCA for the provision and payment of RHC services to an RHC as long as they are licensed or certified in good standing and meet OHCA enrollment requirements.

[Source: Added at 13 Ok Reg 397, eff 11-14-95 (emergency); Added at 13 Ok Reg 1645, eff 5-27-96 ; Amended at 14 Ok Reg 3077, eff 7-1-97 (emergency); Amended at 15 Ok Reg 1528, eff 5-11-98 ; Amended at 16 Ok Reg 141, eff 10-14-98 (emergency); Amended at 16 Ok Reg 1429, eff 5-27-99 ; Amended at 24 Ok Reg 895, eff 5-11-07 ; Amended at 30 Ok Reg 1164, eff 7-1-13 ; Amended at 31 Ok Reg 657, eff 7-1-14 (emergency); Amended at 32 Ok Reg 1069, eff 8-27-15 ; Amended at 34 Ok Reg 612, eff 9-1-17 ; Amended at 36 Ok Reg 1099, eff 7-1-19 (emergency); Amended at 37 Ok Reg 514, eff 1-6-20 (emergency); Amended at 37 Ok Reg 1492, eff 9-14-20 ; Amended at 38 Ok Reg 1043, eff 9-1-21]

317:30-5-355.2. Covered services

The RHC benefit package, as described in 42 C.F.R. § 440.20, consists of RHC services and other ambulatory services.

(1) **RHC services.** RHC services are covered when medically necessary and furnished at the clinic or other outpatient setting, including the member's place of residence.

(A) **Core services.** RHC "core" services include, but are not limited to:

- (i) Services furnished by a physician, PA, APRN, CNM, CP, or CSW.
- (ii) Services and supplies incident to services provided by a physician, PA, APRN, CNM, CP, or CSW are covered in accordance with 42 C.F.R §§ 405.2413 and 405.2415, if the service or supply is:
 - (I) Furnished in accordance with State law;
 - (II) A type commonly furnished in physicians' offices;
 - (III) A type commonly rendered either without charge or included in the RHC's bill;
 - (IV) Furnished as an incidental, although integral, part of a physician's professional services, PA, APRN, CNM, CP or CSW; or

(V) Furnished under the direct supervision of a contracted physician PA, APRN, or CNM; and

(VI) Drugs and biologicals which cannot be self-administered or are specifically covered by Medicare law, are included within the scope of RHC services. Drugs and biologicals commonly used in life saving procedures, such as analgesics, anesthetics (local), antibiotics, anticonvulsants, antidotes and emetics, serums and toxoids are not billed separately.

(iii) Visiting nurse services to the homebound are covered if:

(I) The RHC is located in an area in which the Secretary of Health and Human Services has determined there is a shortage of home health agencies;

(II) The services are rendered to members who are homebound;

(III) The member is furnished nursing care on a part-time or intermittent basis by a registered nurse, licensed practical nurse, or licensed vocational nurse who is employed by or receives compensation for the services from the RHC; and

(IV) The services are furnished under a written plan of treatment as required by 42 C.F.R § 405.2416.

(iv) Certain virtual communication services.

(B) **Preventive services.** In addition to the professional services of a physician, and services provided by an APRN, PA, and CNM which would be covered as RHC services under Medicare, certain primary preventive services are covered under the SoonerCare RHC benefit. The services must be furnished by or under the direct supervision of an RHC practitioner who is a clinic employee:

(i) Prenatal and postpartum care;

(ii) Screening examination under the EPSDT program for members under twenty-one (21);

(iii) Family planning services; and

(iv) Medically necessary screening mammography and follow-up mammograms.

(C) **Off-site services.** RHC services provided off-site of the clinic are covered if the RHC has a compensation arrangement with the RHC practitioner. SoonerCare reimbursement is made to the RHC and the RHC practitioner receives his or her compensation from the RHC. The RHC must have a written contract with the physician and other RHC "core" practitioners that specifically identify how the RHC services provided off-site

are to be billed to SoonerCare. It is expected that services provided in off-site settings are, in most cases, temporary and intermittent, i.e., when the member cannot come to the clinic due to health reasons.

(2) **Other ambulatory services.** Other ambulatory services that may be provided by an RHC include non-primary care services covered by the Oklahoma Medicaid State Plan but are not included in the RHC's core services. These services are separately billable and may be provided by the RHC if the RHC meets the same standards as other contracted providers of those services.

(A) Other ambulatory services include, but are not limited to:

(i) Dental services for members under the age of twenty-one (21) provided by other than a licensed dentist;

(ii) Optometric services provided by other than a licensed optometrist;

(iii) Laboratory tests performed in the RHC lab, including the lab tests required for RHC certification;

(I) Chemical examinations of urine by stick or tablet method or both (including urine ketones);

(II) Hemoglobin or hematocrit;

(III) Blood glucose;

(IV) Examination of stool specimens for occult blood;

(V) Pregnancy tests; and

(VI) Primary culturing for transmittal to a certified laboratory.

(iv) Technical component of diagnostic tests such as x-rays and EKGs (interpretation of the test provided by the RHC physician is included in the encounter rate);

(v) Durable medical equipment;

(vi) Transportation by ambulance;

(vii) Prescribed drugs;

(viii) Prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags) and supplies directly related to colostomy care and the replacement of such devices;

(ix) Specialized laboratory services furnished away from the clinic;

(x) Inpatient services;

(xi) Outpatient hospital services; and

(xii) Applied behavior analysis (ABA); and

(xiii) Diabetes self-management education and support (DSMES) services.

(B) Services listed in (2)(A) of this Section, furnished on-site, require a separate provider agreement(s) with the

OHCA. Service item (2)(A)(iii) does not require a separate contract when furnished on-site, however, certain conditions of participation apply. (Refer to OAC 317:30-5-361 for conditions.)

[Source: Added at 38 Ok Reg 1043, eff 9-1-21]

317:30-5-356. Coverage for adults

Payment is made to RHCs for adult services as set forth in this Section.

(1) **RHC services.** Payment is made for one (1) encounter per member per day. Payment is also limited to four (4) visits per member per month. This limit may be exceeded if the SoonerCare Choice member has elected the RHC as his/her/their Patient Centered Medical Home/Primary Care Provider. Preventive service exceptions include:

(A) **Obstetrical care.** An RHC should have a written contract with its physician, PA, APRN, or CNM that specifically identifies how obstetrical care will be billed to SoonerCare, in order to avoid duplicative billing situations. The agreement should also specifically identify the physician's compensation for RHC and other ambulatory services.

(i) If the clinic compensates the physician, PA, APRN, or CNM to provide obstetrical care, then the clinic must bill the SoonerCare program for each prenatal visit using the appropriate CPT evaluation and management codes.

(ii) If the clinic does not compensate its practitioners to provide obstetrical care, then the independent practitioner must bill the OHCA for prenatal care according to the global method described in the SoonerCare provider specific rules for physicians, PAs, APRNs and CNMs (refer to OAC 317:30-5-22).

(iii) Under both billing methods, payment for prenatal care includes all routine or minor medical problems. No additional payment is made to the prenatal provider except in the case of a major illness distinctly unrelated to pregnancy.

(B) **Family planning services.** Family planning services are available only to members with reproductive capability. Family planning visits do not count as one (1) of the four (4) RHC visits per month.

(2) **Other ambulatory services.** These services are not considered a part of an RHC visit; therefore, these may be billed to the SoonerCare program by the RHC or service provider on the appropriate claim form. Refer to OAC 317:30-1, General Provisions, and OAC 317:30-3-57, 317:30-5-59, and 317:30-3-60 for general coverage and exclusions under the SoonerCare

program. Some specific limitations are applicable to other ambulatory services as set forth in specific provider rules and excerpted as follows:

- (A) Coverage under optometrists for adults is limited to treatment of eye disease not related to refractive errors.
- (B) There is no coverage for eye exams for the purpose of prescribing eyeglasses, contact lenses or other visual aids. (See OAC 317:30-5-431.)

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 13 Ok Reg 397, eff 11-14-95 (emergency); Amended at 13 Ok Reg 1645, eff 5-27-96 ; Amended at 16 Ok Reg 141, eff 10-14-98 (emergency); Amended at 16 Ok Reg 1429, eff 5-27-99 ; Amended at 16 Ok Reg 3413, eff 7-1-99 (emergency); Amended at 17 Ok Reg 1204, eff 5-11-00 ; Amended at 19 Ok Reg 2134, eff 6-27-02 ; Amended at 21 Ok Reg 501, eff 1-1-04 (emergency); Amended at 21 Ok Reg 2176, eff 6-25-04 ; Amended at 23 Ok Reg 2463, eff 6-25-06 ; Amended at 26 Ok Reg 113, eff 8-1-08 (emergency); Amended at 26 Ok Reg 1066, eff 5-11-09 ; Amended at 31 Ok Reg 657, eff 7-1-14 (emergency); Amended at 32 Ok Reg 1069, eff 8-27-15 ; Amended at 33 Ok Reg 846, eff 9-1-16 ; Amended at 34 Ok Reg 192, eff 11-22-16 (emergency); Amended at 34 Ok Reg 657, eff 9-1-17 ; Amended at 38 Ok Reg 774, eff 7-1-21 (emergency); Amended at 38 Ok Reg 1043, eff 9-1-21 ; Amended at 39 Ok Reg 394, eff 12-21-21 (emergency); Amended at 39 Ok Reg 1515, eff 9-12-22]

317:30-5-357. Coverage for children

RHC services and other ambulatory services for children include the same services as for adults. Medical review will be required for additional visits for children. Additional services for children include:

- (1) EPSDT services are covered for eligible members under twenty-one (21) years of age in accordance with OAC 317:30-3-65. An EPSDT exam performed by an RHC must be billed on the appropriate claim form with the appropriate preventive medicine procedure code from the CPT manual. If an EPSDT screening is billed, an RHC encounter should not be billed on the same day. Refer to OAC 317:30-3-65 through 317:30-3-65.12.
- (2) Under EPSDT, coverage is allowed for visual screenings and eyeglasses to correct visual defects. Payment is limited to two (2) glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.
- (3) An EPSDT screening is considered a comprehensive examination. A provider billing the Medicaid program for an EPSDT screening may not bill any other visits for that patient on that same day. It is expected that the screening provider will perform necessary treatment as part of the screening charge. Additional services such as tests, immunizations, etc., required at the time of screening may be billed independently from the screening.
- (4) The administration fee for immunizations should be billed if provided at the same time as a scheduled EPSDT examination.
- (5) Payment may be made directly to the RHC for the professional services of physician assistants performing EPSDT screenings within the certified RHC. The claim form must include the signature of the supervising physician.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 13 Ok Reg 397, eff 11-14-95 (emergency); Amended at 13 Ok Reg 1645, eff 5-27-96 ; Amended at 17 Ok Reg 2368, eff 6-26-00 ; Amended at 19 Ok Reg 2134, eff 6-27-02 ; Amended at 31 Ok Reg 657, eff 7-1-14 (emergency); Amended at 32 Ok Reg 1069, eff 8-27-15 ; Amended at 36 Ok

Reg 1099, eff 7-1-19 (emergency); Amended at 37 Ok Reg 514, eff 1-6-20 (emergency); Amended at 37 Ok Reg 1492, eff 9-14-20 ; Amended at 38 Ok Reg 1043, eff 9-1-21]

317:30-5-358. Vocational rehabilitation [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 19 Ok Reg 2134, eff 6-27-02]

317:30-5-359. Claims for Medicare eligible recipients

Payment is made to rural health clinics utilizing the Medicaid allowable for comparable services.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 19 Ok Reg 2922, eff 7-1-02 (emergency); Amended at 20 Ok Reg 1193, eff 5-27-03]

317:30-5-359.1. Cost reports

(a) Provider-based Rural Health Clinics (RHC) are required to report each RHC on a separate clinic line cost center on the Medicare Cost Report (HCFA 2552). A copy of the HCFA 2552, including the Medicaid Supplemental Worksheet S-2, is submitted to the Oklahoma Health Care Authority (OHCA) as part of the year-end cost report process of the parent hospital.

(b) Independent RHCs are required to submit to the OHCA a completed copy of the Medicare Cost Report for the annual cost reporting period (HCFA 222-92) within the due date for filing the cost report to the fiscal intermediary. Preventive services, i.e., prenatal, EPSDT and family planning visits, should not be counted in total visits in the Medicare cost report. The associated cost for the RHC services covered by Medicaid only should be reported as a non-reimbursable cost on the clinic's Medicare cost report.

[Source: Added at 13 Ok Reg 397, eff 11-14-95 (emergency); Added at 13 Ok Reg 1645, eff 5-27-96 ; Amended at 37 Ok Reg 1542, eff 9-14-20]

317:30-5-359.2. Reimbursement

(a) **Provider-based clinics.** Payments for provider-based clinics will be made for RHC "core" services based on an all-inclusive visit fee established by one of the following:

- (1) An interim rate established by calculating a statewide average rate for RHCs in the state; and
- (2) The statewide average rate will be updated annually by the increase in the Medicare Economic Index (MEI); or
- (3) An Alternative Payment Methodology (APM) established by the RHC periodic rate notification from the Medicare Fiscal Intermediary. In order to receive this rate, the RHC must submit a copy of the periodic rate notification letter for its most recent full cost reporting year received from the fiscal intermediary to the state. The APM rate cannot be lower than mentioned above in (a) (1) or (a)(2).

(b) **Independent clinics.** Payments for independent clinics will be made for RHC "core" services based on an all-inclusive visit fee established by

one of the following:

- (1) An interim rate established by calculating a statewide average rate for RHCs in the state; and
- (2) The statewide average rate will be updated annually by the increase in the MEI; or
- (3) An APM established by the RHCs periodic rate notification from the Medicare Fiscal Intermediary. In order to receive this rate, the RHC must submit a copy of the periodic rate notification letter for its most recent full cost reporting year received from the fiscal intermediary to the state. The APM rate cannot be lower than mentioned above in (b)(1) or (b)(2).

[Source: Added at 13 Ok Reg 397, eff 11-14-95 (emergency); Added at 13 Ok Reg 1645, eff 5-27-96 ; Amended at 15 Ok Reg 1895, eff 3-17-98 (emergency); Amended at 16 Ok Reg 1429, eff 5-27-99 ; Amended at 30 Ok Reg 1164, eff 7-1-13 ; Amended at 37 Ok Reg 1542, eff 9-14-20]

317:30-5-360. Payment rates [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 13 Ok Reg 397, eff 11-14-95 (emergency); Revoked at 13 Ok Reg 1645, eff 5-27-96]

317:30-5-361. Billing

(a) **Encounters.** Payment is made for one (1) encounter per member per day. Encounters with more than one (1) health professional and multiple encounters with the same health professional that takes place on the same day and a single location, constitute a single visit except when the member, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment. Medical review will be required for additional visits for children. Payment is also limited to four (4) visits per member per month for adults. This limit may be exceeded if the SoonerCare Choice member has elected the RHC as his/her/their Patient Centered Medical Home/Primary Care Provider. RHCs 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 HCPCS 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 CPT Manual. Payment is made directly

to the RHC on an encounter basis for on-site dental services by a licensed dentist for members under the age of twenty-one (21).

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

(A) **EPSDT dental screening.** An EPSDT dental screening includes oral examination, prophylaxis and fluoride treatment, charting of needed treatment, and, if necessary, x-rays (including two bite wing films). This service must be filed on claim form ADM-36-D for EPSDT reporting purposes.

(B) **Dental encounter.** A dental encounter consists of all dental treatment other than a dental screening. This service must be billed on the ADM-36-D.

(7) **Visual analysis.** Visual analysis services for a child with glasses, or a child who needs glasses, or a medical eye exam. This includes the refraction and medical eye health evaluation. Visual analysis services are billed using the appropriate revenue code and a HCPCS code. Payment is made directly to the RHC on an encounter basis for on-site optometric services by a licensed optometrist for members under the age of twenty-one (21).

(b) **Services billed separately from encounters.**

(1) 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 from the physical location where services were rendered/performed.

(A) **Laboratory.** The RHC must be CLIA certified for specialized laboratory services performed. Laboratory services must be itemized separately using the appropriate CPT or HCPCS code.

(B) **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.

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

(D) **Contraceptives.** Contraceptives are billed independently from the family planning encounter. A revenue code and the appropriate CPT or HCPC codes are required.

(E) **Eyeglasses.** Eyeglasses prescribed by a licensed optometrist are billed using the appropriate revenue code and HCPCS code. Payment is limited to two eyeglasses per year. Any eyeglasses beyond this limit must be prior authorized and determined to be medically necessary.

(2) Other ambulatory services provided off-site by independent practitioners (through subcontracting agreements or arrangements for services not available at the clinic) must be billed to the SoonerCare program by the provider rendering the

service. Independent practitioners must meet provider eligibility criteria and must have a current contract with the OHCA.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 13 Ok Reg 397, eff 11-14-95 (emergency); Amended at 13 Ok Reg 1645, eff 5-27-96 ; Amended at 16 Ok Reg 3413, eff 7-1-99 (emergency); Amended at 17 Ok Reg 2368, eff 6-26-00 ; Amended at 19 Ok Reg 2134, eff 6-27-02 ; Amended at 24 Ok Reg 895, eff 5-11-07 ; Amended at 26 Ok Reg 249, eff 1-1-09 (emergency); Amended at 26 Ok Reg 1053, eff 5-11-09 ; Amended at 30 Ok Reg 1164, eff 7-1-13 ; Amended at 31 Ok Reg 657, eff 7-1-14 (emergency); Amended at 32 Ok Reg 1069, eff 8-27-15 ; Amended at 34 Ok Reg 641, eff 9-1-17 ; Amended at 38 Ok Reg 1043, eff 9-1-21 ; Amended at 39 Ok Reg 1515, eff 9-12-22]

317:30-5-362. Documentation of records

All services offered by a rural health clinic are to be furnished in accordance with applicable Federal and State laws and regulations. These requirements include written policies as to the description of the services the clinic furnishes directly and also those services provided by agreement or arrangement.

(1) a clinical record system must be maintained in accordance with written policies and procedures, and be available to onsite reviewers upon request.

(2) records necessary to disclose the extent of services the provider furnishes to recipients, including those records as just described, and any information regarding payments claimed by the provider for furnishing services must be retained for a period of six years.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 13 Ok Reg 397, eff 11-14-95 (emergency); Amended at 13 Ok Reg 1645, eff 5-27-96]

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

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

[Source: Added at 31 Ok Reg 1662, eff 9-12-14]

PART 37. ADVANCED PRACTICE REGISTERED NURSE

317:30-5-375. Eligible providers

(a) The advanced practice registered nurse (APRN) must:

(1) Be licensed and in good standing in the state in which services are provided;

(2) Have completed an accredited graduate level advanced practice registered nursing education program approved by the board of nursing in the state in which services are provided; and

(3) Possess a current national certification by a national certifying body recognized by the board of nursing in the state in which services are provided.

(b) APRN services are limited to the scope of practice defined in 59 O.S. § 567.3a and corresponding administrative rules at Oklahoma

Administrative Code (OAC) 485:10-5-1 through 485:10-16-9. Rules regarding certified nurse midwives are referenced in OAC 317:30-5-225. APRNs who practice in states other than Oklahoma must be appropriately licensed in the state in which they practice. In addition, all providers must have a current contract on file with the Oklahoma Health Care Authority.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 16 Ok Reg 141, eff 10-14-98 (emergency); Amended at 16 Ok Reg 1429, eff 5-27-99 ; Amended at 23 Ok Reg 264, eff 10-3-05 (emergency); Added at 23 Ok Reg 1359, eff 5-25-06 ; Amended at 24 Ok Reg 2087, eff 6-25-07 ; Amended at 34 Ok Reg 612, eff 9-1-17 ; Amended at 37 Ok Reg 1512, eff 9-14-20]

317:30-5-376. Coverage by category

Payment is made to advanced practice registered nurses (APRNs) as set forth in this Section.

(1) **Adults.** Payment for adults is made for primary care health services, within the scope of practice of an APRN and within the scope of the Oklahoma Health Care Authority (OHCA) medical programs.

(2) **Children.** Payment for children is made for primary care health services, within the scope of practice of an APRN, to members under twenty-one (21) years of age, including Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screening services.

(A) Payment is made to eligible providers for EPSDT services to members under twenty-one (21) years of age. Specific guidelines for the EPSDT program including the periodicity schedule are found in Oklahoma Administrative Code (OAC) 317:30-3-65 through 317:30-3-65.12.

(B) Comprehensive screening examinations are to be performed by a provider qualified under State law to furnish primary health care services.

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

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 16 Ok Reg 141, eff 10-14-98 (emergency); Amended at 16 Ok Reg 1429, eff 5-27-99 ; Amended at 19 Ok Reg 2922, eff 7-1-02 (emergency); Amended at 20 Ok Reg 1193, eff 5-27-03 ; Amended at 23 Ok Reg 2463, eff 6-25-06 ; Amended at 36 Ok Reg 1099, eff 7-1-19 (emergency); Amended at 37 Ok Reg 514, eff 1-6-20 (emergency); Amended at 37 Ok Reg 1492, eff 9-14-20]

317:30-5-377. Billing instructions [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 14 Ok Reg 2397, eff 2-5-97 (emergency); Amended at 14 Ok Reg 2928, eff 7-11-97 ; Amended at 16 Ok Reg 141, eff 10-14-98 (emergency); Amended at 16 Ok Reg 1429, eff 5-27-99 ; Amended at 17 Ok Reg 2368, eff 6-26-00 ; Revoked at 19 Ok Reg 2134, eff 6-27-02]

PART 39. SKILLED NURSING SERVICES

317:30-5-390. Home and Community-Based Services waivers for adults with an intellectual disability or certain adults with related conditions

(a) **Introduction to waiver services.** Each Home and Community-Based Services (HCBS) waiver that includes services for adults with an intellectual disability or certain adults with related conditions allows payment for home health care services as defined in the waiver approved by the Centers for Medicare and Medicaid Services.

(1) Home health care services are skilled nursing services provided to a member by a registered nurse (RN) or a licensed practical nurse (LPN) that include:

- (A) Direct nursing care;
- (B) Assessment and documentation of health changes;
- (C) Documentation of significant observations;
- (D) Maintenance of nursing plans of care;
- (E) Medication administration;
- (F) Training of the member's health care needs;
- (G) Preventive and health care procedures; and
- (H) Preparing, analyzing, and presenting nursing assessment information regarding the member.

(2) The first thirty-six (36) visits provided by the home health care agency are covered by the Oklahoma Medicaid State Plan.

(b) **Eligible providers.** Skilled nursing services providers must enter into contractual agreements with the Oklahoma Health Care Authority (OHCA) to provide HCBS for adults with an intellectual disability or certain adults with related conditions.

(1) Individual providers must be currently licensed and in good standing in the state in which services are provided as a:

- (A) RN; or
- (B) LPN.

(2) Agency providers must:

- (A) Have a current Medicaid HCBS home health care agency contract; or
- (B) Be certified by the Oklahoma State Department of Health (OSDH) as a home health care agency.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 25 Ok Reg 2675, eff 7-25-08 ; Amended at 29 Ok Reg 1076, eff 6-25-12 ; Amended at 37 Ok Reg 1512, eff 9-14-20]

317:30-5-391. Coverage for skilled nursing services

(a) All skilled nursing services must be ordered and prescribed by a physician, supported by a nursing plan of care, included in the individual plan as described in Oklahoma Administrative Code (OAC) 340:100-5-53 and reflected in the plan of care approved in accordance with OAC 340:100-3-33 and 340:100-3-33.1. For purposes of this Section, a physician is defined as all licensed medical and osteopathic physicians, physician assistants (PAs) and advanced practice registered nurses (APRNs) in accordance with the rules and regulations covering the OHCA's medical care program. Arrangements for waiver skilled nursing

services are made through the personal support team with the specific involvement of the assigned Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD) registered nurse (RN). The DDSD RN develops a nursing service support plan subject to review and authorization by the DDSD state nursing director or designee.

(b) Skilled nursing services are rendered in such a manner as to provide the service recipient as much autonomy as possible.

(1) Skilled nursing services must be flexible and responsive to changes in the service recipient's needs.

(2) Providers are expected to participate in annual personal support team meetings and other team meetings as required.

(3) Appropriate supervision of skilled nursing services including services provided by licensed practical nurses (LPNs) is provided pursuant to State law and regulatory board requirements.

(4) Individual service providers must be RNs or LPNs currently licensed and in good standing in the state in which services are provided.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 16 Ok Reg 3283, eff 6-1-99 (emergency); Amended at 17 Ok Reg 1204, eff 5-11-00 ; Amended at 24 Ok Reg 80, eff 8-2-06 (emergency); Amended at 24 Ok Reg 926, eff 5-11-07 ; Amended at 37 Ok Reg 1512, eff 9-14-20]

317:30-5-392. Description of Skilled Nursing services

Types of Skilled Nursing Services in the waiver programs offered by the Oklahoma Department of Human Services' Developmental Disabilities Services Division (DDSD) are:

(1) **Extended Duty Skilled Nursing Care.** Extended Duty Skilled Nursing Care allows a licensed nurse to provide direct services in a community setting up to 24 hours per day.

(A) Extended Duty Skilled Nursing Care must be:

(i) provided only to those service recipients who have health-related issues that require skilled treatment or other intervention by a licensed nurse more frequently than every two hours;

(ii) ordered by a licensed medical physician, osteopathic physician, physician assistant, or advanced practice nurse;

(iii) justified in amount by the review done in accordance with OAC 340:100-5-26; and

(iv) documented in the service recipient's Plan of Care.

(B) When Extended Duty Skilled Nursing Care is medically indicated in accordance with subparagraph (A) of this paragraph, Extended Duty Skilled Nursing Care includes:

(i) skilled nursing care and interventions rendered directly to the service recipient by the nurse;

(ii) monitoring, evaluation, and documentation of the service recipient's physical or mental status;

- (iii) administration of medication or treatments or both as ordered by the licensed medical physician, osteopathic physician, physician assistant or advanced practice nurse;
- (iv) documentation of medication or treatment administration, skilled nursing interventions, service recipients's responses to medication or treatment, and any adverse reactions, or other significant changes;
- (v) implementation of all tasks and objectives of the written nursing plan of care; and
- (vi) performance of training and general care to the service recipient during periods in which skilled nursing tasks and interventions are not being performed.

(2) **Intermittent Skilled Nursing Care.** Intermittent Skilled Nursing Care involves performance of intermittent skilled tasks or interventions that only a licensed nurse can perform according to Section 1020 of Title 57 of the Oklahoma Statutes and OAC 340:100-5-26.3.

(A) Intermittent Skilled Nursing Care must be:

- (i) ordered by a licensed medical physician, osteopathic physician, physician assistant or advanced practice nurse;
- (ii) justified in amount by the review done in accordance with OAC 340:100-5-26; and
- (iii) documented in the service recipient's Plan of Care.

(B) Intermittent Skilled Nursing Care includes:

- (i) skilled nursing care and interventions rendered directly to the service recipient, as ordered by the licensed medical physician, osteopathic physician, physician assistant, or advanced practice nurse;
- (ii) health-related assessments;
- (iii) administration of medication or treatments ordered by the licensed medical physician, osteopathic physician, physician assistant, or advanced practice nurse;
- (iv) documentation of medication or treatment administration, the service recipient's response to medication or treatment, and any adverse reaction or other significant changes; and
- (v) implementation of all tasks and objectives of the nursing plan of care.

(3) **Individualized Skilled Nurse Training and Evaluation.** Individualized Skilled Nurse Training and Evaluation provides individualized evaluation and oversight of health care needs by a licensed nurse and specific, individualized health training by a licensed nurse to the service recipient or the service recipient's family or paid caregivers in accordance with Section 1020 of Title 56 of the Oklahoma Statutes and OAC 340:100-5-26.3.

(A) The licensed nurse assesses the service recipient's training needs prior to initiating competency-based training and develops a nursing plan of care that outlines the methods, goals, and objectives of the training to be performed. The nurse exercises prudent judgment in making the final decision as to what may be trained and delegated to community service workers, as provided by Section 1020 of Title 56 of the Oklahoma Statutes.

(B) Services include:

- (i) individualized nurse training or evaluation or both provided directly to the service recipient, family or paid caregiver(s), as identified in the individual plan and the nursing plan of care;
- (ii) evaluation and documentation of the competency of individuals trained through return demonstration, written test, verbalization of understanding, or other means suitable to the type of training performed;
- (iii) professional monitoring and supervision to the community service worker in accordance with the applicable licensing requirements and evaluation of:

- (I) the stability of the condition of the service recipient;

- (II) the training and capability of the person receiving training;

- (III) the nature of the task being trained;
- and

- (IV) the proximity and availability of the licensed nurse to the person when the task is being performed; and

- (iv) attendance at required meetings as specified in the individual plan.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 16 Ok Reg 3283, eff 6-1-99 (emergency); Amended at 17 Ok Reg 1204, eff 5-11-00 ; Amended at 24 Ok Reg 80, eff 8-2-06 (emergency); Amended at 24 Ok Reg 926, eff 5-11-07]

317:30-5-393. Coverage limitations for Skilled Nursing Services

- (a) Extended Duty Skilled Nursing Care cannot exceed three eight-hour shifts in a 24-hour period.
- (b) Intermittent Skilled Nursing Care is limited to no more than three skilled task site visits in a 24-hour period of time.
- (c) Individualized Skilled Nurse Training and Evaluation is reimbursed on the basis of a 15-minute unit of service. No more than 16 units of Individualized Skilled Nurse Training and Evaluation can be provided per month, unless the exception is:
- (1) justified in writing by the team in accordance with OAC 340:100-3-33.1;
 - (2) recommended by the DDS/D area nurse manager; and
 - (3) meets the requirements of OAC 340:100-3-33.1.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 16 Ok Reg 3283, eff 6-1-99 (emergency); Amended at 17 Ok Reg 1204, eff 5-11-00 ; Amended at 19 Ok Reg 2134, eff 6-27-02 ; Amended at 24 Ok Reg 80, eff 8-2-06 (emergency); Amended at 24 Ok Reg 926, eff 5-11-07]

317:30-5-394. Diagnosis codes [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 16 Ok Reg 3283, eff 6-1-99 (emergency); Amended at 17 Ok Reg 1204, eff 5-11-00 ; Revoked at 30 Ok Reg 1169, eff 7-1-13]

PART 41. FAMILY SUPPORT SERVICES

317:30-5-410. Home and Community-Based Services Waivers for persons with an intellectual disability or certain persons with related conditions

- (a) The Oklahoma Health Care Authority (OHCA) administers Home and Community-Based Services (HCBS) Waivers for persons with an intellectual disability and certain persons with related conditions that are operated by the Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD). Each waiver allows payment for family support services as defined in the waiver approved by the Centers for Medicare and Medicaid Services (CMS). Waiver services:
- (1) when utilized with services normally covered by SoonerCare, other generic services, and natural supports provide for health and developmental needs of members who otherwise would not be able to live in a home or community setting;
 - (2) are provided with the goal of promoting independence through strengthening the member's capacity for self-care and self-sufficiency;
 - (3) are centered on the needs and preferences of the member and support the integration of the member within his/her community; and
 - (4) do not include room and board. The costs associated with room and board must be met by the member.

(b) The DDS case manager develops the Individual Plan (IP) and Plan of Care (Plan) per OAC 340:100-5-53. The IP contains descriptions of the services provided, documentation of the amount, frequency and duration of the services, and types of service providers.

(1) Services:

(A) are authorized per OAC 340:100-3-33 and 100-3-33.1.

(B) provided prior to the development of the IP or not included in the IP are not compensable. The Plan may not be backdated;

(C) may be provided on an emergency basis when approved by the area manager or designee. The plan must be revised to reflect the additional services; and

(D) are provided by qualified provider entities contracted with the OHCA.

(2) Members have freedom of choice of providers and in the selection of HCBS or institutional services.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 24 Ok Reg 879, eff 5-11-07 ; Amended at 26 Ok Reg 2114, eff 6-25-09 ; Amended at 29 Ok Reg 1076, eff 6-25-12]

317:30-5-411. Coverage

All family support services will be included in the member's Individual Plan (IP). Arrangements for care under this program must be made with the member's case manager.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 24 Ok Reg 879, eff 5-11-07]

317:30-5-412. Description of services

Family support services include services identified in (1) through (6) of this section. Providers of any family support service must have an applicable SoonerCare Provider Agreement for Home and Community-Based Services (HCBS) Waiver Providers for persons with developmental disabilities.

(1) **Transportation services.** Transportation services are provided per Oklahoma Administrative Code (OAC) 317:40-5-103.

(2) **Assistive technology (AT) devices and services.** AT devices and services are provided per OAC 317:40-5-100.

(3) **Architectural modification.** Architectural modification services are provided per OAC 317:40-5-101.

(4) **Family training.**

(A) **Minimum qualifications.**

(i) Individual providers must have a Developmental Disabilities Services (DDS) Family Training application and training curriculum approved by DDS staff. Individual providers must hold a current licensure, certification, or a bachelor's degree in a human service field related to the approved training curriculum, or other bachelor's degree combined with a minimum of five 5 years'

experience in the intellectual disabilities field. Only individuals named on the SoonerCare Provider Agreement to provide Family Training services may provide service to members.

(ii) Agency or business providers must have a (DDS) Family Training application and training curriculum approved by DDS staff. Agency or business provider training staff must hold a current licensure, certification, or a bachelor's degree in a human service field related to the approved training curriculum or other bachelor's degree combined with a minimum of five (5) years experience in the intellectual disabilities field. The credentials of new training staff hired by an approved DDS HCBS Family Training agency or business provider must be submitted to and approved by the DDS programs manager for Family Training prior to new staff training members or members' families.

(B) Description of services. Family Training services include instruction in skills and knowledge pertaining to the support and assistance of members. Services are:

- (i) Intended to allow families to become more proficient in meeting the needs of members who are eligible;
- (ii) Provided in any community setting;
- (iii) Provided in either group, consisting of two (2) to fifteen (15) persons, or individual formats;
- (iv) For members served through DDS HCBS Waivers and their families. For the purpose of this service, family is defined as any person who lives with, or provides care to a member served on the Waiver;
- (v) Included in the member's Individual Plan (Plan) and arranged through the member's case manager; and
- (vi) Intended to yield outcomes as defined in the member's Plan.

(C) Coverage limitations. Coverage limitations for family training include (i) through (iv) of this subparagraph.

- (i) The limitation for individual family training is \$6,500 per Plan of Care (POC) year.
- (ii) The limitation for group family training is \$6,500 per POC year.
- (iii) Session rates for individual and group sessions do not exceed a range comparable to rates charged by persons with similar credentials providing similar services.
- (iv) Rates must be justified based on costs incurred to deliver the service and are evaluated to determine if costs are reasonable.

(D) **Documentation requirements.** Providers must maintain documentation fully disclosing the extent of services furnished that specifies (i) through (ix) of this subparagraph. Progress reports for each member served must be submitted to the DDS case manager per OAC 340:100-5-52.

- (i) The service date.
- (ii) The start and stop time for each session.
- (iii) The signature of the trainer.
- (iv) The credentials of the trainer.
- (v) The specific issues addressed.
- (vi) The methods used to address issues.
- (vii) The progress made toward outcomes.
- (viii) The member's response to the session or intervention.
- (ix) Any new issues identified during the session.

(5) **Family counseling.**

(A) **Minimum qualifications.** Counseling providers must hold current licensure as clinical social workers, psychologists, licensed professional counselors, or licensed marriage and family therapists.

(B) **Description of services.** Family counseling offered to members and his or her natural, adoptive, or foster family members, helps to develop and maintain healthy, stable relationships among all family members.

- (i) Emphasis is placed on the acquisition of coping skills by building upon family strengths.
- (ii) Knowledge and skills gained through family counseling services increase the likelihood the member remains in or returns to his or her own home.
- (iii) All family counseling needs are documented in the member's Plan.
- (iv) Services are rendered in any confidential setting where the member or family resides or the provider conducts business.

(C) **Coverage limitations.** Coverage limitations for family counseling are outlined in (i) and (ii) of this subparagraph.

- (i) Individual counseling is accounted for in units of 15 minutes with a limitation of 400 units per POC year.
- (ii) Group counseling, with a six (6) person maximum, is accounted for in units of 30 minutes with a limitation of 225 units per POC year.

(D) **Documentation requirements.** Providers must maintain documentation fully disclosing the extent of services furnished that specifies:

- (i) The service date;
- (ii) The start and stop time for each session;
- (iii) The signature of the therapist;
- (iv) The credentials of the therapist;

- (v) The specific issues addressed;
- (vi) The methods used to address issues;
- (vii) The progress made toward resolving issues and meeting outcomes;
- (viii) The member's response to the session or intervention; and
- (ix) Any new issue identified during the session.

(E) **Reporting requirements.** Progress reports for each member served must be submitted to the DDS case manager per OAC 340:100-5-52.

(6) **Specialized medical supplies.** Specialized medical supplies are provided per OAC 317:40-5-104.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 14 Ok Reg 3733, eff 9-18-97 (emergency); Amended at 15 Ok Reg 22, eff 9-18-97 (emergency); Amended at 15 Ok Reg 1528, eff 5-11-98 ; Amended at 19 Ok Reg 2134, eff 6-27-02 ; Amended at 20 Ok Reg 163, eff 10-8-02 (emergency); Amended at 20 Ok Reg 1216, eff 5-27-03 ; Amended at 23 Ok Reg 815, eff 2-1-06 (emergency); Amended at 23 Ok Reg 2555, eff 6-25-06 ; Amended at 24 Ok Reg 879, eff 5-11-07 ; Amended at 28 Ok Reg 1409, eff 6-25-11 ; Amended at 32 Ok Reg 1073, eff 8-27-15 ; Amended at 40 Ok Reg 2216, eff 9-11-23]

317:30-5-413. Diagnosis codes [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 30 Ok Reg 1169, eff 7-1-13]

PART 43. AGENCY COMPANION, SPECIALIZED FOSTER CARE, DAILY LIVING SUPPORTS, GROUP HOMES, AND COMMUNITY TRANSITION SERVICES

317:30-5-420. Home and Community-Based Services Waivers for persons with an intellectual disability or certain persons with related conditions

The Oklahoma Health Care Authority (OHCA) administers Home and Community-Based Services (HCBS) Waivers for persons with an intellectual disability and certain persons with related conditions that are operated by the Oklahoma Department of Human Services Developmental Disabilities Services Division (DDSD). The Community Waiver and Homeward Bound Waiver allow payment for residential supports as defined in the waiver approved by the Centers for Medicare and Medicaid Services (CMS).

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 25 Ok Reg 124, eff 10-1-07 (emergency); Amended at 25 Ok Reg 1192, eff 5-25-08 ; Amended at 29 Ok Reg 1076, eff 6-25-12]

317:30-5-421. Coverage

Residential supports must be included in the member's Individual Plan (IP). Arrangements for care under this program must be made through the member's case manager.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 25 Ok Reg 124, eff 10-1-07 (emergency); Amended at 25 Ok Reg 1192, eff 5-25-08]

317:30-5-422. Description of services

Residential supports include:

- (1) agency companion services (ACS) per Oklahoma Administrative Code (OAC)317:40-5;
- (2) specialized foster care (SFC) per OAC 317:40-5;
- (3) daily living supports (DLS):
 - (A) Community Waiver per OAC 317:40-5-150; and
 - (B) Homeward Bound Waiver per OAC 317:40-5-153;
- (4) group home services provided per OAC 317:40-5-152; and
- (5) community transition services (CTS).
 - (A) Minimum qualifications. The provider must enter into contractual agreements with the Oklahoma Health Care Authority (OHCA) to provide ACS, habilitation training specialist (HTS) services, or DLS, in addition to a contract to provide CTS.
 - (B) Description of services. CTS is a one-time setup expense for members transitioning from an intermediate care facility for individuals with intellectual disabilities (ICF/IID) or provider-operated residential setting to the member's own home or apartment. The cost per member of CTS cannot exceed limitations set forth by OHCA. The member's name must be on the lease, deed or rental agreement. CTS:
 - (i) are furnished only when the member is unable to meet such expense and must be documented in the member's Individual Plan (IP);
 - (ii) include security deposits, essential furnishings, such as major appliances, dining table/chairs, bedroom set, sofa, chair, window coverings, kitchen pots/pans, dishes, eating utensils, bed/bath linens, kitchen dish towel/potholders, a one month supply of laundry/cleaning products, and setup fees or deposits for initiating utility service, including phone, electricity, gas, and water . CTS also includes moving expenses, services/items necessary for the member's health and safety, such as pest eradication, allergen control, a one-time cleaning prior to occupancy, flashlight, smoke detector, carbon monoxide detector, first aid kit, fire extinguisher, and a tempering valve or other anti-scald device when determined by the Team necessary to ensure the member's safety; and
 - (iii) does not include:
 - (I) recreational items, such as television, cable, satellite, internet, video cassette recorder (VCR), digital video disc (DVD)

- player, compact disc (CD) player, MP3 player, or computer used primarily as a diversion or recreation;
- (II) monthly rental or mortgage expenses;
- (III) food;
- (IV) personal hygiene items;
- (V) disposable items, such as paper plates/napkins, plastic utensils, disposable food storage bags, aluminum foil, and plastic wrap;
- (VI) items that are considered decorative, such as rugs, pictures, bread box, canisters, or a clock;
- (VII) any item not considered an essential, one-time expense; or
- (VIII) regular ongoing utility charges;
- (iv) prior approval for exceptions and/or questions regarding eligible items and/or expenditures are directed to the programs manager for community transition services at DHS DDS state office;
- (v) authorizations are issued for the date a member transitions;
- (vi) may only be authorized for members approved for the Community Waiver; and
- (vii) may not be authorized for items purchased more than 30 days after the date of transition.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 25 Ok Reg 124, eff 10-1-07 (emergency); Amended at 25 Ok Reg 1192, eff 5-25-08 ; Amended at 26 Ok Reg 2114, eff 6-25-09 ; Amended at 32 Ok Reg 1073, eff 8-27-15]

317:30-5-423. Coverage limitations

- (a) Coverage limitations for residential supports for members with an intellectual disability are:
 - (1) Description: agency companion services (ACS); Unit: one day; Limitation: 366 units per year;
 - (2) Description: specialized foster care (SFC); Unit: one day; Limitation: 366 units per year;
 - (3) Description: daily living supports (DLS); Unit: one day; Limitation: 366 units per year; and
 - (4) Description: group home services; Unit: one day; Limitation: 366 units per year.
- (b) Members may not receive ACS, SFC, DLS and group home services at the same time.
- (c) Community transition services (CTS) are limited to \$2,400 per eligible member.
 - (1) CTS is limited to one transition over the member's lifetime. If the member's situation changes after receipt of CTS and hospitalization or readmission to an intermediate care facility for the mentally retarded (ICF/MR) is necessary, CTS is not authorized upon transition back into the community.

(2) Members moving into a group home, SFC, or ACS arrangement in the companion's home are not eligible to receive CTS.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 19 Ok Reg 2134, eff 6-27-02 ; Amended at 25 Ok Reg 124, eff 10-1-07 (emergency); Amended at 25 Ok Reg 1192, eff 5-25-08 ; Amended at 29 Ok Reg 1076, eff 6-25-12]

317:30-5-424. Diagnosis code [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 25 Ok Reg 124, eff 10-1-07 (emergency); Amended at 25 Ok Reg 1192, eff 5-25-08 ; Revoked at 30 Ok Reg 1169, eff 7-1-13]

PART 45. OPTOMETRISTS

317:30-5-430. Eligible providers

Payment can be made to a licensed optometrist who has a current contract on file with the Oklahoma Health Care Authority (OHCA) for services within the scope of Optometric practice as defined by controlling State law; provided, however, that services performed by out-of-state providers shall only be compensable to the extent that they are covered services.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 17 Ok Reg 3354, eff 8-1-00 (emergency); Amended at 18 Ok Reg 1130, eff 5-11-01 ; Amended at 34 Ok Reg 664, eff 9-1-17]

317:30-5-431. Coverage by category

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

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

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

(B) The global surgery fee allowance includes preoperative evaluation and management services rendered the day before or the day of surgery, the surgical procedure, and routine postoperative period. Co-management for cataract surgery is filed using appropriate CPT codes, modifiers and guidelines. If an optometrist has agreed to provide

postoperative care, the surgeon's information must be in the referring provider's section of the claim.

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

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

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

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 17 Ok Reg 3354, eff 8-1-00 (emergency); Amended at 18 Ok Reg 1130, eff 5-11-01 ; Amended at 19 Ok Reg 2922, eff 7-1-02 (emergency); Amended at 20 Ok Reg 1193, eff 5-27-03 ; Amended at 23 Ok Reg 2463, eff 6-25-06 ; Amended at 24 Ok Reg 2824, eff 5-1-07 (emergency); Amended at 25 Ok Reg 653, eff 2-1-08 (emergency); Amended at 25 Ok Reg 2634, eff 7-25-08]

317:30-5-432. Procedure Codes

(a) The appropriate procedure codes used for billing eye care services are found in the Current Procedural Terminology (CPT) and HCPCS Coding Manuals.

(b) Vision screening is a component of all eye exams performed by ophthalmologists or optometrists and is not billed separately.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 17 Ok Reg 3354, eff 8-1-00 (emergency); Amended at 18 Ok Reg 1130, eff 5-11-01 ; Amended at 19 Ok Reg 2134, eff 6-27-02 ; Amended at 25 Ok Reg 653, eff 2-1-08 through 7-14-08 (emergency)¹; Amended at 25 Ok Reg 2634, eff 7-25-08]

Editor's Note: ¹*This emergency action expired on 7-14-08 before being superseded by a permanent action. Upon expiration of an emergency amendatory action, the last effective permanent text is reinstated. Therefore, on 7-15-08 (after the 7-14-08 expiration of the emergency action), the text of 317:30-5-432 reverted back to the permanent text that became effective 6-27-02, as was last published in the 2006 Edition of the OAC, and remained as such until amended again by permanent action on 7-25-08.*

317:30-5-432.1. Corrective lenses and optical supplies

(a) When medically necessary, payment will be made for lenses, frames, low vision aids and certain tints for children. Coverage includes lenses and frames to protect children with monocular vision. Coverage includes two sets of non-high-index polycarbonate lenses and frames per year. Any lenses and frames beyond this limit must be prior authorized and determined to be medically necessary. All non-high-index lenses must be polycarbonate.

(b) Corrective lenses must be based on medical need. Medical need includes a significant change in prescription or replacement due to normal lens wear.

(c) SoonerCare provides frames when medically necessary. Frames are expected to last at least one year and must be reusable. If a lens prescription changes, the same frame must be used if possible.

(d) Providers must accept SoonerCare reimbursement as payment in full for services rendered, except when authorized by SoonerCare (e.g., copayments, other cost sharing arrangements authorized by the State).

(1) Providers must be able to dispense standard lenses and frames which SoonerCare would fully reimburse with no cost to the eligible member.

(2) If the member wishes to select lenses and frames with special features which exceed the SoonerCare allowable fee, and are not medically necessary, the member may be billed the excess cost. The provider must obtain signed consent from the member acknowledging that they are selecting lenses and/or frames that will not be covered in full by SoonerCare and that they will be responsible to pay the excess cost. The signed consent must be included in the member's medical record.

(e) Replacement of or additional lenses and frames are allowed when medically necessary. The OHCA does not cover lenses or frames meant as a backup for the initial lenses/frames. Prior authorization is not required unless the number of glasses exceeds two per year. The provider must always document in the member record the reason for the replacement or additional lenses and frames. The OHCA or its designated agent will conduct ongoing monitoring of replacement frequencies to ensure OHCA policy is followed. Payment adjustments will be made on claims not meeting these requirements.

(f) A fitting fee will be paid if there is documentation in the record that the provider or technician took measurements of the member's anatomical facial characteristics, recorded lab specifications and made final adjustment of the spectacles to the visual axes and anatomical topography. A fitting fee can only be paid in conjunction with a pair of covered lenses and frames.

(g) Bifocal lenses for the treatment of accommodative esotropia are a covered benefit. Progressive lenses, trifocals, photochromic lenses and tints for children require prior authorization and must satisfy the medical necessity standard. Payment is limited to two glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.

(h) Progressive lenses, aspheric lenses, tints, coatings and photochromic lenses for adults are not compensable and may be billed to the patient.

(i) Replacement of lenses and frames due to abuse and neglect by the member is not covered.

(j) Bandage contact lenses are a covered benefit for adults and children. Contact lenses for medically necessary treatment of conditions such as aphakia, keratoconus, following keratoplasty, aniseikonia/anisometropia or albinism are a covered benefit for adults and children. Other contact lenses for children require prior authorization and must satisfy the medical necessity standard.

[Source: Added at 25 Ok Reg 653, eff 2-1-08 through 7-14-08 (emergency)¹; Added at 25 Ok Reg 2634, eff 7-25-08 ; Amended at 31 Ok Reg 648, eff 7-1-14 (emergency); Amended at 32 Ok Reg 1031, eff 8-27-15 ; Amended at 33 Ok Reg 824, eff 9-1-16 ; Amended at 34 Ok Reg 56, eff 9-22-16 (emergency); Amended at 34 Ok Reg 698, eff 9-1-17]

Editor's Note: ¹*This emergency action expired before being superseded by a permanent action. Upon expiration of an emergency action enacting a new Section, the Section is no longer effective. Therefore, on 7-15-08 (after the 7-14-08 expiration of this emergency action), Section 317:30-5-432.1 was no longer effective, and remained as such until added again by permanent action on 7-25-08.*

317:30-5-433. Diagnosis codes [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 17 Ok Reg 3354, eff 8-1-00 (emergency); Revoked at 18 Ok Reg 1130, eff 5-11-01]

PART 47. OPTICAL SUPPLIERS

317:30-5-450. Eligible providers

Payment can be made to optical suppliers who have a current SoonerCare contract with the OHCA.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 33 Ok Reg 824, eff 9-1-16]

317:30-5-451. Coverage by category

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

- (1) **Adults.** There is no provision for the coverage of glasses for adults, or for the purchase of visual aids.
- (2) **Children.** Payment is made for medically necessary lenses and frames. Refer to OAC 317:30-5-432.1. for specific guidelines.
- (3) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 17 Ok Reg 3354, eff 8-1-00 (emergency); Amended at 18 Ok Reg 1130, eff 5-11-01 ; Amended at 19 Ok Reg 2922, eff 7-1-02 (emergency); Amended at 20 Ok Reg 1193, eff 5-27-03 ; Amended at 25 Ok Reg 653, eff 2-1-08 through 7-14-08 (emergency)¹; Amended at 25 Ok Reg 2634, eff 7-25-08]

Editor's Note: ¹*This emergency action expired on 7-14-08 before being superseded by a permanent action. Upon expiration of an emergency amendatory action, the last effective permanent text is reinstated. Therefore, on 7-15-08 (after the 7-14-08 expiration of the emergency action), the text of 317:30-5-451 reverted back to the permanent text that became effective 5-27-03, as was last published in the 2006 Edition of the OAC, and remained as such until amended again by permanent action on 7-25-08.*

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

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 17 Ok Reg 3354, eff 8-1-00 (emergency); Amended at 18 Ok Reg 1130, eff 5-11-01 ; Amended at 19 Ok Reg 2134, eff 6-27-02 ; Revoked at 25 Ok Reg 653, eff 2-1-08 through 7-14-08 (emergency)¹; Revoked at 25 Ok Reg 2634, eff 7-25-08]

Editor's Note: ¹*This emergency action expired on 7-14-08 before being superseded by a permanent action. Upon expiration of an emergency action revoking a section, the last effective permanent text is reinstated. Therefore, on 7-15-08 (after the 7-14-08 expiration of the emergency action), the text of 317:30-5-452 reverted back to the permanent text that became effective 6-27-02, as was last published in the 2006 Edition of the OAC, and remained as such until revoked again by permanent action on 7-25-08.*

PART 49. FAMILY PLANNING CENTERS [REVOKED]

317:30-5-465. Eligible providers [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 29 Ok Reg 1085, eff 6-25-12]

317:30-5-466. Coverage by category [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 13 Ok Reg 4045, eff 9-17-96 (emergency); Amended at 14 Ok Reg 1780, eff 5-27-97 ; Amended at 19 Ok Reg 2922, eff 7-1-02 (emergency); Amended at 20 Ok Reg 1193, eff 5-27-03 ; Amended at 24 Ok Reg 303, eff 12-1-06 (emergency); Amended at 24 Ok Reg 895, eff 5-11-07 ; Revoked at 29 Ok Reg 1085, eff 6-25-12]

317:30-5-467. Coverage limitations [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 19 Ok Reg 2134, eff 6-27-02 ; Amended at 24 Ok Reg 303, eff 12-1-06 (emergency); Amended at 24 Ok Reg 895, eff 5-11-07 ; Revoked at 29 Ok Reg 1085, eff 6-25-12]

PART 51. HABILITATION SERVICES

317:30-5-480. Home and Community-Based Services for persons with an intellectual disability or certain persons with related conditions

The Oklahoma Health Care Authority (OHCA) administers Home and Community-Based Services (HCBS) Waivers for persons with intellectual disabilities or certain persons with related conditions that are operated by the Oklahoma Department of Human Services Developmental Disabilities Services Division (DDSD). Each waiver allows Medicaid compensable services provided to persons who are:

- (1) medically and financially eligible; and
- (2) not covered through the OHCA's SoonerCare program.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 14 Ok Reg 769, eff 1-24-97 (emergency); Amended at 14 Ok Reg 1792, eff 5-27-97 ; Amended at 24 Ok Reg 879, eff 5-11-07 ; Amended at 25 Ok Reg 2675, eff 7-25-08 ; Amended at 29 Ok Reg 1076, eff 6-25-12]

317:30-5-481. Coverage

All habilitation services will be included in the member's Individual Plan (IP). Arrangements for care under this program must be made with the member's case manager.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 24 Ok Reg 879, eff 5-11-07]

317:30-5-482. Description of services

Habilitation services include the services identified in (1) through (15) of this Section. Habilitation services providers must have an applicable agreement with the Oklahoma Health Care Authority (OHCA) to provide Developmental Disabilities Services (DDS) through Home and Community-Based Services (HCBS).

(1) **Dental services.** Dental services are provided per Oklahoma Administrative Code (OAC) 317:40-5-112.

(A) **Minimum qualifications.** Dental services providers must have non-restrictive licensure by the Oklahoma State Board of Dentistry to practice dentistry in Oklahoma.

(B) **Description of services.** Dental services include services for maintenance or improvement of dental health as well as relief of pain and infection. These services may include:

- (i) Oral examinations;
- (ii) Medically necessary images;
- (iii) Prophylaxis;
- (iv) Flouride application;
- (v) Development of a sequenced treatment plan that prioritizes:
 - (I) Pain elimination;
 - (II) Adequate oral hygiene; and
 - (III) Restoring or improving ability to chew;
- (vi) Routine training of member or primary caregiver regarding oral hygiene; and

(vii) Preventive, restorative, replacement, and repair services to achieve or restore functionality provided after appropriate review when applicable, per OAC 317:40-5-112.

(C) **Coverage limitations.** Dental service coverage is specified in the member's Individual Plan (IP) in accordance with applicable Waiver limits. Cosmetic dental services are not authorized.

(2) **Nutrition services.** Nutrition Services are provided, per OAC 317:40-5-102.

(3) **Occupational therapy services.**

(A) **Minimum qualifications.** Occupational therapists and occupational therapy assistants have current, non-restrictive licensure by the Oklahoma Board of Medical Licensure and Supervision. Occupational therapy assistants are supervised by occupational therapists, per OAC 317:30-5-295 (b) (1).

(B) **Service description.** Occupational therapy services include evaluation, treatment, and consultation in leisure management, daily living skills, sensory motor, perceptual motor, mealtime assistance, assistive technology, positioning, and mobility. Occupational therapy services may include occupational therapy assistants, within the limits of the occupational therapist's practice.

(i) Services are:

(I) Intended to help the member achieve greater independence to reside and participate in the community; and

(II) Rendered in any community setting as specified in the member's IP. The IP includes a practitioner's prescription.

(ii) For this Section's purposes, a practitioner means medical and osteopathic physicians, physician assistants, and other licensed health care professionals with prescriptive authority to order occupational therapy services in accordance with the rules and regulations governing the SoonerCare program.

(iii) Service provision includes a written report or record documentation in the member's record, as required.

(C) **Coverage limitations.** For compensable services, payment is made to the individual occupational therapist for direct services or for services provided by a qualified occupational therapist assistant within the occupational therapist's employment. Payment is made in fifteen-minute (15-minute) units, with a limit of four hundred and eighty (480) units per Plan of Care (POC) year. Payment is not allowed solely for written reports or record documentation.

(4) **Physical therapy services.**

(A) **Minimum qualifications.** Physical therapists and physical therapist assistants must have current, non-restrictive licensure with the Oklahoma Board of Medical Licensure and Supervision. The physical therapist supervises the physical therapist assistant, per OAC 317:30-5-290.1 (b) (1).

(B) **Service description.** Physical therapy services include evaluation, treatment, and consultation in locomotion or mobility skeletal and muscular conditioning, assistive technology, and positioning to maximize the member's mobility and skeletal/muscular well-being. Physical therapy services may include physical therapist assistants, within the limits of the physical therapist's practice.

(i) Services are intended to help the member achieve greater independence to reside and participate in the community. Services are provided in any community setting as specified in the member's IP. The IP includes a practitioner's prescription. For this Section's purposes, practitioners are defined as licensed medical and osteopathic physicians and physician assistants in accordance with the rules and regulations covering the OHCA SoonerCare program.

(ii) Service provision includes a written report or record documentation in the member's record, as required.

(C) **Coverage limitations.** For compensable services, payment is to individual physical therapists for direct services or for services provided by a qualified physical therapist assistant within the physical therapist's employment. Payment is made in fifteen-minute (15-minute) units with a limit of four hundred and eighty (480) units per POC. Payment is not allowed solely for written reports or record documentation.

(5) **Psychological services.**

(A) **Minimum qualifications.** Qualification to provide psychological services requires current, non-restrictive licensure as a psychologist by the Oklahoma State Board of Examiners of Psychologists, or by the licensing board in the state where the service is provided. Psychological technicians who have completed all board certification and training requirements may provide services under a licensed psychologist's supervision.

(B) **Service description.** Psychological services include evaluation, psychotherapy, consultation, and behavioral treatment. Service is provided in any community setting as specified in the member's IP. The provider develops, implements, evaluates, and revises the Protective Intervention Protocol (PIP) corresponding to the relevant outcomes identified in the member's IP.

- (i) Services are:
 - (I) Intended to maximize a member's psychological and behavioral well-being; and
 - (II) Provided in individual and group formats, with a six-person maximum.
- (ii) Service approval is based on assessed needs per OAC 340:100-5-51.

(C) Coverage limitations.

- (i) Payment is made in fifteen (15) minute units. A minimum of fifteen (15) minutes for each individual and group encounter is required.
- (ii) Psychological services are authorized for a period, not to exceed twelve (12) months.
 - (I) Initial authorization does not exceed one hundred and ninety-two (192) units, forty-eight (48) service hours.
 - (II) Authorizations may not exceed two hundred and eighty-eight (288) units per POC year unless the DDS Behavior Support Services director or designee makes an exception.
 - (III) No more than twelve (12) hours of services, forty-eight (48) units, may be billed for PIP preparation. Any clinical document is prepared within sixty (60) calendar days of the request. Further, if the document is not prepared, payments are suspended until the requested document is provided.
 - (IV) When revising a PIP to accommodate recommendations of a required committee review, the provider may bill for only one (1) revision. The time for preparing the revision is clearly documented and does not exceed four (4) hours.

(6) Psychiatric services.

- (A) **Minimum qualifications.** Qualification as a psychiatric services provider requires a current, non-restrictive license to practice medicine in Oklahoma. Certification by the American Board of Psychiatry and Neurology or satisfactory completion of an approved residency program in psychiatry is required.
- (B) **Service description.** Psychiatric services include outpatient evaluation, psychotherapy, medication and prescription management and consultation, and are provided to eligible members. Services are provided in the community setting specified in the member's IP.
 - (i) Services are intended to contribute to the member's psychological well-being.

(ii) A minimum of thirty (30) minutes for encounter and record documentation is required.

(C) **Coverage limitations.** A unit is thirty (30) minutes, with a limit of two hundred (200) units, per POC year.

(7) **Speech-language pathology services.**

(A) **Minimum qualifications.** Qualification as a speech-language pathology services provider requires current, non-restrictive licensure as a speech-language pathologist, speech-language pathology assistant, or speech-language pathology clinical fellow, by the Oklahoma Board of Examiners for Speech-Language Pathology and Audiology, per OAC 317:30-5-675.

(B) **Service description.** Speech therapy includes evaluation, treatment, and consultation in communication, oral motor activities, and/or feeding activities provided to eligible members. Services are intended to maximize the member's community living skills and may be provided in the community setting specified in the member's IP.

(i) The IP includes a practitioner's prescription. For this Section's purposes, practitioners are defined as licensed medical and osteopathic physicians, physician assistants, and other licensed professionals with prescriptive authority to order speech or language services or both in accordance with rules and regulations covering the OHCA SoonerCare program.

(ii) A minimum of fifteen (15) minutes for encounter and record documentation is required.

(C) **Coverage limitations.** A unit is fifteen (15) minutes, with a limit of two hundred and eighty-eight (288) units, per POC. Payment is not allowed solely for written reports or record documentation.

(8) **Habilitation training specialist (HTS) services.**

(A) **Minimum qualifications.** Providers complete Oklahoma Human Services (OKDHS) DDS-sanctioned training curriculum. Residential habilitation providers:

(i) Are at least eighteen (18) years of age or older;

(ii) Are specifically trained to meet members' unique needs;

(iii) Have not been convicted of, pled guilty to, or pled nolo contendere to misdemeanor assault and battery, or a felony, per Section (§) 1025.2 of Title 56 of the Oklahoma Statutes (56 O.S. § 1025.2) unless a waiver is granted, per 56 O.S. § 1025.2; and

(iv) Receive supervision and oversight from contracted-agency staff with a minimum of four (4) years of any combination of college-level education or full-time equivalent experience in serving persons with disabilities.

(B) **Service description.** HTS services include services to support the member's self-care, daily living, and adaptive and leisure skills needed to reside successfully in the community. Services are provided in community-based settings in a manner that contributes to the member's independence, self-sufficiency, community inclusion, and well-being.

(i) Payment is not made for:

(I) Routine care and supervision family normally provides; or

(II) Services furnished to a member by a person who is legally responsible, per OAC 340:100-3-33.2.

(ii) Family members who provide HTS services meet the same standards as providers who are unrelated to the member. HTS staff residing in the same household as the member may not provide services in excess of forty (40) hours per week. Members who require HTS services for more than forty (40) hours per week use staff members who do not reside in the household, and who are employed by the member's chosen provider agency, to deliver the balance of necessary support staff hours. Exceptions may be authorized, when needed, for members who receive services through the Homeward Bound Waiver.

(iii) Payment does not include room and board or maintenance, upkeep, or improvement of the member's or family's residence.

(iv) For members who also receive intensive personal supports (IPS), the member's IP clearly specifies the role of the HTS and person providing IPS to ensure there is no service duplication.

(v) Review and approval by the DDS plan of care reviewer is required.

(vi) Pre-authorized HTS services accomplish the same objectives as other HTS services, but are limited to situations where the HTS provider is unable to obtain required professional and administrative oversight from an OHCA-approved oversight agency. For pre-authorized HTS services, the service:

(I) Provider receives DDS area staff oversight; and

(II) Is pre-approved by the DDS director or his or her designee.

(C) **Coverage limitations.** HTS services are authorized per OAC 317:40-5-110, 317:40-5-111, 317:40-7-13, and 340:100-3-33.1.

(i) A unit is fifteen (15) minutes.

(ii) Individual HTS service providers are limited to a maximum of forty (40) hours per week regardless of the number of members served.

(iii) More than one (1) HTS may provide care to a member on the same day.

(iv) Payment cannot be made for services provided by two (2) or more HTSs to the same member during the same hours of a day.

(v) An HTS may receive reimbursement for providing services to only one (1) member at any given time. This does not preclude services from being provided in a group setting where services are shared among group members.

(vi) HTS providers may not perform any job duties associated with other employment including on-call duties, at the same time they are providing HTS services.

(9) **Remote Supports (RS).** RS is provided per OAC 317:40-4-4.

(10) **Self Directed HTS (SD HTS).** SD HTS are provided per OAC 317:40-9-1.

(11) **Self Directed Goods and Services (SD GS).** SD GS are provided per OAC 317:40-9-1.

(12) **Audiology services.**

(A) **Minimum qualifications.** Audiologists have licensure as an audiologist by the Oklahoma Board of Examiners for Speech Pathology and Audiology per OAC 317:30-5-675 (d) (1).

(B) **Service description.** Audiology services include individual evaluation, treatment, and consultation in hearing to eligible members. Services are intended to maximize the member's auditory receptive abilities.

(i) The member's IP includes a practitioner's prescription. For this Section's purposes, practitioners are defined as licensed medical and osteopathic physicians, and physician assistants in accordance with OAC 317:30-5-1 covering the OHCA SoonerCare program.

(ii) A minimum of fifteen (15) minutes for encounter and record documentation is required.

(C) **Coverage limitations.** Audiology services are provided in accordance with the member's IP.

(13) **Prevocational services.**

(A) **Minimum qualifications.** Prevocational services providers:

(i) Are eighteen (18) years of age or older;

(ii) Complete OKDHS DDS-sanctioned training curriculum;

(iii) Are not convicted of, pled guilty to, or pled nolo contendere to misdemeanor assault and battery, or a felony per 56 O.S. § 1025.2, unless a waiver is granted per 56 O.S. § 1025.2; and

(iv) Receive supervision and oversight from a person with a minimum of four (4) years of any combination of college-level education or full-time equivalent experience in serving persons with disabilities.

(B) **Service description.** Prevocational services are not available to persons who can be served under a program funded per Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (IDEA) per Section 1401 et seq. of Title 20 of the United States Code.

(i) Prevocational services are learning and work experiences where the member can develop general, non-job, task-specific strengths that contribute to employability in paid employment in integrated community settings.

(ii) Activities include teaching concepts such as communicating effectively with supervisors, co-workers, and customers, attendance, task completion, problem solving, and safety. These activities are associated with building skills necessary to perform work.

(iii) Pre-vocational services are delivered to further habilitation goals that lead to greater opportunities for competitive, integrated employment. All prevocational services are reflected in the member's IP. Documentation is maintained in the record of each member receiving this service, noting the service is not otherwise available through a program funded under the Rehabilitation Act of 1973 or IDEA.

(iv) Services include:

(I) Center-based prevocational services, per OAC 317:40-7-6;

(II) Community-based prevocational services per, OAC 317:40-7-5;

(III) Enhanced community-based prevocational services per, OAC 317:40-7-12; and

(IV) Supplemental supports, as specified in OAC 317:40-7-13.

(C) **Coverage limitations.** A unit of center-based or community-based prevocational services is one (1) hour and payment is based on the number of hours the member participates in the service. All prevocational services and supported-employment services combined may not exceed the annual costs set forth in OKDHS Appendix D-26, Developmental Disabilities Services Rates Schedule. The services that may not be provided to the same member at the same time as prevocational services are:

(i) HTS;

- (ii) IPS;
- (iii) Adult Day Services;
- (iv) Daily Living Supports (DLS);
- (v) Homemaker; or
- (vi) Therapy services, such as occupational therapy; physical therapy; nutrition, speech, or psychological services; family counseling; or family training, except to allow the therapist to assess the individual's needs at the workplace or to provide staff training, per OAC 317:40-7-6.

(14) **Supported employment.**

(A) **Minimum qualifications.** Supported employment providers:

- (i) Are eighteen (18) years of age or older;
- (ii) Complete the OKDHS DDS-sanctioned training curriculum;
- (iii) Are not convicted of, pled guilty to, or pled nolo contendere to misdemeanor assault and battery, or a felony, per 56 O.S. § 1025.2 unless a waiver is granted, per 56 O.S. § 1025.5; and
- (iv) Receive supervision and oversight from a person with a minimum of four (4) years of any combination of college-level education or full-time equivalent experience in serving persons with disabilities.

(B) **Services description.** For members receiving HCBS Waiver services, supported employment is conducted in various settings, particularly worksites where persons without disabilities are employed, and includes activities that are outcome based and needed to sustain paid work, including supervision and training. The supported employment outcome is sustained paid employment at or above minimum wage, but not less than the customary wage and benefit level the employer pays for the same or similar work individuals without disabilities perform. The paid employment occurs in an integrated setting in the general workforce in a job that meets personal and career goals.

- (i) When supported-employment services are provided at a worksite where persons without disabilities are employed, payment:
 - (I) Is made for the adaptations, supervision, and training members require as a result of their disabilities; and
 - (II) Does not include payment for the supervisory activities rendered as a normal part of the business setting.
- (ii) Services include:
 - (I) Job coaching per OAC 317:40-7-7;
 - (II) Enhanced job coaching per OAC 317:40-7-12;

(III) Employment training specialist services per OAC 317:40-7-8; and

(IV) Stabilization per OAC 317:40-7-11.

(iii) Supported-employment services furnished under HCBS Waivers are not available under a program funded by the Rehabilitation Act of 1973 or IDEA.

(iv) Documentation that the service is not otherwise available under a program funded by the Rehabilitation Act of 1973 or IDEA is maintained in each member's record.

(v) Federal financial participation may not be claimed for incentive payment subsidies or unrelated vocational training expenses, such as:

(I) Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;

(II) Payments passed through to users of supported-employment programs; or

(III) Payments for vocational training not directly related to a member's supported-employment program.

(C) Coverage limitations. A unit is fifteen (15) minutes and payment is made per OAC 317:40-7-1 through 317:40-7-21. All prevocational services and supported-employment services combined cannot exceed \$27,000, per POC year. The DDS case manager assists the member to identify other alternatives to meet identified needs above the limit. The services that may not be provided to the same member, at the same time as supported-employment services are:

(i) HTS;

(ii) IPS;

(iii) Adult Day Services;

(iv) DLS;

(v) Homemaker; or

(vi) Therapy services, such as occupational therapy; physical therapy; nutrition, speech, or psychological services, family counseling, or family training, except to allow the therapist to assess the individual's needs at the workplace or to provide staff training.

(15) IPS.

(A) Minimum qualifications. IPS provider agencies must have a current provider agreement with OHCA and OKDHS DDS. Providers:

(i) Are eighteen (18) years of age or older;

(ii) Complete OKDHS DDS-sanctioned training curriculum;

- (iii) Are not convicted of, pled guilty to, or pled nolo contendere to misdemeanor assault and battery, or a felony, per 56 O.S. § 1025.2 unless a waiver is granted, per 56 O.S. § 1025.2;
- (iv) Receive supervision and oversight from a person with a minimum of four (4) years of any combination of college-level education or full-time equivalent experience in serving persons with disabilities; and
- (v) Receive oversight regarding specific methods to be used with the member to meet the member's complex behavioral or health support needs.

(B) Service description.

(i) IPS:

- (I) Are support services provided to members who need an enhanced level of direct support in order to successfully reside in a community-based setting; and
- (II) Build on the support level HTS or DLS staff provides by utilizing a second staff person on duty to provide assistance and training in self-care, daily living, and recreational and habilitation activities.

(ii) The member's IP clearly specifies the role of HTS and the person providing IPS to ensure there is no service duplication.

(iii) The DDS POC reviewer is required to review and approve services.

(C) Coverage limitations. IPS are limited to twenty-four (24) hours per day and are included in the member's IP, per OAC 317:40-5-151 and 317:40-5-153.

(16) Adult day services.

(A) Minimum qualifications. Adult day service provider agencies:

- (i) Meet licensing requirements, per 63 O.S. § 1-873 et seq. and comply with OAC 310:605; and
- (ii) Are approved by the OKDHS DDS director and have a valid OHCA contract for adult day services.

(B) Service description. Adult day services provide assistance with retaining or improving the member's self-help ability adaptive and socialization skills, including the opportunity to interact with peers in order to promote a maximum level of independence and function. Services are provided in a non-residential setting away from the home or facility where the member resides.

(C) Coverage limitations. Adult day services are furnished four (4) or more hours per day on a regularly scheduled basis, for one (1) or more days per week. A unit is fifteen (15) minutes for up to a maximum of six (6) hours daily, at which point a unit is one (1) day. All services are authorized in the member's IP.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 14 Ok Reg 769, eff 1-24-97 (emergency); Amended at 14 Ok Reg 1792, eff 5-27-97 ; Amended at 15 Ok Reg 3816, eff 7-1-98 (emergency); Amended at 16 Ok Reg 1429, eff 5-27-99 ; Amended at 19 Ok Reg 2134, eff 6-27-02 ; Amended at 22 Ok Reg 1007, eff 2-1-05 (emergency); Amended at 21 Ok Reg 2460, eff 7-11-05 ; Amended at 23 Ok Reg 3179, eff 6-7-06 (emergency); Amended at 24 Ok Reg 879, eff 5-11-07 ; Amended at 25 Ok Reg 2675, eff 7-25-08 ; Amended at 27 Ok Reg 1429, eff 6-11-10 ; Amended at 29 Ok Reg 1088, eff 6-25-12 ; Amended at 29 Ok Reg 1788, eff 7-20-12 (emergency); Amended at 30 Ok Reg 1171, eff 7-1-13 ; Amended at 32 Ok Reg 1073, eff 8-27-15 ; Amended at 35 Ok Reg 1446, eff 9-14-18 ; Amended at 38 Ok Reg 411, eff 2-1-21 (emergency); Amended at 38 Ok Reg 1006, eff 9-1-21 ; Amended at 39 Ok Reg 1517, eff 9-12-22 ; Amended at 41 Ok Reg, Number 12, effective 1-30-24 (emergency)]

317:30-5-483. Diagnosis codes [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 30 Ok Reg 1169, eff 7-1-13]

PART 53. SPECIALIZED FOSTER CARE

317:30-5-495. Home and Community-Based Services Waivers for persons with an intellectual disability or certain persons with related conditions

(a) **Introduction to waiver services.** The Oklahoma Health Care Authority (OHCA) administers Home and Community-Based Services (HCBS) Waivers for persons with an intellectual disability or certain persons with related conditions that are operated by Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD). The Community Waiver and Homeward Bound Waiver allow payment for specialized foster care (SFC), also known as specialized family care, as defined in the waiver approved by Centers for Medicare and Medicaid Services.

(b) **Eligible providers.** All SFC providers must:

- (1) enter into contractual agreements with the OHCA to provide HCBS for persons with an intellectual disability or certain persons with related conditions;
- (2) have an approved home profile per OAC 317:40-5-40;
- (3) complete training per OAC 340:100-3-38;
- (4) have the ability to implement the member's Individual Plan (IP); and
- (5) be emotionally and financially stable, in good health, and of reputable character.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 15 Ok Reg 3820, eff 7-1-98 (emergency); Amended at 16 Ok Reg 1429, eff 5-27-99 ; Amended at 25 Ok Reg 2675, eff 7-25-08 ; Amended at 29 Ok Reg 1076, eff 6-25-12]

317:30-5-496. Coverage

All specialized foster care must be included in the member's Individual Plan (IP). Arrangements for care under this program must be made through the member's case manager.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 25 Ok Reg 2675, eff 7-25-08]

317:30-5-497. Description of services

Specialized foster care (SFC) is an individualized living arrangement offering 24-hour per day supervision, supportive assistance, and training in daily living skills. Services are intended to allow the member to reside with a surrogate family. Services are provided to one to three members in the home in which the SFC provider resides. Four levels of SFC, based upon the member's age and level of need as determined by the Personal Support Team, are:

- (1) maximum supervision - for members 18 years of age or younger with extensive needs;
- (2) close supervision - for members 18 years of age or younger with moderate needs ;
- (3) maximum supervision - for members 19 years of age or older with extensive needs; and
- (4) close supervision - for members 19 years of age or older with moderate needs.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 15 Ok Reg 3820, eff 7-1-98 (emergency); Amended at 16 Ok Reg 1429, eff 5-27-99 ; Amended at 25 Ok Reg 2675, eff 7-25-08]

317:30-5-498. Coverage limitations

- (a) Coverage limitations for specialized foster care (SFC) are:
- (1) Description: close supervision; Unit: one day; 366 units each 12 months.
 - (2) Description: maximum supervision; Unit: one day; 366 units each 12 months.
- (b) Members are required to pay room and board expenses from their own funds as SFC does not include the cost of room and board.
- (c) Members may not simultaneously receive group home services, daily living supports, or agency companion services.
- (d) Members who are in the custody of the Oklahoma Department of Human Services (OKDHS) and in out-of-home placement funded by OKDHS Children and Family Services Division are not eligible for SFC.
- (e) When a member changes providers, only the outgoing service provider claims for the date the member moves.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 15 Ok Reg 3820, eff 7-1-98 (emergency); Amended at 16 Ok Reg 1429, eff 5-27-99 ; Amended at 19 Ok Reg 2134, eff 6-27-02 ; Amended at 25 Ok Reg 2675, eff 7-25-08]

317:30-5-499. Diagnosis code [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 25 Ok Reg 2675, eff 7-25-08 ; Revoked at 30 Ok Reg 1169, eff 7-1-13]

PART 55. RESPITE CARE

317:30-5-515. Home and Community-Based Services Waivers for persons with an intellectual disability or certain persons with related conditions

The Oklahoma Health Care Authority administers Home and Community-Based Services (HCBS) Waivers for persons with an intellectual disability or certain persons with related conditions that are operated by the Oklahoma Department of Human Services Developmental Disabilities Services Division. Each waiver allows payment for respite care as defined in the waiver approved by the Centers for Medicare and Medicaid Services.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 25 Ok Reg 2756, eff 6-1-08 (emergency); Amended at 26 Ok Reg 1067, eff 5-11-09 ; Amended at 29 Ok Reg 1076, eff 6-25-12]

317:30-5-516. Coverage

All respite care must be included in the member's Individual Plan (IP). Arrangements for this service must be made through the member's case manager.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 25 Ok Reg 2756, eff 6-1-08 (emergency); Amended at 26 Ok Reg 1067, eff 5-11-09]

317:30-5-517. Description of services

Respite care is:

- (1) available to eligible members not receiving daily living supports or group home services and who are unable to care for themselves; and
- (2) furnished on a short-term basis due to the absence or need for relief of those persons normally providing the care, and includes:
 - (A) homemaker respite per OAC 317:30-5-535 through 317:30-5-538;
 - (B) daily respite provided in a group home.
 - (i) Group homes providing respite must be licensed per OAC 340:100-6.
 - (ii) Respite care provided in a group home is authorized as respite at the applicable group home rate as identified in the member's Plan of Care;
 - (C) daily respite provided in an agency companion services (ACS) home.
 - (i) Respite must be approved in accordance with the home profile process, per OAC 317:40-5-40, and required training, per OAC 340:100-3-38.
 - (ii) Respite provided in an ACS home is authorized as respite at the applicable level of support per OAC 317:40-5-3.
 - (iii) Respite providers are limited to providing 52 days of respite per year when they concurrently provide ACS; and

(D) daily respite provided in any other approved home.

Respite:

(i) must be approved in accordance with the home profile process, per OAC 317:40-5-40, and required training, per OAC 340-100-3-38;

(ii) is based on the member's needs and includes:

(I) maximum supervision - for members with extensive needs;

(II) close supervision - for members with moderate needs; and

(III) intermittent supervision - for members with minimum needs; and

(iii) providers must:

(I) pass a background investigation per OAC 317:40-5-40 and OAC 340:100-3-39; and

(II) be at least 18 years of age.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 25 Ok Reg 2756, eff 6-1-08 (emergency); Amended at 26 Ok Reg 1067, eff 5-11-09]

317:30-5-518. Coverage limitations

(a) Payment is not made for daily respite care and specialized foster care or agency companion services (ACS) for the same member on the same date of service.

(b) Respite care:

(1) is not available to members in Oklahoma Department of Human Services (DHS) custody or in out-of-home placement funded by DHS Child Welfare Services; and

(2) for members not receiving ACS, is limited to 30 days or 720 hours annually per member, except as approved by the DHS Developmental Disabilities Services director and authorized in the member's Plan of Care; or

(3) for members receiving ACS, is limited per Oklahoma Administrative Code 317:40-5-3.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 19 Ok Reg 2134, eff 6-27-02 ; Amended at 25 Ok Reg 2756, eff 6-1-08 (emergency); Amended at 26 Ok Reg 1067, eff 5-11-09 ; Amended at 34 Ok Reg 674, eff 9-1-17]

317:30-5-519. Diagnosis code [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 25 Ok Reg 2756, eff 6-1-08 (emergency); Amended at 26 Ok Reg 1067, eff 5-11-09 ; Revoked at 30 Ok Reg 1169, eff 7-1-13]

PART 57. HOSPICE CARE

317:30-5-525. Eligible providers [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 21 Ok Reg 2460, eff 7-11-05]

317:30-5-526. Coverage by category [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95]

317:30-5-527. Hospice reimbursement [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95]

317:30-5-528. Billing [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 19 Ok Reg 2134, eff 6-27-02]

PART 58. HOSPICE

317:30-5-530. Eligible providers

(a) Providers of hospice services will meet applicable state and federal licensing requirements and meet Medicare certification requirements to provide hospice services.

(b) Providers of hospice services will enter into a contractual agreement with the State Medicaid Agency, Oklahoma Health Care Authority (OHCA).

[Source: Added at 23 Ok Reg 29, eff 8-1-05 (emergency); Added at 23 Ok Reg 1354, eff 5-25-06 ; Amended at 40 Ok Reg 2192, eff 9-11-23]

317:30-5-531. Coverage for adults

(a) **Definition. "Hospice care"** means a comprehensive, holistic program of palliative and/or comfort care and support provided to the member and his/her family when a physician certifies that the member has a terminal illness and has a life expectancy of six (6) months or less.

(b) **Requirements.**

(1) Hospice services must be related to the palliation and management of the member's illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills.

(2) Hospice care is performed under the direction of a physician as per the member's plan of care in an approved hospital hospice facility, in-home hospice program, or nursing facility.

(c) **Eligibility.** Coverage for hospice services is provided to Medicaid eligible expansion adults only.

(1) Expansion adults defined by 42 Code of Federal Regulations § 435.119 who are age nineteen (19) or older and under sixty-five (65), at or below one hundred thirty-three percent (133%) of the

federal poverty level (FPL), and who are not categorically related to the aged, blind, or disabled eligibility group are eligible for hospice services.

(2) Hospice care eligibility requires physician certification that the member is terminally ill and includes a medical prognosis with a life expectancy of six (6) months or less if the illness runs its normal course. The terminal prognosis also must be supported by clinical documentation in the medical record.

(3) For information regarding hospice provision provided through waivers, refer to Oklahoma Administrative Code (OAC) 317:30-5-763, 317:30-5-1200, and 317:30-5-1202.

(d) **Covered services.** Hospice care services can include but are not limited to:

- (1) Nursing care;
- (2) Physician services (e.g., physicians employed or working under arrangements made with the hospice);
- (3) Medical equipment and supplies;
- (4) Drugs for symptom control and pain relief;
- (5) Home health aide services;
- (6) Personal care services;
- (7) Physical, occupational and/or speech therapy;
- (8) Medical social services;
- (9) Dietary counseling; and
- (10) Grief and bereavement counseling to the member and/or family are required but are not reimbursable.

(e) **Prior authorization.** All services must be prior authorized, and a written plan of care must be established before services are rendered. For medical review purposes, all hospice services will be authenticated in accordance with OAC 317:30-3-30.

(f) **Service election.**

(1) The member or member's legal guardian or authorized representative must sign an election statement, choosing hospice care instead of routine medical care with the objective to treat and cure the member's terminal illness, and by doing so waives his or her right to other Medicaid benefits, except for care not related to the terminal illness and care provided by the attending physician.

(2) Once the member, legal guardian, or member's authorized representative has elected hospice care, the hospice medical team assumes responsibility for the member's medical care for the terminal illness.

(g) **Service revocation.**

(1) Hospice care services may be revoked by the member, legal guardian, or authorized representative at any time.

(2) Upon revoking the election of Medicaid coverage of hospice care for a particular election period, the member resumes Medicaid coverage of the benefits waived when hospice care was elected.

(3) The member may at any time elect to receive hospice coverage for any other hospice election periods for which he or she is eligible.

(h) **Service frequency.** Hospice care services:

(1) Are available for an initial two (2) ninety-day (90-day) certification periods. After the two (2) initial ninety-day (90-day) periods, a member is allowed an unlimited number of sixty-day (60-day) certification periods during the remainder of the member's lifetime. Each certification period requires a new prior authorization.

(2) Require a hospice physician or nurse practitioner to have a face-to-face encounter with the member to determine if the member's terminal illness necessitates continuing hospice care services. The encounter should take place prior to the one hundred eightieth (180th) day recertification and each subsequent recertification thereafter; and attest that such visit took place.

(i) **Documentation.** Initial documentation requirements for requesting services, documentation requirements for continuation of services, and the full hospice guidelines can be found at OHCA's website, <https://oklahoma.gov/ohca>.

(j) **Reimbursement.**

(1) SoonerCare shall provide hospice care reimbursement:

(A) For each day that an individual is under the care of a hospice, the hospice will be reimbursed an amount applicable to the level, type and intensity of the services furnished to the individual for that day in accordance with the Oklahoma Medicaid State Plan.

(B) For independent physician direct services in accordance with the Oklahoma Medicaid State Plan.

(2) Through the Oklahoma Medicaid State Plan, the OHCA established payment amounts for the following categories:

(A) **Routine hospice care.** Member is at home and not receiving hospice continuous care.

(B) **Continuous home care.** Member is not in an inpatient facility and receives hospice on a continuous basis at home; primarily consisting of nursing care to achieve palliation and management of acute medical symptoms during a brief period of crisis only as necessary to maintain the terminally ill patient at home. If less skilled care is needed on a continuous basis to enable the person to remain at home, this is covered as routine hospice care.

(C) **Inpatient respite care.** Member receives care in an approved inpatient facility on a short-term basis for respite.

(D) **General inpatient care.** Member receives general inpatient care in an inpatient facility for pain control or acute or chronic symptom management that cannot be managed at home.

(E) **Nursing facility (NF)/intermediate care facilities for individuals with intellectual disabilities (ICF/IID) care.** Member receives hospice care in a NF or ICF/IID. Hospice nursing facility or ICF/IID room and board per

diem rates are reimbursed to the in-home hospice provider at a rate equal to 95% of the skilled nursing facility rate. The hospice provider is responsible for passing the room and board payment through to the NF or ICF/IID. If Medicare is the primary payer of hospice benefits, OHCA will only reimburse the hospice provider for coinsurance and deductible amounts per the Oklahoma Medicaid State Plan and will continue to pay the room and board to the nursing facility.

(F) **Service intensity add-on.** Member receives care by a registered nurse (RN) or social worker when provided in the last seven (7) days of his/her life.

(G) **Other general reimbursement items.**

(i) **Date of discharge.** For the day of discharge from an inpatient unit, the appropriate home care rate is to be paid unless the patient dies as an inpatient. When the patient is discharged as deceased, the inpatient rate, either general or respite, is to be paid for the discharge date.

(ii) **Inpatient day cap.** Payments to a hospice for inpatient care must be limited according to the number of days of inpatient care furnished to Medicaid patients. During the twelve-month (12-month) period beginning October 1 of each year and ending September 30, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) may not exceed twenty percent (20%) of the aggregate total number of days of hospice care provided to all Medicaid recipients during that same period. This limitation is applied once each year, at the end of the hospices' cap period.

(iii) **Obligation of continuing care.** After the member's Medicare hospice benefit expires, the patient's Medicaid hospice benefits do not expire. The hospice must continue to provide the recipient's care until the patient expires or until the member revokes the election of hospice care.

[Source: Added at 23 Ok Reg 29, eff 8-1-05 (emergency); Added at 23 Ok Reg 1354, eff 5-25-06 ; Amended at 40 Ok Reg 2192, eff 9-11-23]

317:30-5-532. Coverage for children

Hospice is palliative and/or comfort care provided to the member and his/her family when a physician certifies that the member has a terminal illness and has a life expectancy of six months or less. A hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional and spiritual stresses which are experienced during the final stages of illness and death. Hospice services must be related to the palliation and management of the member's illness, symptom control, or to enable the individual to maintain activities

of daily living and basic functional skills.

(1) Payment is made for home based hospice services for terminally ill individuals with a life expectancy of six months or less when the member and/or family has elected hospice benefits. Hospice services are available to eligible members without forgoing any other service to which the member is entitled under SoonerCare for curative treatment of the terminal illness. Once the member has elected hospice care, the hospice medical team assumes responsibility for the member's medical care for the terminal illness in the home environment. Hospice providers are not responsible for curative treatments for members that elect such services while on hospice. Hospice care includes nursing care, physician services, medical equipment and supplies, drugs for symptom control and pain relief, home health aide and personal care, physical, occupational and/or speech therapy, medical social services, dietary counseling and grief and bereavement counseling to the member and/or family. Services must be prior authorized.

(2) Hospice care is available for two 90-day periods and an unlimited number of 60-day periods during the remainder of the member's lifetime. Beginning January 1, 2011, a hospice physician or nurse practitioner must have a face to face encounter with the member to determine if the member's terminal illness necessitates continuing hospice care services. The encounter must take place prior to the 180th day recertification and each subsequent recertification thereafter; and attests that such visit took place. The member and/or the family may voluntarily terminate hospice services. Hospice services must be reasonable and necessary for the palliation or management of a terminal illness or related conditions. A certification that the individual is terminally ill must be completed by the member's attending physician or the Medical Director of an Interdisciplinary Group. Nurse practitioners serving as the attending physician may not certify the terminal illness; however, effective January 1, 2011, nurse practitioners may re-certify the terminal illness.

(3) Services must be prior authorized. A written plan of care must be established before services are provided. The plan of care should be submitted with the prior authorization request.

[Source: Added at 23 Ok Reg 29, eff 8-1-05 (emergency); Added at 23 Ok Reg 1354, eff 5-25-06 ; Amended at 28 Ok Reg 511, eff 1-6-11 (emergency); Amended at 28 Ok Reg 1489, eff 6-25-11]

PART 59. HOMEMAKER SERVICES

317:30-5-535. Homemaker Service in Home and Community-Based Services (HCBS) Waiver for persons with an intellectual disability or certain persons with related conditions

(a) **Introduction to waiver services.** The Oklahoma Health Care Authority (OHCA) administers HCBS Waivers for persons with an intellectual disability or certain persons with related conditions that are operated by Oklahoma Human Services (OKDHS) Developmental Disabilities Services (DDS). Each waiver allows payment for homemaker service as defined in the waiver approved by the Centers for Medicare and Medicaid Services.

(b) **Eligible providers.** Homemaker services providers enter into contractual agreements with the OHCA to provide HCBS for persons with an intellectual disability or related conditions.

(1) Providers must complete the OKDHS DDS sanctioned training per Oklahoma Administrative Code 340:100-3-38.

(2) Homemaker service is included in the member's Individual Plan (Plan). Arrangements for this service must be made through the member's DDS case manager.

(3) Homemaker service includes general household activities, such as meal preparation and routine household care when the regular caregiver responsible for these activities is temporarily absent or unable to manage the home and care for others in the home.

(4) Limits are specified in the member's Plan.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 25 Ok Reg 2675, eff 7-25-08 ; Amended at 29 Ok Reg 1076, eff 6-25-12 ; Amended at 40 Ok Reg 2216, eff 9-11-23]

317:30-5-536. Coverage [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 25 Ok Reg 2675, eff 7-25-08 ; Revoked at 40 Ok Reg 2216, eff 9-11-23]

317:30-5-537. Description of services [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 19 Ok Reg 2134, eff 6-27-02 ; Amended at 25 Ok Reg 2675, eff 7-25-08 ; Revoked at 40 Ok Reg 2216, eff 9-11-23]

317:30-5-538. Diagnosis codes [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 25 Ok Reg 2675, eff 7-25-08 ; Revoked at 30 Ok Reg 1169, eff 7-1-13]

PART 61. HOME HEALTH AGENCIES

317:30-5-545. Eligible providers

All eligible home health service providers must be Medicare certified, or have deemed status with Medicare, and have a current contract with the Oklahoma Health Care Authority (OHCA). Home health agencies billing for medical supplies, equipment, and appliances must have a supplier contract and bill equipment on claim form CMS-1500.

Additionally, home health services providers that did not participate in Medicaid prior to January 1, 1998, must meet the "Capitalization Requirements" set forth in 42 Code of Federal Regulations (C.F.R.) § 489.28. Home health services providers that do not meet these requirements will not be permitted to participate in the Medicaid program.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 16 Ok Reg 59, eff 9-11-98 (emergency); Amended at 16 Ok Reg 1429, eff 5-27-99 ; Amended at 24 Ok Reg 332, eff 12-1-06 (emergency); Amended at 24 Ok Reg 929, eff 5-11-07 ; Amended at 39 Ok Reg 394, eff 12-21-21 (emergency); Amended at 39 Ok Reg 1430, eff 9-12-22]

317:30-5-546. Coverage by category

Payment is made for home health services as set forth in this section when a face-to-face encounter has occurred in accordance with provisions of 42 Code of Federal Regulations (C.F.R.) § 440.70. Payment is made for home health services provided by a home health agency in the member's residence and in any setting in which normal life activities take place except for a hospital, long-term care facility, or intermediate care facility for individuals with intellectual disabilities. For individuals eligible for Part B of Medicare, payment is made utilizing the Medicaid allowable for comparable services.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 15 Ok Reg 4182, eff 8-5-98 (emergency); Amended at 16 Ok Reg 1429, eff 5-27-99 ; Amended at 16 Ok Reg 3451, eff 7-1-99 (emergency); Amended at 17 Ok Reg 1204, eff 5-11-00 ; Amended at 18 Ok Reg 477, eff 1-1-01 (emergency); Amended at 18 Ok Reg 1130, eff 5-11-01 ; Amended at 19 Ok Reg 2922, eff 7-1-02 (emergency); Amended at 20 Ok Reg 1193, eff 5-27-03 ; Amended at 34 Ok Reg 672, eff 9-1-17 ; Amended at 39 Ok Reg 394, eff 12-21-21 (emergency); Amended at 39 Ok Reg 1430, eff 9-12-22]

317:30-5-547. Reimbursement and procedure codes

(a) Nursing services and home health aide services are covered services on a per visit basis. Thirty-six (36) visits per calendar year of nursing and/or home health aide services for any member do not require prior authorization; however, any visit surpassing the thirty-sixth (36) visit will require prior authorization and medical review.

(b) Reimbursement for durable medical equipment and supplies will be made using the amount derived from the lesser of the Oklahoma Health Care Authority (OHCA) fee schedule or the provider's usual and customary charge. When a procedure code is not assigned a maximum allowable fee for a unit of service, a fee will be established. Once the service has been provided, the supplier is required to include a copy of the invoice documenting the supplier's cost of the item with the claim.

(c) Reimbursement for oxygen and oxygen supplies is as follows:

(1) Payment for oxygen systems (stationary, liquid and oxygen concentrators) is based on continuous rental, i.e., a continuous monthly payment is made as long as it is medically necessary. The rental payment includes all contents and supplies, i.e., regulators, tubing, masks, etc. Portable oxygen systems are also considered continuous rental. Ownership of the equipment remains with the supplier.

(2) Separate payment will not be made for maintenance, servicing, delivery, or for the supplier to pick up the equipment when it is no longer medically necessary.

(3) Payment for oxygen and oxygen equipment and supplies will not exceed the Medicare fee for the same procedure code. The fee schedule will be reviewed annually and adjustments to the fee schedule may be made at any time based on efficiency, budget considerations, and quality of care as determined by the OHCA.

(4) Physical therapy, occupational therapy, and/or speech pathology and audiology services, are not covered when provided by a home health agency.

(d) All home health services are billed using Healthcare Common Procedure Coding System (HCPCS) codes.

[Source: Amended at 16 Ok Reg 3451, eff 7-1-99 (emergency); Amended at 17 Ok Reg 1204, eff 5-11-00 ; Amended at 20 Ok Reg 374, eff 1-1-03 (emergency); Amended at 20 Ok Reg 1920, eff 6-26-03 ; Amended at 24 Ok Reg 2890, eff 7-1-07 (emergency); Amended at 25 Ok Reg 1161, eff 5-25-08 ; Amended at 27 Ok Reg 628, eff 4-13-10 (emergency); Amended at 27 Ok Reg 1451, eff 6-11-10 ; Amended at 39 Ok Reg 394, eff 12-21-21 (emergency); Amended at 39 Ok Reg 1430, eff 9-12-22 ; Amended at 40 Ok Reg 2172, eff 9-11-23]

317:30-5-548. Procedure codes [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 16 Ok Reg 3451, eff 7-1-99 (emergency); Amended at 17 Ok Reg 1204, eff 5-11-00 ; Amended at 19 Ok Reg 2134, eff 6-27-02 ; Amended at 39 Ok Reg 394, eff 12-21-21 (emergency); Amended at 39 Ok Reg 1430, eff 9-12-22 ; Revoked at 40 Ok Reg 2172, eff 9-11-23]

317:30-5-549. Prosthetic devices [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 14 Ok Reg 764, eff 11-25-96 (emergency); Amended at 14 Ok Reg 1780, eff 5-27-97 ; Amended at 16 Ok Reg 3451, eff 7-1-99 (emergency); Amended at 17 Ok Reg 1204, eff 5-11-00 ; Amended at 18 Ok Reg 477, eff 1-1-01 (emergency); Amended at 18 Ok Reg 1130, eff 5-11-01 ; Revoked at 39 Ok Reg 394, eff 12-21-21 (emergency); Revoked at 39 Ok Reg 1430, eff 9-12-22]

PART 62. PRIVATE DUTY NURSING

317:30-5-555. Private Duty Nursing (PDN)

PDN is medically necessary care provided on a regular basis by a licensed practical nurse or registered nurse. PDN is the level of care that would routinely be provided by the nursing staff of a hospital or skilled nursing facility. PDN services are provided:

(1) In the member's primary residence, unless it is medically necessary for a nurse to accompany the individual in the community.

(A) The individual's place of residence is wherever the individual lives, whether the residence is the individual's own dwelling, a relative's home, or other type of living arrangement. The place of residence cannot include a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities (ICF/IID).

- (B) The place of service in the community cannot include the residence or business location of the provider of PDN services unless the provider of PDN is a live-in caregiver.
- (2) To assist during transportation to routine, Medicaid-compensable health care appointments and/or to the nearest appropriate emergency room.
 - (A) The private duty nurse may not drive the vehicle during transportation.
 - (B) PDN services are not available for non-routine extended home absences unrelated to medically necessary treatment or medical care. [Refer to Oklahoma Administrative Code 317:30-5-558(4) and (13)].

[Source: Added at 23 Ok Reg 33, eff 8-1-05 (emergency); Added at 23 Ok Reg 1364, eff 5-25-06 ; Amended at 28 Ok Reg 14, eff 8-13-10 (emergency); Amended at 28 Ok Reg 1429, eff 6-25-11 ; Amended at 37 Ok Reg 1605, eff 9-14-20 ; Amended at 39 Ok Reg 1523, eff 9-12-22]

317:30-5-556. Eligible providers

- (a) A home health agency that desires to be reimbursed by SoonerCare for private duty nursing (PDN) must meet the following requirements prior to providing services to eligible SoonerCare members:
 - (1) The agency must be fully contracted with OHCA as a provider; and,
 - (2) The agency must meet the requirements of Oklahoma Administrative Code (OAC) 317:30-5-545, and it must be licensed by the Oklahoma State Health Department (OSDH) as a home care agency.
- (b) The provider of PDN services, within the agency, must be a licensed practical nurse or a registered nurse who is currently licensed and in good standing in the state in which services are provided.

[Source: Added at 23 Ok Reg 33, eff 8-1-05 (emergency); Added at 23 Ok Reg 1364, eff 5-25-06 ; Amended at 24 Ok Reg 333, eff 12-1-06 (emergency); Amended at 24 Ok Reg 930, eff 5-11-07 ; Amended at 28 Ok Reg 14, eff 8-13-10 (emergency); Amended at 28 Ok Reg 1429, eff 6-25-11 ; Amended at 37 Ok Reg 1605, eff 9-14-20]

317:30-5-557. Coverage by category

(a) **Adults.** SoonerCare does not cover adults [twenty-one (21) years of age and over] for private duty nursing (PDN) with the exception of subsection (c).

(b) **Children.** SoonerCare does cover children [under twenty-one (21) years of age] if:

- (1) The member is eligible for SoonerCare; and
- (2) The Oklahoma Health Care Authority (OHCA), in its discretion, deems the services medically necessary. Medical necessity is determined in accordance with Oklahoma Administrative Code (OAC) 317:30-5-560.1.

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

(d) **1915(c) home and community-based services (HCBS) waivers.** If private duty nursing services are provided, they will be defined within each waiver and must be prior authorized.

[Source: Added at 23 Ok Reg 33, eff 8-1-05 (emergency); Added at 23 Ok Reg 1364, eff 5-25-06 ; Amended at 28 Ok Reg 14, eff 8-13-10 (emergency); Amended at 28 Ok Reg 1429, eff 6-25-11 ; Amended at 39 Ok Reg 1523, eff 9-12-22]

317:30-5-558. Private duty nursing (PDN) coverage limitations

The following provisions apply to all PDN services and provide coverage limitations:

- (1) All services must be prior authorized to receive payment from the Oklahoma Health Care Authority (OHCA). Prior authorization means authorization in advance of services provided in accordance with Oklahoma Administrative Code (OAC) 317:30-3-31 and 317:30-5-560.1;
- (2) A treatment plan must be completed by an eligible PDN provider before requesting prior authorization and must be updated at least annually and signed by the physician [medical doctor (MD), or doctor of osteopathy, (DO)], a physician assistant (PA), or advanced practice registered nurse (APRN)];
- (3) An assessment by an OHCA care management nurse is required prior to the authorization for services. The assessment will be conducted by the OHCA through one (1) of the following:
 - (A) Telephone;
 - (B) Virtually; or
 - (C) Face-to-face;
- (4) Care in excess of the designated hours per day granted in the prior authorization is not SoonerCare compensable. Prior-authorized but unused service hours cannot be "banked," "saved," or otherwise "accumulated" for use at a future date or time. If such hours or services are provided, they are not SoonerCare compensable.
- (5) Any medically necessary PDN care provided outside of the home must be counted in and cannot exceed the number of hours requested on the treatment plan and approved by OHCA.

(6) PDN services do not include office time or administrative time in providing the service. The time billed is for direct nursing services only.

(7) Staff must be engaged in purposeful activity that directly benefits the member receiving services. Staff must be physically able and mentally alert to carry out the duties of the job. At no time will OHCA compensate an organization for nursing staff time when sleeping.

(8) OHCA will not approve PDN services if all health and safety issues cannot be met in the setting in which services are provided.

(9) A provider must not misrepresent or omit facts in a treatment plan.

(10) It is outside the scope of coverage to deliver care in a manner outside of the treatment plan or to deliver units over the authorized units of care.

(11) PDN is not authorized in excess of sixteen (16) hours per day. There may be approval for additional hours for a period not to exceed thirty (30) days, if:

(A) The member has an acute episode that would otherwise require hospitalization or immediately following a hospital stay; or

(B) The primary caregiver is temporarily and involuntarily unable to provide care.

(C) The OHCA has discretion and the final authority to approve or deny any additional PDN hours and will take into consideration that the additional hours are not to be a substitute for institutionalized care.

(12) Family and/or caregivers and/or guardians (hereinafter, "caregivers") are required to provide some of the nursing care to the member without compensation. PDN services shall not be provided solely to allow the member's caregiver to work or go to school, nor solely to allow respite for the caregiver.

(13) PDN services will not be approved for overnight trips away from the member's primary residence that are unrelated to medically necessary treatment or medical care.

(A) For a member to receive Medicaid-reimbursable PDN services on an overnight trip that is related to medically necessary treatment or medical care, all provisions of this Part must be met. If said trip occurs out of state, OAC 317:30-3-89 through 317:30-3-92 must also be met.

(B) In instances in which the member's family is temporarily absent due to vacations, any additional PDN hours must be paid for by the family, or provided by other trained family members without SoonerCare reimbursement.

(14) PDN services will not be approved when services are reimbursed or reimbursable by other insurance, other governmental programs, or Medicaid program services that the member receives or is eligible to receive. For example, if a member receives Medicaid-reimbursable PDN services pursuant

to an Individualized Education Program (IEP) in a public school, then those PDN school hours will be counted in the member's daily allotment of PDN services.

[Source: Added at 23 Ok Reg 33, eff 8-1-05 (emergency); Added at 23 Ok Reg 1364, eff 5-25-06 ; Amended at 24 Ok Reg 333, eff 12-1-06 (emergency); Amended at 24 Ok Reg 930, eff 5-11-07 ; Amended at 28 Ok Reg 14, eff 8-13-10 (emergency); Amended at 28 Ok Reg 1429, eff 6-25-11 ; Amended at 37 Ok Reg 1605, eff 9-14-20 ; Amended at 39 Ok Reg 1523, eff 9-12-22]

317:30-5-559. How Private Duty Nursing (PDN) services are authorized

PDN services may be initiated after completion of the following steps:

- (1) A treatment plan for the patient has been created by an eligible PDN provider per Oklahoma Administrative Code (OAC) 317:30-5-560;
- (2) A prior authorization request is submitted with the appropriate Oklahoma Health Care Authority (OHCA) required data elements and the treatment plan;
- (3) An assessment (telephonic, virtual, or face-to-face) has been conducted by an OHCA care management nurse, per OAC 317:30-5-558 (3); and
- (4) An OHCA physician has determined the medical necessity of the service, including but not limited to, scoring the member's needs on the OHCA PDN assessment.

[Source: Added at 23 Ok Reg 33, eff 8-1-05 (emergency); Added at 23 Ok Reg 1364, eff 5-25-06 ; Amended at 28 Ok Reg 14, eff 8-13-10 (emergency); Amended at 28 Ok Reg 1429, eff 6-25-11 ; Amended at 32 Ok Reg 1081, eff 8-27-15 ; Amended at 39 Ok Reg 1523, eff 9-12-22]

317:30-5-560. Treatment plan

(a) An eligible organization must create a treatment plan for the member as part of the authorization process for private duty nursing (PDN) services. The initial treatment plan must be signed by the member's attending physician [medical doctor (MD), or doctor of osteopathy, (DO)], a physician assistant (PA), or advanced practice registered nurse (APRN).

(b) The treatment plan must include all of the following:

- (1) Diagnosis;
- (2) Prognosis;
- (3) Anticipated length of treatment;
- (4) Number of PDN requested hours per day;
- (5) Assessment needs and frequency (e.g., vital signs, glucose checks, neuro checks, respiratory);
- (6) Medication method of administration and frequency;
- (7) Age-appropriate feeding requirements (diet, method and frequency);
- (8) Respiratory needs;
- (9) Mobility requirements including need for turning and positioning, and the potential for skin breakdown;
- (10) Developmental deficits;
- (11) Casting, orthotics, therapies;
- (12) Age-appropriate elimination needs;

- (13) Seizure activity and precautions;
- (14) Age-appropriate sleep patterns;
- (15) Disorientation and/or combative issues;
- (16) Age-appropriate wound care and/or personal care;
- (17) Communication issues;
- (18) Social support needs;
- (19) Name, skill level, and availability of all caregivers; and
- (20) Other pertinent nursing needs such as dialysis, isolation.

[Source: Added at 23 Ok Reg 33, eff 8-1-05 (emergency); Added at 23 Ok Reg 1364, eff 5-25-06 ; Amended at 24 Ok Reg 333, eff 12-1-06 (emergency); Amended at 24 Ok Reg 930, eff 5-11-07 ; Amended at 28 Ok Reg 14, eff 8-13-10 (emergency); Amended at 28 Ok Reg 1429, eff 6-25-11 ; Amended at 32 Ok Reg 1081, eff 8-27-15 ; Amended at 39 Ok Reg 1523, eff 9-12-22]

317:30-5-560.1. Prior authorization requirements

- (a) Authorizations are provided for a maximum period of six (6) months.
- (b) Authorizations require:
 - (1) A treatment plan for the member;
 - (2) An assessment (telephonic, virtual, or face-to-face) has been conducted by an Oklahoma Health Care Authority (OHCA) care management nurse, per Oklahoma Administrative Code (OAC) 317:30-5-558 (2); and
 - (3) An OHCA physician to determine medical necessity including use of the OHCA Private Duty Nursing (PDN) assessment.
- (c) The number of hours authorized may differ from the hours requested on the treatment plan based on the review by an OHCA physician.
- (d) If the member's condition necessitates a change in the treatment plan, the provider must request a new prior authorization.
- (e) Changes in the treatment plan may necessitate another assessment (telephonic, virtual, or face-to-face) by an OHCA care management nurse.

[Source: Added at 23 Ok Reg 33, eff 8-1-05 (emergency); Added at 23 Ok Reg 1364, eff 5-25-06 ; Amended at 24 Ok Reg 333, eff 12-1-06 (emergency); Amended at 24 Ok Reg 930, eff 5-11-07 ; Amended at 28 Ok Reg 14, eff 8-13-10 (emergency); Amended at 28 Ok Reg 1429, eff 6-25-11 ; Amended at 32 Ok Reg 1081, eff 8-27-15 ; Amended at 39 Ok Reg 1523, eff 9-12-22]

317:30-5-560.2. Record documentation

- (a) The treatment plan must be updated and signed by the attending physician [medical doctor (MD), or doctor of osteopathy, (DO)], a physician assistant (PA), or advanced practice registered nurse (APRN) at least annually.
- (b) Copies of the attending physician's orders and, at a minimum, the last thirty (30) days of medical records for the actual care provided must be maintained and include the following:
 - (1) The beginning and ending time of the care and must be signed by the person providing care;
 - (2) The nurse's credentials;
 - (3) All provisions of the treatment plan, such as vital signs, medication administration, glucose/neuro checks, vital signs, respiratory assessments, and all applicable treatments must be documented; and

(4) Meet the record retention requirements set forth in Oklahoma Administrative Code (OAC) 317:30-3-15.

[Source: Added at 23 Ok Reg 33, eff 8-1-05 (emergency); Added at 23 Ok Reg 1364, eff 5-25-06 ; Amended at 24 Ok Reg 333, eff 12-1-06 (emergency); Amended at 24 Ok Reg 930, eff 5-11-07 ; Amended at 39 Ok Reg 1523, eff 9-12-22]

PART 63. AMBULATORY SURGICAL CENTERS (ASC)

317:30-5-565. Eligible providers

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

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 26 Ok Reg 527, eff 1-2-09 (emergency); Amended at 26 Ok Reg 2117, eff 6-25-09 ; Amended at 31 Ok Reg 1670, eff 9-12-14]

317:30-5-566. Ambulatory Surgery Center services

(a) **Reimbursement.** Reimbursement is made for selected services based on the Medicare approved list of covered services that can be performed at an ASC. Services not covered as Medicare ASC procedures and otherwise covered under SoonerCare may be reimbursed as determined by the OHCA. Ambulatory surgery center services are paid on a rate-per-service basis that varies according to the Health Care Procedure Coding System (HCPCS) codes. Separate payments may be made to the ASC for covered ancillary services. To be considered a covered ancillary service for which separate payment is made, the items and services must be provided integral to covered surgical procedures, that is, immediately before, during, or immediately after the covered surgical procedure.

(b) **Multiple surgeries.** Multiple procedures furnished during the same visit are discounted. The full amount is paid for the procedure with the highest payment rate. Fifty percent is paid for any other procedure(s) performed at the same time if the procedure is subject to discounting based on the discount indicator established by Medicare.

(c) **Payment indicators.** Payment indicators identify whether the service described by a HCPCS code is paid under the ASC methodology and if so, whether payment is made separately or packaged. SoonerCare follows Medicare's guidelines for packaged/bundled service costs.

(d) **Minor procedures.** Minor procedures that are normally performed in a physician's office are not covered in an ambulatory surgery center unless medically necessary and they are on the Medicare list for procedures approved to be performed in an ASC. Services not covered as Medicare ASC procedures and otherwise covered under SoonerCare may be reimbursed as determined by the OHCA.

(e) **Dental Procedures.** For OHCA payment purposes, the ASC list has been expanded to cover dental services for adults in an ICF/MR and all children.

(1) Non-emergency routine dental that is provided in an ambulatory surgery center is covered for children under the following circumstances:

(A) The child has a medical history of uncontrolled bleeding or other medical condition renders in-office treatment impossible.

(B) The child has uncontrollable behavior in the dental office even with premedication.

(C) The child needs extensive dental procedures or oral surgery procedures.

(2) Non-emergency routine dental that is provided in an ambulatory surgical center is covered for children and/or adults who are residents in ICFs/MR only under the following circumstances:

(A) A concurrent hazardous medical condition exists;

(B) The nature of the procedure requires hospitalization;
or

(C) Other factors (e.g. behavioral problems due to mental impairment) necessitate hospitalization.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 19 Ok Reg 2134, eff 6-27-02 ; Amended at 20 Ok Reg 2881, eff 7-1-03 (emergency); Amended at 21 Ok Reg 2176, eff 6-25-04 ; Amended at 23 Ok Reg 2487, eff 6-25-06 ; Amended at 24 Ok Reg 317, eff 12-1-06 (emergency); Amended at 24 Ok Reg 905, eff 5-11-07 ; Amended at 25 Ok Reg 2698, eff 7-25-08 ; Amended at 26 Ok Reg 527, eff 1-2-09 (emergency); Amended at 26 Ok Reg 2117, eff 6-25-09 ; Amended at 27 Ok Reg 705, eff 2-4-10 (emergency); Amended at 27 Ok Reg 1457, eff 6-11-10]

317:30-5-567. Coverage by category

Payment is made for ambulatory surgical center services as set forth in this Section.

(1) **Children.** Payment is made for children for medically necessary surgical procedures which are included on Medicare's list of covered ASC surgical procedures and dental procedures in certain circumstances. Services not covered as Medicare ASC procedures and otherwise covered under SoonerCare may be reimbursed as determined by the Oklahoma Health Care Authority (OHCA).

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

(B) Federal 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. For more information regarding experimental or investigational

including clinical trials, see Oklahoma Administrative Code 317:30-3-57.1.

(2) **Adults.** Payment is made for adults for medically necessary surgical procedures which are included on Medicare's list of covered ASC surgical procedures. Services not covered as Medicare ASC procedures and otherwise covered under SoonerCare may be reimbursed as determined by the OHCA.

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

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 19 Ok Reg 2134, eff 6-27-02 ; Amended at 19 Ok Reg 2922, eff 7-1-02 (emergency); Amended at 20 Ok Reg 1193, eff 5-27-03 ; Amended at 24 Ok Reg 317, eff 12-1-06 (emergency); Amended at 24 Ok Reg 905, eff 5-11-07 ; Amended at 26 Ok Reg 527, eff 1-2-09 (emergency); Amended at 26 Ok Reg 2117, eff 6-25-09 ; Amended at 27 Ok Reg 705, eff 2-4-10 (emergency); Amended at 27 Ok Reg 1457, eff 6-11-10 ; Amended at 38 Ok Reg 970, eff 9-1-21]

317:30-5-568. Elective sterilizations

Payment is made to ambulatory surgical centers for elective sterilizations performed in behalf of eligible individuals if all of the following circumstances are met:

- (1) The patient must be at least 21 years of age at the time the consent form is signed,
- (2) The patient must be mentally competent,
- (3) A properly completed federally mandated consent for sterilization form is attached to the claim, and
- (4) The form is signed and dated at least 30 days, but not more than 180 days prior to surgery.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 24 Ok Reg 114, eff 9-1-07 (emergency); Amended at 25 Ok Reg 1161, eff 5-25-08]

PART 64. CLINIC SERVICES

317:30-5-575. General information

(a) **Clinic services.** Clinic services means preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. The term includes the following services furnished to outpatients:

(1) Services furnished at the clinic by or under the direction of a physician or a dentist.

(2) Services furnished outside the clinic, by clinic personnel under the direction of a physician, to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address.

(b) **Prior authorization.** OHCA requires prior authorization for certain procedures to validate the medical need for the service.

(c) **Medical necessity.** Medical necessity requirements are listed at OAC 317:30-3-1(f).

[Source: Added at 28 Ok Reg 1394, eff 6-25-11]

317:30-5-576. Eligible providers

(a) **General requirements.** To be an eligible clinic provider, a clinic must be under the direction of a physician who is on the premises and who is a SoonerCare enrolled provider. In addition, the supervising physician must meet any other applicable licensure or certification required by State law or meet Medicare certification for participation. All clinic providers must have a current contract with the Oklahoma Health Care Authority (OHCA). The OHCA will review all clinic contracts to ensure compliance with all OHCA requirements, as well as all State and Federal laws. The OHCA has discretion and the final authority to approve or deny any provider contract.

(b) **National Provider Identification (NPI).** The clinic must have an organizational NPI number and each individual licensed physician and licensed non-physician practitioner must have an individual NPI and meet the provider qualification requirements applicable to the same service when it is furnished in other settings.

(c) **Written patient care policies.** A clinic under this Part must establish, in writing:

(1) a description of health services provided by the clinic;

(2) policies concerning the medical management of health problems including health conditions which require referral to physicians and provision of emergency health services; and

(3) policies concerning the maintenance and review of health records by the physician or dentist.

[Source: Added at 28 Ok Reg 1394, eff 6-25-11]

317:30-5-577. Coordination of care

The SoonerCare member's Primary Care Provider (PCP) is responsible for coordinating or delivering preventive and primary care services which are medically necessary to all SoonerCare members

enrolled with him/her. If a service is rendered in the clinic setting, the clinic must forward information for the patient file regarding the diagnosis, services rendered and need for follow-up to the member's PCP, in order to ensure continuity of care.

[Source: Added at 28 Ok Reg 1394, eff 6-25-11]

317:30-5-578. Limitation on services

Coverage is the same for adults and children unless otherwise indicated. Services are subject to the same limitations elsewhere in OHCA rules unless otherwise specified and to professional services rendered by health professionals acting within the scope of practice under State law.

[Source: Added at 28 Ok Reg 1394, eff 6-25-11]

317:30-5-579. Prescription drugs purchased under the 340B Drug Discount Program provided by Clinics

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

[Source: Added at 32 Ok Reg 1082, eff 8-27-15]

PART 65. CASE MANAGEMENT SERVICES FOR OVER 21 [REVOKED]

317:30-5-585. Eligible providers [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 14 Ok Reg 1229, eff 8-7-96 (emergency); Amended at 14 Ok Reg 2402, eff 11-25-96 (emergency); Amended at 14 Ok Reg 774, eff 1-24-97 (emergency); Amended at 14 Ok Reg 1792, eff 5-27-97 ; Amended at 18 Ok Reg 2571, eff 6-25-01 ; Amended at 24 Ok Reg 2847, eff 7-1-07 (emergency); Amended at 25 Ok Reg 1200, eff 5-25-08 ; Revoked at 27 Ok Reg 808, eff 3-3-10 (emergency); Revoked at 27 Ok Reg 1458, eff 6-11-10]

317:30-5-586. Coverage by category [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 14 Ok Reg 1229, eff 8-7-96 (emergency); Amended at 14 Ok Reg 1780, eff 5-27-97 ; Amended at 18 Ok Reg 2571, eff 6-25-01 ; Amended at 24 Ok Reg 2847, eff 7-1-07 (emergency); Amended at 25 Ok Reg 1200, eff 5-25-08 ; Revoked at 27 Ok Reg 808, eff 3-3-10 (emergency); Revoked at 27 Ok Reg 1458, eff 6-11-10]

317:30-5-586.1. Prior authorization [REVOKED]

[Source: Added at 18 Ok Reg 2571, eff 6-25-01 ; Amended at 23 Ok Reg 771, eff 3-9-06 (emergency); Amended at 23 Ok Reg 2440, eff 6-25-06 ; Amended at 24 Ok Reg 2847, eff 7-1-07 (emergency); Amended at 25 Ok Reg 1200, eff 5-25-08 ; Revoked at 27 Ok Reg 2760, eff 7-20-10 (emergency); Revoked at 28 Ok Reg 1439, eff 6-25-11]

317:30-5-587. Reimbursement [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 14 Ok Reg 1229, eff 8-7-96 (emergency); Amended at 14 Ok Reg 1780, eff 5-27-97 ; Amended at 18 Ok Reg 2571, eff 6-25-01 ; Amended at 19 Ok Reg 2134, eff 6-27-02 ; Revoked at 24 Ok Reg 2847, eff 7-1-07 (emergency); Revoked at 25 Ok Reg 1200, eff 5-25-08]

317:30-5-588. Billing [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 14 Ok Reg 1229, eff 8-7-96 (emergency); Amended at 14 Ok Reg 1780, eff 5-27-97 ; Revoked at 24 Ok Reg 2847, eff 7-1-07 (emergency); Revoked at 25 Ok Reg 1200, eff 5-25-08]

317:30-5-589. Documentation of records [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 18 Ok Reg 2571, eff 6-25-01 ; Amended at 24 Ok Reg 2853, eff 7-1-07 (emergency); Amended at 25 Ok Reg 1200, eff 5-25-08 ; Revoked at 27 Ok Reg 2760, eff 7-20-10 (emergency); Revoked at 28 Ok Reg 1439, eff 6-25-11]

PART 67. BEHAVIORAL HEALTH CASE MANAGEMENT SERVICES [REVOKED]

317:30-5-595. Eligible providers [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 14 Ok Reg 1232, eff 8-7-96 (emergency); Amended at 14 Ok Reg 777, eff 11-25-96 (emergency); Amended at 14 Ok Reg 774, eff 1-24-97 (emergency); Amended at 14 Ok Reg 1792, eff 5-27-97 ; Amended at 18 Ok Reg 2571, eff 6-25-01 ; Amended at 20 Ok Reg 2886, eff 7-1-03 (emergency); Amended at 21 Ok Reg 2210, eff 6-25-04 ; Amended at 23 Ok Reg 2557, eff 6-25-06 ; Amended at 24 Ok Reg 2853, eff 7-1-07 (emergency); Amended at 25 Ok Reg 1200, eff 5-25-08 ; Amended at 27 Ok Reg 808, eff 3-3-10 (emergency); Amended at 27 Ok Reg 1458, eff 6-11-10 ; Amended at 27 Ok Reg 2760, eff 7-20-10 (emergency); Amended at 28 Ok Reg 1439, eff 6-25-11 ; Amended at 30 Ok Reg 1146, eff 7-1-13 ; Amended at 31 Ok Reg 1679, eff 9-12-14 ; Amended at 32 Ok Reg 1083, eff 8-27-15 ; Revoked at 33 Ok Reg 804, eff 9-1-16]

317:30-5-596. Coverage by category [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 14 Ok Reg 1232, eff 8-7-96 (emergency); Amended at 14 Ok Reg 1780, eff 5-27-97 ; Amended at 18 Ok Reg 2571, eff 6-25-01 ; Amended at 20 Ok Reg 2886, eff 7-1-03 (emergency); Amended at 21 Ok Reg 2210, eff 6-25-04 ; Amended at 23 Ok Reg 2557, eff 6-25-06 ; Amended at 24 Ok Reg 2853, eff 7-1-07 (emergency); Amended at 25 Ok Reg 1200, eff 5-25-08 ; Amended at 27 Ok Reg 808, eff 3-3-10 (emergency); Amended at 27 Ok Reg 1458, eff 6-11-10 ; Amended at 27 Ok Reg 2760, eff 7-20-10 (emergency); Amended at 28 Ok Reg 1439, eff 6-25-11 ; Amended at 29 Ok Reg 413, eff 3-7-12 (emergency); Amended at 29 Ok Reg 1125, eff 6-25-12 ; Amended at 31 Ok Reg 1679, eff 9-12-14 ; Amended at 32 Ok Reg 1083, eff 8-27-15 ; Revoked at 33 Ok Reg 804, eff 9-1-16]

317:30-5-596.1. Prior authorization [REVOKED]

[Source: Added at 18 Ok Reg 2571, eff 6-25-01 ; Amended at 20 Ok Reg 2886, eff 7-1-03 (emergency); Amended at 21 Ok Reg 2210, eff 6-25-04 ; Amended at 23 Ok Reg 771, eff 3-9-06 (emergency); Amended at 23 Ok Reg 2557, eff 6-25-06 ; Amended at 24 Ok Reg 2853, eff 7-1-07 (emergency); Amended at 25 Ok Reg 1200, eff 5-25-08 ; Amended at 27 Ok Reg 808, eff 3-3-10 (emergency); Amended at 27 Ok Reg 1458, eff 6-11-10 ; Amended at 29 Ok Reg 413, eff 3-7-12 (emergency); Amended at 29 Ok Reg 1125, eff 6-25-12 ; Amended at 30 Ok Reg 1146, eff 7-1-13]

317:30-5-596.2. Direct and Indirect Case Management services [REVOKED]

[Source: Added at 20 Ok Reg 2886, eff 7-1-03 (emergency); Added at 21 Ok Reg 2210, eff 6-25-04 ; Amended at 23 Ok Reg 2557, eff 6-25-06 ; Revoked at 27 Ok Reg 808, eff 3-3-10 (emergency); Revoked at 27 Ok Reg 1458, eff 6-11-10]

317:30-5-597. Reimbursement [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 14 Ok Reg 1232, eff 8-7-96 (emergency); Amended at 14 Ok Reg 1780, eff 5-27-97 ; Amended at 18 Ok Reg 2571, eff 6-25-01 ; Amended at 19 Ok Reg 2134, eff 6-27-02 ; Amended at 20 Ok Reg 2886, eff 7-1-03 (emergency); Amended at 21 Ok Reg 2210, eff 6-25-04 ; Revoked at 23 Ok Reg 2557, eff 6-25-06]

317:30-5-598. Billing [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 14 Ok Reg 1232, eff 8-7-96 (emergency); Amended at 14 Ok Reg 1780, eff 5-27-97 ; Amended at 18 Ok Reg 2571, eff 6-25-01 ; Revoked at 23 Ok Reg 2557, eff 6-25-06]

317:30-5-599. Documentation of records [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 18 Ok Reg 2571, eff 6-25-01 ; Amended at 20 Ok Reg 2886, eff 7-1-03 (emergency); Amended at 21 Ok Reg 2210, eff 6-25-04 ; Amended at 23 Ok Reg 2557, eff 6-25-06 ; Amended at 24 Ok Reg 2853, eff 7-1-07 (emergency); Amended at 25 Ok Reg 1200, eff 5-25-08 ; Revoked at 33 Ok Reg 804, eff 9-1-16]

PART 69. CERTIFIED REGISTERED NURSE ANESTHETISTS

317:30-5-605. Eligible providers

Payment is made directly to Certified Registered Nurse Anesthetists (CRNA) for compensable anesthesia services within their scope of practice under state law. The CRNA must be licensed to practice under applicable state laws. In addition, the CRNA must have a current provider contract on file with the Oklahoma Health Care Authority (OHCA).

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 26 Ok Reg 1759, eff 7-1-09 (emergency); Amended at 27 Ok Reg 937, eff 5-13-10]

317:30-5-606. Coverage by category

Payment is made to certified registered nurse anesthetists as set forth in this Section.

(1) **Adults.** Payment is made for the administration of anesthesia to adults within the scope of the Authority's medical programs, provided the services are reasonable and necessary for the treatment of illness or injury, or to improve the functioning of a malformed body member.

- (2) **Children.** Coverage for children is the same as for adults.
- (3) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 19 Ok Reg 2134, eff 6-27-02 ; Amended at 19 Ok Reg 2922, eff 7-1-02 (emergency); Amended at 20 Ok Reg 1193, eff 5-27-03]

317:30-5-607. Billing instructions

The CRNA is responsible for entering the correct anesthesia procedure code on the appropriate claim form. Anesthesia codes from the Physicians' Current Procedural Terminology or Medicare assigned codes should be used.

- (1) Payment is made only for the major procedure during an operative session.
- (2) All anesthesia procedure codes must have a modifier. Without the modifier, the claim will be denied. Payment to the CRNA is limited to 80% of the physician allowable for anesthesia services without medical direction using modifier QZ and 50% of the physician allowable when services are provided under the medical direction of an anesthesiologist using modifier QX.
- (3) Certain codes in the Medicine section of the CPT are used to identify extraordinary anesthesia services. Additional payment can be made when applicable for extremes of age, total body hypothermia and controlled hypertension.
- (4) All other qualifying circumstances, i.e., physical status, emergency, etc., have been structured into the total allowable for the procedure.
- (5) Hypothermia total body or regional is not covered unless medical necessity is documented and approved through review by the Authority's Medical Consultants.
- (6) Payment for placement of central venous catheter, injection of anesthesia substance or similar procedures will be made only when the procedure is distinctly separate from the anesthesia procedure.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 19 Ok Reg 2134, eff 6-27-02 ; Amended at 20 Ok Reg 1924, eff 6-26-03 ; Amended at 26 Ok Reg 1759, eff 7-1-09 (emergency); Amended at 27 Ok Reg 937, eff 5-13-10]

317:30-5-608. Elective sterilizations [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 26 Ok Reg 1759, eff 7-1-09 (emergency); Revoked at 27 Ok Reg 937, eff 5-13-10]

317:30-5-609. Hysterectomies [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 26 Ok Reg 1759, eff 7-1-09 (emergency); Revoked at 27 Ok Reg 937, eff 5-13-10]

317:30-5-610. Abortions [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 15 Ok Reg 4194, eff 7-20-98 (emergency); Amended at 16 Ok Reg 1429, eff 5-27-99 ; Revoked at 26 Ok Reg 1759, eff 7-1-09 (emergency); Revoked at 27 Ok Reg 937, eff 5-13-10]

317:30-5-611. Payment methodology

Payment to the CRNA is limited to 80% of the physician allowable for anesthesia services performed without medical direction and 50% of the physician allowable when services are provided under the medical direction of a licensed physician.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 26 Ok Reg 1759, eff 7-1-09 (emergency); Amended at 27 Ok Reg 937, eff 5-13-10]

PART 70. ANESTHESIOLOGIST ASSISTANTS

317:30-5-612. Eligible providers

Payment is made directly to Anesthesiologist Assistants (AA) for compensable anesthesia services within their scope of practice under state law. The AA must be licensed to practice under applicable state laws. In addition, the AA must have a current provider contract on file with the Oklahoma Health Care Authority (OHCA).

[Source: Added at 26 Ok Reg 1759, eff 7-1-09 (emergency); Added at 27 Ok Reg 937, eff 5-13-10]

317:30-5-613. Coverage by category

Payment is made to Anesthesiologist Assistants as set forth in this Section.

- (1) **Adults.** Payment is made for the administration of anesthesia to adults within the scope of the Authority's medical programs, provided the services are reasonable and necessary for the treatment of illness or injury, or to improve the functioning of a malformed body member.
- (2) **Children.** Coverage for children is the same as for adults.
- (3) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services.

[Source: Added at 26 Ok Reg 1759, eff 7-1-09 (emergency); Added at 27 Ok Reg 937, eff 5-13-10]

317:30-5-614. Billing instructions

The AA is responsible for entering the correct anesthesia procedure code on the appropriate claim form. Anesthesia codes from the Physicians' Current Procedural Terminology or Medicare assigned codes should be used.

- (1) Payment is made only for the major procedure during an operative session.

(2) All anesthesia procedure codes must have a modifier. Without the modifier, the claim will be denied. Payment is made to an AA for services provided under the direct supervision of a licensed anesthesiologist and is limited to 50% of the physician allowable using modifier QX.

(3) Certain codes in the Medicine section of the CPT are used to identify extraordinary anesthesia services. Additional payment can be made when applicable for extremes of age, total body hypothermia and controlled hypertension.

(4) All other qualifying circumstances, i.e., physical status, emergency, etc., have been structured into the total allowable for the procedure.

(5) Hypothermia total body or regional is not covered unless medical necessity is documented and approved through review by the Authority's Medical Consultants.

(6) Payment for placement of central venous catheter, injection of anesthesia substance or similar procedures will be made only when the procedure is distinctly separate from the anesthesia procedure.

[Source: Added at 26 Ok Reg 1759, eff 7-1-09 (emergency); Added at 27 Ok Reg 937, eff 5-13-10]

317:30-5-615. Payment methodology

Payment to the AA is limited to 50% of the physician allowable for anesthesia services.

[Source: Added at 26 Ok Reg 1759, eff 7-1-09 (emergency); Added at 27 Ok Reg 937, eff 5-13-10]

PART 71. EARLY INTERVENTION CASE MANAGEMENT SERVICES

317:30-5-620. Eligible providers

Services are provided statewide by case management providers established for the purpose of providing early intervention case management services. Services must be made available to all eligible recipients on a statewide basis, in a manner that ensures continuity of services, without duplication and in compliance with federal and state mandates and regulations related to servicing the targeted population in a uniform and consistent manner.

(1) **Department of Education criteria.** OHCA will reimburse case managers who meet program criteria set by the Oklahoma State Department of Education (OSDE), the certification agency.

Case manager qualifications are:

(A) Knowledge or community-based, facility and institutional resources available to the target group and the experience to link to said resources;

(B) Experience in working in education, health or human service field;

- (C) Administrative experience to meet state and federal requirements as well as requirements set out by the certifying agency;
- (D) Ability to maintain programmatic and financial records required by the certifying agency including the capacity to document case records consistent with program standards and state and federal requirements;
- (E) Graduation from an accredited college or university with a bachelor's degree in education, social work, health-related field and one year of experience in one of more of these fields;
- (F) Receipt of approved State Department of Education Training; and

(2) **Provider agreement.**

- (A) A memorandum of agreement between the Oklahoma Health Care Authority (OHCA) and the Oklahoma State Department of Education (OSDE) for Medicaid reimbursement of early intervention case management services must be in effect before reimbursement can be made for compensable services. The agreement outlines the contractual requirements for reimbursement.
- (B) Provision of case management services will not restrict an individual's free choice of medical providers. Eligible case management providers must be certified by the OSDE in keeping with certification standards referenced in State Law Title 70, Section 3- 104, Part 9 to ensure that the case managers for the targeted group of recipients are capable of assisting the recipients in receiving the full range of services they need. Recipients will have free choice of providers of other medical care under the plan.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 16 Ok Reg 1927, eff 6-11-99]

317:30-5-621. Coverage by category

Payment is made for early intervention case management

- (1) **Adults.** There is no coverage.
- (2) **Children.** Coverage for children (age 0 to age 3) is as follows:
 - (A) **Description.**

- (i) Services under case management are not comparable in amount, duration and scope. The target group for case management services are developmentally disabled infants and toddlers (ages 0-3) who are eligible for early intervention services under Oklahoma's implementation plan to meet provisions of the Individuals with Disabilities Education Act (IDEA), Amendments of 1997.
 - (ii) Case management refers to services provided to assist a client in gaining access to needed medical, social, educational and other services essential to meeting basic human needs. Case

management may include, but is not limited to:

- (I) referral, coordination and linkage to needed services;
- (II) arranging for service delivery to ensure access to needed services;
- (III) monitoring and follow-up of client's activities to insure access, quality and delivery of needed services; and
- (IV) preparation of case record documentation documenting the above activities.

(B) Non-Duplication of services. To the extent any eligible recipients in the identified targeted population are receiving TCM services from another provider agency, as a result of being members of other covered targeted groups, the providers assure that case management activities are coordinated to avoid unnecessary duplication of service. To the extent any of the services required by the client are a Medicaid covered benefit of a managed care organization of which the client is a member, the provider will assure that timely referrals are made and that coordination of care occurs. Case management services shall be directed through a case manager who is an individual solely dedicated to that function. OHCA reimbursement will require that case managers may not provide clinical services and clinical staff may not provide case management services.

(C) Providers. Case management services must be provided by a qualifying provider of early intervention case management as certified by the State Department of Education, pursuant to the requirements of the Individuals with Disabilities Education Act, Amendments of 1997.

(3) Special Health Care Needs program. For children who are not eligible for Medicaid, and the application has been approved for Special Health Care Needs services through the Oklahoma Department of Human Services, a request for prior authorization for services must be submitted to the Medical Authorization Unit of OHCA for review and approval.

(4) Individuals eligible for Part B of Medicare. Case Management Services provided to Medicare eligible recipients should be filed directly with the fiscal agent.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 16 Ok Reg 1927, eff 6-11-99]

317:30-5-622. Reimbursement

Reimbursement for early intervention case management services will be based on a unit of service of 10 minutes.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 16 Ok Reg 1927, eff 6-11-99 ; Amended at 19 Ok Reg 2134, eff 6-27-02]

317:30-5-623. Billing [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 16 Ok Reg 1927, eff 6-11-99 ; Revoked at 19 Ok Reg 2134, eff 6-27-02]

317:30-5-624. Documentation of records

All early intervention case management services rendered must be reflected by documentation in the records. When billing for procedures which are reimbursed on a time frame basis, documentation should be placed in the patient's chart as to the beginning and ending times for the services claimed.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95]

PART 73. EARLY INTERVENTION SERVICES

317:30-5-640. General provisions and eligible providers

(a) General provisions.

(1) Payment is made to eligible providers certified by the Oklahoma State Department of Education (OSDE) or the Oklahoma State Department of Health (OSDH) for the delivery of Early Periodic Screening, Diagnosis and Treatment (EPSDT) services to infants and toddlers from birth up to their third birthday with developmental disabilities, pursuant to the requirements of the Individuals with Disabilities Education Improvement Act (IDEIA) of 2004, Public Law 108-446 Part C, and subsequent amendments.

(2) EPSDT services are comprehensive child-health services, designed to ensure the availability of, and access to, required health care resources and to help parents and guardians of SoonerCare eligible children use these resources. Effective EPSDT services assure that health problems are diagnosed and treated early before they become more complex and their treatment more costly. The OSDE and the OSDH play a significant role in educating parents about EPSDT services.

(3) An Individualized Family Services Plan (IFSP) entitles the SoonerCare eligible child to medically necessary and appropriate health related EPSDT treatment services. Such services must be allowable under federal Medicaid regulations and must be necessary to ameliorate or correct defects of physical or mental illnesses or conditions.

(4) Federal regulations require that the State set standards and protocols for each component of EPSDT services. The standards must provide for services at intervals that meet reasonable standards of medical and dental practice. The standards must also provide for EPSDT services at other intervals as medically necessary to determine the existence of certain physical and mental illnesses or conditions. SoonerCare providers who offer

EPSDT screenings must assure that the screenings they provide meet the minimum standards for those services in order to be reimbursed at the level established for EPSDT services.

(b) Eligible providers. Eligible providers are state education and health departments and their contract agencies as designated in the State's Plan for Early Intervention Services, developed in response to the requirements of Part C of the IDEA and who are enrolled as eligible SoonerCare providers. A completed contract to provide EPSDT health related services must be submitted to the Oklahoma Health Care Authority (OHCA). Providers must have a SoonerCare provider agreement in order to receive reimbursement.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 16 Ok Reg 1927, eff 6-11-99 ; Amended at 23 Ok Reg 2562, eff 6-25-06 ; Amended at 31 Ok Reg 1684, eff 9-12-14]

317:30-5-640.1. Periodicity schedule

(a) The Oklahoma Health Care Authority requires that all physicians providing reimbursable Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screens adopt and utilize the American Academy of Pediatrics and Bright Futures periodicity schedule.

(b) Medicaid-eligible children and adolescents enrolled in SoonerCare are referred to their SoonerCare provider for EPSDT screens. In cases where the SoonerCare provider authorizes the qualified provider of health related services to perform the screen or fails to schedule an appointment within three (3) weeks and a request has been made and documented by the staff of the Oklahoma State Department of Education and Oklahoma State Department of Health (OSDH), or the latter's contractors, the OSDH may then furnish the EPSDT child-health screening and bill it as a fee-for-service (FFS) activity. Results of the child-health screening are forwarded to the member's SoonerCare provider.

(c) For periodic and interperiodic screening examination, please refer to Oklahoma Administrative Code 317:30-3-65 through 317:30-3-65.12.

[Source: Added at 16 Ok Reg 1927, eff 6-11-99 ; Amended at 23 Ok Reg 2562, eff 6-25-06 ; Amended at 35 Ok Reg 1394, eff 10-1-18 ; Amended at 39 Ok Reg 1425, eff 9-12-22]

317:30-5-641. Coverage by category

Payment is made for early intervention services as set forth in this Section.

(1) **Adults.** There is no coverage for services rendered to adults.

(2) **Children.** Payment is made for compensable services rendered by the Oklahoma State Department of Health (OSDH) and its contractors, pursuant to the State's plan for Early Intervention services required under Part C of the IDEA.

(A) **Child health screening examination.** An initial screening may be requested by the family of an eligible individual at any time and must be provided without regard to whether the individual's age coincides with the established periodicity schedule. Coordination - referral is

made to the SoonerCare provider to assure at a minimum, that periodic screens are scheduled and provided in accordance with the periodicity schedule following the initial screening.

(B) Child health encounter (EPSDT partial screen).

The child health encounter (the EPSDT partial screen) may include a diagnosis and treatment encounter, a follow-up health encounter, or a home visit. A child health encounter may include:

- (i) Child health history,
- (ii) Physical examination,
- (iii) Developmental assessment,
- (iv) Nutrition assessment and counseling,
- (v) Social assessment and counseling,
- (vi) Indicated laboratory and screening tests,
- (vii) Screening for appropriate immunizations,
- (viii) Health counseling, and
- (ix) Treatment of common childhood illness and conditions.

(C) Hearing and Hearing Aid evaluation. Hearing evaluations must meet guidelines found at Oklahoma Administrative Code (OAC) 317:30-5-676.

(D) Audiometry test. Audiometric test (Immittance [Impedance] audiometry or tympanometry) includes bilateral assessment of middle ear status and reflex studies (when appropriate) provided by a state licensed audiologist as listed in OAC 317:30-5-675 (d) (1) and (2).

(E) Ear impression (for earmold). Ear impression (for earmold) includes taking impression of client's ear and providing a finished earmold which is used with the client's hearing aid provided by a state licensed audiologist as listed in OAC 317:30-5-675 (d) (1) and (2).

(F) Speech language evaluation. Speech language evaluation must be provided by a fully licensed speech-language pathologist.

(G) Physical therapy evaluation. Physical therapy evaluation must be provided by a fully licensed physical therapist.

(H) Occupational therapy evaluation. Occupational therapy evaluation must be provided by a fully licensed occupational therapist.

(I) Psychological evaluation and testing. Psychological evaluation and testing must be provided by State-licensed, board certified, psychologists.

(J) Vision testing. Vision testing examination must be provided by a State licensed Doctor of Optometry (O.D.) or licensed physician specializing in ophthalmology (M.D. or D.O.). At a minimum, vision services include diagnosis and treatment for defects in vision.

(K) Treatment encounter. A treatment encounter may occur through the provision of individual, family or group

treatment services to infants and toddlers who are identified as having specific disorders or delays in development, emotional or behavioral problems, or disorders of speech, language, vision, or hearing. These types of encounters are initiated following the completion of a diagnostic encounter and subsequent development of the Individual Family Services Plan (IFSP), and may include the following:

(i) **Hearing and Vision Services.** These services include assisting the family in managing the child's vision and/or hearing disorder such as auditory training, habilitation training, communication management, orientation and mobility, and counseling the family. This encounter is designed to assist children and families with management issues that arise as a result of hearing and/or vision loss. These services are usually provided by vision impairment teachers or specialists and orientation specialists, and mobility specialists. These services may be provided in the home or community setting, such as a specialized day care center. Hearing services must be provided by:

- (I) A state-licensed audiologist; or
- (II) A fully licensed, speech-language pathologist; or
- (III) An audiologist or speech-language pathologist who has completed the equivalent educational requirements and work experience necessary for the certificate or has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

(ii) **Speech-language therapy services.** Speech-language therapy services must be provided by:

- (I) A fully licensed, speech-language pathologist who meets the requirements found at OAC 317:30-5-675 (a) (1) through (3);
- (II) A licensed speech-language pathology assistant who is working under the supervision of a speech-language pathologist and meets the requirements found at OAC 317:30-5-675 (b) (1) through (4); or
- (III) A licensed speech-language pathology clinical fellow, who is working under the supervision of a fully licensed speech-language pathologist and meets the requirements found at OAC 317:30-5-675 (c) (1) through (4).

(iii) **Physical therapy services.** Physical therapy services must be provided by a fully licensed physical therapist or physical therapist assistant, per OAC 317:30-5-290.1.

(iv) **Occupational therapy services.** Occupational therapy may include provision of services to improve, develop or restore impaired ability to function independently and must be provided by a fully licensed occupational therapist or occupational therapy assistant, per OAC 317:30-5-295.

(v) **Nursing services.** Nursing services may include the provision of services to protect the health status of infants and toddlers, correct health problems, and assist in removing or modifying health related barriers and must be provided by a registered nurse or licensed practical nurse under supervision of a registered nurse. Services may include medically necessary procedures rendered in the child's home.

(vi) **Psychological services.** Psychological and counseling services are planning and managing a program of psychological services, including the provision of counseling or consultation to the family of the infant or toddler, when the service is for the direct benefit of the child and assists the family to better understand and manage the child's disabilities. Psychological services must be provided by a State-licensed psychologist.

(vii) **Psychotherapy counseling services.** Psychotherapy counseling services are the provision of counseling for children and parents. All services must be for the direct benefit of the child. Psychotherapy counseling services must be provided by a State licensed Social Worker, a State Licensed Professional Counselor, a State licensed Psychologist, State licensed Marriage and Family Therapist, or a State licensed Behavioral Practitioner, or under Board Supervision to be licensed in one of the above stated areas.

(viii) **Family Training and Counseling for Child Development.** Family Training and Counseling for Child Development services are the provision of training and counseling regarding concerns and problems in development. Services integrate therapeutic intervention strategies into the daily routines of a child and family in order to restore or maintain function and/or to reduce dysfunction resulting from a mental or physical disability or developmental delay. All services must be for the direct benefit of the child. Family Training and

Counseling for Child Development services must be provided by a Certified Child Development Specialist.

(L) **Immunizations.** Immunizations must be coordinated with the Primary Care Physician for those infants and toddlers enrolled in SoonerCare. An administration fee, only, can be paid for immunizations provided by the OSDH.

(M) **Assistive Technology.** Assistive technology is the provision of services that help to select a device and assist a student with a disability(ies) to use an Assistive Technology device including coordination with other therapies and training of the child and caregiver. Services must be provided by a:

- (i) A fully licensed speech-language pathologist as listed in OAC 317:30-5-675 (a) (1) through (3);
- (ii) A fully licensed physical therapist as listed in OAC 317:30-5-290.1 (a); or
- (iii) A fully licensed occupational therapist as listed in OAC 317:30-5-295 (a).

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 16 Ok Reg 1927, eff 6-11-99 ; Amended at 18 Ok Reg 2579, eff 6-25-01 ; Amended at 23 Ok Reg 2562, eff 6-25-06 ; Amended at 31 Ok Reg 1684, eff 9-12-14 ; Amended at 38 Ok Reg 411, eff 2-1-21 (emergency); Amended at 38 Ok Reg 1006, eff 9-1-21]

317:30-5-641.1. Periodic and interperiodic screening examination [REVOKED]

[Source: Added at 16 Ok Reg 1927, eff 6-11-99 ; Amended at 23 Ok Reg 2562, eff 6-25-06 ; Amended at 38 Ok Reg 985, eff 9-1-21 ; Revoked at 39 Ok Reg 1425, eff 9-12-22]

317:30-5-641.2. Interperiodic screening examination [REVOKED]

[Source: Added at 16 Ok Reg 1927, eff 6-11-99 ; Revoked at 23 Ok Reg 2562, eff 6-25-06]

317:30-5-641.3. Reporting of suspected child abuse/neglect Refer to OAC 317:30-5-2(b)(6).

[Source: Added at 16 Ok Reg 1927, eff 6-11-99 ; Amended at 23 Ok Reg 2562, eff 6-25-06]

317:30-5-642. Services [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 16 Ok Reg 1927, eff 6-11-99 ; Amended at 18 Ok Reg 2579, eff 6-25-01 ; Amended at 18 Ok Reg 3633, eff 8-22-01 (emergency); Amended at 19 Ok Reg 1067, eff 5-13-02 ; Amended at 19 Ok Reg 2134, eff 6-27-02 ; Revoked at 23 Ok Reg 2562, eff 6-25-06]

317:30-5-643. Billing [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 16 Ok Reg 1927, eff 6-11-99 ; Amended at 18 Ok Reg 2579, eff 6-25-01 ;

317:30-5-644. Documentation of records

All early intervention services rendered must be reflected by documentation in the records. Documentation of records must include the provider's signature or identifiable initials for every prescription or treatment. Documentation of records may be completed manually or electronically in accordance with guidelines found at OAC 317:30-3-15. Each required element of the age specific screening must be documented with a description of any noted problem anomaly or concern. In addition, a plan for following necessary diagnostic evaluations, procedures and treatments, must be documented.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 16 Ok Reg 1927, eff 6-11-99 ; Amended at 18 Ok Reg 2579, eff 6-25-01 ; Amended at 19 Ok Reg 2134, eff 6-27-02 ; Amended at 23 Ok Reg 2562, eff 6-25-06 ; Amended at 31 Ok Reg 1684, eff 9-12-14]

PART 75. FEDERALLY QUALIFIED HEALTH CENTERS

317:30-5-659. Definitions

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

"**APRN**" means advanced practice registered nurse.

"**C.F.R**" means the U.S. Code of Federal Regulations.

"**CLIA**" means the Clinical Laboratory Improvement Amendments.

"**CMS**" means the Centers for Medicare and Medicaid Services.

"**CNM**" means certified nurse midwife.

"**Core services**" means outpatient services that may be covered when furnished to a patient at the Center or other location, including the patient's place of residence.

"**CPT**" means current procedural terminology.

"**CSW**" means clinical social worker.

"**Encounter**" or "**visit**" means a face-to-face contact between an approved health care professional as authorized in the FQHC pages of the Oklahoma Medicaid State Plan and an eligible SoonerCare member for the provision of defined services through a Health Center within a twenty-four (24) hour period ending at midnight, as documented in the patient's medical record.

"**FFS**" means the current OHCA's fee-for-service reimbursement rate.

"**FQHC**" means Federally Qualified Health Center.

"**HHS**" means the U.S. Department of Health and Human Services.

"**HRSA**" means the Health Resources and Services Administration.

"**Licensed behavioral health professional (LBHP)**" means any of the following practitioners:

(A) An allopathic or osteopathic physician with a current license and board certification in psychiatry or board eligible in the state in which services are provided, or a current resident in psychiatry practicing as described in

OAC 317:30-5-2.

(B) A practitioner with a current license to practice in the state in which services are provided, within one (1) of the areas of practice listed in (i) through (vi).

- (i) Psychology;
- (ii) Social work (clinical specialty only);
- (iii) Professional counselor;
- (iv) Marriage and family therapist;
- (v) Behavioral practitioner; or
- (vi) Alcohol and drug counselor.

(C) An advanced practice registered nurse certified in a psychiatric mental health specialty, and licensed as a registered nurse (RN) with a current certification of recognition from the board of nursing in the state in which services are provided.

(D) A physician assistant who is licensed and in good standing in the state and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or counseling functions.

"OAC" means the Oklahoma Administrative Code.

"OHCA" means the Oklahoma Health Care Authority.

"Other ambulatory services" means other health services covered under the Oklahoma Medicaid State Plan other than core services.

"PA" means physician assistant.

"Physician" means:

- (A) A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which the function is performed or who is a licensed physician employed by the Public Health Service;
- (B) Within limitations as to the specific services furnished, a doctor of dentistry or dental, a doctor of optometry, or a doctor of podiatry.

"Physicians' services" means professional services that are performed by a physician at the Health Center (or are performed away from the Center, excluding inpatient hospital services) whose agreement with the Center provides that he or she will be paid by the Health Center for such services.

"PPS" means prospective payment system all-inclusive per visit rate method specified in the Oklahoma Medicaid State Plan.

[Source: Added at 38 Ok Reg 1043, eff 9-1-21]

317:30-5-660. Eligible providers

(a) FQHCs are community-based health care providers that receive federal funds to provide primary care services in underserved areas. FQHCs may be Community Health Centers, Migrant Health Centers, Health Care for the Homeless, and Health Centers for Residents of Public Housing. The facilities in this Part may also be referred to as "Health Centers" or "Centers".

(b) To qualify as an FQHC SoonerCare provider, Health Centers must meet one (1) of the following requirements:

- (1) Received a grant under Section 330 of the Public Health Service (PHS) Act or is funded by the same grant contracted to the recipient;
- (2) Based on the recommendation of the Health Resources and Services Administration within the Public Health Service, is determined by the Secretary to meet the requirements for receiving such a grant, which qualifies the entity as an "FQHC look-alike";
- (3) Treated by the Secretary of HHS as a comprehensive federally funded health center; or
- (4) Operating as an outpatient health program or facility of a tribe or tribal organization under the Indian Self-Determination Act or as an urban Indian organization getting funds under Title V of the Indian Health Care Improvement Act.

(c) Any entity seeking to qualify as a FQHC should contact the U.S. Public Health Service.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 23 Ok Reg 3183, eff 6-7-06 (emergency); Amended at 24 Ok Reg 2105, eff 6-25-07 ; Amended at 38 Ok Reg 1043, eff 9-1-21]

317:30-5-660.1. Health Center multiple sites contracting

- (a) Health Centers may contract as SoonerCare Traditional providers and as a PCP under SoonerCare Choice (Refer to OAC 317:25-7-5).
- (b) Health Centers are required to submit a list of all entities affiliated or owned by the Center including any programs that do not have Health Center status, along with all OHCA provider numbers.
- (c) Payment for FQHC services is based on a PPS reimbursement. (Refer to OAC 317:30-5-664.10) In order to be eligible for reimbursement under this method for covered services, in traditional primary care settings, each site must submit an approval copy of the HRSA Notice of Grant Award Authorization for Public Health Services Funds under Section 330, (or a copy of the recommendation letter from the HRSA designating the facility as a "Look Alike" FQHC) at the time of enrollment.

[Source: Added at 23 Ok Reg 3183, eff 6-7-06 (emergency); Added at 24 Ok Reg 2105, eff 6-25-07 ; Amended at 28 Ok Reg 123, eff 10-14-10 (emergency); Amended at 28 Ok Reg 1443, eff 6-25-11 ; Amended at 32 Ok Reg 1087, eff 8-27-15 ; Amended at 38 Ok Reg 1043, eff 9-1-21]

317:30-5-660.2. Health Center professional staff

- (a) Health Centers must either directly employ or contract the services of professional staff who is licensed or certified and in good standing in the state in which services are provided. Services must be within the scope of the professional's license or certification for which claims are submitted to OHCA or its designated agent.
- (b) Professional staff contracted or employed by the Health Center recognized by the OHCA for direct reimbursement are required to individually enroll with the OHCA and will be affiliated with the organization which contracts or employs them. Participating Health

Centers are required to submit a list of names upon request of all practitioners working within the Center and a list of all individual OHCA provider numbers. Reimbursement for services rendered at or on behalf of the Health Center is made to the organization. Practitioners eligible for direct reimbursement for providing services to a clinic patient outside of the clinic may bill with their individual assigned number if they are not compensated under agreement by the Health Center.

(c) Other providers who are not eligible for direct reimbursement may be recognized by OHCA for the provision and payment of FQHC services to a health center as long as they are licensed or certified in good standing and meet OHCA enrollment requirements.

[Source: Added at 23 Ok Reg 3183, eff 6-7-06 (emergency); Added at 24 Ok Reg 2105, eff 6-25-07 ; Amended at 38 Ok Reg 1043, eff 9-1-21]

317:30-5-660.3. Health Center enrollment requirements for specialty behavioral health services

(a) For the provision of behavioral health related case management services and psychosocial rehabilitation services, Health Centers must contract as an outpatient behavioral health agency and meet the requirements found at OAC 317:30-5-241.3 and 317:30-5-241.6.

(b) Health Centers which provide substance use treatment services must also be certified by the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS).

[Source: Added at 23 Ok Reg 3183, eff 6-7-06 (emergency); Added at 24 Ok Reg 2105, eff 6-25-07 ; Amended at 28 Ok Reg 123, eff 10-14-10 (emergency); Amended at 28 Ok Reg 1443, eff 6-25-11 ; Amended at 33 Ok Reg 804, eff 9-1-16 ; Amended at 34 Ok Reg 674, eff 9-1-17 ; Amended at 41 Ok Reg, Number 14, effective 3-8-24 (emergency)]

317:30-5-660.4. Health Center enrollment requirements for health services in a school setting

(a) Physical and behavioral health services provided in accordance with the Individuals with Disabilities Education Act (IDEA) and pursuant to an Individual Education Plan (IEP) or Individual Family Service Plan (IFSP) are the responsibility of the school district. Health Centers must contract with the school district and invoice the school district for services rendered. (Refer to OAC 317:30-5-1020 through 30-5-1027). Reimbursement is made directly to the school.

(b) Payment may be made for FQHC services to Health Centers that have a school-based health center that meets the definition of Section 2110(c) (9) of the Social Security Act.

[Source: Added at 23 Ok Reg 3183, eff 6-7-06 (emergency); Added at 24 Ok Reg 2105, eff 6-25-07 ; Amended at 28 Ok Reg 123, eff 10-14-10 (emergency); Amended at 28 Ok Reg 1443, eff 6-25-11]

317:30-5-660.5. Health Center service definitions [REVOKED]

[Source: Added at 23 Ok Reg 3183, eff 6-7-06 (emergency); Added at 24 Ok Reg 2105, eff 6-25-07 ; Amended at 28 Ok Reg 123, eff 10-14-10 (emergency); Amended at 28 Ok Reg 1443, eff 6-25-11 ; Amended at 33 Ok Reg 826, eff 9-1-16 ; Revoked at 38 Ok Reg 1043, eff 9-1-21]

317:30-5-661. Coverage by category [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 13 Ok Reg 411, eff 11-14-95 (emergency); Amended at 13 Ok Reg 1645, eff 5-27-96 ; Amended at 16 Ok Reg 141, eff 10-14-98 (emergency); Amended at 16 Ok Reg 1429, eff 5-27-99 ; Amended at 19 Ok Reg 2922, eff 7-1-02 (emergency); Amended at 20 Ok Reg 1193, eff 5-27-03 ; Amended at 23 Ok Reg 3183, eff 6-7-06 (emergency); Amended at 24 Ok Reg 2105, eff 6-25-07 ; Revoked at 38 Ok Reg 1043, eff 9-1-21]

317:30-5-661.1. Coverage of core services

Health Center services are covered for SoonerCare adults and children as set forth in this Part, unless otherwise specified.

- (1) Services furnished by a physician, PA, APRN, CNM, CP, or CSW.
- (2) Services and supplies incident to services provided by a physician, PA, APRN, CNM, CP, or CSW are covered in accordance with 42 C.F.R §§ 405.2413 and 405.2415, if the service or supply is:
 - (A) Furnished in accordance with State law;
 - (B) A type commonly furnished in physicians' offices;
 - (C) A type commonly rendered either without charge or included in the FQHC's bill;
 - (D) Furnished as an incidental, although integral, part of a physician, PA, APRN, CNM, CP or CSW services; or
 - (E) Furnished under the direct supervision of a physician PA, APRN, or CNM; and
 - (F) Drugs and biologicals which cannot be self-administered or are specifically covered by Medicare law, are included within the scope of FQHC services. Drugs and biologicals commonly used in life saving procedures, such as analgesics, anesthetics (local), antibiotics, anticonvulsants, antidotes and emetics, serums and toxoids are not billed separately.
 - (G) "Services and supplies incident to" include but are not limited to services such as minor surgery, reading x-rays, setting casts or simple fractures and other activities that involve evaluation or treatment of a patient's condition. They also include laboratory services performed by the Health Center, specimen collection for laboratory services furnished by an off-site CLIA certified laboratory and injectable drugs.
- (3) Visiting nurse services to the homebound are covered if:
 - (A) The FQHC is located in an area in which the Secretary of Health and Human Services has determined there is a shortage of home health agencies;
 - (B) The services are rendered to members who are homebound;
 - (C) The member is furnished nursing care on a part-time or intermittent basis by a registered nurse, licensed practical nurse, or licensed vocational nurse who is employed by or receives compensation for the services

- from the FQHC; and
(D) The services are furnished under a written plan of treatment as required by 42 C.F.R § 405.2416.
- (4) Preventive primary services in accordance with 42 C.F.R § 405.2448;
 - (5) Medical nutrition services in accordance with OAC 317:30-5-1075 through 317:30-5-1076; and
 - (6) Preventive primary dental services.

[Source: Added at 23 Ok Reg 3183, eff 6-7-06 (emergency); Added at 24 Ok Reg 2105, eff 6-25-07 ; Amended at 28 Ok Reg 123, eff 10-14-10 (emergency); Amended at 28 Ok Reg 1443, eff 6-25-11 ; Amended at 34 Ok Reg 612, eff 9-1-17 ; Amended at 38 Ok Reg 1043, eff 9-1-21]

317:30-5-661.2. Services and supplies "incident to" Health Center encounters [REVOKED]

[Source: Added at 23 Ok Reg 3183, eff 6-7-06 (emergency); Added at 24 Ok Reg 2105, eff 6-25-07 ; Revoked at 38 Ok Reg 1043, eff 9-1-21]

317:30-5-661.3. Visiting Nurse services [REVOKED]

[Source: Added at 23 Ok Reg 3183, eff 6-7-06 (emergency); Added at 24 Ok Reg 2105, eff 6-25-07 ; Revoked at 38 Ok Reg 1043, eff 9-1-21]

317:30-5-661.4. Behavioral health professional services provided at Health Centers and other settings

(a) Medically necessary behavioral health services that are primary, preventive, and therapeutic and that would be covered if provided in another setting may be provided by Health Centers. Services provided by a Health Center (refer to OAC 317:30-5-241 for a description of services) must meet the same requirements as services provided by other behavioral health providers. Rendering providers must be eligible to individually enroll or meet the requirements as an agency/organization provider specified in OAC 317:30-5-240.2 and 317:30-5-280. Behavioral Health Services include:

- (1) Assessment/Evaluation;
- (2) Crisis Intervention Services;
- (3) Individual/Interactive Psychotherapy;
- (4) Group Psychotherapy;
- (5) Family Psychotherapy;
- (6) Psychological Testing; and
- (7) Case Management (as an integral component of services 1-6 above).

(b) Medically necessary behavioral health professional therapy services are covered when provided in accordance with a documented individualized treatment plan, developed to treat the identified behavioral health disorder(s). A one-on-one standard clinical session must be completed by a health care professional authorized in the approved FQHC State Plan pages in order to bill the PPS encounter rate for the session. Services rendered by providers not authorized under the approved FQHC state plan pages to bill the PPS encounter rate will be

reimbursed pursuant to the SoonerCare fee-for-service fee schedule and must comply with rules found at OAC 317:30-5-280 through 317:30-5-283. Behavioral health services must be billed on an appropriate claim form using appropriate Current Procedural Terminology (CPT) procedure code and guidelines. The time indicated on the claim form must be the time actually spent with the member.

(c) Centers are reimbursed the PPS rate for services when rendered by approved health care professionals, as authorized under FQHC state plan pages, if the Health Center receives funding pursuant to Section 330 or is otherwise funded under Public Law to provide primary health care services at locations off-site (not including satellite or mobile locations) to Health Center patients on a temporary or intermittent basis, unless otherwise limited by Federal law.

(d) Health Centers that operate day treatment programs in school settings must meet the requirements found at OAC 317:30-5-240.2(b)(7).

(e) In order to support the member's access to behavioral health services, these services may take place in settings away from the Health Center. Off-site behavioral health services must take place in a confidential setting.

[Source: Added at 23 Ok Reg 3183, eff 6-7-06 (emergency); Added at 24 Ok Reg 2105, eff 6-25-07 ; Amended at 28 Ok Reg 123, eff 10-14-10 (emergency); Amended at 28 Ok Reg 1443, eff 6-25-11 ; Amended at 33 Ok Reg 804, eff 9-1-16 ; Amended at 34 Ok Reg 674, eff 9-1-17]

317:30-5-661.5. Health Center preventive primary care services

(a) Preventive primary care services, as described in 42 C.F.R § 405.2448, are those health services that:

- (1) A Health Center is required to provide as preventive primary health services under section 330 of the Public Health Service Act;
- (2) Are furnished by or under the direct supervision of a physician, PA, APRN, CNM, CP, CSW or other approved health care professional as authorized in the approved FQHC State Plan pages;
- (3) Are furnished by a member of the Health Center's health care staff who is an employee of the Center or provides services under arrangements with the Center; and
- (4) Includes only drugs and biologicals that cannot be self-administered.

(b) Preventive primary care services which may be paid for when provided by Health Centers include:

- (1) Medical social services;
- (2) Nutritional assessment and referral;
- (3) Preventive health education;
- (4) Children's eye and ear examinations;
- (5) Prenatal and post-partum care;
- (6) Perinatal services;
- (7) Well child care, including periodic screening (refer to OAC 317:30-3-65);
- (8) Immunizations, including tetanus-diphtheria booster and influenza vaccine;

- (9) Family planning services;
- (10) Taking patient history;
- (11) Blood pressure measurement;
- (12) Weight;
- (13) Physical examination targeted to risk;
- (14) Visual acuity screening;
- (15) Hearing screening;
- (16) Cholesterol screening;
- (17) Stool testing for occult blood;
- (18) Dipstick urinalysis;
- (19) Risk assessment and initial counseling regarding risks;
- (20) Tuberculosis testing for high risk patients;
- (21) Clinical breast exam;
- (22) Referral for mammography; and
- (23) Thyroid function test.
- (24) Dental services (specified procedure codes).

(c) Primary care services do not include:

- (1) Health education classes, or group education activities, including media productions and publications, group or mass information programs;
- (2) Eyeglasses, hearing aids or preventive dental services (except under EPSDT);
- (3) Screening mammography provided at a Health Center unless the Center meets the requirements as specified in OAC 317:30-5-900; and
- (4) Vaccines covered by the Vaccines for Children program (refer to OAC 317:30-5-14).

[Source: Added at 23 Ok Reg 3183, eff 6-7-06 (emergency); Added at 24 Ok Reg 2105, eff 6-25-07 ; Amended at 28 Ok Reg 123, eff 10-14-10 (emergency); Amended at 28 Ok Reg 1443, eff 6-25-11 ; Amended at 38 Ok Reg 1043, eff 9-1-21]

317:30-5-661.6. Health Center preventive and primary care exclusions [REVOKED]

[Source: Added at 23 Ok Reg 3183, eff 6-7-06 (emergency); Added at 24 Ok Reg 2105, eff 6-25-07 ; Revoked at 38 Ok Reg 1043, eff 9-1-21]

317:30-5-661.7. Allowable Places of services

(a) Services provided to members within the four walls of the Health Center and approved Health Center satellites including mobile health clinics operated by the Center are allowable for reimbursement under the PPS.

(b) Off-site services provided by employed practitioners of the Health Center to patients temporarily homebound or in any skilled nursing facility because of a medical condition that prevents the patient from going to the Health Center for health care are also allowable for reimbursement under the PPS encounter rate if the service would be reimbursed the PPS at the Center. It is expected that services provided in off-site settings should be, in most cases, temporary and intermittent, i.e., when the member cannot come to the clinic due to health reasons.

[Source: Added at 23 Ok Reg 3183, eff 6-7-06 (emergency); Added at 24 Ok Reg 2105, eff 6-25-07 ; Amended at 28 Ok Reg 123, eff 10-14-10 (emergency); Amended at 28 Ok Reg 1443, eff 6-25-11]

317:30-5-662. Reimbursement [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 23 Ok Reg 3183, eff 6-7-06 (emergency); Revoked at 24 Ok Reg 2105, eff 6-25-07]

317:30-5-663. Billing [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 13 Ok Reg 411, eff 11-14-95 (emergency); Amended at 13 Ok Reg 1645, eff 5-27-96 ; Amended at 16 Ok Reg 141, eff 10-14-98 (emergency); Amended at 16 Ok Reg 1429, eff 5-27-99 ; Amended at 19 Ok Reg 2134, eff 6-27-02 ; Revoked at 23 Ok Reg 3183, eff 6-7-06 (emergency); Revoked at 24 Ok Reg 2105, eff 6-25-07]

317:30-5-664. Timely filing [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 19 Ok Reg 2134, eff 6-27-02 ; Revoked at 23 Ok Reg 3183, eff 6-7-06 (emergency); Revoked at 24 Ok Reg 2105, eff 6-25-07]

317:30-5-664.1. Provision of other health services outside of the Health Center core services

(a) If the Center chooses to provide other Oklahoma Medicaid State Plan covered health services which are not included in the Health Center core service definition in OAC 317:30-5-661.1, the practitioners of those services are subject to the same program coverage limitations, enrollment, and billing procedures described by the OHCA, and these services (e.g., home health services) are not included in the Prospective Payment System settlement methodology in OAC 317:30-5-664.12.

(b) Other medically necessary health services that will be reimbursed at the fee-for-service rate include, but are not limited to:

- (1) Dental services (refer to OAC 317:30-5-696) except for primary preventive dental services;
- (2) Eyeglasses (refer to OAC 317:30-5-431, 317:30-5-432.1 and 317:30-5-451);

- (3) Clinical lab tests performed in the Center lab (other than the specific laboratory tests set out for Health Centers' certification and covered as Health Center services);
- (4) Technical component of diagnostic tests such as x-rays and EKGs (interpretation of the test provided by the Center physician is included as physician professional services);
- (5) Durable medical equipment (refer to OAC 317:30-5-210);
- (6) Transportation by ambulance (refer to OAC 317:30-5-335);
- (7) Prescribed drugs (refer to OAC 317:30-5-70);
- (8) Prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags) and supplies directly related to colostomy care and the replacement of such devices;
- (9) Specialized laboratory services furnished away from the clinic;
- (10) Psychosocial rehabilitation services (refer to OAC 317:30-5-241.3);
- (11) Behavioral health related case management services (refer to OAC 317:30-5-241.6); and
- (12) Applied behavior analysis (ABA) (refer to OAC 317:30-3-65.12).
- (13) Diabetes self-management education and support (DSMES) services (refer to OAC 317:30-5-1080 through 317:30-5-1084).
- (14) Long-acting reversible contraceptive devices (devices are not considered part of the FQHC encounter rate and can be billed separately).

[Source: Added at 23 Ok Reg 3183, eff 6-7-06 (emergency); Added at 24 Ok Reg 2105, eff 6-25-07 ; Amended at 33 Ok Reg 804, eff 9-1-16 ; Amended at 34 Ok Reg 674, eff 9-1-17 ; Amended at 36 Ok Reg 1099, eff 7-1-19 (emergency); Amended at 37 Ok Reg 514, eff 1-6-20 (emergency); Amended at 37 Ok Reg 1492, eff 9-14-20 ; Amended at 38 Ok Reg 1043, eff 9-1-21 ; Amended at 39 Ok Reg 423, eff 12-30-21 (emergency); Amended at 39 Ok Reg 1490, eff 9-12-22]

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, 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 and other approved health services at the PPS rate.
- (c) Primary and preventive behavioral health services rendered by health care professionals authorized in the FQHC approved state plan pages will be reimbursed at the PPS encounter rate.
- (d) Vision services provided by Optometrists within the scope of their licensure for non-dual eligible members and allowed under the Medicaid State Plan are reimbursed pursuant to the SoonerCare fee-for-service fee schedule.

[Source: Added at 23 Ok Reg 3183, eff 6-7-06 (emergency); Added at 24 Ok Reg 2105, eff 6-25-07 ; Amended at 26 Ok Reg 249, eff 1-1-09 (emergency); Amended at 26 Ok Reg 1053, eff 5-11-09 ; Amended

at 28 Ok Reg 123, eff 10-14-10 (emergency); Amended at 28 Ok Reg 1443, eff 6-25-11 ; Amended at 34 Ok Reg 641, eff 9-1-17]

317:30-5-664.11. PPS rate reconciliation to Health Centers [REVOKED]

[Source: Added at 23 Ok Reg 3183, eff 6-7-06 (emergency); Added at 24 Ok Reg 2105, eff 6-25-07 ; Revoked at 28 Ok Reg 123, eff 10-14-10 (emergency); Revoked at 28 Ok Reg 1443, eff 6-25-11]

317:30-5-664.12. Determination of Health Center PPS rate

(a) **Methodology.** The methodology for establishing each facility's PPS rate is found in Attachment 4.19 B of the OHCA's State Plan, as amended effective January 1, 2001, and incorporated herein by reference.

(b) **Scope of service adjustment.** If a Center significantly changes its scope of services, the Center may request in writing that new baseline encounter rates be determined. Adjustments to encounter rates are made if it is determined that a significant change in the scope-of-service has occurred which impacts the base rate, as indicated within the State Plan. If there is a change in scope-of-service, it is the responsibility of the FQHC to request OHCA to review services that have had a change to the scope-of-service. The OHCA may initiate a rate adjustment in accordance with procedures in the State Plan, based on audited financial statements or cost reports, if the scope of services has been modified or would otherwise result in a change to the Center's current rate. If a new rate is set, the rate will be effective on the date the change in scope-of-service was implemented.

[Source: Added at 23 Ok Reg 3183, eff 6-7-06 (emergency); Added at 24 Ok Reg 2105, eff 6-25-07 ; Amended at 31 Ok Reg 657, eff 7-1-14 (emergency); Amended at 32 Ok Reg 1069, eff 8-27-15]

317:30-5-664.13. Individuals eligible for Part B of Medicare

For individuals eligible for Part B of Medicare, payment is made utilizing the SoonerCare allowable for comparable services.

[Source: Added at 23 Ok Reg 3183, eff 6-7-06 (emergency); Added at 24 Ok Reg 2105, eff 6-25-07]

317:30-5-664.14. Health Center record keeping

(a) Adequate records must be maintained to show what services were provided in the encounter claimed.

(b) All outpatient behavioral health services must be reflected by documentation in the patient records in accordance with OAC 317:30-5-248.

[Source: Added at 23 Ok Reg 3183, eff 6-7-06 (emergency); Added at 24 Ok Reg 2105, eff 6-25-07]

317:30-5-664.15. Health Center cost reporting

(a) All Health Centers requesting SoonerCare reimbursement must complete an annual report, in a format prescribed by the OHCA, covering a 12-month period of operations based upon the Center's reporting period, to accommodate all allowable costs.

- (b) Health Centers that have several sites must file the required cost report.
- (c) The cost report may be used to adjust payments based on increases or decreases in change in scope of services provided.
- (d) Health Centers select the annual period for reporting purposes, subject to approval by the OHCA.
- (e) Once the Health Center has selected a reporting period and obtained the approval of the OHCA, the Center must adhere to the period initially selected unless a change has been authorized in writing by the OHCA. Such a change is made only after the OHCA has established that the reason for such a change is valid.
- (f) Periodically, the OHCA may contract for an independent audit of the Health Center's cost report.

[Source: Added at 23 Ok Reg 3183, eff 6-7-06 (emergency); Added at 24 Ok Reg 2105, eff 6-25-07]

317:30-5-664.2. Prior authorization and referrals

- (a) Health Center encounters for core services, whether medical or behavioral health, are not subject to prior authorization. However, some Health Center services may require a referral from a PCP/CM.
- (b) Other SoonerCare State Plan covered health services that the Center chooses to provide are subject to all applicable Medicaid regulations which govern the provision and coverage for that service.

[Source: Added at 23 Ok Reg 3183, eff 6-7-06 (emergency); Added at 24 Ok Reg 2105, eff 6-25-07]

317:30-5-664.3. FQHC encounters

- (a) FQHC encounters that are billed to the OHCA must meet the definition in this Section and are limited to services covered by OHCA. Only encounters provided by an authorized health care professional listed in the approved FQHC State Plan pages within the scope of their licensure trigger a PPS encounter rate.
- (b) An encounter is defined as a face-to-face contact between a health care professional and a member for the provision of defined services through a FQHC within a twenty-four (24) hour period ending at midnight, as documented in the member's medical record.
- (c) An FQHC may bill for one (1) medically necessary encounter per twenty-four (24) hour period when the appropriate modifier is applied. Medical review will be required for additional visits for children. For information about multiple encounters, refer to OAC 317:30-5-664.4. Payment is limited to four (4) visits per member per month for adults. This limit may be exceeded if the SoonerCare Choice member has elected the FQHC as his/her/their Patient Centered Medical Home/Primary Care Provider.
- (d) Services considered reimbursable encounters (including any related medical supplies provided during the course of the encounter) include:
- (1) Medical;
 - (2) Diagnostic;
 - (3) Dental, medical and behavioral health screenings;
 - (4) Vision;

- (5) Physical therapy;
- (6) Occupational therapy;
- (7) Podiatry;
- (8) Behavioral health;
- (9) Speech;
- (10) Hearing;
- (11) Medically necessary FQHC encounters with a registered nurse or licensed practical nurse and related medical supplies (other than drugs and biologicals) furnished on a part-time or intermittent basis to home-bound members (refer to OAC 317:30-5-661.3); and
- (12) Any other medically necessary health services (i.e. optometry and podiatry) are also reimbursable as permitted within the FQHCs scope of services when medically reasonable and necessary for the diagnosis or treatment of illness or injury, and must meet all applicable coverage requirements.

(e) Services and supplies incident to the services of a physician, PA, APRN, CNM, CP and CSW are reimbursable within the encounter, as described in 42 C.F.R § 405.2413 and OAC 317:30-5-661.1.

(f) Only drugs and biologicals which cannot be self-administered are included within the scope of this benefit.

[Source: Added at 23 Ok Reg 3183, eff 6-7-06 (emergency); Added at 24 Ok Reg 2105, eff 6-25-07 ; Amended at 28 Ok Reg 123, eff 10-14-10 (emergency); Amended at 28 Ok Reg 1443, eff 6-25-11 ; Amended at 31 Ok Reg 657, eff 7-1-14 (emergency); Amended at 32 Ok Reg 1069, eff 8-27-15 ; Amended at 36 Ok Reg 912, eff 9-1-19 ; Amended at 38 Ok Reg 1043, eff 9-1-21 ; Amended at 39 Ok Reg 1515, eff 9-12-22]

317:30-5-664.4. Multiple encounters at Federally Qualified Health Centers (FQHC)

An FQHC may bill for more than one (1) medically necessary encounter per 24-hour period under certain conditions when the appropriate modifier is applied.

- (1) It is intended that multiple medically necessary encounters will occur on an infrequent basis.
- (2) An FQHC may not develop FQHC procedures that routinely involve multiple encounters for a single date of service, unless medical necessity warrants multiple encounters.
- (3) Each service must have distinctly different diagnoses in order to meet the criteria for multiple encounters. For example, a medical visit and a dental visit on the same day are considered different services with distinctly different diagnoses.
- (4) Similar services, even when provided by two (2) different health care practitioners, are not considered multiple encounters.
- (5) Encounters with more than one (1) FQHC practitioner on the same day, regardless of the length or complexity of the visit, would constitute a single visit. An exception is when the patient has either or both of these:
 - (A) An illness or injury requiring additional diagnosis or treatment subsequent to the first encounter; and/or
 - (B) A qualified medical visit, a qualified mental health and/or dental visit on the same day.

[Source: Added at 23 Ok Reg 3183, eff 6-7-06 (emergency); Added at 24 Ok Reg 2105, eff 6-25-07 ; Revoked at 31 Ok Reg 657, eff 7-1-14 (emergency); Revoked at 32 Ok Reg 1069, eff 8-27-15 ; Added at 36 Ok Reg 912, eff 9-1-19]

317:30-5-664.5. Federally Qualified Health Center (FQHC) encounter exclusions and limitations

(a) Service limitations governing the provision of all services apply pursuant to Oklahoma Administrative Code (OAC) 317:30. Excluded from the definition of reimbursable encounter core services are:

- (1) Services provided by an independently Clinical Laboratory Improvement Amendments certified and enrolled laboratory;
- (2) Radiology services including nuclear medicine and diagnostic ultrasound services;
- (3) Venipuncture for lab tests is considered part of the encounter and cannot be billed separately. When a member is seen at the clinic for a lab test only, use the appropriate Current Procedural Terminology code. A visit for "lab test only" is not considered a Center encounter;
- (4) Medical supplies, equipment, and appliances not generally provided during the course of a Center visit such as diabetic supplies. However, gauze, band-aids, or other disposable products used during an office visit are considered as part of the cost of an encounter and cannot be billed separately under SoonerCare;
- (5) Supplies and materials that are administered to the member are considered a part of the physician's or other health care

practitioner's service;

(6) Drugs or medication treatments provided during a clinic visit are included in the encounter rate. For example, a member has come into the Center with high blood pressure and is treated at the Center with a hypertensive drug or drug samples provided to the Center free of charge are not reimbursable services and are included in the cost of an encounter. Prescriptions are not included in the encounter rate and must be billed through the pharmacy program by a qualified enrolled pharmacy;

(7) Administrative medical examinations and report services;

(8) Emergency services including delivery for pregnant members that are eligible under the Non-Qualified (ineligible) provisions of OAC 317:35-5-25;

(9) SoonerPlan family planning services;

(10) Long-acting reversible contraceptive devices (devices are not considered part of the FQHC encounter rate and can be billed separately);

(11) Optometry and podiatric services other than for dual eligible for Part B of Medicare;

(12) Diabetes self-management education and support (DSMES) services (refer to OAC 317:30-5-1080 through 317:30-5-1084); and

(13) Other services that are not defined in this rule or the Oklahoma Medicaid State Plan.

(b) In addition, the following limitations and requirements apply to services provided by FQHCs:

(1) Physician services are not covered in a hospital; and

(2) Behavioral health case management and psychosocial rehabilitation services are limited to FQHCs enrolled under the provider requirements in OAC 317:30-5-240 and contracted with OHCA as an outpatient behavioral health agency.

[Source: Added at 23 Ok Reg 3183, eff 6-7-06 (emergency); Added at 24 Ok Reg 2105, eff 6-25-07 ; Amended at 28 Ok Reg 123, eff 10-14-10 (emergency); Amended at 28 Ok Reg 1443, eff 6-25-11 ; Amended at 29 Ok Reg 1085, eff 6-25-12 ; Amended at 33 Ok Reg 804, eff 9-1-16 ; Amended at 39 Ok Reg 394, eff 12-21-21 (emergency); Amended at 39 Ok Reg 423, eff 12-30-21 (emergency); Amended at 39 Ok Reg 1490, eff 9-12-22]

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

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

[Source: Added at 23 Ok Reg 3183, eff 6-7-06 (emergency); Added at 24 Ok Reg 2105, eff 6-25-07 ; Amended at 31 Ok Reg 1662, eff 9-12-14]

317:30-5-664.7. Dental services provided by Health Centers

(a) **Adults.** The Health Center core service benefit to adults is intended to provide services requiring immediate treatment, relief of pain and/or extraction and is not intended to restore teeth as described in OAC 317:30-5-696. Core services are limited to treatment for conditions such as:

- (1) Acute infection;
 - (2) Acute abscesses;
 - (3) Severe tooth pain; and
 - (4) Tooth re-implantation, when clinically appropriate.
- (b) **Children.** Medically necessary dental services for members under twenty-one (21) are covered.
- (c) **Exclusions and limitations.** Other medically necessary dental services which are not considered core services may be billed by the Health Center utilizing the current SoonerCare fee schedule, including but not limited to smoking and tobacco use cessation.
- (d) **Claims.** Health Centers must submit all claims for SoonerCare reimbursement for dental services on the American Dental Association (ADA) form.
- (e) **Other provisions.** For additional coverage, medical necessity criteria, exclusions, billing, and prior authorization requirements, refer to OAC 317:30-5-695 through 317:30-5-705.

[Source: Added at 23 Ok Reg 3183, eff 6-7-06 (emergency); Added at 24 Ok Reg 2105, eff 6-25-07 ; Amended at 28 Ok Reg 123, eff 10-14-10 (emergency); Amended at 28 Ok Reg 1443, eff 6-25-11 ; Amended at 38 Ok Reg 1043, eff 9-1-21]

317:30-5-664.8. Obstetrical care provided by Health Centers

- (a) **Billing written agreement.** In order to avoid duplicative billing situations, a Health Center must have a written agreement with its physician, certified nurse midwife, advanced practice nurse, or physician assistant that specifically identifies how obstetrical care will be billed. The agreement must specifically identify the service provider's compensation for Health Center core services and other health services that may be provided by the Health Center.
- (b) **Prenatal or postpartum services.**
- (1) If the Health Center compensates the physician, certified nurse midwife or advanced practice nurse for the provision of obstetrical care, then the Health Center bills the Oklahoma Health Care Authority (OHCA) for each prenatal and postpartum visit separately using the appropriate Current Procedural Terminology (CPT) evaluation and management code(s) as provided in the Health Center billing manual.
 - (2) If the clinic does not compensate the provider for the provision of obstetrical care, then the provider must bill the OHCA for prenatal care according to the global method described in the SoonerCare Traditional provider specific rules for physicians, certified nurse midwives, physician assistants, and advanced practice nurses [refer to Oklahoma Administrative Code (OAC) 317:30-5-22].
 - (3) Under both billing methods, payment for prenatal care includes all routine or minor medical problems. No additional payment is made to the prenatal provider except in the case of a major illness distinctly unrelated to pregnancy.
- (c) **Delivery services.** Delivery services are billed using the appropriate CPT codes for delivery. If the clinic does not compensate the provider for the provision of obstetrical care, then the provider must be individually

enrolled and bill for those services using his or her assigned provider number. The costs associated with the delivery must be excluded from the cost settlement/encounter rate setting process.

[Source: Added at 23 Ok Reg 3183, eff 6-7-06 (emergency); Added at 24 Ok Reg 2105, eff 6-25-07 ; Amended at 33 Ok Reg 846, eff 9-1-16 ; Amended at 34 Ok Reg 192, eff 11-22-16 (emergency); Amended at 34 Ok Reg 657, eff 9-1-17 ; Amended at 36 Ok Reg 863, eff 9-1-19]

317:30-5-664.9. Family planning services provided by Health Centers

Family planning services provided to SoonerCare Traditional and Choice members are considered Health Center core services.

[Source: Added at 23 Ok Reg 3183, eff 6-7-06 (emergency); Added at 24 Ok Reg 2105, eff 6-25-07]

**PART 77. SPEECH-LANGUAGE PATHOLOGISTS,
SPEECH-LANGUAGE PATHOLOGY ASSISTANTS,
CLINICAL FELLOWS AND AUDIOLOGISTS**

317:30-5-675. Eligible providers

(a) Speech-language pathologist (SLP).

- (1) Must be appropriately licensed in good standing in the state in which they practice and working in accordance with the Speech-Language Pathology and Audiology Licensing Act or other applicable statute(s); and
- (2) Entered into a Provider Agreement with the Oklahoma Health Care Authority (OHCA) to provide speech-language pathology services.

(b) Speech-language pathology assistant (SLPA).

- (1) Must be working under the supervision of a fully licensed speech-language pathologist;
- (2) Must be appropriately licensed in good standing in the state in which they practice and working in accordance with the Speech-Language Pathology and Audiology Licensing Act or other applicable statute(s);
- (3) Entered into a provider agreement with the OHCA to provide speech-language pathology services; and
- (4) Provided the name of their OHCA-contracted supervising speech-language pathologist upon enrollment.

(c) Clinical fellow.

- (1) Must be working under the supervision of a fully licensed speech-language pathologist;
- (2) Must have a clinical fellow license in good standing in the state in which they practice and working in accordance with the Speech-Language Pathology and Audiology Licensing Act or other applicable statute(s);
- (3) Entered into a provider agreement with the OHCA to provide speech-language pathology services; and

(4) Provided the name of their OHCA-contracted supervising speech-language pathologist upon enrollment.

(d) Audiologists.

(1) Must be appropriately licensed in good standing in the state in which they practice and working in accordance the Speech-Language Pathology and Audiology Licensing Act or other applicable statute(s); and

(2) Entered into a provider agreement with the Oklahoma Health Care Authority (OHCA) to provide speech-language pathology and audiology services.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 17 Ok Reg 3516, eff 9-1-00 (emergency); Amended at 18 Ok Reg 1130, eff 5-11-01 ; Amended at 38 Ok Reg 411, eff 2-1-21 (emergency); Amended at 38 Ok Reg 1006, eff 9-1-21]

317:30-5-676. Coverage by category; payment rates and procedure codes

(a) **Coverage.** Payment is made for speech and hearing services as set forth in this Section.

(1) **Children.** Coverage for children is as follows:

(A) **Preauthorization required.** All therapy services, including the initial evaluation, must be prior authorized. Prior to the initial evaluation, the therapist must have on file a signed and dated prescription or referral for the therapy services from the member's physician or other licensed practitioner of the healing arts. The prescribing or referring provider must be able to provide, if requested, clinical documentation from the member's medical record that supports the medical necessity for the evaluation and referral.

(B) **Speech-language pathology services.**

(i) Speech-language pathology services may include speech-language evaluations, individual and group therapy services provided by a fully licensed and certified speech-language pathologist, a licensed speech-language pathology clinical fellow, and services within the scope of practice of a speech-language pathology assistant as directed by the supervising speech-language pathologist, as listed in Oklahoma Administrative Code (OAC) 317:30-5-675 (a) through (c).

(ii) Initial evaluations must be prior authorized and provided by a fully licensed speech-language pathologist.

(C) **Hearing aids.** Hearing and hearing aid evaluations include pure tone air, bone and speech audiometry by a state licensed audiologist. Payment is made for a hearing aid following a recommendation by a medical or osteopathic physician and a hearing aid evaluation by a state licensed audiologist.

(2) **Adults.** There is no coverage for adults for services rendered by individually contracted providers. Coverage for adults is permitted in an outpatient hospital setting as described in OAC 317:30-5-42.1.

(3) **Individuals eligible for Part B of Medicare.** Services provided to Medicare eligible recipients are filed directly with the fiscal agent.

(b) **Payment rates.** All speech-language pathology and hearing services are reimbursed per the methodology described in the Oklahoma Medicaid State Plan.

(c) **Procedure codes.** The appropriate procedure codes used for billing speech and hearing services are found in the Physicians' Current Procedural Terminology (CPT) Coding Manual.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 14 Ok Reg 524, eff 12-24-96 (emergency); Amended at 14 Ok Reg 1785, eff 5-27-97 ; Amended at 16 Ok Reg 1927, eff 6-11-99 ; Amended at 17 Ok Reg 3516, eff 9-1-00 (emergency); Amended at 18 Ok Reg 1130, eff 5-11-01 ; Amended at 24 Ok Reg 82, eff 8-2-06 (emergency); Amended at 24 Ok Reg 932, eff 5-11-07 ; Amended at 29 Ok Reg 477, eff 5-11-12 ; Amended at 30 Ok Reg 336, eff 1-14-13 (emergency); Amended at 30 Ok Reg 1163, eff 7-1-13 ; Amended at 38 Ok Reg 411, eff 2-1-21 (emergency); Amended at 38 Ok Reg 1006, eff 9-1-21 ; Amended at 39 Ok Reg 1425, eff 9-12-22]

317:30-5-677. Payment rates [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 17 Ok Reg 3516, eff 9-1-00 (emergency); Amended at 18 Ok Reg 1130, eff 5-11-01 ; Amended at 38 Ok Reg 411, eff 2-1-21 (emergency); Amended at 38 Ok Reg 1006, eff 9-1-21 ; Revoked at 39 Ok Reg 1425, eff 9-12-22]

317:30-5-678. Procedure codes [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 17 Ok Reg 3516, eff 9-1-00 (emergency); Amended at 18 Ok Reg 1130, eff 5-11-01 ; Revoked at 39 Ok Reg 1425, eff 9-12-22]

317:30-5-679. Claim form [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 19 Ok Reg 2134, eff 6-27-02]

317:30-5-680. Team therapy (Co-treatment)

Therapists, or therapy assistants, working together as a team to treat one (1) or more members cannot bill separately for the same or different service provided at the same time to the same member.

(1) Current Procedural Terminology (CPT) codes are used for billing the services of one (1) therapist or therapy assistant. The therapist cannot bill for his/her services and those of another therapist or a therapy assistant, when both provide the same or different services, at the same time, to the same member.

(2) If multiple therapies (physical therapy, occupational therapy, and/or speech therapy) are provided to one (1) member at the same time, only one (1) therapist can bill for the entire service, or each therapist can divide the service units.

(3) Providers must report the CPT code for the time actually spent in the delivery of the modality requiring constant attendance and therapy services. Pre- and post-delivery services are not to be counted in determining the treatment service time. The time counted must begin when the therapist is directly working with the member to deliver treatment services.

(4) The time counted is the time the member is being treated. If the member requires both a therapist and an assistant, or even two (2) therapists, each service unit of time the member is being treated can count as only one (1) unit of each code. The service units billed must equal the total time the member was receiving actual therapy services. It is not allowable for each therapist or therapy assistant to bill for the entire therapy session. The time the member spends not being treated, for any reason, must not be billed.

[Source: Added at 28 Ok Reg 12, eff 8-13-10 (emergency); Added at 28 Ok Reg 1475, eff 6-25-11 ; Amended at 38 Ok Reg 411, eff 2-1-21 (emergency); Amended at 38 Ok Reg 1006, eff 9-1-21]

PART 79. DENTISTS

317:30-5-695. Eligible dental providers and definitions

- (a) Eligible dental providers in Oklahoma's SoonerCare program are:
- (1) Individuals licensed as dentists under Title 59 of Oklahoma Statutes (O.S.), Sections (§§) 328.21, 328.22, and 328.23 (licensed dentists, specialty dentists and out of state dentists);
 - (2) Individuals issued permits as dental interns under 59 O.S. § 328.26;
 - (3) Individuals who are third and fourth year dental students at an accredited Oklahoma dental college; and
 - (4) Any individual issued a license in another state as a dentist.
- (b) All eligible providers must be in good standing with regard to their license. Any revocation or suspension status of a provider referenced in subsection (a) above renders the provider ineligible for payment or subject to recoupment under SoonerCare.
- (c) Eligible providers must document and sign records of services rendered in accordance with guidelines found at Oklahoma Administrative Code (OAC) 317:30-3-15.
- (d) The American Dental Association's version of Code on Dental Procedures and Nomenclature (CDT) is used by the Oklahoma Health Care Authority (OHCA) to communicate information related to codes, and procedures for administration. Definitions, nomenclature, and descriptors as listed in the CDT will apply, with the exception of more specific definitions or limitations set forth.
- (1) "**Decay**" means carious lesions in a tooth; decomposition and/or dissolution of the calcified and organic components of the tooth structure.
 - (2) "**Images**" means radiographs and diagnostic imaging that are part of the clinical record. Images should only be taken for

clinical reasons as determined by the dentist and must be of diagnostic quality, properly identified, and dated.

(3) **"Medically necessary extractions"** means, but is not limited to, an extraction of a tooth that has met medically necessary criteria due to the presence of pathology, trauma, severe periodontal involvement, significant caries, pain or infection.

(4) **"Medically necessary oral healthcare"** means treatment deemed necessary by a physician or dentist when a patient's medical condition or treatment is or will be likely complicated by an untreated oral health problem.

(5) **"Palliative treatment"** means action that relieves pain but is not curative. Palliative treatment is an all-inclusive service. No other codes are reimbursable on the same date of service.

(6) **"Radiographic caries"** means dissolution of the calcified and organic components of tooth tissue that has penetrated the enamel and is approaching the dentinoenamel junction.

(7) **"Unbundling"** means billing separately for several individual procedures that are included within one (1) CDT or Current Procedural Terminology (CPT) code.

(8) **"Upcoding"** means reporting a more complex and/or higher cost procedure than actually performed.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 14 Ok Reg 2404, eff 4-2-97 (emergency); Amended at 15 Ok Reg 1528, eff 5-11-98 ; Amended at 16 Ok Reg 692, eff 12-31-98 (emergency); Amended at 16 Ok Reg 1429, eff 5-27-99 ; Amended at 17 Ok Reg 3201, eff 6-21-00 (emergency); Amended at 18 Ok Reg 1130, eff 5-11-01 ; Amended at 18 Ok Reg 2961, eff 5-17-01 (emergency); Amended at 19 Ok Reg 1067, eff 5-13-02 ; Amended at 23 Ok Reg 2489, eff 6-25-06 ; Amended at 24 Ok Reg 660, eff 2-1-07 (emergency); Amended at 24 Ok Reg 2088, eff 6-25-07 ; Amended at 25 Ok Reg 2759, eff 5-1-08 (emergency); Amended at 26 Ok Reg 2120, eff 6-25-09 ; Amended at 28 Ok Reg 1419, eff 6-25-11 ; Amended at 33 Ok Reg 826, eff 9-1-16 ; Amended at 35 Ok Reg 1453, eff 9-14-18 ; Amended at 37 Ok Reg 1607, eff 9-14-20]

317:30-5-695.1. Payment for eligible providers

To receive payment from the Oklahoma Health Care Authority, an eligible provider must:

- (1) hold an active Medicaid contract with the OHCA;
- (2) submit a claim form in the format required by the OHCA; and
- (3) submit the claim timely to the OHCA.

[Source: Added at 17 Ok Reg 3201, eff 6-21-00 (emergency); Added at 18 Ok Reg 1130, eff 5-11-01 ; Amended at 23 Ok Reg 2489, eff 6-25-06]

317:30-5-695.2. Payment for dental interns and students

(a) For those eligible providers under OAC 317:30-5-695(a)(2) and (3) (dental interns who hold permits or third and fourth year students), in addition to the requirements of OAC 317:30-5-695.1, the following requirements must be met for OHCA to pay a claim:

- (1) the patient must be examined by an attending dentist in the dental training program;
- (2) the care delivered to the Medicaid client by the student or intern must be supervised by the attending dentist; and
- (3) the supervision by the attending dentist must be documented in the patient's medical record.

(b) Payment is made by the OHCA on behalf of the student or intern as provided above to the attending dentist and/or the institution providing the dental service.

[Source: Added at 17 Ok Reg 3201, eff 6-21-00 (emergency); Added at 18 Ok Reg 1130, eff 5-11-01 ; Amended at 18 Ok Reg 2961, eff 5-17-01 (emergency); Amended at 19 Ok Reg 1067, eff 5-13-02 ; Amended at 23 Ok Reg 2489, eff 6-25-06]

317:30-5-696. Coverage by category

Payment is made for dental services as set forth in this Section.

(1) **Adults.** The OHCA Dental Program provides basic medically necessary treatment. The services listed below are compensable for members twenty-one (21) years of age and over without prior authorization.

(A) **Comprehensive oral evaluation.** The comprehensive oral evaluation may be performed when a member has not been seen by the same dentist for more than thirty-six (36) months. The comprehensive oral evaluation must precede any images, and chart documentation must include image interpretations, six-point periodontal charting, and both medical and dental health history of the member. The comprehensive treatment plan should be the final result of this procedure.

(B) **Periodic oral evaluation.** This procedure may be provided for a member once every six (6) months. An examination must precede any images, and chart documentation must include image interpretations, and both medical and dental health history of member. The comprehensive treatment plan should be the final result of this procedure.

(C) **Limited oral evaluation.** This procedure is only compensable to the same dentist or practice for two (2) visits prior to a comprehensive or periodic evaluation examination being completed.

(D) **Images.** To be SoonerCare compensable, images must be of diagnostic quality and medically necessary. A clinical examination must precede any images. Documentation must indicate medical necessity and diagnostic findings. Images must be properly labeled with date and member name. Periapical images must include at least three (3) millimeters beyond the apex of the tooth being imaged. Panoramic films are only compensable when chart documentation clearly indicates reasons for the exposure based on clinical findings. This type of panoramic film exposure is not to rule out or evaluate caries. Prior authorization and a narrative detailing medical necessity are required for additional panoramic films taken within three (3) years of the original set.

(E) **Dental prophylaxis.** Dental prophylaxis is provided once every six (6) months along with topical application of fluoride.

(F) **Periodontal Maintenance.** This procedure is provided once every six (6) months for members who have a history of periodontitis and are no longer eligible for oral prophylaxis.

(G) **Smoking and tobacco use cessation counseling.** Smoking and tobacco use cessation counseling is covered per Oklahoma Administrative Code (OAC) 317:30-5-2 (DD) (i) through (iv).

(H) **Medically necessary extractions.** Medically necessary extractions, as defined in OAC 317:30-5-695. Tooth extraction must have medical need documented.

(I) **Medical and surgical services.** Medical and surgical services performed by a dentist or physician to the extent such services may be performed under State law when those services would be covered if performed by a physician.

(J) **Additional services.** Additional covered services, which require a prior authorization, are outlined in OAC 317:30-5-698.

(2) **Children.** The OHCA Dental Program for children provides medically necessary treatment. For services rendered to a minor, the minor's parent or legal guardian must provide a signed, written consent prior to the service being rendered, unless there is an explicit state or federal exception to this requirement. The services listed below are compensable for members under twenty-one (21) years of age without prior authorization. All other dental services must be prior authorized. Anesthesia services are covered for children in the same manner as adults per OAC 317:30-5-696.1. All providers performing preventive services must be available to perform needed restorative services for those members receiving any evaluation and preventive services.

(A) **Comprehensive oral evaluation.** A comprehensive oral evaluation may be performed when a member has not been seen by the same dentist for more than thirty-six (36) months. The comprehensive oral evaluation must precede any images, and chart documentation must include image interpretations, caries risk assessment, six-point periodontal charting, and both medical and dental health history of member. The comprehensive treatment plan should be the final result of this procedure.

(B) **Periodic oral evaluation.** This procedure may be provided for a member once every six (6) months. An examination must precede any images, and chart documentation must include image interpretations, and both medical and dental health history of member. The comprehensive treatment plan should be the final result of this procedure.

(C) **Limited oral evaluation.** This procedure is only compensable to the same dentist or practice for two (2) visits prior to a comprehensive or periodic evaluation examination being completed.

(D) **Images.** To be SoonerCare compensable, images must be of diagnostic quality and medically necessary. A clinical examination must precede any images, and chart documentation must indicate medical necessity and diagnostic findings. Images must be properly labeled with date and member name. Periapical images must include at least three (3) millimeters beyond the apex of the tooth being imaged. Panoramic films and two (2) bitewings are considered full mouth images. Full mouth images as noted above or traditional [minimum of twelve (12) periapical films and two (2) posterior bitewings] are allowable once in a three (3) year period and must be of diagnostic quality. Individually listed intraoral images by the same dentist/dental office are considered a complete series if the number of individual images equals or exceeds the traditional number for a complete series. Panoramic films are only compensable when chart documentation clearly indicates reasons for the exposure based on clinical findings. This type of exposure is not to rule out or evaluate caries. Prior authorization and a detailed medical need narrative are required for additional panoramic films taken within three (3) years of the original set.

(E) **Dental sealants.** Tooth numbers 2, 3, 14, 15, 18, 19, 30 and 31 must be caries free on the interproximal and occlusal surfaces to be eligible for this service. This service is available through eighteen (18) years of age and is compensable once every thirty-six (36) months if medical necessity is documented.

(F) **Interim caries arresting medicament application.** This service is available for primary and permanent teeth once every six (6) months for two (2) occurrences per tooth in a lifetime. The following criteria must be met for reimbursement:

- (i) A member is documented to be unable to receive restorative services in the typical office environment within a reasonable amount of time;
- (ii) A tooth that has been treated should not have any non-carious structure removed;
- (iii) A tooth that has been treated should not receive any other definitive restorative care for three (3) months following an application;
- (iv) Reimbursement for extraction of a tooth that has been treated will not be allowed for three (3) months following an application; and
- (v) The specific teeth treated and number and location of lesions must be documented.

(G) **Dental prophylaxis.** This procedure is provided once every six (6) months along with topical application of fluoride.

(H) **Periodontal Maintenance.** This procedure is provided once every six (6) months for members who have

a history of periodontitis and are no longer eligible for oral prophylaxis.

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

(i) Stainless steel crowns are allowed if:

(I) The child is five (5) years of age or under;

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

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

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

(I) Primary teeth treated with pulpal therapy, if the above conditions exist;

(II) Primary teeth where three (3) surfaces of extensive decay exist; or

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

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

(iv) Placement of a stainless steel crown is allowed once for a minimum period of twenty-four (24) months. No other restoration on that tooth is compensable during that period of time. A stainless steel crown is not a temporizing treatment to be used while a permanent crown is being fabricated.

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

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

(I) Posterior permanent teeth that have completed endodontic therapy if three (3) or more surfaces of tooth is destroyed;

(II) Posterior permanent teeth that have three (3) or more surfaces of extensive decay; or

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

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

(iii) Placement of a stainless steel crown excludes placement of any other type of crown for a period of twenty-four (24) months. No other restoration on that tooth is compensable during that period of time.

(K) **Pulpotomies and pulpectomies.**

(i) Therapeutic pulpotomies and pulpal debridement are allowable once per lifetime. Pre- and post-operative periapical images must be available for review, if requested. Therapeutic pulpotomies and pulpal debridement is available for the following:

- (I) Primary molars having at least seventy percent (70%) or more of their root structure remaining or more than twelve (12) months prior to normal exfoliation;
- (II) Tooth numbers O and P before age five (5) years;
- (III) Tooth numbers E and F before six (6) years;
- (IV) Tooth numbers N and Q before five (5) years;
- (V) Tooth numbers D and G before five (5) years.

(ii) Therapeutic pulpotomies and pulpal debridement are allowed for primary teeth if exfoliation of the teeth is not expected to occur for at least one (1) year or if seventy percent (70%) or more of root structure is remaining.

(L) **Space maintainers.** Certain limitations apply with regard to this procedure. Providers are responsible for recementation of any maintainer placed by them for six (6) months post insertion.

(i) **Band and loop type space maintenance.** This procedure must be provided in accordance with the following guidelines:

- (I) This procedure is compensable for all primary molars where permanent successor is missing or where succedaneous tooth is more than five (5) millimeters below the crest of the alveolar ridge.
- (II) First primary molars are not allowed space maintenance if the second primary and first permanent molars are present and in cuspal interlocking occlusion regardless of the presence or absence of normal relationship.
- (III) If there are missing posterior teeth bilaterally in the same arch, under the above guidelines, bilateral space maintainer is the treatment of choice.
- (IV) The teeth numbers shown on the claim must be those of the missing teeth.
- (V) Post-operative bitewing images must be available for review.
- (VI) Bilateral band and loop space maintainer is allowed if member does not

have eruption of the four (4) mandibular anterior teeth in position or if sedation case that presents limitations to fabricate other space maintenance appliances.

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

(I) Lingual arch bar is used when permanent incisors are erupted and the second primary molar (K or T) is missing in the same arch.

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

(III) Pre and post-operative images must be available.

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

(i) **Inhalation of nitrous oxide.** Use of nitrous oxide is compensable for four (4) occurrences per year and is not separately reimbursable, if provided on the same date as IV sedation, non-intravenous conscious sedation, or general anesthesia. The medical need for this service must be documented in the member's record.

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

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

(O) **Protective restorations.** This restoration includes removal of decay, if present, and is reimbursable for the same tooth on the same date of service with a direct or indirect pulp cap, if needed. Permanent restoration of the tooth is allowed after sixty (60) days unless the tooth

becomes symptomatic and requires pain relieving treatment.

(P) **Smoking and tobacco use cessation counseling.** Smoking and tobacco use cessation counseling is covered per OAC 317:30-5-2 (DD) (i) through (iv).

(Q) **Additional services.** Additional covered services, which require a prior authorization, are outlined in OAC 317:30-5-698.

(3) **1915(c) home and community-based services (HCBS) waivers.** Dental services are defined in each waiver and must be prior authorized.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 14 Ok Reg 2404, eff 4-2-97 (emergency); Amended at 15 Ok Reg 1528, eff 5-11-98 ; Amended at 15 Ok Reg 3822, eff 6-24-98 (emergency); Amended at 16 Ok Reg 692, eff 12-31-98 (emergency); Amended at 16 Ok Reg 1429, eff 5-27-99 ; Amended at 19 Ok Reg 2134, eff 6-27-02 ; Amended at 19 Ok Reg 2922, eff 7-1-02 (emergency); Amended at 20 Ok Reg 1193, eff 5-27-03 ; Amended at 20 Ok Reg 1924, eff 6-26-03 ; Amended at 23 Ok Reg 2489, eff 6-25-06 ; Amended at 24 Ok Reg 660, eff 2-1-07 (emergency); Amended at 24 Ok Reg 2088, eff 6-25-07 ; Amended at 25 Ok Reg 2759, eff 5-1-08 (emergency); Amended at 26 Ok Reg 530, eff 2-1-09 (emergency); Amended at 26 Ok Reg 2121, eff 6-25-09 ; Amended at 28 Ok Reg 1419, eff 6-25-11 ; Amended at 29 Ok Reg 1107, eff 6-25-12 ; Amended at 31 Ok Reg 665, eff 7-1-14 (emergency); Amended at 31 Ok Reg 1670, eff 9-12-14 ; Amended at 32 Ok Reg 1088, eff 8-27-15 ; Amended at 33 Ok Reg 51, eff 10-1-15 (emergency); Amended at 33 Ok Reg 832, eff 9-1-16 ; Amended at 34 Ok Reg 699, eff 9-1-17 ; Amended at 35 Ok Reg 116, eff 10-4-17 (emergency); Amended at 35 Ok Reg 1453, eff 9-14-18 ; Amended at 37 Ok Reg 1607, eff 9-14-20 ; Amended at 38 Ok Reg 1054, eff 9-1-21 ; Amended at 39 Ok Reg 425, eff 12-21-21 (emergency); Amended at 39 Ok Reg 1464, eff 9-12-22]

317:30-5-696.1. Anesthesia

Payment is made for medical and surgical services performed by a dentist to the extent such services may be performed under State law either by a doctor of dental surgery or dental medicine, when those services would be covered if performed by a physician. Payment is made to Dentists who have received appropriate formal education in conscious sedation and general anesthesia.

(1) Training to competency in conscious sedation techniques may be acquired at the predoctoral, postgraduate, graduate, or continuing education level. Dentists who wish to utilize conscious sedation are expected to successfully complete formal training which is structured in accordance with the American Dental Association's educational guidelines as well as the board of Dentistry for the State in which they practice.

(2) The knowledge and skills required for the administration of deep sedation and general anesthesia are beyond the scope of pre-doctoral and continuing education. Only dentists who have successfully completed an accredited/approved residency program in anesthesiology, for the administration of anesthetic agents will be permitted to provide and bill for this service.

(3) All anesthesia services must be provided in accordance with OAC 317:30-5-7.

(A) Dentists who provide or supervise deep sedation or general anesthesia are required to have training in anesthesiology, oral surgery or pediatric dentistry, such as in a residency curriculum.

(B) To be considered qualified to supervise the administration of general anesthesia or deep sedation, OHCA requires a minimum of eighteen (18) hours of courses related to the administration of anesthesia, deep sedation or medical emergencies in the dental office every three (3) years.

[Source: Added at 24 Ok Reg 660, eff 2-1-07 (emergency); Added at 24 Ok Reg 2088, eff 6-25-07 ; Amended at 33 Ok Reg 826, eff 9-1-16]

317:30-5-697. Oral surgery procedures

Some elective oral surgery procedures require a written report or treatment plan be reviewed by the OHCA Dental Consultant prior to surgery to determine if the service is within the scope of the Dental Program. All oral surgeons may bill on the HCFA-1500 using CPT codes or the ADA dental claim form using the HCPCS, Level II, Dental codes.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 20 Ok Reg 2891, eff 7-1-03 (emergency); Amended at 21 Ok Reg 2210, eff 6-25-04]

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

(a) **Prior authorizations.** Providers must have prior authorization for certain specified services before delivery of that service, unless the service is provided on an emergency basis [See Oklahoma Administrative Code (OAC) 317:30-5-695(d)(2)]. Requests for dental services requiring prior authorization must be accompanied by sufficient documentation.

(b) **Requests for prior authorization.** Requests for prior authorization, and any related documents, must be submitted electronically through the OHCA secure provider portal. Prior authorized services must be billed exactly as they appear on the prior authorization. Payment is not made for any services provided prior to receiving authorization except for the relief of pain.

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

(d) **Adults.** Listed below are examples of services requiring prior authorization for members twenty-one (21) years of age and over/older. Minimum required records to be submitted with each request are right and left mounted bitewings and periapical films or images of tooth/teeth involved or the edentulous areas if not visible in the bitewings. Images must be of diagnostic quality. Images must be identified by the tooth number and include date of exposure, member name, member ID, provider name, and provider ID. All images, regardless of the media, must be submitted together with a completed and signed comprehensive treatment plan that details all needed treatment at the time of examination, with the prior authorization requesting all needed treatment. The images, digital media, and photographs must be of sufficient type and quality to clearly demonstrate for the reviewer, the pathology which is the basis for the authorization request.

Documentation of a periodontal evaluation with six (6) point measurements for teeth to remain must be included with requests.

(1) **Removable prosthetics.**

(A) This includes full and partial dentures.

(i) One (1) per every five (5) years is available for adults under twenty-five (25) years of age.

(ii) One (1) per every seven (7) years is available for adults twenty-five (25) years of age and over.

(iii) Provider is responsible for any needed follow up for a period of two (2) years post insertion.

(B) Partial dentures are allowed for replacement of missing anterior permanent teeth or two (2) or more missing posterior teeth in the same arch. Provider must indicate which teeth will be replaced.

(2) **Periodontal scaling and root planing.** Procedure involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. This procedure requires that each tooth involved have three (3) or more of the six-point measurements (probing pocket depths) equivalent to four (4) millimeters or greater, and image supported alveolar bone loss. Image supported subgingival calculus, and bleeding on probing, must be demonstrated on multiple teeth for consideration of scaling and root planing. A minimum of two (2) teeth per quadrant must be involved, with the appropriate CDT code usage for fewer than four (4) teeth per quadrant. This procedure is not allowed in conjunction with any other periodontal surgery. Four quadrants of scaling and root planing will not be approved in conjunction with recent oral prophylaxis.

(3) **Scaling in the presence of generalized moderate or severe gingival inflammation.** Procedure is designed for removal of plaque, calculus and stain from supra- and subgingival tooth surfaces when there is generalized moderate or severe gingival inflammation as indicated by generalized suprabony pockets and bleeding on probing, in the absence of periodontitis (alveolar bone loss). Generalized supra- and subgingival calculus, and moderate to severe inflammation must be demonstrated, with probing pocket depths of five (5) mm or greater. This procedure is intended for scaling of the entire mouth in lieu of oral prophylaxis, and is only performed after a comprehensive evaluation has been completed.

(e) **Children.** Listed below are examples of services requiring prior authorization for members under twenty-one (21) years of age. Minimum required records to be submitted with each request are right and left mounted bitewings and periapical films or images of tooth/teeth involved or the edentulous areas if not visible in the bitewings. Images must be of diagnostic quality. Images must be identified by the tooth number and include date of exposure, member name, member ID, provider name, and provider ID. All images, regardless of the media, must be submitted together with a completed and signed comprehensive treatment plan that details all needed treatment at the time of examination, and a completed prior authorization requesting all needed treatments. The images, digital

media, and photographs must be of sufficient quality to clearly demonstrate for the reviewer, the pathology which is the basis for the authorization request.

(1) **Endodontics.** Root canal therapy is not considered an emergency procedure unless due to trauma to an anterior tooth. The provider must document the member's improved oral hygiene and flossing ability and submit it with the prior authorization request to be considered when requesting endodontic therapy for multiple teeth. Pulpal debridement may be performed for the relief of pain while waiting for the decision from the Oklahoma Health Care Authority (OHCA) on request for endodontics.

(A) Payment is made for services provided in accordance with the following guidelines:

- (i) Permanent teeth only;
- (ii) Only ADA accepted materials are acceptable under the OHCA policy;
- (iii) Pre and post-operative periapical images must be available for review;
- (iv) Providers are responsible for any follow-up treatment required by a failed endodontically treated tooth within twenty-four (24) months post completion;
- (v) A tooth will not be approved if it appears there is not adequate natural tooth structure remaining to establish good tooth/restorative margins or if crown to root ratio is poor. Approval of second molars is contingent upon proof of medical necessity; and
- (vi) An endodontic procedure may not be approved if the tooth requires a post and core to retain a crown due to lack of tooth structure.

(B) Endodontics will not be considered if:

- (i) An opposing tooth has super erupted;
- (ii) The tooth impinges upon space of adjacent tooth space by one third or greater;
- (iii) Fully restored tooth will not be in functional occlusion with opposing tooth;
- (iv) Opposing second molars are involved unless prior authorized;
- (v) The member has multiple teeth failing due to previous inadequate root canal therapy or follow-up.

(C) All rampant, active caries must be removed prior to requesting endodontics.

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

(2) Crowns for permanent teeth. Crowns are compensable for restoration of natural teeth for members who are sixteen (16) through twenty (20) years of age. Certain criteria and limitations apply.

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

- (i) All rampant, active caries must be removed prior to requesting any type of crown;
- (ii) The tooth must be decayed to such an extent to prevent proper cuspal or incisal function;
- (iii) The clinical crown is fractured or destroyed by one-half or more; and
- (iv) Endodontically treated teeth must have three (3) or more surfaces restored or lost due to carious activity to be considered for a crown.

(B) The conditions listed above in (A)(i) through (iv) must be clearly visible on the submitted images when a request is made for any type of crown.

(C) Routine build-up(s) for authorized crowns are included in the fee for the crown.

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

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

(F) Chart documentation must include the OHCA caries risk assessment form demonstrating member is at a low to moderate risk and be submitted with the prior authorization request for crowns for permanent teeth.

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

(3) Partial dentures.

(A) This appliance is the treatment of choice for replacement of missing anterior permanent teeth or two (2) or more missing posterior teeth in the same arch for members sixteen (16) years of age and older.

(B) Interim partial dentures are available for children five (5) years of age and older.

(C) Provider must indicate which teeth will be replaced.

(D) Members must have improved oral hygiene documented for at least twelve (12) months in the provider's records and submitted with prior authorization request to be considered.

(E) Provider is responsible for any needed follow up for a period of two (2) years post insertion.

(F) This appliance includes all necessary clasps and rests.
(4) **Occlusal guard.** Narrative of medical necessity must be sent with prior authorization.

(5) **Fixed cast non-precious metal or porcelain/metal bridges.** Only members seventeen (17) through twenty (20) years of age will be considered for this treatment. Destruction of healthy teeth to replace a single missing tooth is not considered medically necessary. Members must have excellent oral hygiene documented for at least eighteen (18) months in the requesting provider's records and submitted with prior authorization request to be considered. Provider is responsible for any needed follow up until member loses eligibility.

(6) **Periodontal scaling and root planing.** Procedure involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. This procedure requires that each tooth involved have three (3) or more of the six-point measurements (probing pocket depths) equivalent to four (4) millimeters or greater, and image supported alveolar bone loss. Image supported subgingival calculus, and bleeding on probing, must be demonstrated on multiple teeth for consideration of scaling and root planing. A minimum of two (2) teeth per quadrant must be involved, with the appropriate CDT code usage for fewer than four (4) teeth per quadrant. This procedure is not allowed in conjunction with any other periodontal surgery. Four quadrants of scaling and root planing will not be approved in conjunction with recent oral prophylaxis.

(7) **Scaling in the presence of generalized moderate or severe gingival inflammation.** Procedure is designed for removal of plaque, calculus and stain from supra- and subgingival tooth surfaces when there is generalized moderate or severe gingival inflammation as indicated by generalized suprabony pockets and bleeding on probing, in the absence of periodontitis (alveolar bone loss). Generalized supra- and subgingival calculus, and moderate to severe inflammation must be demonstrated, with probing pocket depths of five (5) mm or greater. This procedure is intended for scaling of the entire mouth in lieu of oral prophylaxis, and is only performed after a comprehensive evaluation has been completed.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 13 Ok Reg 899, eff 8-1-95 (emergency); Amended at 13 Ok Reg 1645, eff 5-27-96 ; Amended at 15 Ok Reg 3822, eff 6-24-98 (emergency); Amended at 16 Ok Reg 692, eff 12-31-98 (emergency); Amended at 16 Ok Reg 1429, eff 5-27-99 ; Amended at 23 Ok Reg 2489, eff 6-25-06 ; Amended at 24 Ok Reg 660, eff 2-1-07 (emergency); Amended at 24 Ok Reg 2088, eff 6-25-07 ; Amended at 25 Ok Reg 2759, eff 5-1-08 (emergency); Amended at 26 Ok Reg 530, eff 2-1-09 (emergency); Amended at 26 Ok Reg 2121, eff 6-25-09 ; Amended at 28 Ok Reg 1419, eff 6-25-11 ; Amended at 29 Ok Reg 1107, eff 6-25-12 ; Amended at 31 Ok Reg 1670, eff 9-12-14 ; Amended at 32 Ok Reg 1088, eff 8-27-15 ; Amended at 33 Ok Reg 826, eff 9-1-16 ; Amended at 34 Ok Reg 699, eff 9-1-17 ; Amended at 37 Ok Reg 1607, eff 9-14-20 ; Amended at 38 Ok Reg 1054, eff 9-1-21 ; Amended at 39 Ok Reg 425, eff 12-21-21 (emergency); Amended at 39 Ok Reg 1464, eff 9-12-22]

317:30-5-699. Restorations

(a) Utilization parameters.

(1) The Oklahoma Health Care Authority utilization parameters allow only one (1) permanent restorative service to be provided per tooth per twenty-four (24) months.

(2) Additional restorations may be authorized upon approval of OHCA in cases of trauma.

(3) The provider is responsible for follow-up or any required replacement of a failed restoration, if the member is currently SoonerCare eligible.

(4) Providers must document type of isolation used in treatment progress notes.

(5) For members who are under twenty-one (21) years of age and who are receiving a restoration are eligible within three (3) months for consideration of a single crown if endodontically treated.

(b) Coverage for dental restorations. Restoration of incipient lesions is not considered medically necessary treatment. Any diagnosis not supported by images requires documentation of the medical need on which the diagnosis was made. Services for dental restorations are covered, for adults and children, as follows:

(1) If the mesial occlusal pit and the distal occlusal pit on an upper molar tooth are restored at the same appointment, this is a one (1) surface restoration.

(2) If any two (2) separate surfaces on a posterior tooth are restored at the same appointment, it is a two (2) surface restoration.

(3) If any three (3) separate surfaces on a posterior tooth are restored at the same appointment, it is a three (3) surface restoration.

(4) If the mesial, distal, facial and/or lingual of an upper anterior tooth is restored at the same appointment, this is a four (4) surface restoration.

(5) If any two (2) separate surfaces on an anterior tooth are restored at the same appointment, it is a two (2) surface restoration.

(6) If any three (3) separate surfaces on an anterior tooth are restored at the same appointment, it is a three (3) surface restoration.

(7) An incisal angle restoration is defined as one (1) of the angles formed by the junction of the incisal and the mesial or distal surface of an anterior tooth. If any of these surfaces are restored at the same appointment, even if separate, it is considered as a single incisal angle restoration.

(8) When four (4) or more separate surfaces on a posterior tooth are restored at the same appointment it is a four (4) surface restoration.

(9) Wide embrasure cavity preparations do not become extra surfaces unless at least one half of cusp or surface is involved in the restoration. An MODFL restoration would have to include the mesial-occlusal-distal surfaces as well as either the buccal groove pit or buccal surface or at least one half the surface of one of the buccal cusps. The same logic applies for the lingual surface.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 16 Ok Reg 692, eff 12-31-98 (emergency); Amended at 16 Ok Reg 1429, eff 5-27-99 ; Amended at 23 Ok Reg 2489, eff 6-25-06 ; Amended at 26 Ok Reg 530, eff 2-1-09 (emergency); Amended at 26 Ok Reg 2121, eff 6-25-09 ; Amended at 28 Ok Reg 1419, eff 6-25-11 ; Amended at 30 Ok Reg 1177, eff 7-1-13 ; Amended at 31 Ok Reg 1670, eff 9-12-14 ; Amended at 32 Ok Reg 1088, eff 8-27-15 ; Amended at 33 Ok Reg 826, eff 9-1-16 ; Amended at 39 Ok Reg 425, eff 12-21-21 (emergency); Amended at 39 Ok Reg 1464, eff 9-12-22]

317:30-5-700. Orthodontic services

(a) Orthodontic services are available for members who are SoonerCare-eligible and under eighteen (18) years of age at the time the request for prior authorization for treatment is received. In order to be eligible for SoonerCare orthodontic services, members must be referred through an OHCA contracted primary care dentist using the DEN-2 form found on the Oklahoma Health Care Authority (OHCA) website; a member can receive a referral from a primary care dentist to the orthodontist only after meeting the following:

- (1) The member has had a caries free initial visit; or
- (2) Has all decayed areas restored and has remained caries free for twelve 12 months; and
- (3) Has demonstrated competency in maintaining an appropriate level of oral hygiene.

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

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

- (1) A handicapping malocclusion, as measured on the Oklahoma Health Care Authority (OHCA) Handicapping Labio-Lingual Deviation Index of Malocclusion (DEN-6) form, with a minimum score of thirty (30);
- (2) Any classification secondary to cleft palate or other maxillofacial deformity;
- (3) If a single tooth or anterior crossbite is the only medical need finding, service will be limited to interceptive treatment;
- (4) Fixed appliances only; and
- (5) Permanent dentition with the exception of cleft defects.

(d) Reimbursement for orthodontic services is limited to:

- (1) Orthodontists, or
- (2) General or Pediatric dental practitioners who have completed at least two-hundred (200) certified hours of continuing education in the field of orthodontics practice and submit for review at least twenty-five successfully completed comprehensive cases. Of these twenty-five comprehensive cases, ten or more must be extraction cases. An applicant for this certification must practice in an OHCA deemed under-served area. The comprehensive cases

submitted must be of a complexity consistent with type of handicapping malocclusion likely to be treated in the SoonerCare program.

(A) Cases submitted must include at least one (1) of each of the following types:

- (i) Deep overbite where multiple teeth are impinging upon the soft tissue of the palate;
- (ii) Impacted canine or molar requiring surgical exposure;
- (iii) Bilateral posterior crossbite requiring fixed rapid palatal expansion; and
- (iv) Skeletal class II or III requiring orthognathic surgery.

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

(C) The OHCA requires all general dentists providing comprehensive orthodontic care to submit a copy of the Oklahoma Board of Dentistry continuing education report and verification that at least twenty (20) continuing education hours in the field of orthodontics has been completed per reporting period. All verification reports must be submitted to OHCA Dental Unit every three (3) years, no later than August 30. In addition, verification of adequate progress for all active orthodontic cases will be reviewed by the OHCA Dental Unit upon completion of twenty-four (24) months of therapy.

(e) The following limitations apply to orthodontic services:

- (1) Cosmetic orthodontic services are not a covered benefit of the SoonerCare program and no requests should be submitted;
- (2) All orthodontic procedures require prior authorization for payment;
- (3) Prior authorization for orthodontic treatment is not a notification of the member's eligibility and does not guarantee payment. Payment for authorized services depends on the member's eligibility at the beginning of each treatment year. Treatment year is determined by date of banding; and
- (4) The member must be SoonerCare-eligible and under eighteen (18) years of age at the time the request for prior authorization for treatment is received by the OHCA. Services cannot be added or approved after eligibility has expired. It is the orthodontist's responsibility to verify that the member has current SoonerCare eligibility and the date of birth indicates the member is under age eighteen (18).

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

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

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

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 13 Ok Reg 601, eff 11-21-95 (emergency); Amended at 13 Ok Reg 1645, eff 5-27-96 ; Amended at 16 Ok Reg 692, eff 12-31-98 (emergency); Amended at 16 Ok Reg 1429, eff 5-27-99 ; Amended at 18 Ok Reg 262, eff 11-21-00 (emergency); Amended at 18 Ok Reg 1130, eff 5-11-01 ; Amended at 19 Ok Reg 334, eff 11-14-01 (emergency); Amended at 19 Ok Reg 1067, eff 5-13-02 ; Amended at 22 Ok Reg 104, eff 7-6-04 (emergency); Amended at 21 Ok Reg 2492, eff 7-11-05 ; Amended at 23 Ok Reg 2489, eff 6-25-06 ; Amended at 27 Ok Reg 2765, eff 7-20-10 (emergency); Amended at 28 Ok Reg 1419, eff 6-25-11 ; Amended at 30 Ok Reg 1177, eff 7-1-13 ; Amended at 31 Ok Reg 1670, eff 9-12-14 ; Amended at 32 Ok Reg 1088, eff 8-27-15 ; Amended at 33 Ok Reg 826, eff 9-1-16 ; Amended at 37 Ok Reg 1607, eff 9-14-20 ; Amended at 39 Ok Reg 425, eff 12-21-21 (emergency); Amended at 39 Ok Reg 1464, eff 9-12-22]

317:30-5-700.1. Orthodontic prior authorization

(a) Orthodontic services are available for members who are SoonerCare-eligible and under eighteen (18) years of age, at the time the request for prior authorization for treatment is received, per Oklahoma Administrative Code 317:30-5-700. The following records and documentation, plainly labeled with the member's full name, recipient identification number (RID), and the orthodontist's name are required for prior authorization of orthodontic services and must be submitted to the Dental Unit of the Oklahoma Health Care Authority (OHCA) Dental Program when the member has a total score of not less than thirty (30) points or meets other eligibility criteria in paragraph (d).

- (1) Completed prior authorization requesting all needed treatments;
- (2) Complete and scored Handicapping Labio-Lingual Deviation (HDL) Index with Diagnosis of Angle's classification;
- (3) Detailed description of any oral maxillofacial anomaly;
- (4) Estimated length of treatment;
- (5) Intraoral photographs showing teeth in centric occlusion and/or photographs of trimmed anatomically occluded diagnostic casts. A lingual view of casts may be included to verify impinging overbites;
- (6) Cephalometric images with tracing, and panoramic film, with a request for prior authorization of comprehensive orthodontic treatment;
- (7) Completed OHCA caries risk assessment form;
- (8) If diagnosed as a surgical case, submit an oral surgeon's written opinion that orthognathic surgery is indicated and the surgeon is willing to provide this service; and
- (9) Additional pertinent information as determined necessary by the orthodontist or as requested by the OHCA.

(b) All images and required documentation must be submitted in one (1) package. OHCA is not responsible for lost or damaged materials.

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

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

- (1) Other medical, social, or emotional conditions are limited to those conditions that affect the medical, social or emotional function of the child;
- (2) Other medical, social, or emotional conditions are not scored if the sole condition sought to be improved is the cosmetic appearance of the child;
- (3) Such other medical, social, or emotional conditions must be demonstrated by objective evidence such as supported documentation outside the child's immediate family (e.g., a child's teacher, primary care physician, behavioral health provider, school counselor);
- (4) Objective evidence must be submitted with the HLD;
- (5) When such other medical, social, or emotional conditions are reflected on the HLD, the OHCA orthodontic consultant must review the data and use his or her professional judgment to score the value of the conditions; and
- (6) The OHCA orthodontic consultant may consult with and utilize the opinion of the orthodontist who completes the form.

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

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

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

(A) Authorization for the first year begins on the date of banding and includes the placement of appliances, arch wires, and a minimum of six (6) adjustments. It is expected that orthodontic members be seen every four (4) to eight (8) weeks for the duration of active treatment.

(B) Subsequent adjustments will be authorized in one (1) year intervals and the treating orthodontist must provide a comprehensive progress report at the twenty-four (24) month interval.

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

(2) Claim and payment are made as follows:

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

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

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

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

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

(j) Electronic images of casts and/or oral/facial images may be requested by OHCA or representatives of OHCA. Providers will be reimbursed for either the study model or images when obtained for orthodontic evaluation and/or therapy.

(1) Documentation of casts and/or photographic images must be kept in the client's medical record and medical necessity identified on the submitted electronic claim.

(2) For photographic images, the oral/facial portfolio must include a view of the complete lower arch, complete upper arch, and left and right maximum intercuspation of teeth.

(A) Maximum intercuspation refers to the occlusal position of the mandible in which the cusps of the teeth of both arches fully interpose themselves with the cusps of the teeth of the opposing arch.

(B) Intercuspation defines both the anterior-posterior and lateral relationships of the mandible and the maxilla, as well as the superior-inferior relationship known as the vertical dimension of occlusion.

(3) 3-D model images or photographic images not in compliance with the diagnostic guidelines will not be compensable. The provider may be allowed to resubmit new images that adhere to the diagnostic guidelines. If the provider does not provide appropriate documentation, the request for treatment will be denied.

[Source: Added at 13 Ok Reg 1645, eff 5-27-96 ; Amended at 13 Ok Reg 3585, eff 7-16-96 (emergency); Amended at 14 Ok Reg 1780, eff 5-27-97 ; Amended at 15 Ok Reg 542, eff 11-5-97 (emergency); Amended at 15 Ok Reg 1528, eff 5-11-98 ; Amended at 15 Ok Reg 3822, eff 6-24-98 (emergency); Amended at 16 Ok Reg 1429, eff 5-27-99 ; Amended at 18 Ok Reg 262, eff 11-21-00 (emergency); Amended at 18 Ok Reg 1130, eff 5-11-01 ; Amended at 19 Ok Reg 334, eff 11-14-01 (emergency); Amended at 19 Ok Reg 1067, eff 5-13-02 ; Amended at 20 Ok Reg 521, eff 1-6-03 (emergency); Amended at 20 Ok Reg 1216, eff 5-27-03 ; Amended at 23 Ok Reg 2489, eff 6-25-06 ; Amended at 27 Ok Reg 2765, eff 7-20-10 (emergency); Amended at 28 Ok Reg 1419, eff 6-25-11 ; Amended at 31 Ok Reg 1670, eff 9-12-14 ; Amended at 32 Ok Reg 1088, eff 8-27-15 ; Amended at 33 Ok Reg 826, eff 9-1-16 ; Amended at 34 Ok Reg 699, eff 9-1-17 ; Amended at 37 Ok Reg 1607, eff 9-14-20 ; Amended at 39 Ok Reg 425, eff 12-21-21 (emergency); Amended at 39 Ok Reg 1464, eff 9-12-22 ; Amended at 41 Ok Reg, Number 12, effective 1-30-24 (emergency)]

317:30-5-701. Surface identification

Surfaces requiring dental treatment must be indicated using standard Latin abbreviations. The following capital letters are used on claims:

- (1) M - Mesial
- (2) D - Distal
- (3) O - Occlusal
- (4) L - Lingual
- (5) F - Facial
- (6) I - Incisal
- (7) B - Buccal.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 23 Ok Reg 2489, eff 6-25-06]

317:30-5-702. Dental diagnosis codes [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 16 Ok Reg 692, eff 12-31-98 (emergency); Revoked at 16 Ok Reg 1429, eff 5-27-99]

317:30-5-703. Tooth numbering system

(a) For adult teeth, the universal tooth numbering system (1 through 32) is used. For primary teeth, tooth letters A through T are used.

(b) No other tooth letter or number system is accepted. All procedures performed on a specific tooth require the appropriate tooth number.

(c) Supernumerary teeth are identified as follows:

(1) **Permanent dentition.** Supernumerary teeth are identified by the numbers 51 through 82, beginning with the area of the upper right third molar, following around the upper arch and continuing on the lower arch to the area of the lower right third molar. For example, supernumerary number 51 is adjacent to the upper right molar number 1, and supernumerary number 82 is adjacent to the lower right third molar number 32.

(2) **Primary dentition.** Supernumerary teeth are identified by the placement of the letter "S" following the letter identifying the adjacent primary tooth. For example, supernumerary "AS" is adjacent to "A" and supernumerary "TS" is adjacent to "T".

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 16 Ok Reg 692, eff 12-31-98 (emergency); Amended at 16 Ok Reg 1429, eff 5-27-99 ; Amended at 23 Ok Reg 2489, eff 6-25-06]

317:30-5-704. Billing instructions

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

(b) **Prior authorization.** Where applicable, the appropriate arch, quadrant, or tooth surface and tooth number must be included on the claim. Diagnosis codes are requested to be listed in box 34 of the current

American Dental Association (ADA) dental claim form. For mailed prior authorizations, a completed HCA-13D form is required.

(c) **Images.** Any type of film or prints submitted will not be returned. All images must be dated, mounted and have patient's name, recipient identification number (RID), provider name and provider number.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 15 Ok Reg 3822, eff 7-1-98 (emergency); Amended at 16 Ok Reg 692, eff 12-31-98 (emergency); Amended at 16 Ok Reg 1429, eff 5-27-99 ; Amended at 23 Ok Reg 2489, eff 6-25-06 ; Amended at 31 Ok Reg 1670, eff 9-12-14 ; Amended at 33 Ok Reg 826, eff 9-1-16 ; Amended at 37 Ok Reg 1607, eff 9-14-20 ; Amended at 41 Ok Reg, Number 12, effective 1-30-24 (emergency)]

317:30-5-705. Billing and reimbursement

(a) Dental claims, and any related documents, must be submitted electronically or through the OHCA secure provider portal. Electronic submission must be made on the HIPAA compliant Form 837D.

(b) Billing and reimbursement methodology, including copayments, are outlined in the Oklahoma Medicaid State Plan.

[Source: Added at 16 Ok Reg 692, eff 12-31-98 (emergency); Added at 16 Ok Reg 1429, eff 5-27-99 ; Amended at 23 Ok Reg 2489, eff 6-25-06 ; Amended at 31 Ok Reg 1670, eff 9-12-14 ; Amended at 33 Ok Reg 826, eff 9-1-16 ; Amended at 37 Ok Reg 1607, eff 9-14-20 ; Amended at 39 Ok Reg 425, eff 12-21-21 (emergency); Amended at 39 Ok Reg 1464, eff 9-12-22]

PART 80. MOBILE AND PORTABLE DENTAL SERVICES

317:30-5-706. Mobile dental units

(a) **Definition. "Mobile dental unit"** means a motor vehicle or trailer that contains dental equipment and is used to provide dental services to eligible SoonerCare members on-site in accordance with Title 59 of Oklahoma Statutes (O.S.), Section 328.3 (59 O.S. §328.3).

(b) **Eligible providers.** For dental services provided at a mobile dental unit to be eligible for SoonerCare reimbursement, a dental group shall meet all applicable requirements set forth in the Oklahoma Board of Dentistry rules, the Oklahoma State Dental Act (59 O.S., Ch. 7), and the requirements in this Section, including but not limited to, all licensing and permitting requirements.

(1) All dentists working at a mobile dental unit shall be currently licensed in good standing with the Oklahoma Board of Dentistry. All other contracted providers of the dental group, working at a mobile dental unit, shall meet all credentialing/certification requirements, as per their specialty. In addition, all members of the dental group working at a mobile dental unit shall comply with the requirements at Oklahoma Administrative Code (OAC) 317:30-5-695.

(2) The license, certification, accreditation, and/or permit (or a photocopy of these documents) of every individual provider in the dental group shall be prominently displayed at the mobile dental unit, pursuant to 59 O.S., Section (§) 328.21.

(3) For services provided in a mobile dental unit, the permit to operate the mobile dental unit shall be prominently displayed in

the mobile dental unit vehicle, pursuant to 59 O.S. §328.40a.

(4) In accordance with OAC 317:30-5-695.1, every dental group providing services at a mobile dental unit must be fully contracted with the Oklahoma Health Care Authority (OHCA) as a dental group provider and must also be fully contracted with OHCA as a mobile dental unit.

(5) Every individual dentist practicing at a mobile dental unit must be fully contracted with the OHCA as a dentist.

(6) Dental groups and individual providers providing dental services at a mobile dental unit shall comply with all applicable state and federal Medicaid laws, including, but not limited to, OHCA administrative rules, the Code of Federal Regulations, and the Oklahoma State Medicaid Plan.

(c) **Coverage.** Refer to OAC 317:30-5-696 for dental coverage descriptions for children and adults.

(d) **Description of services.** Mobile dental units must treat both children and adults and provide urgent, preventive, and restorative dental services that are appropriate to provide in this setting.

(1) All current dental rules at OAC 317, Part 79, still apply to all mobile dental services including, but not limited to, prior authorizations, medically necessity criteria, documentation, and limitations.

(2) Endodontics, orthodontics, prosthodontics, periodontics, and permanent crowns will not be covered in mobile clinic.

(3) Mobile dental units will be required to refer a member to a SoonerCare contracted dental provider for any follow-up care when needed or to access services that cannot be provided in the mobile unit.

(e) **Limited provider service area.** Mobile dental units should serve members in SoonerCare dental provider shortage areas. Dental provider shortage areas mean Oklahoma counties that have less than ten (10) Medicaid general dental providers.

(f) **Billing and reimbursement.** Billing and reimbursement policies in accordance with OAC 317:30-5-704 through 317:30-5-705 apply to mobile dental services.

(g) **Post Care.** Each member receiving dental care at a mobile dental unit must receive an information sheet at the end of the visit. The information sheet must contain:

(1) The name of the dentist, dental hygienist, and/or dental assistant who provided the dental services at the mobile dental unit;

(2) Valid contact information which can include a business telephone number, email address and/or other emergency contact number for the dental group and/or dentist that provided the dental services at the mobile dental unit;

(3) A listing of the treatment rendered, including, when applicable, billing codes, fees, and tooth numbers;

(4) A description of any follow-up treatment that is needed or recommended; and

(5) Referrals to specialists or other dentists if the mobile dental unit providers were unable to provide the necessary treatment

and/or additional care is needed.

(6) All dental records including radiographs from that visit should be provided to the member and/or forwarded to the dental provider providing follow-up care. Electronic and/or printed forms of records are acceptable.

[Source: Added at 37 Ok Reg 1616, eff 9-14-20 ; Amended at 40 Ok Reg 370, eff 11-4-22 (emergency); Amended at 40 Ok Reg 2218, eff 9-11-23]

317:30-5-707. Portable dental units

(a) **Definition.** Portable dental unit means a non-facility in which dental equipment used in the practice of dentistry is transported to and used on a temporary basis at an out-of-office location at either group homes for juveniles or public and private schools.

(b) **Eligible providers.** For dental services provided at a portable dental unit to be eligible for SoonerCare reimbursement, a dental group shall meet all applicable requirements set forth in the Oklahoma Board of Dentistry rules, the Oklahoma State Dental Act (59 O.S., Ch. 7), and the requirements in this Section, including but not limited to, all licensing and permitting requirements.

(1) All dentists working at a portable dental unit shall be currently licensed in good standing with the Oklahoma Board of Dentistry. All other contracted providers of the dental group, working at a portable dental unit, shall meet all credentialing/certification requirements, as per their specialty. In addition, all members of the dental group working at a portable dental unit shall comply with the requirements at Oklahoma Administrative Code (OAC) 317:30-5-695.

(2) The license or permit (or a photocopy of the license or permit) of every individual provider shall be prominently displayed at the portable dental unit site, pursuant to Title of 59 O.S. § 328.21.

(3) In accordance with OAC 317:30-5-695.1, every dental group providing services at a portable dental unit must be fully contracted with the OHCA as a dental group provider.

(4) Every individual dentist practicing at a portable dental unit must be fully contracted with the OHCA as a dentist.

(5) Dental groups and individual providers providing dental services at a portable dental unit shall comply with all state and federal Medicaid laws, including, but not limited to, OHCA administrative rules, the Code of Federal Regulations, and the Oklahoma State Medicaid Plan.

(c) **Coverage.** Portable dental unit services are only available for SoonerCare-eligible individuals under the age of twenty-one (21) and limited to the services noted in (1) through (3) of this Subsection. All portable dental units must have a SoonerCare-contracted, Oklahoma-licensed dentist onsite to supervise all other portable dental unit staff. Coverage for dental services provided to children/adolescents at a portable dental unit is limited to:

(1) One (1) fluoride application per member per twelve (12) months;

- (2) One (1) dental screening annually that is performed by a SoonerCare-contracted, Oklahoma-licensed dentist; and
- (3) Dental sealants on tooth numbers 2, 3, 14, 15, 18, 19, 30, and 31. The OHCA will not reimburse the application of dental sealants for a given OHCA member more than once every thirty-six (36) months, regardless of whether the services are provided at a portable dental unit, or at some other authorized place of service.

(d) **Post Care.** Each member receiving dental care at a portable dental unit must receive an information sheet at the end of the visit. The information sheet must contain:

- (1) The name of the dentist, dental hygienist, and/or dental assistant who provided the dental services at the portable dental unit;
- (2) A valid business telephone number and/or other emergency contact number for the dental group and/or dentist that provided the dental services at the portable dental unit;
- (3) A listing of the treatment rendered, including, when applicable, billing codes, fees, and tooth numbers;
- (4) A description of any follow-up treatment that is needed or recommended; and
- (5) Referrals to specialists or other dentists if the portable dental unit providers were unable to provide the necessary treatment and/or additional care is needed.

(e) **Billing.** Refer to OAC 317:30-5-704 through 317:30-5-705 for billing instructions and guidelines. Please note that for any dental service provided through a portable dental unit that is billed to SoonerCare, the appropriate place of service must be identified on the claim to receive reimbursement.

[Source: Added at 37 Ok Reg 1616, eff 9-14-20 ; Amended at 40 Ok Reg 370, eff 11-4-22 (emergency); Amended at 40 Ok Reg 2218, eff 9-11-23]

317:30-5-708. Parental consent requirements

Individual providers at a mobile or portable dental unit shall not perform any service on a minor without having obtained, prior to the provision of services, a signed, written consent from the minor's parent or legal guardian, that includes, at a minimum, the:

- (1) Name of the dental group and/or dentist providing the dental services at the mobile and/or portable dental unit;
- (2) Permanent business mailing address of the dental group and/or dentist providing the dental services at the mobile and/or portable dental unit;
- (3) Business telephone number of the dental group and/or dentist providing the dental services at the mobile and/or portable dental unit. This telephone number must be available for emergency calls;
- (4) Full printed name of the child to receive services;
- (5) Child's SoonerCare Member ID number; and
- (6) An inquiry of whether the child has had dental care in the past twelve (12) months and if the child has a dental appointment

scheduled with his/her regular dentist. If applicable, parent should list the name and address of the dentist and/or dental office where the care is provided.

[Source: Added at 37 Ok Reg 1616, eff 9-14-20 ; Amended at 40 Ok Reg 370, eff 11-4-22 (emergency); Amended at 40 Ok Reg 2218, eff 9-11-23]

317:30-5-709. Coverage [REVOKED]

[Source: Added at 37 Ok Reg 1616, eff 9-14-20 ; Revoked at 40 Ok Reg 370, eff 11-4-22 (emergency); Revoked at 40 Ok Reg 2218, eff 9-11-23]

317:30-5-710. Post-care [REVOKED]

[Source: Added at 37 Ok Reg 1616, eff 9-14-20 ; Revoked at 40 Ok Reg 370, eff 11-4-22 (emergency); Revoked at 40 Ok Reg 2218, eff 9-11-23]

317:30-5-711. Billing [REVOKED]

[Source: Added at 37 Ok Reg 1616, eff 9-14-20 ; Revoked at 40 Ok Reg 370, eff 11-4-22 (emergency); Revoked at 40 Ok Reg 2218, eff 9-11-23]

PART 81. CHIROPRACTORS

317:30-5-720. Eligible providers

- (a) Must be appropriately licensed, in good standing in the state in which they practice, and working in accordance with the Oklahoma Chiropractic Practice Act or other applicable statute(s); and
- (b) Entered into a provider agreement with the Oklahoma Health Care Authority (OHCA) to provide chiropractic services.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 39 Ok Reg 419, eff 1-1-22 (emergency); Amended at 39 Ok Reg 1487, eff 9-12-22]

317:30-5-721. Coverage by category

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

- (1) **Children.** There is no coverage for children.
- (2) **Adults.** There is no coverage for adults.
- (3) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services.
- (4) **Manual spinal manipulation services for pain management.** Refer to Oklahoma Administrative Code 317:30-5-727.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 19 Ok Reg 2922, eff 7-1-02 (emergency); Amended at 20 Ok Reg 1193, eff 5-27-03 ; Amended at 39 Ok Reg 419, eff 1-1-22 (emergency); Amended at 39 Ok Reg 1487, eff 9-12-22]

PART 82. ALTERNATIVE TREATMENTS FOR PAIN MANAGEMENT

317:30-5-725. General

Alternative treatments for pain management are non-pharmacological treatments recommended by a physician or other licensed practitioner of the healing arts for adults age twenty-one (21) or older with acute, subacute, and chronic spinal/back pain or injury. Treatments are intended to reduce pain, increase mobility, optimize function, and decrease use and misuse of opioid medications and may include the services listed in Part 82, of this Chapter.

[Source: Added at 39 Ok Reg 419, eff 1-1-22 (emergency); Added at 39 Ok Reg 1487, eff 9-12-22]

317:30-5-726. Eligible providers

(a) **Manual spinal manipulation.** Providers must meet the requirements outlined at Oklahoma Administrative Code (OAC) 317:30-5-720.

(b) **Physical therapy (PT) for alternative treatments for pain management.** Providers must meet the requirements outlined at OAC 317:30-5-290.1.

[Source: Added at 39 Ok Reg 1487, eff 9-12-22]

317:30-5-727. Manual spinal manipulation

Chiropractic services are limited to manual spinal manipulation. This includes the manipulation of the five (5) regions of the spinal column for the treatment of back pain in a member with a primary diagnosis of acute or chronic pain and is performed by a licensed chiropractor.

(1) **Medical necessity.** All manual spinal manipulation services should be determined to be medically necessary for the affected member. Documentation in the member's plan of care should support the medical necessity of the need for manual spinal manipulation services. The Oklahoma Health Care Authority (OHCA) will serve as the final authority pertaining to all determinations of medical necessity. Refer to Oklahoma Administrative Code (OAC) 317:30-3-1(f) for policy on medical necessity.

(2) **Documentation/requirements.** All documentation submitted to request manual spinal manipulation services should demonstrate, through adequate objective medical records, evidence sufficient to justify the member's need for the service, in accordance with OAC 317:30-3-1(f)(2).

(A) **Evaluations.** One (1) initial evaluation and one (1) re-evaluation, for chiropractic manual spinal manipulation, are allowed per calendar year and do not require a PA.

(B) **Prior authorization (PA).** Documentation, for a PA request, will include the following:

- (i) The member is over twenty-one (21) years of age;
- (ii) Attestation stating that manual spinal manipulation services are being used in place of opioid treatment for pain or used to decrease the use of opioids;
- (iii) Primary diagnosis of acute or chronic spinal pain or neuromusculoskeletal disorder related to the spinal column;
- (iv) Plan of care that is designed for the treatment of spinal pain;
- (v) Signed informed consent for care;
- (vi) For full guidelines, please refer to www.okhca.org/mau.

(C) **Subsequent PA requests.** Requests for a subsequent PA will include the following:

- (i) All documentation found at (2)(B)(i) through (v) of this Section;
- (ii) Medical records that document that the treatments meet the functional needs of the member;
- (iii) Treatment goals for acute pain/injury, chronic pain management, or chronic back pain;
- (iv) Treatment evaluations that should demonstrate improvement, including but not limited to, improved function, decreased use of pain medications, increased activity level;
- (v) Records showing persistent or recurrent conditions;
- (vi) For full guidelines, please refer to www.okhca.org/mau.

(3) **Frequency/coverage.**

- (A) SoonerCare covers up to twelve (12) manual spinal manipulation visits per calendar year with an approved PA.
- (B) Manual spinal manipulation for the treatment of acute or chronic back pain is the only chiropractic service covered by SoonerCare.

(4) **Reimbursement.** All alternative treatments for pain management services, that are outlined in Part 82 of this Chapter, are reimbursed per the methodology established in the Oklahoma Medicaid State Plan.

(5) **Discontinuation of services.**

- (A) If the member's condition is not improving, or the member's condition is regressing, services will not be considered medically necessary.
- (B) The OHCA may withdraw authorization of payment at any time if it is determined that the member and/or provider is not in compliance with any of the requirements set forth in this Section.

(6) **Non-covered services.**

(A) Manual spinal manipulation provided solely for maintenance.

(B) Chiropractor services that are not for the alternative treatments of pain management listed in Part 82 of this Chapter.

(C) Manual spinal manipulation services that are provided in a setting other than the chiropractor's office, including but not limited to, inpatient or outpatient hospitals, nursing facilities, rest homes, or the member's home.

[Source: Added at 39 Ok Reg 1487, eff 9-12-22]

317:30-5-728. Physical therapy (PT) for alternative treatments for pain management

PT is used to improve a person's ability to move, reduce or manage pain, restore function, and prevent disability. For pain management, PT is provided in a non-hospital based setting with the aim of decreasing pain and suffering while improving physical and mental functioning.

(1) **Medical necessity.** All services/diagnosis found in the full guidelines at www.okhca.org/mau for alternative treatments for pain management should be determined to be medically necessary for the affected member. Documentation in the member's plan of care should support the medical necessity of the need for alternative treatments for pain management services. The Oklahoma Health Care Authority (OHCA) will serve as the final authority pertaining to all determinations of medical necessity. Refer to Oklahoma Administrative Code (OAC) 317:30-3-1(f) for policy on medical necessity.

(2) **Documentation/requirements.** All documentation submitted to request services should demonstrate, through adequate objective medical records, evidence sufficient to justify the member's need for the service, in accordance with OAC 317:30-3-1(f)(2).

(A) **Evaluations.** One (1) initial PT evaluation and one (1) PT re-evaluation, when necessary, will be covered per calendar year at a non-hospital-based setting and do not require a PA, when the service is performed for the evaluation of therapy services related to alternative treatments of pain management.

(B) **Prior authorization (PA).** Documentation, for a PA request, will include the following:

- (i) The member is over twenty-one (21) years of age;
- (ii) A prescription or a referral from the member's physician or other licensed practitioner of the healing arts, dated within the previous ninety (90) days requesting the PT services for pain management;
- (iii) Attestation stating that PT services are being used in place of opioid treatment for pain or used

- to decrease the use of opioids;
- (iv) Medical records, from the member's physician or other licensed practitioner of the healing arts, documenting the need for the pain management referral;
- (v) Documentation from the physical therapist that supports the need for the requested services;
- (vi) A detailed report, from the physical therapist, that is gathered from any tool, test, or measure;
- (vii) Measurable goals that includes the following:
 - (I) Timeframe;
 - (II) Baseline;
 - (III) Conditions for how goals are expected to be met;
 - (IV) A statement of rationale; and
 - (V) Prognosis for achievement.
- (viii) A detailed intervention plan that includes:
 - (I) Frequency and duration of the services and the anticipated length of the intervention;
 - (II) Location of where the services are provided;
 - (III) Member and/or family/caregiver involvement in the management and carry-over of the intervention;
 - (IV) Reasons if the intervention was unsuccessful.
- (ix) A completed therapy PA request form;
- (x) For full guidelines, please refer to www.okhca.org/mau.

(C) **Subsequent PA requests.** Requests for a subsequent PA will include the following:

- (i) All documentation found at (2)(B) (i) through (viii) of this Section;
- (ii) Detailed listing of previous goals, including instances of which goals were unmet and why they were not achieved;
- (iii) Treatment goals for acute pain/injury, chronic pain management, or chronic back pain;
- (iv) Records showing persistent or recurrent conditions;
- (v) Treatment evaluations that show avoidance/prevention or reduction of opioid use;
- (vi) A completed therapy PA request form;
- (vii) For full guidelines, please refer to www.okhca.org/mau.

(3) **Frequency/coverage.** A PA for PT for adult treatment of pain management services may be approved for a total of forty-eight (48) units per calendar year. A PT unit for the treatment of pain management in adults is 15 minutes. A visit may consist of multiple units of service on the same date, the time for units of

service is added together and rounded up only once per visit.

(4) **Reimbursement.** All alternative treatments for pain management services, that are outlined in Part 82 of this Chapter, are reimbursed per the methodology established in the Oklahoma Medicaid State Plan.

(5) **Discontinuation of services.**

(A) If the member's condition is not improving, or the member's condition is regressing, then services will not be considered medically necessary.

(B) The OHCA may withdraw authorization of payment at any time if it is determined that the member and/or provider is not in compliance with any of the requirements set forth in this section.

(6) **Non-covered services.**

(A) PT provided solely for maintenance.

(B) Therapeutic or physical modalities used to augment a PT program.

[Source: Added at 39 Ok Reg 1487, eff 9-12-22]

PART 83. THERAPEUTIC FOSTER CARE

317:30-5-740. Definitions

The following words or terms used in this Part shall have the following meaning, unless the context clearly indicates otherwise:

"Therapeutic foster care (TFC) agency" means a foster care agency that provides foster care as defined in Section 1355.20 of Title 45 of the Code of Federal Regulation as twenty-four (24) hour substitute care for children placed away from their parents or guardians and for whom the title IV-E agency has placement and care responsibility. TFC settings are foster family homes.

"TFC home" means an agency-supervised, private family home in which foster parents have been trained to provide individualized, structured services in a safe, nurturing family-living environment. The children receiving services in this setting have moderate behavioral and emotional health needs, and may also present secondary physical, developmental, intellectual, and/or social disorder that is supported alongside the mental health needs. TFC homes are considered the least restrictive out-of-home placement for these children.

"Therapeutic foster care (TFC) model" means a model in which children in the TFC environment receive increased individualized behavioral health and other support services from qualified staff. Because TFC members require exceptional levels of skill, time, and supervision, the number of unrelated children placed per home is limited; no more than two (2) TFC members may be placed in a home at any one (1) time unless additional cases are specifically authorized by Child Welfare Services (CWS) of the Oklahoma Department of Human Services (OKDHS), or Oklahoma Office of Juvenile Affairs (OJA).

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 13 Ok Reg 4049, eff 9-17-96 (emergency); Amended at 14 Ok Reg 1780, eff 5-27-97 ; Amended at 17 Ok Reg 2402, eff 6-26-00 ; Amended at 20 Ok Reg 523, eff 12-1-02 (emergency); Amended at 20 Ok Reg 1216, eff 5-27-03 ; Amended at 23 Ok Reg 2566, eff 6-25-06 ; Amended at 24 Ok Reg 2857, eff 7-1-07 through 7-14-08 (emergency)¹; Amended at 25 Ok Reg 2683, eff 7-25-08 ; Amended at 27 Ok Reg 1360, eff 4-21-10 (emergency); Amended at 28 Ok Reg 1419, eff 6-25-11 ; Amended at 33 Ok Reg 863, eff 9-1-16 ; Amended at 37 Ok Reg 101, eff 10-2-19 (emergency); Amended at 37 Ok Reg 1549, eff 9-14-20]

Editor's Note: ¹*This emergency action expired on 7-14-08 before being superseded by a permanent action. Upon expiration of an emergency amendatory action, the last effective permanent text is reinstated. Therefore, on 7-15-08 (after the 7-14-08 expiration of the emergency action), the text of 317:30-5-740 reverted back to the permanent text that became effective 6-25-06, as was last published in the 2006 Edition of the OAC, and remained as such until amended by permanent action on 7-25-08.*

317:30-5-740.1. Eligible providers and requirements

(a) **TFC Agency.** Eligible TFC agencies must have:

- (1) Current certification from the Oklahoma Department of Human Services (OKDHS) as a child placing agency;
- (2) A contract with the Child Welfare Division of OKDHS, or Oklahoma Office of Juvenile Affairs (OJA);
- (3) A contract with the Oklahoma Health Care Authority (OHCA); and
- (4) A current accreditation status appropriate to provide behavioral health services in a foster care setting from:
 - (A) The Joint Commission; or
 - (B) The Commission on Accreditation of Rehabilitative Facilities (CARF); or
 - (C) The Council on Accreditation (COA).

(b) **Treatment team.** TFC agencies are primarily responsible for treatment planning and coordination of the member's treatment team. This team is typically composed of an OKDHS or OJA caseworker, the member, the member's foster parent(s), as well as others closely involved with the member and family, including the biological parents when applicable.

- (1) The team must include the following providers:
 - (A) **Licensed behavioral health professional (LBHP) and/or licensure candidate.** An LBHP is a master's level professional that provides treatment and supervises other treatment staff in maintaining clinical standards of care and providing direct clinical services. A licensure candidate is a practitioner actively and regularly receiving board-approved supervision, or extended supervision by a fully-licensed clinician if the board's supervision requirement is met but the individual is not yet licensed. In addition to the requirements at OAC 317:30-5-240.3(a) and (b), the LBHP or licensure candidate in a TFC setting must demonstrate a general professional or educational

background in the following areas:

- (i) Case management, assessment, and treatment planning;
- (ii) Treatment of victims of physical, emotional, and sexual abuse;
- (iii) Treatment of children with attachment disorders;
- (iv) Treatment of children with hyperactivity or attention deficit disorders;
- (v) Treatment methodologies for emotionally disturbed children;
- (vi) Normal childhood development and the effect of abuse and/or neglect on childhood development;
- (vii) Anger management;
- (viii) Crisis intervention; and
- (ix) Trauma-informed methodology.

(B) Treatment parent specialist (TPS). The TPS serves as an integral member of the team of professionals providing services for the member. The TPS receives extensive training in diagnosed mental health issues, and behavior management/modification and skill-based parenting techniques; and implements the in-home portion of the treatment plan with close supervision and support. The TPS renders services for the member, provides or arranges suitable transportation for therapy and other treatment appointments, writes daily detailed notes regarding interventions and practical applications of learned skills, and attends treatment team meetings. The TPS must be under the supervision of an LBHP or licensure candidate of the foster care agency and meet the following criteria:

(i) Qualifications.

- (I) Have a high school diploma or equivalent;
- (II) Have an employment and/or contractual relationship with the foster care agency as a foster parent, and have successfully met all required background screening requirements, including, but not limited to, fingerprint screenings conducted by the Oklahoma State Bureau of Investigation (OSBI) and Federal Bureau of Investigation (FBI), and OKDHS background screenings;
- (III) Complete the initial thirty-six (36) hours of pre-service training, prior to becoming a TFC parent;

(ii) Responsibilities.

- (I) Have a minimum of twice monthly face-to-face supervision with the licensed, or under-supervision for licensure, LBHP, independent of the member's family

therapy;

(II) Have weekly contact with the foster care agency professional staff;

(III) Complete the required eighteen (18) hours of in-service training per calendar year; and

(IV) Work with the multidisciplinary team and the member's biological family toward reunification, if appropriate, or other permanency plan.

(2) The team may also include the following providers:

(A) **Certified alcohol and drug counselor (CADC).** A bachelor's level team member with a current certification as a CADC in the state in which services are provided.

(B) **Certified behavioral health case manager (CM II).** A bachelor's level team member that may provide support services and case management. In addition to the minimum requirements at Oklahoma Administrative Code (OAC) 317:30-5-240.3(h)(1), the CM II must:

(i) Have a minimum of one (1) year of experience in providing direct care and/or treatment to children and/or families; and

(ii) Have access to weekly consultation with a licensed behavioral health professional (LBHP) or licensure candidate.

(iii) The CM II must also follow requirements at OAC 317:30-5-241.3 for providing psychosocial rehabilitation (PSR) services.

(C) **Licensed psychiatrist and/or psychologist.** TFC agencies must provide staff with access to professional psychiatric or psychological consultation as deemed necessary for the planning, implementation, and appropriate management of the member's treatment. See OAC 317:30-5-240.3(a) and 317:25-7-5.

(c) **Agency assurances.** The TFC agency must ensure that each individual who renders treatment services meets the minimum provider qualifications for the service and, if eligible for direct enrollment, is fully contracted with the OHCA. Additionally, the TFC agency must comply with all state and federal Medicaid law, including, but not limited to, OHCA administrative rules, the Code of Federal Regulations (C.F.R.), and the Oklahoma State Medicaid Plan.

(d) **Policies and procedures.** Eligible TFC agency providers shall have written policies and procedures for the orientation of new staff and foster parents which is reviewed and updated annually, for the following:

(1) Pre-service training of foster parents in treatment methodologies and service needs of emotionally and behaviorally disturbed children;

(2) Treatment of victims of physical, emotional, and sexual abuse;

(3) Treatment of children with attachment disorders;

(4) Treatment of children with hyperactive or attention deficit disorders;

- (5) Normal childhood development and the effect of abuse and/or neglect on childhood development;
- (6) Treatment of children and families with substance use disorders;
- (7) The Inpatient Mental Health and Substance Abuse Treatment of Minors Act;
- (8) Anger management;
- (9) Inpatient authorization procedures;
- (10) Crisis intervention;
- (11) Grief and loss issues for children in foster care;
- (12) The significance/value of birth families to children receiving behavioral health services in a foster care setting; and
- (13) Trauma-informed methodology.

[Source: Added at 17 Ok Reg 2402, eff 6-26-00 ; Amended at 20 Ok Reg 523, eff 12-1-02 (emergency); Amended at 20 Ok Reg 1216, eff 5-27-03 ; Amended at 24 Ok Reg 2857, eff 7-1-07 (emergency); Amended at 25 Ok Reg 1200, eff 5-25-08 ; Amended at 27 Ok Reg 1360, eff 4-21-10 (emergency); Amended at 28 Ok Reg 1419, eff 6-25-11 ; Amended at 31 Ok Reg 1696, eff 9-12-14 ; Amended at 32 Ok Reg 1109, eff 8-27-15 ; Amended at 33 Ok Reg 863, eff 9-1-16 ; Amended at 37 Ok Reg 101, eff 10-2-19 (emergency); Amended at 37 Ok Reg 1549, eff 9-14-20]

317:30-5-740.2. Provider selection

Parents who retain legal custody of a TFC child may select any eligible TFC agency as the provider of services. In the case of members in the custody of the State of Oklahoma, the State, acting in its custodial role, selects the TFC agency.

[Source: Added at 17 Ok Reg 2402, eff 6-26-00 ; Amended at 37 Ok Reg 101, eff 10-2-19 (emergency); Amended at 37 Ok Reg 1549, eff 9-14-20]

317:30-5-741. Coverage by category

(a) **Adults.** Behavioral health services in TFC settings are not covered for adults.

(b) **Children.** Behavioral health services are allowed in TFC settings for children under twenty-one (21) as medically necessary. Members receiving services in this setting have moderate behavioral and emotional health needs, and may also present secondary physical, developmental, intellectual, and/or social disorder that is supported alongside the mental health needs. The designated members must continually meet medical necessity criteria to be eligible for coverage in this setting. Requests for behavioral health services in a TFC setting must be prior authorized and may be approved up to a maximum of six (6) month extensions.

(c) **Medical necessity criteria.** In order to satisfy medical necessity criteria, all of the following conditions must be met:

- (1) The member must have a diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM-V), with the exception of V codes and adjustment disorders, with a detailed description of the symptoms supporting the diagnosis. Members with a provisional diagnosis may receive TFC services for a maximum of thirty (30) days.
- (2) An assessment must be completed by a licensed behavioral health professional (LBHP) or licensure candidate as defined in

Oklahoma Administrative Code (OAC) 317:30-5-240.3(a) and (b) within the thirty (30) day provisional period described above, that confirms a diagnosis from the DSM-V with the exception of V codes and adjustments disorders, and that includes a detailed description of the symptoms supporting the diagnosis to continue treatment in a TFC setting.

(3) Conditions are directly attributed to moderate behavioral and emotional needs as the primary need for professional attention.

(4) The current disabling symptoms could not have been/have not been manageable in a less intensive treatment program, or the level of care is warranted in order to reduce the risk of regression of symptoms and/or sustain the gains made at a higher level of care.

(5) Evidence that the members' needs prohibit full integration in a family/home setting without the availability of twenty-four (24) hour crisis response/behavior management and clinical interventions from professional staff, preventing the member from living in a traditional family home.

(6) The member is medically stable and not actively suicidal or homicidal and not in need of substance abuse detoxification services.

(7) The legal guardian [Oklahoma Department of Human Services (OKDHS)/ Oklahoma Office of Juvenile Affairs (OJA) if custody member] or parent of the member agrees to actively participate in the member's treatment needs and planning.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 13 Ok Reg 4049, eff 9-17-96 (emergency); Amended at 14 Ok Reg 1780, eff 5-27-97 ; Amended at 17 Ok Reg 2402, eff 6-26-00 ; Amended at 20 Ok Reg 523, eff 12-1-02 (emergency); Amended at 20 Ok Reg 1216, eff 5-27-03 ; Amended at 23 Ok Reg 2566, eff 6-25-06 ; Amended at 27 Ok Reg 1360, eff 4-21-10 (emergency); Amended at 28 Ok Reg 1419, eff 6-25-11 ; Amended at 29 Ok Reg 413, eff 3-7-12 (emergency); Amended at 29 Ok Reg 1125, eff 6-25-12 ; Amended at 31 Ok Reg 1696, eff 9-12-14 ; Amended at 32 Ok Reg 1109, eff 8-27-15 ; Amended at 33 Ok Reg 863, eff 9-1-16 ; Amended at 37 Ok Reg 101, eff 10-2-19 (emergency); Amended at 37 Ok Reg 1549, eff 9-14-20]

317:30-5-742. Description of services

(a) Treatment services must be provided in the least restrictive, non-institutional therapeutic environment. The TFC setting is restorative in nature, allowing members with moderate behavioral and emotional health needs who may also have a secondary physical, developmental, intellectual, and/or social disorder that is supported alongside the mental health needs to develop the necessary control to function in a less restrictive setting.

(b) Behavioral health services must include an individual plan of care (IPC) for each member served. The IPC requirements are set out in Oklahoma Administrative Code (OAC) 317:30-5-742.2.

(c) Treatment services in a TFC setting must include at least one (1) hour of individual, family, and/or group therapy per week, as set forth in OAC 317:30-5-742.2(3). Treatment may also include, but is not limited to, an array of the following services:

(1) Substance abuse/chemical dependency education, prevention, and therapy;

(2) Psychosocial rehabilitation and support services;

- (3) Behavior management;
- (4) Crisis intervention; and
- (5) Case management.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 13 Ok Reg 4049, eff 9-17-96 (emergency); Amended at 14 Ok Reg 1780, eff 5-27-97 ; Amended at 17 Ok Reg 2402, eff 6-26-00 ; Amended at 20 Ok Reg 523, eff 12-1-02 (emergency); Amended at 20 Ok Reg 1216, eff 5-27-03 ; Amended at 23 Ok Reg 2566, eff 6-25-06 ; Amended at 24 Ok Reg 2857, eff 7-1-07 (emergency); Amended at 25 Ok Reg 1200, eff 5-25-08 ; Amended at 27 Ok Reg 1360, eff 4-21-10 (emergency); Amended at 28 Ok Reg 1419, eff 6-25-11 ; Amended at 33 Ok Reg 863, eff 9-1-16 ; Amended at 37 Ok Reg 101, eff 10-2-19 (emergency); Amended at 37 Ok Reg 1549, eff 9-14-20]

317:30-5-742.1. Reimbursement

- (a) TFC services will be paid at the current fee-for-service (FFS) rate. Services provided to a member without a written individual plan of care (IPC) as described in Oklahoma Administrative Code (OAC) 317:30-742.2 will not be reimbursed.
- (b) Additional services may require prior authorization by the OHCA, or its designated agent. Refer to OAC 317:30-3-31. Documentation must be provided to ensure that services are not duplicative. If additional services are approved for a member in state custody, the Oklahoma Department of Human Services (OKDHS), or Oklahoma Office of Juvenile Affairs (OJA) will collaborate with the provider of such services as directed by the OHCA.
- (c) Reimbursement for TFC services is not available for the following:
 - (1) Room and board;
 - (2) Educational costs;
 - (3) Supported employment;
 - (4) Inpatient psychiatric services;
 - (5) Respite care;
 - (6) Day treatment services;
 - (7) Partial hospitalization services; and
 - (8) Intensive outpatient services.
- (d) Case management services are reimbursed to government providers as per the methodology in the approved Oklahoma Medicaid State Plan.

[Source: Added at 17 Ok Reg 2402, eff 6-26-00 ; Amended at 20 Ok Reg 523, eff 12-1-02 (emergency); Amended at 20 Ok Reg 1216, eff 5-27-03 ; Amended at 24 Ok Reg 2857, eff 7-1-07 (emergency); Amended at 25 Ok Reg 1200, eff 5-25-08 ; Amended at 27 Ok Reg 1360, eff 4-21-10 (emergency); Amended at 28 Ok Reg 1419, eff 6-25-11 ; Amended at 37 Ok Reg 101, eff 10-2-19 (emergency); Amended at 37 Ok Reg 1549, eff 9-14-20]

317:30-5-742.2. Individual plan of care (IPC)

All behavioral health services in a TFC setting are provided as a result of an individual assessment of the member's needs and documented in the IPC.

(1) Assessment.

(A) **Definition.** Gathering and assessment of historical and current bio-psycho-social information which includes face-to-face contact with the member and the member's foster parent(s) or legal guardian or other person, including biological parent(s) when applicable, who have pertinent information about the member resulting in a written

summary report, diagnosis, and recommendations. All TFC agencies must assess each individual to determine whether he or she could be an appropriate candidate for TFC services.

(B) **Qualified professional.** This service is performed by a licensed behavioral health professional (LBHP) or licensure candidate.

(C) **Limitations.** Assessments are compensable on behalf of a member who is seeking services for the first time from the TFC agency. This service is not compensable if the member has previously received or is currently receiving services from the agency, unless there has been a gap in service of more than six (6) months and it has been more than one (1) year since the previous assessment.

(D) **Documentation requirements.** The assessment must include all elements and tools required by the OHCA. In the case of members under the age of eighteen (18), it is performed with the direct, active, face-to-face participation of the member and foster parent(s) or legal guardian or other persons, including biological parent(s) when applicable. The member's level of participation is based on age, developmental, and clinical appropriateness. The assessment must include all related diagnoses from the Diagnostic and Statistical Manual of Mental Disorders (DSM-V). The assessment must contain, but is not limited to, the following:

- (i) Date, to include month, day, and year of the assessment session(s);
- (ii) Source of information;
- (iii) Member's first name, middle initial, and last name;
- (iv) Gender;
- (v) Birth date;
- (vi) Home address;
- (vii) Telephone number;
- (viii) Referral source;
- (ix) Reason for referral;
- (x) Person to be notified in case of emergency;
- (xi) Presenting reason for seeking services;
- (xii) Start and stop time for each unit billed;
- (xiii) Dated signature of foster parent(s) or legal guardian [Oklahoma Department of Human Services (OKDHS) or Oklahoma Office of Juvenile Affairs (OJA)] or other persons, including biological parents(s) (when applicable) participating in the face-to-face assessment. Signatures are required for members fourteen (14) years of age and over;
- (xiv) Bio-psychosocial information which must include:

- (I) Identification of the member's strengths, needs, abilities, and preferences;

- (II) History of the presenting problem;
- (III) Previous psychiatric treatment history, including treatment of psychiatric issues, substance use, drug and alcohol addiction, and other addictions;
- (IV) Health history and current biomedical conditions and complications;
- (V) Alcohol, drug, and/or other addictions history;
- (VI) Trauma, abuse, neglect, violence, and/or sexual assault history of self and/or others, including OKDHS involvement;
- (VII) Family and social history, including psychiatric, substance use, drug and alcohol addiction, other addictions, and trauma/abuse/neglect;
- (VIII) Educational attainment, difficulties, and history;
- (IX) Cultural and religious orientation;
- (X) Vocational, occupational, and military history;
- (XI) Sexual history, including human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), other sexually transmitted diseases (STDs), and at-risk behaviors;
- (XII) Marital or significant other relationship history;
- (XIII) Recreation and leisure history;
- (XIV) Legal or criminal record, including the identification of key contacts (e.g. attorneys, probation officers);
- (XV) Present living arrangements;
- (XVI) Economic resources; and
- (XVII) Current support system, including peer and other recovery supports.

(xv) Mental status and level of functioning information, including, but not limited to, questions regarding the following:

- (I) Physical presentation, such as general appearance, motor activity, attention, and alertness;
- (II) Affective process, such as mood, affect, manner, and attitude;
- (III) Cognitive process, such as intellectual ability, social-adaptive behavior, thought processes, thought content, and memory; and
- (IV) All related diagnoses from the DSM-V.

(xvi) Pharmaceutical information for both current and past medications, to include the following:

- (I) Name of medication;
- (II) Strength and dosage of medication;
- (III) Length of time on the medication; and
- (IV) Benefit(s) and side effects of medication.

(xvii) LBHP's interpretation of findings and diagnosis; and

(xviii) Dated signature and credentials of the qualified practitioner who performed the face-to-face behavioral assessment. If performed by a licensure candidate, it must be countersigned by the LBHP who is responsible for the member's care.

(2) IPC requirements.

(A) **Signature requirement.** A written IPC following a comprehensive evaluation for each member must be formulated by the TFC agency staff within thirty (30) days of admission to the program with documented input from the member, the legal guardian (OKDHS/ OJA), the foster parent(s), the treatment provider(s), and the biological parent(s) when applicable. An IPC is not valid until all dated signatures are present, including signatures from the member [if fourteen (14) years of age and over], the legal guardian, the foster parent, and the treatment provider (s). If the service is performed by a licensure candidate, it must be countersigned by the LBHP who is responsible for the member's care. This plan must be revised and updated every three (3) months with documented involvement of the legal guardian and member.

(B) **Individualization.** The IPC must be individualized and take into account the member's age, history, diagnosis, assessed functional levels, culture, and the effect of past and current traumatic experiences in the life of the member. It includes the member's documented diagnosis, appropriate goals, and corresponding reasonable and attainable treatment objectives, and action steps within the expected timelines. Each member's IPC needs to address the TFC agency's plans with regard to the provision of services. Each plan of care must clearly identify the type of services required to meet the member's treatment needs and frequency over a given period of time.

(C) **Qualified professional.** This service is performed by an LBHP or licensure candidate.

(D) **Time requirements.** IPC updates must be conducted face-to-face and are required at least every ninety (90) days during active treatment. However, updates can be conducted whenever it is clinically needed, as determined by the qualified practitioner and member.

(E) **Documentation requirements.** Comprehensive and integrated service plan content must identify:

- (i) Member strengths, needs, abilities, and preferences (SNAP);
- (ii) Identified presenting challenges, problems, needs, and diagnosis;
- (iii) Specific goals for the member;
- (iv) Objectives that are specific, attainable, realistic, and time-limited;
- (v) Each type of service and estimated frequency to be received;
- (vi) The name and credentials of all the practitioners who will be providing and responsible for each service;
- (vii) Any needed referrals for service;
- (viii) Specific discharge criteria; and
- (ix) Member's involvement in, and responses to, the treatment plan, and his/her signature and date [if fourteen (14) years of age and over].

(F) **Amendments and updates.** Amendment of an existing IPC to revise or add goals, objectives, service provider(s), service type, and service frequency, must be documented in either a scheduled three (3) month plan update or within the existing IPC through an addendum until the review/update is due. Any changes must, prior to implementation, be signed and dated by the member [if fourteen (14) years of age and over], the legal guardian, the foster parent, as well as the primary LBHP and any new provider(s). If the service is performed by a licensure candidate, it must be countersigned by the LBHP who is responsible for the member's care. IPC updates must address the following:

- (i) Update to the bio-psychosocial assessment, re-evaluation of diagnosis, and IPC goals and/ or objectives;
- (ii) Progress, or lack of, on previous IPC goals and/or objectives;
- (iii) A statement documenting a review of the current IPC, and, if no changes are needed, an explanation and a statement addressing the status of the identified problem behavior that led to TFC placement must be included;
- (iv) Change in goals and/or objectives (including target dates) based upon member's progress or identification of new needs, challenges, and problems;
- (v) Change in frequency and/or type of services provided;
- (vi) Change in practitioner(s) who will be responsible for providing services on the plan;
- (vii) Change in discharge criteria; and

(viii) Description of the member's involvement in, and responses to, the treatment plan, and his/her signature and date [if fourteen (14) years of age and over] Refer to Oklahoma Administrative Code (OAC) 317:30-5-742.2. (2)(A).

(3) **Description of services.** Agency services include:

(A) **Individual, family, and/or group therapy.** See Oklahoma Administrative Code (OAC) 317:30-5-241.2(a), (b), and (c). A member must receive one (1) hour of individual, family, and/or group therapy each week that is provided by an LBHP or licensure candidate, and may receive up to two (2) hours each week, if medically needed.

(B) **Crisis intervention.** The provider agency must provide crisis intervention by agency staff as needed twenty-four (24) hours per day, seven (7) days per week. The agency must ensure staff availability to respond to the residential foster parent(s) in a crisis to stabilize a member's behavior and prevent placement disruption. This service is to be provided to the member by an LBHP or a licensure candidate. The licensure candidate must have immediate access to an LBHP who can provide oversight of the licensure candidate and conduct an emergency detention evaluation.

(C) **Discharge planning.** The TFC agency must develop a discharge plan for each member. The discharge plan must be individualized, member-specific, and include an after care plan that is appropriate to the member's needs, identifies the member's needs, includes specific recommendations for follow-up care, and outlines plans that are in place at the time of discharge. The plan for members in parental custody must include, when appropriate, reunification plans with the parent(s)/legal guardian. The plan for members who remain in the custody of OKDHS or OJA must be developed in collaboration with the case worker and finalized at the time of discharge. The discharge plan is to include, at a minimum, recommendations for continued treatment services, educational services, and other appropriate community resources. Appointments for outpatient therapy and medication management (when applicable) should be scheduled prior to discharge. Discharge planning provides a transition from TFC placement into a less restrictive setting within the community. Discharge planning is performed in partnership between Child Welfare Services (CWS) of the OKDHS and an LBHP within the TFC agency.

(D) **Substance use/chemical dependency use therapy.** Substance use/chemical dependency therapy can be provided if a member is identified by diagnosis or documented social history as having emotional or

behavioral problems directly related to substance use and/or chemical dependency. The modalities employed are provided in order to begin, maintain, and enhance recovery from problem drinking, alcoholism, nicotine use and addiction, and/or drug use, drug dependency, and/or drug addiction. This service is to be provided to the member by an LBHP or licensure candidate.

(E) **Substance use rehabilitation services.** Covered substance use rehabilitation services are provided in non-residential settings in regularly scheduled sessions intended for individuals not requiring a more intensive level of care or those who require continuing services following more intensive treatment regimes. The purpose of substance use rehabilitation services is to begin, maintain, and/or enhance recovery from problem drinking, alcoholism, nicotine use and addiction, and/or drug use, drug dependency, and/or drug addiction. Rehabilitation services may be provided individually or in group sessions, and they take the format of an agency-approved, curriculum-based education and skills training. This service is to be provided to the member by a certified behavioral health case manager (CM) II, certified alcohol drug counselor (CADC) or LBHP.

(F) **Psychosocial rehabilitation (PSR).**

(i) **Definition.** PSR services are face-to-face behavioral health rehabilitation services which are necessary to improve the member's ability to function in the community. They are performed to improve the skills and abilities of members to live independently in the community, improve self-care and social skills, and promote lifestyle change and recovery practices. Rehabilitation services may be provided individually or in group sessions, and they take the format of an agency-approved, curriculum-based education, and skills training.

(ii) **Clinical restrictions.** This service is generally performed with only the member and the qualified provider, but may also include a member and the member's family/support system group that focuses on the member's diagnosis, symptom management, and recovery based curriculum. A member who, at the time of service, is not able to cognitively benefit from the treatment due to active hallucinations and/or substance use, or other impairments is not suitable for this service. Family involvement is allowed for support of the member and education regarding his/her recovery, but does not constitute family therapy, which requires an LBHP or licensure candidate.

(iii) **Qualified practitioners.** A CM II, an LBHP, or a licensure candidate may perform PSR, following

development of an IPC curriculum approved by an LBHP or licensure candidate. The CM II must have immediate access to an LBHP who can provide clinical oversight of the CM II and collaborate with the CM II in the provision of services. A minimum of one (1) monthly face-to-face consultation with an LBHP is required.

(iv) **Group sizes.** The maximum staffing ratio is eight (8) members to one (1) practitioner for members under the age of twenty-one (21).

(v) **Limitations.**

(I) In order to develop and improve the member's community and interpersonal functioning and self-care abilities, PSR services may take place in settings away from the behavioral health agency site as long as the setting protects and assures confidentiality. When this occurs, the qualified provider must be present and interacting, teaching, or supporting the defined learning objectives of the member for the entire claimed time.

(II) PSR services are intended for children with Serious Emotional Disturbance (SED), and children with moderate behavioral and emotional health needs who may also have a secondary physical, developmental, intellectual, and/or social disorder that is supported alongside the mental health needs. Members, ages four (4) and five (5), are not eligible for PSR services unless a prior authorization has been granted by OHCA or its designated agent based on a finding of medical necessity.

(III) PSR services are time-limited services designed to be provided over the briefest and most effective period possible and as adjunct (enhancing) interventions to complement more intensive behavioral health therapies. Service limits are based on the member's needs according to the Client Assessment Record (CAR) or other approved tools. Service limitations are designed to maximize efficacy by remaining within reasonable age and developmentally appropriate daily limits.

(vi) **Progress notes.** In accordance with OAC 317:30-5-241.1, the behavioral health IPC developed by the LBHP or licensure candidate must include the member's strengths, functional assets, weaknesses or liabilities, treatment goals,

objectives, and methodologies that are specific and time-limited, and defines the services to be performed by the practitioners and others who comprise the treatment team. When PSR services are prescribed, the plan must address objectives that are specific, attainable, realistic, measurable, and time-limited. The plan must include the appropriate treatment coordination to achieve the maximum reduction of the moderate behavioral and emotional health conditions, and any other secondary physical, developmental, intellectual, and/or social disorder and to restore the member to his or her best possible functional level.

Progress notes for PSR services must include:

(I) Start and stop times for each day attended and the physical location in which the service was rendered;

(II) Specific goal(s) and objectives addressed during the session/group;

(III) Type of skills training provided each day and/or during the week including the specific curriculum used with the member;

(IV) Member satisfaction with staff intervention(s);

(V) Progress, towards attaining, or barriers affecting the attainment of, goals and objectives;

(VI) New goal(s) or objective(s) identified;

(VII) Dated signature of the qualified provider; and

(VIII) Credentials of the qualified provider.

(vii) **Additional documentation requirements.**

Documentation of ongoing consultation and/or collaboration with an LBHP or licensure candidate related to the provision of PSR services.

(G) Therapeutic behavioral services (TBS). Goal directed social skills redevelopment activities for each member to restore, retain, and improve the self-help, communication, socialization, and adaptive skills necessary to reside successfully in home and community based settings. These will be daily activities that are age appropriate, culturally sensitive, and relevant to the goals of the IPC. These may include self-esteem enhancement, violence alternatives, communication skills, or other related skill development. This service is to be provided to the member by the treatment parent specialist (TPS). Services rendered by the TPS are limited to one and one half (1.5) hours daily.

Reg 2857, eff 7-1-07 (emergency); Amended at 25 Ok Reg 1200, eff 5-25-08 ; Amended at 27 Ok Reg 1360, eff 4-21-10 (emergency); Amended at 28 Ok Reg 1419, eff 6-25-11 ; Amended at 31 Ok Reg 1696, eff 9-12-14 ; Amended at 32 Ok Reg 1096, eff 8-27-15 ; Amended at 33 Ok Reg 863, eff 9-1-16 ; Amended at 34 Ok Reg 699, eff 9-1-17 ; Amended at 37 Ok Reg 101, eff 10-2-19 (emergency); Amended at 37 Ok Reg 1549, eff 9-14-20]

317:30-5-743. Payment rates and recoupment [REVOKED]

[**Source:** Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 13 Ok Reg 3646, eff 10-1-95 (emergency); Amended at 13 Ok Reg 1645, eff 5-27-96 ; Amended at 13 Ok Reg 4049, eff 9-17-96 (emergency); Amended at 14 Ok Reg 1780, eff 5-27-97 ; Amended at 17 Ok Reg 2402, eff 6-26-00 ; Revoked at 27 Ok Reg 1360, eff 4-21-10 (emergency); Revoked at 28 Ok Reg 1419, eff 6-25-11]

317:30-5-743.1. Service quality review (SQR)

There will be an SQR performed by the Oklahoma Health Care Authority (OHCA) or its designated agent of each TFC agency that provides care to members. The OHCA will designate the members of the SQR team. This team will consist of at least two (2) team members and will be comprised of licensed behavioral health professionals (LBHPs) and/or registered nurses (RNs). The SQR will consist of a survey of current members receiving services, as well as members for which claims have been filed with OHCA for TFC services. Observation and contact with members may be incorporated. The review includes validation of certain factors, all of which must be met for the services to be compensable. Following the review, the SQR team will report its findings to the TFC agency. The TFC agency will be provided with written notification if the findings of the SQR have resulted in any deficiencies. A copy of the final report will be sent to the TFC agency's accrediting body. Deficiencies found during the SQR may result in a recoupment of the compensation received for that service. The individual plan of care (IPC) is considered to be critical to the integrity of care and treatment and must be completed within the timelines designated at Oklahoma Administrative Code (OAC) 317:30-5-742.2. If the IPC is missing, or it is found that the member did not meet medical necessity criteria at any time, all paid services will be recouped for each day the IPC was missing from the date the plan of care was due for completion or the date from which medical necessity criteria was no longer met.

[**Source:** Added at 23 Ok Reg 2566, eff 6-25-06 ; Amended at 24 Ok Reg 2857, eff 7-1-07 (emergency); Amended at 25 Ok Reg 1200, eff 5-25-08 ; Amended at 27 Ok Reg 1360, eff 4-21-10 (emergency); Amended at 28 Ok Reg 1419, eff 6-25-11 ; Amended at 33 Ok Reg 863, eff 9-1-16 ; Amended at 37 Ok Reg 101, eff 10-2-19 (emergency); Amended at 37 Ok Reg 1549, eff 9-14-20]

317:30-5-744. Billing

(a) Claims must be submitted in accordance with guidelines found at Oklahoma Administrative Code (OAC) 317:30-3-11, 317:30-3-11.1, and 317:30-3-20.

(b) Claims for dually eligible individuals (Medicare/Medicaid) should be filed directly with the Oklahoma Health Care Authority (OHCA).

[**Source:** Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 13 Ok Reg 4049, eff 9-17-96 (emergency); Amended at 14 Ok Reg 1780, eff 5-27-97 ; Amended at 17 Ok Reg 2402, eff 6-26-00 ; Amended at 19 Ok Reg 2134, eff 6-27-02 ; Amended at 27 Ok Reg 1360, eff 4-21-10 (emergency); Amended at 28 Ok Reg 1419, eff 6-25-11 ; Amended at 32 Ok

Reg 719, eff 7-1-15 (emergency); Amended at 33 Ok Reg 791, eff 9-1-16 ; Amended at 37 Ok Reg 101, eff 10-2-19 (emergency); Amended at 37 Ok Reg 1549, eff 9-14-20]

317:30-5-745. Documentation of records

Providers must maintain an appropriate records system. Current individual plans of care, case files, and progress notes are maintained in the provider's files during the time the member is receiving services. All services must be reflected by documentation in the records.

Documentation of services must include all of the following:

- (1) The date the service was provided;
- (2) The beginning and ending time the service was provided;
- (3) A description of the member's response to the service;
- (4) The type of service provided (individual, group, or family session; group rehabilitative treatment; social skills (re)development; basic living skills (re)development; crisis behavior management and redirection; or discharge planning); and
- (5) The dated signature with credentials of the person providing the service. If the service is performed by a licensure candidate, it must be countersigned by the licensed behavioral health professional (LBHP) who is responsible for the member's care. Refer to Oklahoma Administrative Code (OAC) 317:30-5-742.2. (2) (A).

[**Source:** Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 17 Ok Reg 2402, eff 6-26-00 ; Amended at 20 Ok Reg 523, eff 12-1-02 (emergency); Amended at 20 Ok Reg 1216, eff 5-27-03 ; Amended at 23 Ok Reg 2566, eff 6-25-06 ; Amended at 27 Ok Reg 1360, eff 4-21-10 (emergency); Amended at 28 Ok Reg 1419, eff 6-25-11 ; Amended at 37 Ok Reg 101, eff 10-2-19 (emergency); Amended at 37 Ok Reg 1549, eff 9-14-20]

317:30-5-746. Prior authorization and appeal of prior authorization decision

(a) All behavioral health services must be prior authorized by the Oklahoma Health Care Authority (OHCA) or its designated agent before the service is rendered by an eligible provider. Without prior authorization, payment is not authorized.

(b) If a denial decision is made, an appeal may be initiated by the member or the member's legal guardian. The denial can be appealed to the OHCA within thirty (30) calendar days of the receipt of the notification of the denial by the OHCA or its designated agent.

[**Source:** Added at 17 Ok Reg 2402, eff 6-26-00 ; Amended at 23 Ok Reg 771, eff 3-9-06 (emergency); Amended at 23 Ok Reg 2440, eff 6-25-06 ; Amended at 24 Ok Reg 2857, eff 7-1-07 (emergency); Amended at 25 Ok Reg 1200, eff 5-25-08 ; Amended at 36 Ok Reg 864, eff 9-1-19 ; Amended at 37 Ok Reg 101, eff 10-2-19 (emergency); Amended at 37 Ok Reg 1549, eff 9-14-20]

PART 84. INTENSIVE TREATMENT FAMILY CARE

317:30-5-750. Definitions

The following words or terms used in this Part shall have the following meaning, unless the context clearly indicates otherwise:

"Intensive treatment family care (ITFC) agency" means an agency that provides foster care as defined in Section 1355.20 of Title 45 of the Code of Federal Regulation, as twenty-four (24) hour substitute care for children placed away from their parents or guardians and for whom the title IV-E agency has placement and care responsibility. ITFC settings are foster family homes.

"Intensive treatment family care (ITFC) home" means an agency-supervised, private family home in which foster parents [at least one (1) parent must be a stay-at home parent] have been trained to provide individualized, structured services in a safe, nurturing family-living environment. These services are provided to children with severe behavioral and emotional health needs. They may also present a secondary physical, developmental, intellectual, and/or social disorder that is supported alongside the mental health needs of the member. These members require a higher level of care that cannot be provided in the traditional foster care or TFC home. ITFC homes provide the higher level of care needed for these children and help prevent placement in a more restrictive setting, including an inpatient setting.

"Intensivetreatment family care (ITFC) model" means a model in which children in the ITFC environment receive intensive individualized behavioral health and other support services from qualified staff. Because ITFC members require exceptional levels of skill, time, and supervision, the number of unrelated children placed per home is limited; no more than one (1) ITFC member may be placed in a home at any one (1) time unless additional cases are specifically authorized by Child Welfare Services (CWS) of the Oklahoma Department of Human Services (OKDHS), or Oklahoma Office of Juvenile Affairs (OJA).

[Source: Added at 37 Ok Reg 101, eff 10-2-19 (emergency); Added at 37 Ok Reg 1549, eff 9-14-20]

317:30-5-750.1. Eligible providers and requirements

(a) **ITFC agency.** Eligible ITFC agencies must have:

- (1) Current certification from the Oklahoma Department of Human Services (OKDHS) as a child placing agency;
 - (2) A contract with the Child Welfare Division of OKDHS, or Oklahoma Office of Juvenile Affairs (OJA);
 - (3) A contract with the Oklahoma Health Care Authority (OHCA);
- and
- (4) A current accreditation status appropriate to provide behavioral health services in a foster care setting from:
 - (A) The Joint Commission; or
 - (B) The Commission on Accreditation of Rehabilitative Facilities (CARF); or
 - (C) The Council on Accreditation (COA).

(b) **Treatment team.** ITFC agencies are primarily responsible for treatment planning and coordination of the member's treatment team. This team is typically composed of an OKDHS or OJA caseworker, the member, the member's foster parent(s), as well as others closely involved with the member and family, including the biological parents when applicable.

(1) The team must include the following providers:

(A) **Licensed behavioral health professional (LBHP).**

A master's level professional who provides treatment and supervises other treatment staff in maintaining clinical standards of care and providing direct clinical services. In addition to the requirements at OAC 317:30-5-240.3(a), the LBHP in an ITFC setting must demonstrate a general professional or educational background in the following areas:

- (i) Case management, assessment, and treatment planning;
- (ii) Treatment of victims of physical, emotional, and sexual abuse;
- (iii) Treatment of children with attachment disorders;
- (iv) Treatment of children with hyperactivity or attention deficit disorders;
- (v) Treatment methodologies for emotionally disturbed children;
- (vi) Normal childhood development and the effect of abuse and/or neglect on childhood development;
- (vii) Anger management;
- (viii) Crisis intervention; and
- (ix) Trauma-informed methodology.

(B) **Treatment parent specialist (TPS).** The TPS serves as an integral member of the team of professionals providing services for the members. The TPS receives extensive training in diagnosed mental health issues, and behavior management/modification and skill-based parenting techniques; and implements the in-home portion of the treatment plan with close supervision and support. The TPS renders services for the member, provides or arranges suitable transportation for therapy and other treatment appointments, writes daily detailed notes regarding interventions and practical applications of learned skills, and attends treatment team meetings. The TPS must be under the supervision of an LBHP of the ITFC agency and meet the following criteria:

(i) **Qualifications.**

- (I) Have a high school diploma or equivalent, and either some post-secondary education and/or a combination of at least two (2) years of personal/professional experience working with children with significant needs;
- (II) Have an employment and/or contractual relationship with the ITFC agency as a foster parent, and have successfully met all required background screening requirements, including, but not limited to, fingerprint screenings conducted by the

Oklahoma State Bureau of Investigation (OSBI) and Federal Bureau of Investigation (FBI), and OKDHS background screenings;
(III) Completed all evidence-informed ITFC foster parent training, as outlined in this Section;

(IV) Complete a minimum of twenty (20) hours of required annual continuing education trainings. Six (6) hours of the twenty (20) training hours must be clinical in nature;

(V) Agree to have at least one (1) parent in the ITFC home serve as a full-time, stay-at-home parent in order to sufficiently meet the significant needs of the member placed in the ITFC home; and

(ii) **Responsibilities.**

(I) Have a minimum of twice monthly face-to-face supervision with the LBHP, independent of the member's family therapy;

(II) Have weekly contact with the ITFC agency professional staff;

(III) Utilize individualized curriculum-based education and support materials with the member to support the member's skill development outside of the clinical setting;

(IV) Agree, by contract with the ITFC agency, to serve the member in his or her ITFC home through completion of the treatment designated on his or her individual plan of care (IPC), and without disruption to the service array; and

(V) Work with the multidisciplinary team and the member's biological family toward reunification, if appropriate, or other permanency plan.

(2) The team may also include the following providers:

(A) **Certified alcohol and drug counselor (CADC).** A bachelor's level team member with a current certification as a CADC in the state in which services are provided.

(B) **Certified behavioral health case manager (CM) II.** A bachelor's level team member who may provide support services and case management. In addition to the minimum requirements at Oklahoma Administrative Code (OAC) 317:30-5-240.3(h)(1), the CM II must:

(i) Have a minimum of one (1) year of experience in providing direct care and/or treatment to children and/or families; and

(ii) Have access to weekly consultation with a licensed behavioral health professional (LBHP).

(iii) The CM II must also follow requirements at OAC 317:30-5-241.3 for providing psychosocial rehabilitation (PSR) services.

(C) **Licensed psychiatrist and/or psychologist.** ITFC agencies must provide staff with access to professional psychiatric or psychological consultation as deemed necessary for the planning, implementation, and appropriate management of the member's treatment. See OAC 317:30-5-240.3(a) and 317:25-7-5.

(c) **Agency assurances.** The ITFC agency must ensure that each individual who renders treatment services meets the minimum provider qualifications for the service and is fully contracted with the OHCA. Additionally, the ITFC agency must comply with all state and federal Medicaid law, including, but not limited to, OHCA administrative rules, the Code of Federal Regulations (C.F.R.), and the Oklahoma State Medicaid Plan.

(d) **Policies and procedures.** Eligible ITFC agencies shall have written policies and procedures for the orientation of new staff and foster parents which is reviewed and updated annually, for the following:

- (1) Pre-service training of foster parents in treatment methodologies and service needs of emotionally and behaviorally disturbed children;
- (2) Treatment of victims of physical, emotional, and sexual abuse;
- (3) Treatment of children with attachment disorders;
- (4) Treatment of children with hyperactive or attention deficit disorders;
- (5) Normal childhood development and the effect of abuse and/or neglect on childhood development;
- (6) Treatment of children and families with substance use disorders;
- (7) The Inpatient Mental Health and Substance Abuse Treatment of Minors Act;
- (8) Anger management;
- (9) Inpatient authorization procedures;
- (10) Crisis intervention;
- (11) Grief and loss issues for children in foster care;
- (12) The significance/value of birth families to children receiving behavioral health services in a foster care setting; and
- (13) Trauma-informed methodology.

[Source: Added at 37 Ok Reg 101, eff 10-2-19 (emergency); Added at 37 Ok Reg 1549, eff 9-14-20]

317:30-5-750.2. Provider selection

Parents who retain legal custody of an ITFC member may select any eligible ITFC agency as the provider of services. In the case of members in the custody of the State of Oklahoma, the State, acting in its custodial role, selects the ITFC agency.

[Source: Added at 37 Ok Reg 101, eff 10-2-19 (emergency); Added at 37 Ok Reg 1549, eff 9-14-20]

317:30-5-751. Coverage by category

(a) **Adults.** Behavioral health services in ITFC settings are not covered for adults.

(b) **Children.** Behavioral health services are allowed in ITFC settings for children under twenty-one (21) as medically necessary. Members receiving services in this setting have severe behavioral and emotional health needs and may also present a secondary physical, developmental, intellectual, and/or social disorder that is supported alongside the mental health needs. ITFC homes provide the higher level of care needed for these children and help prevent placement in an inpatient or more restrictive setting. The designated members must continually meet medical necessity criteria to be eligible for coverage in this setting. Requests for behavioral health services in an ITFC setting must be prior authorized and may be approved up to a maximum of three (3) month extensions.

(c) **Medical necessity criteria.** In order to satisfy medical necessity criteria, all of the following conditions must be met:

(1) The member must have a diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM-V), with the exception of V codes and adjustment disorders, with a detailed description of the symptoms supporting the diagnosis. Members with a provisional diagnosis may receive ITFC services for a maximum of thirty (30) days.

(2) An assessment must be completed by a licensed behavioral health professional (LBHP) as defined in Oklahoma Administrative Code (OAC) 317:30-5-240.3(a) within the thirty (30) day provisional period described above, that confirms a diagnosis from the DSM-V with the exception of V codes and adjustments disorders, and that includes a detailed description of the symptoms supporting the diagnosis to continue treatment in an ITFC setting.

(3) Conditions are directly attributed to a primary medical diagnosis of a severe behavioral and emotional health need, and may also be attributed to a secondary medical diagnosis of a physical, developmental, intellectual and/or social disorder that is supported alongside the mental health needs.

(4) The current disabling symptoms could not have been/have not been manageable in a less intensive treatment program, or the level of care is warranted in order to reduce the risk of regression of symptoms and/or sustain the gains made at a higher level of care.

(5) Evidence that the members' needs prohibit full integration in a family/home setting without the availability of twenty-four (24) hour crisis response/behavior management and intensive clinical interventions from professional staff, preventing the member from living in a traditional or therapeutic foster home.

(6) The member is medically stable and not actively suicidal or homicidal and not in need of substance abuse detoxification services.

(7) The legal guardian [Oklahoma Department of Human Services (OKDHS)/ Oklahoma Office of Juvenile Affairs (OJA) if custody member] or parent of the member agrees to actively participate in the member's treatment needs and planning.

[Source: Added at 37 Ok Reg 101, eff 10-2-19 (emergency); Added at 37 Ok Reg 1549, eff 9-14-20]

317:30-5-752. Description of services

(a) Treatment services must be provided in the least restrictive, non-institutional therapeutic environment. The ITFC setting is restorative in nature, allowing members with severe behavioral and emotional health needs, who may also present a secondary physical, developmental, intellectual, and/or social disorder that is supported alongside the mental health needs, to develop the necessary control to function in a less restrictive setting.

(b) Behavioral health services must include an individual plan of care (IPC) for each member served. The IPC requirements are set out in Oklahoma Administrative Code (OAC) 317:30-5-753.

(c) Treatment services in an ITFC must include at least two (2) hours of individual, family, and/or group therapy per week, as set forth in OAC 317:30-5-753(3). Treatment may also include, but is not limited to, an array of the following services:

- (1) Substance abuse/chemical dependency education, prevention, and therapy;
- (2) Psychosocial rehabilitation and support services;
- (3) Behavior management;
- (4) Crisis intervention; and
- (5) Case management.

[Source: Added at 37 Ok Reg 101, eff 10-2-19 (emergency); Added at 37 Ok Reg 1549, eff 9-14-20]

317:30-5-753. Individual plan of care (IPC) requirements

All behavioral health services in an ITFC setting are provided as a result of an individual assessment of the member's needs and documented in the IPC.

(1) Assessment.

(A) **Definition.** Gathering and assessment of historical and current bio-psychosocial information which includes face-to-face contact with the member and the member's foster parent(s) or legal guardian or other person, including biological parent(s) when applicable, who have pertinent information about the member resulting in a written summary report, diagnosis, and recommendations. All ITFC agencies must assess each individual to determine whether they could be an appropriate candidate for ITFC services.

(B) **Qualified professional.** This service is performed by a licensed behavioral health professional (LBHP).

(C) **Limitations.** Assessments are compensable on behalf of a member who is seeking services for the first time from

the ITFC agency. This service is not compensable if the member has previously received or is currently receiving services from the agency, unless there has been a gap in service of more than six (6) months and it has been more than one (1) year since the previous assessment.

(D) **Documentation requirements.** The assessment must include all elements and tools required by the Oklahoma Health Care Authority (OHCA). In the case of members under the age of eighteen (18), it is performed with the direct, active, face-to-face participation of the member and foster parent(s) or legal guardian or other persons, including biological parent(s) when applicable. The member's level of participation is based on age, developmental, and clinical appropriateness. The assessment must include all related diagnoses from the Diagnostic and Statistical Manual of Mental Disorders (DSM-V). The assessment must contain, but is not limited to, the following:

- (i) Date, including month, day, and year of the assessment session(s);
- (ii) Source of information;
- (iii) Member's first name, middle initial, and last name;
- (iv) Gender;
- (v) Birth date;
- (vi) Home address;
- (vii) Telephone number;
- (viii) Referral source;
- (ix) Reason for referral;
- (x) Person to be notified in case of emergency;
- (xi) Presenting reason for seeking services;
- (xii) Start and stop time for each unit billed;
- (xiii) Dated signature of foster parent(s) or legal guardian [Oklahoma Department of Human Services (OKDHS) or Oklahoma Office of Juvenile Affairs (OJA)] or other persons, including biological parent(s) (when applicable) participating in the face-to-face assessment. Signatures are required for members fourteen (14) years of age and over;
- (xiv) Bio-psychosocial information, which must include:

- (I) Identification of the member's strengths, needs, abilities, and preferences;
- (II) History of the presenting problem;
- (III) Previous psychiatric treatment history, including treatment of psychiatric issues, substance use, drug and alcohol addiction, and other addictions;
- (IV) Health history and current biomedical conditions and complications;

- (V) Trauma, abuse, neglect, violence, and/or sexual assault history of self and/or others, including OKDHS involvement;
- (VI) Family and social history, including psychiatric, substance use, drug and alcohol addiction, other addictions, and trauma/abuse/neglect;
- (VII) Educational attainment, difficulties, and history;
- (VIII) Cultural and religious orientation;
- (IX) Vocational, occupational, and military history;
- (X) Sexual history, including human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), other sexually transmitted diseases (STDs), and at-risk behaviors;
- (XI) Marital or significant other relationship history;
- (XII) Recreation and leisure history;
- (XIII) Legal or criminal record, including the identification of key contacts (e.g. attorneys, probation officers);
- (XIV) Present living arrangements;
- (XV) Economic resources; and
- (XVI) Current support system, including peer and other recovery supports.

(xv) Mental status and level of functioning information, including, but not limited to, questions regarding the following:

- (I) Physical presentation, such as general appearance, motor activity, attention, and alertness;
- (II) Affective process, such as mood, affect, manner, and attitude;
- (III) Cognitive process, such as intellectual ability, social-adaptive behavior, thought processes, thought content, and memory; and
- (IV) All related diagnoses from the DSM-V.

(xvi) Pharmaceutical information for both current and past medications, to include the following:

- (I) Name of medication;
- (II) Strength and dosage of medication;
- (III) Length of time on the medication; and
- (IV) Benefit(s) and side effects of medication.

(xvii) LBHP's interpretation of findings and diagnosis; and

(xviii) Dated signature and credentials of the LBHP who performed the face-to-face behavioral

assessment.

(2) **IPC requirements.**

(A) **Signature requirement.** A written IPC following a comprehensive evaluation for each member must be formulated by the ITFC agency staff within thirty (30) days of admission to the program with documented input from the member, the legal guardian (OKDHS/OJA), the foster parent(s), the treatment provider(s), and the biological parent(s) when applicable. An IPC is not valid until all dated signatures are present, including signatures from the member [if fourteen (14) years of age and over], the legal guardian, the foster parent, and the treatment provider(s). This plan must be reviewed every thirty (30) days with documented involvement of the legal guardian and member. The review includes an evaluation of the member's progress in the treatment setting, as well as in other environments, such as home, school, social engagements, etc.

(B) **Individualization.** The IPC must be individualized and take into account the member's age, history, diagnosis, functional levels, culture, and the effect of past and current traumatic experiences in the life of the member. It includes the member's documented diagnosis, appropriate goals, corresponding reasonable and attainable treatment objectives, and action steps within the expected timelines. Each member's IPC needs to address the ITFC agency's plans with regard to the provision of services. Each plan of care must clearly identify the type of services required to meet the member's treatment needs and frequency over a given period of time.

(C) **Qualified professional.** This service is performed by an LBHP.

(D) **Time requirements.** IPC updates must be conducted face-to-face and are required at least every ninety (90) days during active treatment. However, updates can be conducted whenever it is clinically needed, as determined by an LBHP. Updates should reflect changes to treatment based on the members' progress or lack thereof.

(E) **Documentation requirements.** Comprehensive and integrated service plan content must address the following:

- (i) Member strengths, needs, abilities, and preferences (SNAP);
- (ii) Identified presenting challenges, problems, needs and diagnosis;
- (iii) Specific goals for the member;
- (iv) Objectives that are specific, attainable, realistic, and time-limited;
- (v) Each type of service and estimated frequency to be received;

- (vi) The name and credentials of all the practitioners who will be providing and responsible for each service;
- (vii) Any needed referrals for service;
- (viii) Specific discharge criteria; and
- (ix) Description of the member's involvement in, and responses to, the treatment plan, and his/her signature and date [if fourteen (14) years of age and older].

(F) **Amendments and updates.** Amendment of an existing IPC to revise or add goals, objectives, service provider(s), service type, and service frequency must be documented in the existing IPC through an addendum until the review/update is due. Any changes must, prior to implementation, be signed and dated by the member [if fourteen (14) years of age and over], the legal guardian, the foster parent, as well as the primary LBHP and any new provider(s). IPC updates must address the following:

- (i) Update to the bio-psychosocial assessment, re-evaluation of diagnosis, and IPC goals and/ or objectives;
- (ii) Progress, or lack of, on previous IPC goals and/or objectives;
- (iii) A statement documenting a review of the current IPC, and, if no changes are needed, an explanation and a statement addressing the status of identified problem behaviors that led to ITFC placement must be included;
- (iv) Change in goals and/or objectives (including target dates) based upon member's progress or identification of new needs, challenges, and problems;
- (v) Change in frequency and/or type of services provided;
- (vi) Change in practitioner(s) who will be responsible for providing services on the plan;
- (vii) Change in discharge criteria; and
- (viii) Description of the member's involvement in, and responses to, the treatment plan, and his/her signature and date [if fourteen (14) years of age and older].

(3) **Description of services.** Agency services include:

(A) **Individual, family, and/or group therapy.** See OAC 317:30-5-241.2(a), (b), and (c). The number of units of individual, family, and/or group therapy within the ITFC setting differ from the number of units available in the outpatient setting. A member must receive two (2) hours of individual, family, and/or group therapy each week that is provided by an LBHP, and may receive up to three (3) hours each week, if medically needed.

(B) **Crisis intervention.** The provider agency must provide crisis intervention by ITFC agency staff as needed twenty-four (24) hours per day, seven (7) days per week. The agency must ensure staff is available to respond to the ITFC foster parent(s) in a crisis to stabilize a member's behavior and prevent placement disruption. This service is to be provided to the member by an LBHP.

(C) **Discharge planning.** The ITFC agency must develop a discharge plan for each member. The discharge plan must be individualized, member-specific, and include an after-care plan that is appropriate to the member's needs, identifies the member's needs, includes specific recommendations for follow-up care, and outlines plans that are in place at the time of discharge. The plan for members in parental custody must include, when appropriate, reunification plans with the parent(s)/legal guardian. The plan for members who remain in the custody of OKDHS or OJA must be developed in collaboration with the case worker and be finalized at the time of discharge. The discharge plan is to include, at a minimum, recommendations for continued treatment services, educational services, and other appropriate community resources. Appointments for outpatient therapy and medication management (when applicable) should be scheduled prior to discharge. Discharge planning provides a transition from ITFC placement into a lesser restrictive setting within the community. Discharge planning is performed in partnership between Child Welfare Services (CWS) of the Oklahoma Department of Human Services (OKDHS) and an LBHP within the ITFC agency.

(D) **Substance use/chemical dependency use therapy.** Substance use/chemical dependency therapy can be provided if a member is identified by diagnosis or documented social history as having emotional or behavioral problems directly related to substance use and/or chemical dependency. The modalities employed are provided in order to begin, maintain, and/or enhance recovery from problem drinking, alcoholism, nicotine use and addiction, and/or drug use, drug dependency, and/or drug addiction. This service is provided to the member by an LBHP.

(E) **Substance use rehabilitation services.** Covered substance use rehabilitation services are provided in non-residential settings in regularly scheduled sessions intended for individuals not requiring a more intensive level of care or those who require continuing services following more intensive treatment regimes. The purpose of substance use rehabilitation services is to begin, maintain, and/or enhance recovery from problem drinking, alcoholism, nicotine use and addiction, and/or drug use,

drug dependency, and/or drug addiction. Rehabilitation services may be provided individually or in group sessions, and they take the format of an agency-approved, curriculum-based education and skills training. This service is provided to the member by a certified behavioral health case manager (CM) II, a certified alcohol drug counselor (CADC), or an LBHP.

(F) Psychosocial rehabilitation (PSR).

(i) **Definition.** PSR services are face-to-face behavioral health rehabilitation services which are necessary to improve the member's ability to function in the community. They are performed to improve the skills and abilities of members to live independently in the community, improve self-care and social skills, and promote lifestyle change and recovery practices. Rehabilitation services may be provided individually or in group sessions, and they take the format of an agency-approved, curriculum-based education and skills training.

(ii) **Clinical restrictions.** This service is generally performed with only the member and the qualified provider, but may also include the member's family/support system group that focuses on the member's diagnosis, symptom management, and recovery-based curriculum. A member who, at the time of service, is not able to benefit from the treatment due to active hallucinations and/or substance use, or other impairment, is not suitable for this service. Family involvement is allowed for support of the member and education regarding his/her recovery, but does not constitute family therapy, which requires an LBHP.

(iii) **Qualified practitioners.** A CM II or an LBHP may perform PSR, following development of an IPC curriculum. The CM II must have immediate access to an LBHP who can provide clinical oversight of the CM II and collaborate with the CM II in the provision of services. A minimum of one (1) monthly face-to-face consultation with an LBHP is required.

(iv) **Group sizes.** The maximum staffing ratio is eight (8) members to one (1) service provider for members under the age of twenty-one (21).

(v) Limitations.

(I) In order to develop and improve the member's community and interpersonal functioning and self-care abilities, PSR services may take place in settings away from the behavioral health agency site as long as the setting protects and assures confidentiality. When this occurs, the

qualified provider must be present and interacting, teaching, or supporting the defined learning objectives of the member for the entire claimed time.

(II) PSR services are intended for members with Serious Emotional Disturbance (SED), and members with severe behavioral and emotional health needs who may also have a secondary physical, developmental, intellectual, and/or social disorder that is supported alongside the mental health needs. Members, ages four (4) and five (5), are not eligible for PSR services unless a prior authorization has been granted by OHCA or its designated agent, based on a finding of medical necessity.

(III) PSR services are time-limited services designed to be provided over the briefest and most effective period possible and as adjunct (enhancing) interventions to complement more intensive behavioral health therapies. Service limits are based on the member's needs according to the Client Assessment Record (CAR) or other approved tools. Service limitations are designed to maximize efficacy by remaining within reasonable age and developmentally appropriate daily limits.

(vi) **Progress notes.** In accordance with OAC 317:30-5-241.1, the behavioral health IPC developed by the LBHP must include the member's strengths, functional assets, weaknesses or liabilities, treatment goals, objectives, and methodologies that are specific and time-limited, and defines the services to be performed by the practitioners and others who comprise the treatment team. When PSR services are prescribed, the plan must address objectives that are specific, attainable, realistic, measurable, and time-limited. The plan must include the appropriate treatment coordination to achieve the maximum reduction of the severe behavioral and emotional health conditions, and any other secondary physical, developmental, intellectual, and/or social disorders and to restore the member to his or her best possible functional level. Progress notes for PSR services must include:

(I) Start and stop times for each day attended and the physical location in which the service was rendered;

- (II) Specific goal(s) and objectives addressed during the session/group;
- (III) Type of skills training provided each day and/or during the week including the specific curriculum used with the member;
- (IV) Member satisfaction with staff intervention(s);
- (V) Progress towards attaining, or barriers affecting the attainment of, goals and objectives;
- (VI) New goal(s) or objective(s) identified;
- (VII) Dated signature of the qualified provider; and
- (VIII) Credentials of the qualified provider.

(vii) **Additional documentation requirements.**

Documentation of ongoing consultation and/or collaboration with an LBHP related to the provision of PSR services.

(G) Therapeutic behavioral services (TBS). Goal-directed social skills redevelopment activities for each member to restore, retain, and improve the self-help, communication, socialization, and adaptive skills necessary to reside successfully in home and community based settings. These will be daily activities that are age appropriate, culturally sensitive, and relevant to the goals of the IPC. These may include self-esteem enhancement, violence alternatives, communication skills, or other related skill development. This service is to be provided to the member by the treatment parent specialist (TPS). Services rendered by the TPS are limited to one and a half (1.5) hours daily.

[Source: Added at 37 Ok Reg 101, eff 10-2-19 (emergency); Added at 37 Ok Reg 1549, eff 9-14-20]

317:30-5-754. Service quality review (SQR)

(a) Providers must maintain an appropriate records system. Current individual plans of care, case files, and progress notes are maintained in the provider's files during the time the member is receiving services. All services must be reflected by documentation in the records.

Documentation of services must include all of the following:

- (1) The date the service was provided;
- (2) The beginning and ending time the service was provided;
- (3) A description of the member's response to the service;
- (4) The type of service provided (individual, group, or family session; group rehabilitative treatment; social skills (re)development; basic living skills (re)development; crisis behavior management and redirection; or discharge planning); and
- (5) The dated signature with credentials of the person providing the service.

(b) There will be an SQR review performed by the Oklahoma Health Care Authority (OHCA) or its designated agent of each ITFC agency that provides care to members. The OHCA will designate the members of the SQR team. This team will consist of at least two (2) team members and will be comprised of licensed behavioral health professionals (LBHPs) and/or registered nurses (RNs). The SQR will consist of a survey of current members receiving services, as well as members for which claims have been filed with OHCA for ITFC services. Observation and contact with members may be incorporated. The review includes validation of certain factors, all of which must be met for the services to be compensable. Following the review, the SQR team will report its findings to the ITFC agency. The ITFC agency will be provided with written notification if the findings of the SQR have resulted in any deficiencies. A copy of the final report will be sent to the ITFC agency's accrediting body. Deficiencies found during the SQR may result in a recoupment of the compensation received for that service. The individual plan of care (IPC) is considered to be critical to the integrity of care and treatment and must be completed within the timelines designated at Oklahoma Administrative Code (OAC) 317:30-5-753. If the IPC is missing, or it is found that the member did not meet medical necessity criteria at any time, all paid services will be recouped for each day the IPC was missing from the date the plan of care was due for completion or the date from which medical necessity criteria was no longer met.

[Source: Added at 37 Ok Reg 101, eff 10-2-19 (emergency); Added at 37 Ok Reg 1549, eff 9-14-20]

317:30-5-755. Billing

(a) Claims must be submitted in accordance with guidelines found at Oklahoma Administrative Code (OAC) 317:30-3-11, 317:30-3-11.1 and 317:30-3-20.

(b) Claims for dually eligible individuals (Medicare/Medicaid) should be filed directly with the Oklahoma Health Care Authority (OHCA).

[Source: Added at 37 Ok Reg 101, eff 10-2-19 (emergency); Added at 37 Ok Reg 1549, eff 9-14-20]

317:30-5-756. Reimbursement

(a) ITFC services will be paid at the current fee-for-service (FFS) rate. Services provided to a member without a written individual plan of care (IPC) as described in Oklahoma Administrative Code (OAC) 317:30-5-753 will not be reimbursed.

(b) Additional services may require prior authorization by the OHCA, or its designated agent. Refer to OAC 317:30-3-31. Documentation must be provided to ensure that services are not duplicative. If additional services are approved for a member in state custody, the Oklahoma Department of Human Services (OKDHS), or Oklahoma Office of Juvenile Affairs (OJA) will collaborate with the provider of such services as directed by the OHCA.

(c) Reimbursement for ITFC services is not available for the following:

- (1) Room and board;
- (2) Educational costs;

- (3) Supported employment;
- (4) Inpatient psychiatric services;
- (5) Respite care;
- (6) Day treatment services;
- (7) Partial hospitalization services; and
- (8) Intensive outpatient services.

(d) Case management services are reimbursed to government providers as per the methodology in the approved Medicaid State Plan.

[Source: Added at 37 Ok Reg 101, eff 10-2-19 (emergency); Added at 37 Ok Reg 1549, eff 9-14-20]

317:30-5-757. Prior authorization and appeal of prior authorization decision

(a) All behavioral health services must be prior authorized by the Oklahoma Health Care Authority (OHCA) or its designated agent before the service is rendered by an eligible provider. Without prior authorization, payment is not authorized.

(b) If a denial decision is made, an appeal may be initiated by the member or the member's legal guardian. The denial can be appealed to the OHCA within thirty (30) calendar days of the receipt of the notification of the denial by the OHCA or its designated agent.

[Source: Added at 37 Ok Reg 101, eff 10-2-19 (emergency); Added at 37 Ok Reg 1549, eff 9-14-20]

PART 85. ADVANTAGE PROGRAM WAIVER SERVICES

317:30-5-760. ADvantage program

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

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 14 Ok Reg 3529, eff 7-23-97 (emergency); Amended at 15 Ok Reg 1528, eff 5-11-98 ; Amended at 18 Ok Reg 265, eff 11-21-00 (emergency); Amended at 18 Ok Reg 1130, eff 5-11-01 ; Amended at 25 Ok Reg 660, eff 2-1-08 through 7-14-08 (emergency)¹; Amended at 25 Ok Reg 2685, eff 7-25-08 ; Amended at 29 Ok Reg 1076, eff 6-25-12]

Editor's Note: ¹*This emergency action expired on 7-14-08 before being superseded by a permanent action. Upon expiration of an emergency amendatory action, the last effective permanent text is reinstated. Therefore, on 7-15-08 (after the 7-14-08 expiration of the emergency*

action), the text of 317:30-5-760 reverted back to the permanent text that became effective 5-11-01, as was last published in the 2006 Edition of the OAC, and remained as such until amended by permanent action on 7-25-08.

317:30-5-761. Eligible providers

ADvantage Program ADvantage Administration (AA) certifies ADvantage Program service providers, except pharmacy providers, and they have a current signed SoonerCare (Medicaid) contract on file with the Oklahoma Health Care Authority (OHCA), the State Medicaid agency.

(1) The provider programmatic-certification process verifies the provider meets licensure, certification, and training standards as specified in the waiver document. All providers, except nursing facility (NF) respite; medical equipment and supplies; and environmental modification providers, must obtain programmatic-certification to be ADvantage program certified.

(2) The provider financial-certification verifies the provider uses sound business management practices and has a financially-stable business. All providers, except for NF respite; medical equipment and supplies; and environmental modification providers, will obtain financial certification to be ADvantage program certified.

(3) At minimum, provider financial certification is re-evaluated annually.

(4) Providers may fail to gain or may lose ADvantage program certification due to failure to meet programmatic or financial standards.

(5) All provider service types must agree to the Conditions of Provider Participation and Service Standards.

(6) The Oklahoma Human Services (OKDHS) Community Living, Aging and Protective Services (CAP) does not authorize the member's CD-PASS services provider to also have an active power of attorney for the member.

(7) OKDHS CAP may authorize a member's legally-responsible spouse or legal guardian to be SoonerCare (Medicaid) reimbursed, per 1915(c) ADvantage Program as a personal care, service provider. Authorization for a spouse or legal guardian as a provider requires the criteria in (A) through (D) of this paragraph and monitoring provisions to be met.

(A) Authorization for a spouse or legal guardian to be a member's care provider may occur only when the member is offered provider choice and documentation demonstrates:

- (i) No provider included on the Certified Agency Report (CAR) or in the member's service area, has available staffing. Documentation also affirms all area providers attempt to employ staff to serve; or
- (ii) The member's needs are so complex that unless the spouse or legal guardian provides the care, the member's risk level would increase; and

(iii) It is mentally or physically detrimental for someone other than the spouse or legal guardian to provide care. This is evidenced by documentation from a qualified clinician or medical provider, such as a physician or licensed psychologist.

(B) The service:

- (i) Meets service or support definition as outlined in the federally-approved waiver document;
- (ii) Is necessary to avoid institutionalization;
- (iii) Is a service or support specified in the person-centered service plan;
- (iv) Is provided by a person who meets the provider qualifications and training standards specified in the waiver for that service;
- (v) Is paid at a rate that does not exceed what is paid to a provider of a similar service and does not exceed what OHCA allows for personal care or personal assistance services payment; and
- (vi) Is not an activity the spouse or legal guardian would ordinarily perform or is responsible to perform.

(C) The spouse or legal guardian service provider complies with:

- (i) Providing no more than forty (40) service hours of services in a seven (7) day period;
- (ii) Planned work schedules that are available in advance for the member's case manager, and variations to the schedule are noted and supplied to the case manager two (2) weeks in advance unless the change is due to an emergency;
- (iii) Maintaining and submitting time sheets and other required documentation for hours paid; and
- (iv) The person-centered service plan as the member's care provider.

(D) In addition to case management, monitoring, and reporting activities required for all waiver services, the State is obligated to additional monitoring requirements when members elect to use a spouse or legal guardian as a paid service provider. The AA monitors, through quarterly documentation the case manager submits, the continued appropriateness of the policy exception that allows the spouse or legal guardian to serve as the member's paid caregiver.

(8) Durable medical equipment and supplies providers comply with Oklahoma Administrative Code 317:30-5-210(2) regarding delivery proof for items shipped to the member's residence.

(9) OKDHS CAP periodically performs a programmatic audit of:

- (A) Adult day health;
- (B) Assisted living;
- (C) Case Management;
- (D) Home care:

- (i) Skilled nursing;
- (ii) Personal care;
- (iii) In-home respite; and
- (iv) Advanced supportive or restorative assistance;
- and
- (v) Therapy services; and

(E) CD-PASS providers.

(10) When, due to a programmatic audit, a provider plan of correction (POC) is required, the AA may stop new cases and referrals to the provider until the POC is approved, implemented, and a follow-up review occurs. Depending on the nature and severity of problems discovered during a programmatic audit (and at OKDHS CAP discretion), members determined to be at risk for health or safety may be transferred from a provider requiring a POC to another provider.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 18 Ok Reg 265, eff 11-21-00 (emergency); Amended at 18 Ok Reg 1130, eff 5-11-01 ; Amended at 18 Ok Reg 2962, eff 5-17-01 (emergency); Amended at 19 Ok Reg 1067, eff 5-13-02 ; Amended at 22 Ok Reg 2731, eff 5-4-05 (emergency); Amended at 23 Ok Reg 1366, eff 5-25-06 ; Amended at 25 Ok Reg 660, eff 2-1-08 through 7-14-08 (emergency)¹; Amended at 25 Ok Reg 2685, eff 7-25-08 ; Amended at 26 Ok Reg 756, eff 4-1-09 (emergency); Amended at 26 Ok Reg 994, eff 5-1-09 (emergency); Amended at 27 Ok Reg 950, eff 5-13-10 ; Amended at 30 Ok Reg 1179, eff 7-1-13 ; Amended at 34 Ok Reg 678, eff 9-1-17 ; Amended at 36 Ok Reg 893, eff 9-1-19 ; Amended at 39 Ok Reg 1491, eff 9-12-22]

Editor's Note: ¹*This emergency action expired on 7-14-08 before being superseded by a permanent action. Upon expiration of an emergency amendatory action, the last effective permanent text is reinstated. Therefore, on 7-15-08 (after the 7-14-08 expiration of the emergency action), the text of 317:30-5-761 reverted back to the permanent text that became effective 5-25-06, as was last published in the 2006 Edition of the OAC, and remained as such until amended by permanent action on 7-25-08.*

317:30-5-762. Coverage

Individuals receiving ADvantage Program services must be determined eligible for the program and must have an approved person-centered service plan. Any ADvantage Program service provided must be listed on the approved person-centered service plan to prevent institutionalization of the member. Waiver services that are expansions of Oklahoma Medicaid State Plan services may only be provided after the member has exhausted services available under the State Plan.

(1) Consumer-Directed Personal Assistance Services and Supports (CD-PASS), services are available to ADvantage Program members in every county.

(2) ADvantage case managers provide information and materials that explain the CD-PASS service option to members. The ADvantage Administration (AA) provides information and material on CD-PASS to case managers for distribution to members.

(3) The member may request CD-PASS services from his or her case manager or call an AA-maintained toll-free number to

request CD-PASS services.

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

(A) member's health and safety with CD-PASS services can reasonably be assured based on a review of service history records and review of a member's capacity and readiness to assume employer responsibilities under CD-PASS with any one of the following findings as basis to deny a request for CD-PASS due to inability to assure member health and safety, when the member:

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

(ii) is unwilling to assume responsibility, or to enlist an authorized representative to assume responsibility, in one or more areas of CD-PASS, such as in service planning assuming the role of employer of the personal services assistant (PSA) or advanced personal services assistant (APSA) provider, in monitoring and managing health or in preparation for emergency backup; or

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

(B) member voluntarily makes an informed choice to receive CD-PASS services. As part of the informed choice decision-making process for CD-PASS, the AA staff or case manager provides consultation and assistance as the member completes a self-assessment of preparedness to assume the role of employer of his or her PSA or APSA. The orientation and enrollment process provides the member with a basic understanding of what is expected of them under CD-PASS, the supports available to assist them to successfully perform employer responsibilities and an overview of the potential risks involved.

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

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

(B) the member is unwilling to assume responsibility or to enlist an authorized representative to assume responsibility in one or more areas of CD-PASS, such as in service planning or in assuming the role of employer of the PSA or APSA provider, or in monitoring and managing

health or in preparation for emergency backup;
(C) the member has a recent history of self-neglect or self-abuse as evidenced by Adult Protective Services intervention and does not have an authorized representative with capacity to assist with CD-PASS responsibilities;
(D) the member abuses or exploits the employee;
(E) the member falsifies time-sheets or other work records;
(F) the member, even with CM/CDA and Financial Management Services assistance, is unable to operate within his or her Individual Budget Allocation; or
(G) inferior quality of services provided by the member's PSA or APSA provider(s), inability of the PSA or APSA provider(s) to provide the number of service units the member requires jeopardizing the member's health and/or safety.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 18 Ok Reg 265, eff 11-21-00 (emergency); Amended at 18 Ok Reg 1130, eff 5-11-01 ; Amended at 22 Ok Reg 2731, eff 5-4-05 (emergency); Amended at 23 Ok Reg 1366, eff 5-25-06 ; Amended at 25 Ok Reg 660, eff 2-1-08 through 7-14-08 (emergency)¹; Amended at 25 Ok Reg 2685, eff 7-25-08 ; Amended at 34 Ok Reg 678, eff 9-1-17]

Editor's Note: ¹*This emergency action expired on 7-14-08 before being superseded by a permanent action. Upon expiration of an emergency amendatory action, the last effective permanent text is reinstated. Therefore, on 7-15-08 (after the 7-14-08 expiration of the emergency action), the text of 317:30-5-762 reverted back to the permanent text that became effective 5-25-06, as was last published in the 2006 Edition of the OAC, and remained as such until amended again by permanent action on 7-25-08.*

317:30-5-763. Description of services

Services included in the ADvantage program are:

(1) Case management.

(A) Case management services, regardless of payment source, assist a member to gain access to medical, social, educational, or other services that may benefit him or her to maintain health and safety. Case managers:

- (i) Initiate and oversee necessary assessments and reassessments to establish or reestablish waiver program eligibility;
- (ii) Develop the member's comprehensive person-centered service plan, listing only the services necessary to prevent institutionalization of the member, as determined through the assessments;
- (iii) Initiate the addition of necessary services or deletion of unnecessary services, as dictated by the member's condition and available support; and

(iv) Monitor the member's condition to ensure delivery and appropriateness of services and initiate person-centered service plan reviews. Case managers submit an individualized Services Backup Plan, on all initial service plans, annually at reassessment, and on updates as appropriate throughout the year, reflecting risk factors and measures in place to minimize risks. When a member requires hospital or nursing facility (NF) services, the case manager:

- (I) Assists the member in accessing institutional care and, as appropriate, periodically monitors the member's progress during the institutional stay;
- (II) Helps the member transition from institution to home by updating the person-centered service plan;
- (III) Prepares services to start on the date the member is discharged from the institution; and
- (IV) Must meet ADvantage program minimum requirements for qualification and training prior to providing services to ADvantage members.

(B) Providers of ADvantage services for the member or for those who have an interest in or are employed by an ADvantage provider for the member must not provide case management or develop the person-centered service plan, except when the ADvantage Administration (AA) demonstrates the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area, also provides other ADvantage services. Prior to providing services to members receiving Consumer Directed Personal Assistance Services and Supports (CD-PASS), case manager supervisors, and case managers are required to receive training and demonstrate knowledge regarding the CD-PASS service delivery model, "Independent Living Philosophy," and demonstrate competency in person-centered planning.

(C) Providers may only claim time for billable case management activities, described as:

- (i) Any task or function, per Oklahoma Administrative Code (OAC) 317:30-5-763(1)(A) that only an ADvantage case manager, because of skill, training, or authority, can perform on behalf of a member; and
- (ii) Ancillary activities, such as clerical tasks, including, but not limited to, mailing, copying, filing, faxing, driving time, or supervisory and administrative activities are not billable case

management activities. The administrative cost of these activities and other normal and customary business overhead costs are included in the reimbursement rate for billable activities.

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

(i) Case management services are billed using a standard rate for reimbursement for billable service activities provided to a member who resides in a county with a population density greater than twenty-five (25) persons per square mile.

(ii) Case management services are billed using a very rural/outside providers' service area rate for billable service activities provided to a member who resides in a county with a population density equal to, or less than twenty-five (25) persons per square mile. Exceptions are services to members who reside in Oklahoma Human Services (OKDHS) Community Living, Aging and Protective Services identified zip codes in Osage County adjacent to the metropolitan areas of Tulsa and Washington counties. Services to these members are prior authorized and billed using the standard rate.

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

(2) Respite.

(A) Respite services are provided to members who are unable to care for themselves. Services are provided on a short-term basis due to the primary caregiver's absence or need for relief. Payment for respite care does not include room and board costs unless more than seven (7) hours are provided in a NF. Respite care is only utilized when other sources of care and support are exhausted. Respite care is only listed on the service plan when it is necessary to prevent institutionalization of the member. Units of services are limited to the number of units approved on the service plan.

(B) In-home respite services are billed per fifteen (15) minute unit of service. Within any one (1) day period, a minimum of eight (8) units [two (2) hours] must be provided with a maximum of twenty-eight (28) units [seven (7) hours] provided. The service is provided in the

member's home.

(C) Facility-based extended respite is filed for a per diem rate when provided in a NF. Extended respite must be at least eight (8) hours in duration.

(D) In-home extended respite is filed for a per diem rate. A minimum of eight (8) hours must be provided in the member's home.

(3) Adult day health (ADH) care.

(A) ADH is furnished on a regularly scheduled basis for one (1) or more days per week in an outpatient setting. It provides both health and social services necessary to ensure the member's optimal functioning. Most assistance with activities of daily living (ADLs), such as eating, mobility, toileting, and nail care are integral to the ADH care service and are covered by the ADH care basic reimbursement rate.

(B) ADH care is a fifteen (15) minute unit of service. No more than eight (8) hours, [thirty-two (32) units] are authorized per day. The number of units of service a member may receive is limited to the number of units approved on the member's approved service plan.

(C) Physical, occupational, and speech therapies are only provided as an enhancement to the basic ADH care service when authorized by the service plan and are billed as a separate procedure. ADH care therapy enhancement is a maximum of one (1) session unit per day of service.

(D) Meals provided as part of this service do not constitute a full nutritional regimen. One (1) meal, that contains at least one-third (1/3) of the current daily dietary recommended intake (DRI), as established by the Food and Nutrition Board of the National Academies of Sciences, Engineering, and Medicine, is provided to those participants who are in the center for four (4) or more hours per day and does not constitute a full nutritional regimen. Member's access to food at any time must also be available in addition to the required meal and is consistent with an individual not receiving Medicaid-funded services and supports.

(E) Personal care service enhancement in ADH is assistance in bathing, hair care, or laundry service, authorized by the person-centered service plan and billed as separate procedures. This service is authorized when an ADvantage waiver member who uses ADH requires assistance with bathing, hair care, or laundry to maintain health and safety. Assistance with bathing, hair care, or laundry is not a usual and customary ADH care service. ADH personal care enhancement is a maximum of one (1) unit per day of bathing, hair care, or laundry service.

(F) OKDHS Home and Community-Based Services (HCBS) waiver settings have qualities defined in Home and Community-Based Services: Waiver Requirements, 42

Code of Federal Regulations, Section (§) 441.301 (c)(4) based on the individual's needs, defined in the member's authorized service plan.

- (i) The ADH center is integrated and supports full access of ADvantage members to the greater community, including opportunities to:
 - (I) Seek employment and work in competitive integrated ADH Center, not a requirement for persons that are retirement age;
 - (II) Engage in community life;
 - (III) Control personal resources; and
 - (IV) Receive services in the community, to the same degree as individuals not receiving ADvantage Program or other Medicaid HBCS waiver services.
- (ii) The ADH is selected by the member from all available service options and given the opportunity to visit and understand the options.
- (iii) The ADH ensures the member's rights of privacy, dignity, respect, and freedom from coercion and restraint.
- (iv) The ADH optimizes the member's initiative, autonomy, and independence in making life choices including, but not limited to:
 - (I) Daily activities;
 - (II) The physical environment; and
 - (III) Social interactions.
- (v) The ADH facilitates the member's choice regarding services and supports including the provider.
- (vi) Each member has the freedom and support to control his or her own schedules, activities, and access to food at any time.
- (vii) Each member may have visitors whenever he or she chooses.
- (viii) The ADH center is physically accessible to the member.

(G) ADH centers that are presumed not to be HCBS settings per 42 C.F.R. § 441.301(c)(5)(v) include, ADH centers:

- (i) In a publicly- or privately-owned facility providing inpatient treatment;
- (ii) On the grounds of or adjacent to a public institution; and
- (iii) With the effect of isolating individuals from the broader community of individuals not receiving ADvantage program or another Medicaid HCBS;

(H) When the ADH is presumed not HCBS, according to 42 C.F.R. § 441.301(c)(5)(v), it may be subject to heightened scrutiny by AA, the Oklahoma Health Care Authority

(OHCA), and the Centers for Medicare and Medicaid Services (CMS). The ADH must provide evidence that the ADH portion of the facility has clear administrative, financial, programmatic, and environmental distinctions from the institution and comply with additional monitoring by the AA.

(4) Environmental modifications.

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

(B) All services require prior authorization.

(5) Specialized medical equipment and supplies.

(A) Specialized medical equipment and supplies are devices, controls, or appliances specified in the person-centered service plan that enable members to increase their abilities to perform ADLs, or to perceive, control, or communicate with the environment in which they live. Necessary items for life support, ancillary supplies, and equipment necessary for the proper functioning of such items, and durable and non-durable medical equipment not available under the Oklahoma Medicaid State Plan are also included. This service excludes any equipment or supply items not of direct medical or remedial benefit to the waiver member and necessary to prevent institutionalization.

(B) Specialized medical equipment and supplies are billed using the appropriate HealthCare Common Procedure Code (HCPC). Reoccurring supplies shipped and delivered to the member are compensable only when the member remains eligible for waiver services, continues to reside in the home, and is not institutionalized in a hospital, skilled nursing facility, or nursing home. It is the provider's responsibility to verify the member's status prior to shipping and delivering these items. Payment for medical supplies is limited to the SoonerCare (Medicaid) rate when established, to the Medicare rate, or to actual acquisition cost, plus thirty percent (30%). All services must have prior authorization.

(6) Advanced supportive/restorative assistance.

(A) Advanced supportive/restorative assistance services are maintenance services used to assist a member who has a chronic, yet stable condition. These services assist with ADLs that require devices and procedures related to altered body functions. These services are for maintenance only and are not utilized as treatment

services.

(B) Advanced supportive/restorative assistance service is billed per fifteen (15) minute unit of service. The number of units of service a member may receive is limited to the number of units approved on the person-centered service plan.

(7) Nursing.

(A) Nursing services are services listed in the person-centered service plan that are within the scope of the state's Nurse Practice Act. These services are provided by a registered nurse (RN), a licensed practical nurse (LPN), or a licensed vocational nurse (LVN) under the supervision of an RN licensed to practice and in good standing in the state in which services are provided. Nursing services may be provided on an intermittent or part-time basis or may be comprised of continuous care. The provision of the nursing service works to prevent or postpone the institutionalization of the member.

(B) Nursing services are services of a maintenance or preventative nature provided to members with stable, chronic conditions. These services are not intended to treat an acute health condition and may not include services reimbursable under either the Medicaid or Medicare home health program. This service primarily provides nurse supervision to the personal care assistant or to the advanced supportive/restorative assistance aide and assesses the member's health and prescribed medical services to ensure they meet the member's needs as specified in the person-centered service plan. A nursing assessment/evaluation, on-site visit is made to each member, with additional visits for members with advanced supportive/restorative assistance services authorized to evaluate the condition of the member and medical appropriateness of services. An assessment/evaluation report is forwarded to the ADvantage program case manager and the skilled nurse in accordance with review schedule determined between the case manager and the skilled nurse and outlined in the member's person-centered service plan, to report the member's condition or other significant information concerning each ADvantage member.

(i) The ADvantage program case manager may recommend authorization of nursing services as part of the interdisciplinary team planning for the member's person-centered service plan and/or assessment/evaluation of the:

(I) Member's general health, functional ability, and needs; and/or

(II) Adequacy of personal care and/or advanced supportive/restorative assistance services to meet the member's needs,

including providing on-the-job training and competency testing for personal care or advanced supportive/restorative care aides per rules and regulations for the delegation of nursing tasks established by the Board of Nursing in the state in which services are provided.

(ii) In addition to assessment/evaluation, the ADvantage program case manager may recommend authorization of nursing services to:

(I) Prepare a one (1) week supply of insulin syringes for a person who is blind and has diabetes and can safely self-inject the medication but cannot fill his or her own syringe. This service includes monitoring the member's continued ability to self-administer the insulin;

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

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

(IV) Provide nail care for a member with diabetes or who has circulatory or neurological compromise; and

(V) Provide consultation and education to the member, member's family, or other informal caregivers identified in the person-centered service plan, regarding the nature of the member's chronic condition. Skills training, including return skills demonstration to establish competency, to the member, family, or other informal caregivers as specified in the person-centered service plan for preventive and rehabilitative care procedures are also provided.

(C) Nursing service includes interdisciplinary team planning and recommendations for the member's person-centered service plan development and/or assessment/evaluation or for other services within the scope of the nurse's license, including private duty nursing. Nursing services are billed per fifteen (15) minute unit of service. A specific procedure code is used to bill for interdisciplinary team planning and recommendations for

the member's person-centered service plan, but other procedure codes may be used to bill for all other authorized nursing services. A maximum of eight (8) units [two (2) hours], per day of nursing for service plan development and assessment evaluation are allowed. An agreement by a provider to perform a nurse evaluation is also an agreement to provide the Medicaid in-home care services for which the provider is certified and contracted. Reimbursement for a nurse evaluation is denied when the provider that produced the nurse evaluation fails to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted.

(8) Skilled nursing services.

(A) Skilled nursing services are listed in the person-centered service plan, within the state's Nurse Practice Act scope, and are ordered by a licensed physician, osteopathic physician, physician assistant, or advanced practice nurse, and are provided by a RN, LPN, or LVN under the supervision of a RN, licensed to practice and in good standing in the state where services are provided. Skilled nursing services provided in the member's home or other community setting are services requiring the specialized skills of a licensed nurse. The scope and nature of these services are intended for treatment of a disease or a medical condition and are beyond the scope of ADvantage nursing services. These intermittent nursing services are targeted toward a prescribed treatment or procedure that must be performed at a specific time or other predictable rate of occurrence. The RN contacts the member's physician to obtain necessary information or orders pertaining to the member's care. When the member has an ongoing need for service activities requiring more or less units than authorized, the RN must recommend, in writing, that the service plan be revised.

(B) Skilled nursing services are provided on an intermittent or part-time basis, and billed per fifteen (15) minute unit of service. Skilled nursing services are provided when nursing services are not available through Medicare or other sources or when SoonerCare plan nursing services limits are exhausted. Amount, frequency, and duration of services are prior-authorized in accordance with the member's person-centered service plan.

(9) Home-delivered meals.

(A) Home-delivered meals provide one (1) meal per day. A home-delivered meal is a meal prepared in advance and brought to the member's home. Each meal must have a nutritional content equal to at least one-third (1/3) of the dietary reference intakes as established by the Food and Nutrition Board of the National Academies of Sciences,

Engineering and Medicine. Home-delivered meals are only provided to members who are unable to prepare meals and lack an informal provider to do meal preparation.

(B) Home-delivered meals are billed per meal, with one (1) meal equaling one (1) unit of service. The limit of the number of units a member is allowed to receive is in accordance with the member's person-centered service plan. The provider must obtain a signature from the member or the member's representative at the time the meal is delivered. In the event the member is temporarily unavailable, such as at a doctor's appointment, and the meal is left at the member's home, the provider must document the reason a signature was not obtained. The signature logs must be available for review.

(10) Occupational therapy services.

(A) Occupational therapy services are services that increase functional independence by enhancing the development of adaptive skills and performance capacities of members with physical disabilities and related psychological and cognitive impairments. Services are provided in the member's home and are intended to help the member achieve greater independence, enabling him or her to reside and participate in the community.

Treatment involves the therapeutic use of self-care, work, and play activities, and may include modification of the tasks or environment to enable the member to achieve maximum independence, prevent further disability, and maintain health. Under a physician's order, a licensed occupational therapist evaluates the member's rehabilitation potential and develops an appropriate written, therapeutic regimen. The regimen utilizes paraprofessional, occupational therapy assistant services, within the limitations of his or her practice, working under the supervision of a licensed occupational therapist. The regimen includes education and training for informal caregivers to assist with or maintain services when appropriate. The occupational therapist ensures monitoring and documentation of the member's rehabilitative progress and reports to the member's case manager and physician to coordinate the necessary addition or deletion of services, based on the member's condition and ongoing rehabilitation potential.

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

(11) Physical therapy services.

(A) Physical therapy services are those services that maintain or improve physical disability through the evaluation and rehabilitation of members disabled by pain, disease, or injury. Services are provided in the member's home and are intended to help the member achieve

greater independence to reside and participate in the community. Treatment involves the use of physical therapeutic means, such as massage, manipulation, therapeutic exercise, cold and/or heat therapy, hydrotherapy, electrical stimulation, and light therapy. Under a physician's order, a licensed physical therapist evaluates the member's rehabilitation potential and develops an appropriate, written, therapeutic regimen. Under the Oklahoma Physical Therapy Practice Act, a physical therapist may evaluate a member's rehabilitation potential and develop and implement an appropriate, written, therapeutic regimen without a referral from a licensed health care practitioner for a period not to exceed thirty (30) calendar days. Any treatment required after the thirty (30) calendar day period requires a prescription from a physician or the physician's assistant of the licensee. The regimen utilizes paraprofessional physical therapy assistant services, within the limitations of his or her practice, working under the licensed physical therapist's supervision. The regimen includes education and training for informal caregivers to assist with and/or maintain services when appropriate. The licensed physical therapist ensures monitoring and documentation of the member's rehabilitative progress and reports to the member's case manager and physician to coordinate the necessary addition or deletion of services, based on the member's condition and ongoing rehabilitation potential. (B) Physical therapy services may be authorized as ADH care therapy enhancement and are a maximum of one (1) session unit per day of service. Payment is not allowed solely for written reports or record documentation.

(12) Speech and language therapy services.

(A) Speech and language therapy services are those that maintain or improve speech and language communication and swallowing disorders/disability through the evaluation and rehabilitation of members disabled by pain, disease, or injury. Services are provided in an ADH service setting and are intended to help the member achieve greater independence to reside and participate in the community. Services involve the use of therapeutic means, such as evaluation, specialized treatment, or development and oversight of a therapeutic maintenance program. Under a physician's order, a licensed speech and language pathologist evaluates the member's rehabilitation potential and develops an appropriate, written, therapeutic regimen. The regimen utilizes speech language pathology assistant services within the limitations of his or her practice, working under the supervision of the licensed speech and language pathologist. The regimen includes education and training for informal caregivers to assist with and/or maintain

services when appropriate. The speech and language pathologist ensures monitoring and documentation of the member's rehabilitative progress and reports to the member's case manager and physician to coordinate the necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Speech and language therapy services are authorized as ADH care-therapy enhancement and are a maximum of one (1) session unit per day of service. Payment is not allowed solely for written reports or record documentation.

(13) Hospice services.

(A) Hospice services are palliative and comfort care provided to the member and his or her family when a physician certifies the member has a terminal illness, with a life expectancy of six (6) months or less, and orders hospice care. ADvantage hospice care is authorized for a six (6) month period and requires physician certification of a terminal illness and orders of hospice care. When the member requires more than six (6) months of hospice care, a physician or nurse practitioner must have a face-to-face visit with the member thirty (30) calendar days prior to the initial hospice authorization end-date, and re-certify that the member has a terminal illness, has six (6) months or less to live, and orders additional hospice care. After the initial authorization period, additional periods of ADvantage hospice may be authorized for a maximum of sixty (60) calendar day increments with physician certification that the member has a terminal illness and six (6) months or less to live. A member's person-centered service plan that includes hospice care must comply with Waiver requirements to be within total person-centered service plan cost limits.

(B) A hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional, and spiritual stresses experienced during the final stages of illness, through the end of life, and bereavement. The member signs a statement choosing hospice care instead of routine medical care with the objective to treat and cure the member's illness. Once the member has elected hospice care, the hospice medical team assumes responsibility for the member's medical care for the illness in the home environment. Hospice care services include nursing care, physician services, medical equipment and supplies, drugs for symptom and pain relief, home health aide and personal care services, physical, occupational and speech therapies, medical social services, dietary counseling, and grief and bereavement counseling to the member and/or the member's family.

(C) A hospice person-centered service plan must be developed by the hospice team in conjunction with the member's ADvantage case manager before hospice services are provided. The hospice services must be related to the palliation or management of the member's terminal illness, symptom control, or to enable the member to maintain ADL and basic functional skills. A member who is eligible for Medicare hospice provided as a Medicare Part A benefit, is not eligible to receive ADvantage hospice services.

(D) Hospice services are billed per diem of service for days covered by a hospice person-centered service plan and while the hospice provider is responsible for providing hospice services as needed by the member or member's family. The maximum total annual reimbursement for a member's hospice care within a twelve (12) month period is limited to an amount equivalent to eighty-five percent (85%) of the Medicare hospice cap payment, and must be authorized on the member's person-centered service plan.

(14) ADvantage personal care.

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

(B) ADvantage home care agency skilled nursing staff working in coordination with an ADvantage case manager is responsible for the development and monitoring of the member's personal care services.

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

(15) Personal emergency response system (PERS).

(A) PERS is an electronic device that enables members at high risk of institutionalization, to secure help in an emergency. Members may also wear a portable "help" button to allow for mobility. PERS is connected to the person's phone and programmed to signal, per member preference, a friend, relative, or a response center, once the "help" button is activated. For an ADvantage member to be eligible for PERS service, the member must meet all service criteria in (i) through (vi). The member:

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

member from getting up unassisted from a fall;
(ii) Lives alone and without a regular caregiver, paid or unpaid, and therefore is left alone for long periods of time;
(iii) Demonstrates the capability to comprehend the purpose of and activate the PERS;
(iv) Has a health and safety plan detailing the interventions beyond the PERS to ensure the member's health and safety in his or her home;
(v) Has a disease management plan to implement medical and health interventions that reduce the possibility of falls by managing the member's underlying medical condition causing the falls; and
(vi) Will likely avoid premature or unnecessary institutionalization as a result of PERS.

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

(16) CD-PASS.

(A) CD-PASS are personal services assistance (PSA) and advanced personal services assistance (APSA) that enables a member in need of assistance to reside in his or her home and community of choice, rather than in an institution; and to carry out functions of daily living, self-care, and mobility. CD-PASS services are delivered as authorized on the person-centered service plan. The member becomes the employer of record and employs the PSA and the APSA. The member is responsible, with assistance from ADvantage program administrative Financial Management Services (FMS), for ensuring the employment complies with state and federal labor law requirements. The member/employer may designate an adult family member or friend, who is not a PSA or APSA to the member, as an "authorized representative" to assist in executing the employer functions. The member/employer:

- (i) Recruits, hires, and, as necessary, discharges the PSA or APSA;
- (ii) Ensures the PSA or APSA has received sufficient instruction and training. If needed, the member/employer will work with the consumer-directed agent/case manager (CDA) to obtain training assistance from ADvantage skilled nurses. Prior to performing an APSA task for the first time, the APSA must demonstrate competency in the tasks in an on-the-job training session conducted by the member, and the member must document the attendant's competency in performing each task in the APSA's personnel file;

- (iii) Determines where and how the PSA or APSA works, hours of work, what is to be accomplished and, within individual budget allocation limits, wages to be paid for the work;
- (iv) Supervises and documents employee work time; and
- (v) Provides tools and materials for work to be accomplished.

(B) The services the PSA may provide include:

- (i) Assistance with mobility and transferring in and out of bed, wheelchair, or motor vehicle, or all;
- (ii) Assistance with routine bodily functions, such as:

- (I) Bathing and personal hygiene;
- (II) Dressing and grooming; and
- (III) Eating, including meal preparation and cleanup;

- (iii) Assistance with home services, such as shopping, laundry, cleaning, and seasonal chores;
- (iv) Companion assistance, such as letter writing, reading mail, and providing escort or transportation to participate in approved activities or events. "Approved activities or events," means community, civic participation guaranteed to all citizens including, but not limited to, exercise of religion, voting or participation in daily life activities in which exercise of choice and decision making is important to the member, and may include shopping for food, clothing, or other necessities, or for participation in other activities or events specifically approved on the person-centered service plan.

(C) An APSA provides assistance with ADLs to a member with a stable, chronic condition, when such assistance requires devices and procedures related to altered body function if such activities, in the opinion of the attending physician or licensed nurse, may be performed if the member were physically capable, and the procedure may be safely performed in the home. Services provided by the APSA are maintenance services and are never used as therapeutic treatment. Members who develop medical complications requiring skilled nursing services while receiving APSA services are referred to his or her attending physician, who may order home health services, as appropriate. APSA includes assistance with health maintenance activities that may include:

- (i) Routine personal care for persons with ostomies, including tracheotomies, gastrostomies, and colostomies with well-healed stoma, external, indwelling, and suprapubic catheters that include changing bags and soap and water hygiene around

the ostomy or catheter site;
(ii) Removing external catheters, inspecting skin, and reapplication of same;
(iii) Administering prescribed bowel program, including use of suppositories and sphincter stimulation, and enemas pre-packaged only without contraindicating rectal or intestinal conditions;
(iv) Applying medicated prescription lotions or ointments and dry, non-sterile dressings to unbroken skin;
(v) Using a lift for transfers;
(vi) Manually assisting with oral medications;
(vii) Providing passive range of motion (non-resistive flexion of joint) therapy, delivered in accordance with the person-centered service plan unless contraindicated by underlying joint pathology;
(viii) Applying non-sterile dressings to superficial skin breaks or abrasions; and
(ix) Using universal precautions as defined by the Centers for Disease Control and Prevention.

(D) FMS are program administrative services provided to participating CD-PASS members/employers by AA. FMS are employer-related assistance that provides Internal Revenue Service (IRS) fiscal reporting agent and other financial management tasks and functions, including, but not limited to:

(i) Processing employer payroll, after the member/employer has verified and approved the employee timesheet, at a minimum of semi-monthly, and associated withholding for taxes, or for other payroll withholdings performed on behalf of the member as employer of the PSA or APSA;
(ii) Other employer-related payment disbursements as agreed to with the member/employer and in accordance with the member/employer's individual budget allocation;
(iii) Responsibility for obtaining criminal and abuse registry background checks on prospective hires for PSA or APSA on the member/employer's behalf;
(iv) Providing orientation and training regarding employer responsibilities, as well as employer information and management guidelines, materials, tools, and staff consultant expertise to support and assist the member to successfully perform employer-related functions; and
(v) Making Hepatitis B vaccine and vaccination series available to PSA and APSA employees in compliance with Occupational Safety and Health Administration (OSHA) standards.

(E) The PSA service is billed per fifteen (15) minute unit of service. The number of units of PSA a member may receive is limited to the number of units approved on the person-centered service plan.

(F) The APSA service is billed per fifteen (15) minute unit of service. The number of units of APSA a member may receive is limited to the number of units approved on the person-centered service plan.

(17) Institution transition services.

(A) Institution transition services are those services necessary to enable a member to leave the institution and receive necessary support through ADvantage waiver services in his or her home and community.

(B) Transitional case management services are services per OAC 317:30-5-763(1) required by the member and included on the member's person-centered service plan that are necessary to ensure the member's health, welfare, and safety, or to enable the member to function with greater independence in the home, and without which, the member would continue to require institutionalization.

ADvantage transitional case management services assist institutionalized members who are eligible to receive ADvantage services in gaining access to needed waiver and other State Plan services, as well as needed medical, social, educational, and other services to assist in the transition, regardless of the funding source for the services to which access is gained. Transitional case management services may be authorized for periodic monitoring of an ADvantage member's progress during an institutional stay and for assisting the member to transition from institution to home by updating the person-centered service plan, including necessary institution transition services to prepare services and supports to be in place or to start on the date the member is discharged from the institution. Transitional case management services may be authorized to assist individuals that have not previously received ADvantage services, but were referred by CAP to the case management provider for assistance in transitioning from the institution to the community with ADvantage services support.

(i) Institution transition case management services are prior authorized and billed per fifteen (15) minute unit of service using the appropriate HCPC procedure code and modifier associated with the location of residence of the member served, per OAC 317:30-5-763(1)(D).

(ii) A unique modifier code is used to distinguish institution transitional case management services from regular case management services.

(C) Institution transition services may be authorized and reimbursed, per the conditions in (i) through (iv).

- (i) The service is necessary to enable the member to move from the institution to his or her home.
- (ii) The member is eligible to receive ADvantage services outside of the institutional setting.
- (iii) Institution transition services are provided to the member within one-hundred and eighty (180) calendar-days of discharge from the institution.
- (iv) Services provided while the member is in the institution are claimed as delivered on the day of discharge from the institution.

(D) When the member receives institution transition services but fails to enter the waiver, any institution transition services provided are not reimbursable.

(18) Assisted living services (ALS).

(A) ALS are personal care and supportive services furnished to waiver members who reside in a homelike, non-institutional setting that includes twenty-four (24) hour on-site response capability to meet scheduled or unpredictable member needs and to provide supervision, safety, and security. Services also include social and recreational programming and medication assistance, to the extent permitted under State law. The ALS provider is responsible for coordinating services provided by third parties to ADvantage members in the assisted living center (ALC). Nursing services are incidental rather than integral to the provision of ALS. ADvantage reimbursement for ALS includes services of personal care, housekeeping, laundry, meal preparation, periodic nursing evaluations, nursing supervision during nursing intervention, intermittent or unscheduled nursing care, medication administration, assistance with cognitive orientation, assistance with transfer and ambulation, planned programs for socialization, activities, and exercise, and for arranging or coordinating transportation to and from medical appointments. Services, except for planned programs for socialization, activities, and exercise, are to meet the member's specific needs as determined through the individualized assessment and documented on the member's person-centered service plan.

(B) The ADvantage ALS philosophy of service delivery promotes member choice, and to the greatest extent possible, member control. A member has control over his or her living space and his or her choice of personal amenities, furnishings, and activities in the residence. The ADvantage member must have the freedom to control his or her schedule and activities. The ALS provider's documented operating philosophy, including policies and procedures, must reflect and support the principles and values associated with the ADvantage assisted living philosophy and approach to service delivery emphasizing

member dignity, privacy, individuality, and independence.
(C) ADvantage ALS required policies for admission and termination of services and definitions.

(i) ADvantage-certified assisted living centers (ALC) are required to accept all eligible ADvantage members who choose to receive services through the ALC, subject only to issues relating to, one (1) or more of the following:

(I) Rental unit availability;

(II) The member's compatibility with other residents;

(III) The center's ability to accommodate residents who have behavior problems, wander, or have needs that exceed the services the center provides; or

(IV) Restrictions initiated by statutory limitations.

(ii) The ALC may specify the number of units the provider is making available to service ADvantage members. At minimum, the ALC must designate ten (10) residential units for ADvantage members. Residential units designated for ADvantage may be used for other residents at the ALC when there are no pending ADvantage members for those units. Exceptions may be requested in writing subject to the approval of AA.

(iii) Mild or moderate cognitive impairment of the applicant is not a justifiable reason to deny ALC admission. Centers are required to specify whether they are able to accommodate members who have behavior problems or wander. Denial of admission due to a determination of incompatibility must be approved by the case manager and the AA. Appropriateness of placement is not a unilateral determination by the ALC. The ADvantage case manager, the member, or member's designated representative, and the ALC in consultation determine the appropriateness of placement.

(iv) The ALC is responsible for meeting the member's needs for privacy, dignity, respect, and freedom from coercion and restraint. The ALC must optimize the member's initiative, autonomy, and independence in making life choices. The ALC must facilitate member choices regarding services and supports, and who provides them. Inability to meet those needs is not recognized as a reason for determining an ADvantage member's placement is inappropriate. The ALC agrees to provide or arrange and coordinate all services listed in the Oklahoma State Department of Health (OSDH) regulations, per OAC 310:663-3-3, except for

specialized services.

(v) In addition, the ADvantage participating ALC agrees to provide or coordinate the services listed in (I) through (III).

(I) Provide an emergency call system for each participating ADvantage member.

(II) Provide up to three (3) meals per day plus snacks sufficient to meet nutritional requirements, including modified special diets, appropriate to the member's needs and choices; and provide members with twenty-four (24) hour access to food by giving members control in the selection of the foods they eat, by allowing the member to store personal food in his or her room, by allowing the member to prepare and eat food in his or her room, and allowing him or her to decide when to eat.

(III) Arrange or coordinate transportation to and from medical appointments. The ALC must assist the member with accessing transportation for integration into the community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, and control his or her personal resources and receive services in the community to the same degree of access as residents not receiving ADvantage services.

(vi) The provider may offer any specialized service or rental unit for members with Alzheimer's disease and related dementias, physical disabilities, or other special needs the facility intends to market. Heightened scrutiny, through additional monitoring of the ALC by AA, is utilized for those ALC's that also provide inpatient treatment; settings on the grounds of or adjacent to a public institution and/or other settings that tend to isolate individuals from the community. The ALC must include evidence that the ALC portion of the facility has clear administrative, financial, programmatic and environmental distinctions from the institution.

(vii) When the provider arranges and coordinates services for members, the provider is obligated to ensure the provision of those services.

(viii) Per OAC 310:663-1-2, "personal care" is defined as "assistance with meals, dressing, movement, bathing or other personal needs or maintenance, or general supervision of the physical and mental well-being of a person [Title 63 of the

Oklahoma Statutes (O.S.), Section (§) 1-1902.17] and includes assistance with toileting." For ADvantage ALS, assistance with "other personal needs" in this definition includes assistance with grooming and transferring. The term "assistance" is clarified to mean hands-on help, in addition to supervision.

(ix) The specific ALS assistance provided along with amount and duration of each type of assistance is based upon the member's assessed need for service assistance and is specified in the ALC's service plan that is incorporated as supplemental detail into the ADvantage comprehensive person-centered service plan. The ADvantage case manager in cooperation with ALC professional staff, develops the person-centered service plan to meet member needs. As member needs change, the person-centered service plan is amended consistent with the assessed, documented need for change in services.

(x) Placement, or continued placement of an ADvantage member in an ALC, is inappropriate when any one (1) or more of the conditions in I through IV exist.

(I) The member's needs exceed the level of services the center provides.

Documentation must support ALC efforts to provide or arrange for the required services to accommodate participant needs.

(II) The member exhibits behaviors or actions that repeatedly and substantially interfere with the rights or well-being of other residents, and the ALC documented efforts to resolve behavior problems including medical, behavioral, and increased staffing interventions.

Documentation must support the ALC's attempted interventions to resolve behavior problems.

(III) The member has a complex, unstable, or unpredictable medical condition and treatment cannot be developed and implemented appropriately in the assisted living environment. Documentation must support the ALC's attempts to obtain appropriate member care.

(IV) The member fails to pay room and board charges or OKDHS determined vendor payment obligation.

(xi) Termination of residence ensues when inappropriately placed. Once a determination is

made that a member is inappropriately placed, the ALC must inform the member, the member's representative, if applicable, the AA, and the member's ADvantage case manager. The ALC must develop a discharge plan in consultation with the member, the member's representative, the ADvantage case manager, and the AA. The ALC and case manager must ensure the discharge plan includes strategies for providing increased services, when appropriate, to minimize risk and meet the higher care needs of members transitioning out of the ALC, when the reason for discharge is inability to meet member needs. When voluntary termination of residency is not arranged, the ALC must provide written notice to the member and to the member's representative, with a copy to the member's ADvantage case manager and the AA. The written notice provides intent to terminate the residency agreement and move the member to an appropriate care provider. The thirty (30) calendar-day requirement must not apply when emergency termination of the residency agreement is mandated by the member's immediate health needs or when the termination of the residency agreement is necessary for the physical safety of the member or other ALC residents. The written involuntary termination of residency notice for reasons of inappropriate placement must include:

- (I) A full explanation of the reasons for the termination of residency;
- (II) The notice date;
- (III) The date notice was given to the member and the member's representative, the ADvantage case manager, and the AA;
- (IV) The date the member must leave ALC; and
- (V) Notification of appeal rights and the process for submitting appeal of termination of Medicaid ALS to OHCA.

(D) ADvantage ALS provider standards in addition to licensure standards.

(i) **Physical environment.**

- (I) The ALC must provide lockable doors on the entry door of each rental unit and an attached, lockable compartment within each member unit for valuables. Members must have exclusive rights to his or her unit with lockable doors at the entrance of the individual or shared rental unit. Keys to rooms may be held by only appropriate ALC staff as designated by the member's choice.

Rental units may be shared only when a request to do so is initiated by the member. Members must be given the right to choose his or her roommate.

(II) The member has a legally enforceable agreement, or lease, with the ALC. The member must have the same responsibilities and protections from eviction as all tenants under the landlord-tenant law of the state, county, city, or other designated entity.

(III) The ALC must provide each rental unit with a means for each member to control the temperature in the residential unit through the use of a damper, register, thermostat, or other reasonable means under the control of the member and that preserves privacy, independence, and safety, provided that the OSDH may approve an alternate means based on documentation that the design of the temperature control is appropriate to the special needs of each member who has an alternate temperature control.

(IV) For ALCs built prior to January 1, 2008, each ALC individual residential unit must have a minimum total living space, including closets and storage areas, of two-hundred and fifty (250) square feet; for ALCs built after December 31, 2007, each ALC individual residential unit must have a minimum total living space, including closets and storage areas, of three-hundred and sixty (360) square feet.

(V) The ALC must provide a private bathroom for each living unit that must be equipped with one (1) lavatory, one (1) toilet, and one (1) bathtub or shower stall.

(VI) The ALC must provide at a minimum; a kitchenette, defined as a space containing a refrigerator, adequate storage space for utensils, and a cooking appliance. A microwave is an acceptable cooking appliance.

(VII) The member is responsible for furnishing the rental unit. When a member is unable to supply basic furnishings defined as a bed, dresser, nightstand, chairs, table, trash can, and lamp, or if furnishings pose a health or safety risk, the member's ADvantage case manager in

coordination with the ALC, must assist the member in obtaining basic furnishings for the rental unit. The member must have the freedom to furnish and decorate the rental unit within the scope of the lease or residency agreement.

(VIII) The ALC must meet the requirements of all applicable federal and state laws and regulations including, but not limited to, state and local sanitary codes, state building and fire safety codes, and laws and regulations governing use and access by persons with disabilities.

(IX) The ALC must ensure the design of common areas accommodates the special needs of the resident population and that the rental unit accommodates the special needs of the member in compliance with the Americans with Disabilities Act accessibility guidelines per Nondiscrimination on the Basis of Disability By Public Accommodations and in in Commercial Facilities, 28 Code of Federal Regulations, Appendix A, at no additional cost to the member.

(X) The ALC must provide adequate and appropriate social and recreational space for residents and the common space must be proportionate to the number of residents and appropriate for the resident population.

(XI) The ALC must provide appropriately monitored outdoor space for resident use.

(XII) The ALC must provide the member with the right to have visitors of his or her choosing at any time. Overnight visitation is allowed as permissible by the Landlord/Tenant Agreement.

(XIII) The ALC must be physically accessible to members.

(ii) **Sanitation.**

(I) The ALC must maintain the facility, including its individual rental units in a clean, safe, and sanitary manner, ensuring that they are insect and rodent free, odorless, and in good repair at all times.

(II) The ALC must maintain buildings and grounds in a good state of repair, in a safe and sanitary condition, and in compliance with the requirements of applicable regulations, bylaws, and codes.

(III) The ALC stores clean laundry in a manner that prevents contamination and changes linens at time intervals necessary to avoid health issues.

(IV) The ALC must provide housekeeping in member rental units to maintain a safe, clean, and sanitary environment.

(V) The ALC must have policies and procedures for members' pets.

(iii) **Health and safety.**

(I) The ALC must provide building security that protects members from intruders with security measures appropriate to building design, environmental risk factors, and the resident population.

(II) The ALC must respond immediately and appropriately to missing members, accidents, medical emergencies, or deaths.

(III) The ALC must have a plan in place to prevent, contain, and report any diseases considered to be infectious or are listed as diseases that must be reported to the OSDH.

(IV) The ALC must adopt policies for the prevention of abuse, neglect, and exploitation that include screening, training, prevention, investigation, protection during investigation, and reporting.

(V) The ALC must provide services and facilities that accommodate the needs of members to safely evacuate in the event of fires or other emergencies.

(VI) The ALC must ensure staff is trained to respond appropriately to emergencies.

(VII) The ALC must ensure that fire safety requirements are met.

(VIII) The ALC must offer meals that provide balanced and adequate nutrition for members.

(IX) The ALC must adopt safe practices for meal preparation and delivery.

(X) The ALC must provide a twenty-four (24) hour response to personal emergencies appropriate to the needs of the resident population.

(XI) The ALC must provide safe transportation to and from ALC sponsored social or recreational outings.

(iv) **Staff to resident ratios.**

(I) The ALC must ensure a sufficient number of trained staff are on duty, awake, and present at all times, twenty-four (24) hours a day, and seven (7) days a week, to meet residents' needs and to carry out all processes listed in the ALC's written emergency and disaster preparedness plan for fires and other disasters.

(II) The ALC must ensure staffing is sufficient to meet ADvantage program members' needs in accordance with each member's ADvantage person-centered service plan.

(III) The ALC must have plans in place to address situations where there is a disruption to the ALC's regular work force.

(v) Staff training and qualifications.

(I) The ALC must ensure staff has qualifications consistent with their job responsibilities.

(II) All staff assisting in, or responsible for, food service must have attended a food service training program offered or approved by OSDH.

(III) The ALC must provide staff orientation and ongoing training to develop and maintain staff knowledge and skills. All direct care and activity staff receive at least eight (8) hours of orientation and initial training within the first month of employment and at least four (4) hours annually thereafter. Staff providing direct care on a dementia unit must receive four (4) additional hours of dementia specific training. Annual first aid and cardiopulmonary resuscitation (CPR) certification do not count toward the four (4) hours of annual training.

(vi) Staff supervision.

(I) The ALC must ensure delegation of tasks to non-licensed staff is consistent and in compliance with all applicable state regulations including, but not limited to, the state's Nurse Practice Act and OSDH Nurse Aide Certification rules.

(II) The ALC must ensure that, where the monitoring of food intake or therapeutic diets is provided at the prescribed services level, a registered dietitian monitors member health and nutritional status.

(vii) Resident rights.

(I) The ALC must provide to each member and each member's representative, at the time of admission, a copy of the resident statutory rights listed in 63 O.S. § 1-1918 amended to include additional rights and the clarification of rights as listed in the ADvantage member assurances. A copy of resident rights must be posted in an easily accessible, conspicuous place in the facility. The facility must ensure that staff is familiar with and observes, the resident rights.

(II) The ALC must conspicuously post for display in an area accessible to residents, employees, and visitors, the ALC's complaint procedures and the name, address, and phone number of a person authorized to receive complaints. A copy of the complaint procedure must also be given to each member, the member's representative, or the legal guardian. The ALC must ensure all employees comply with the ALC's complaint procedure.

(III) The ALC must provide to each member and member's representative, at the time of admission, information about Medicaid grievance and appeal rights, including a description of the process for submitting a grievance or appeal of any decision that decreases Medicaid services to the member.

(viii) **Incident reporting.**

(I) The ALC must maintain a record of incidents that occur and report incidents to the member's ADvantage case manager and to the AA, utilizing the AA Critical Incident Reporting form. Incident reports are also made to Adult Protective Services (APS) and to the OSDH, as appropriate, per ALC licensure rules, utilizing the specific reporting forms required.

(II) Incidents requiring report by licensed ALC's are those defined by OSDH, per OAC 310:663-19-1 and listed on the AA Critical Incident Reporting form.

(III) Reports of incidents must be made to the member's ADvantage case manager and to the AA via electronic submission within one (1) business day of the reportable incident's discovery utilizing the AA Critical Incident Reporting form. When required, a follow-up report of the incident must be submitted via electronic submission to the

member's ADvantage case manager and to the AA. The follow-up report must be submitted within five (5) business days of the incident. The final report must be filed with the member's ADvantage case manager and the AA when the investigation is complete, not to exceed ten (10) business days after the incident.

(IV) Each ALC having reasonable cause to believe that a member is suffering from abuse, neglect, exploitation, or misappropriation of member property must make a report to APS as soon as the person is aware of the situation per 43A O.S. § 10-104.A. Reports are also made to OSDH, as appropriate, per ALC licensure rules.

(V) The preliminary incident report must at minimum, include who, what, when, where, and the measures taken to protect the member and resident(s) during the investigation. The follow-up report must, at minimum, include preliminary information, the extent of the injury or damage, if any, and preliminary investigation findings. The final report, at minimum, includes preliminary and follow-up information, a summary of investigative actions representing a thorough investigation, investigative findings and conclusions, and corrective measures to prevent future occurrences. When it is necessary to omit items, the final report must include why such items were omitted and when they will be provided.

(ix) Provision of, or arrangement for, necessary health services. The ALC must:

(I) Arrange or coordinate transportation for members to and from medical appointments; and

(II) Provide or coordinate with the member and the member's ADvantage case manager for delivery of necessary health services.

The ADvantage case manager is responsible for monitoring that all health-related services required by the member as identified through assessment and documented on the person-centered service plan, are provided in an appropriate and timely manner. The member has the freedom to choose any available provider qualified by licensure or certification to

provide necessary health services in the ALC.

(E) ALCs are billed per diem of service for days covered by the ADvantage member's person-centered service plan and during which the ALS provider is responsible for providing ALS for the member. The per diem rate for ADvantage ALS for a member is one (1) of three (3) per diem rate levels based on a member's need for type of, intensity of, and frequency of service to address member ADLs, instrumental activities of daily living (IADLs), and health care needs. The rate level is based on the Uniform Comprehensive Assessment Tool (UCAT) assessment by the member's ADvantage case manager employed by a case management agency independent of the ALS provider. The determination of the appropriate per diem rate is made by the AA clinical review staff.

(F) The ALC must notify AA ninety (90) calendar days before terminating or not renewing the ALC's ADvantage contract.

(i) The ALC must give notice in writing to the member, the member's representative(s), the AA, and the member's ADvantage case manager ninety (90) calendar days before:

(I) Voluntary cessation of the ALC's ADvantage contract; or

(II) Closure of all or part of the ALC.

(ii) The notice of closure must include:

(I) The proposed ADvantage contract termination date;

(II) The termination reason;

(III) An offer to assist the member secure an alternative placement; and

(IV) Available housing alternatives.

(iii) The facility must comply with all applicable laws and regulations until the closing date, including those related to resident transfer or discharge.

(iv) Following the last move to the last ADvantage member, the ALC must provide in writing to the AA:

(I) The effective date of closure based on the discharge date of the last resident;

(II) A list of members transferred or discharged and where they are relocated; and

(III) The plan for storage of resident records per OAC 310:663-19-3(g), relating to preservation of resident records and the name, address, and phone numbers of the person responsible for the records.

(19) Remote Support (RS) services.

(A) **Purpose and scope.** RS services are intended to promote a member's independence and self-direction. RS services are provided in the member's home to reduce reliance on in person support while ensuring the member's health and safety. RS services are included in the member's person-centered service plan and coordination of these services are made through the case manager.

(i) RS services are:

(I) Based on the member's needs as documented and supported by the member's person-centered service plan and person-centered assessments;

(II) Only authorized when submitted on the member's person-centered service plan with the consent of the member, involved household members, and guardian, as applicable;

(III) The least restrictive option and the member's preferred method to meet an assessed need; and

(IV) Provided when the member and the member's Interdisciplinary Team (IDT) agree to the provision of RS services.

(ii) RS services are not a system of surveillance or for provider convenience.

(B) **Service description.** RS services monitor a member by allowing for live, two-way communication between the member and monitoring staff using one (1) or more of the following systems:

(i) Live video feed;

(ii) Live audio feed;

(iii) Motion-sensor monitoring;

(iv) Radio frequency identification;

(v) Web-based monitoring; or

(vi) Global positioning system (GPS) monitoring devices.

(C) **General provider requirements.** RS service providers must have a valid OHCA SoonerCare (Medicaid) provider agreement to provide provider-based RS services to ADvantage HCBS waiver members and be certified by the AA. Requests for applications to provide RS services are made to AA.

(D) **Risk assessment.** Teams will complete a risk assessment to ensure remote supports can help meet the member's needs in a way that protects the right to privacy, dignity, respect, and freedom from coercion. The risk assessment is reviewed, and any issues are addressed prior to the implementation of remote supports general provider requirements.

(i) Remote support providers ensure the member's health and safety by contacting a member's

informal support or activating the member's back-up plan when a health or safety issue becomes evident during monitoring.

(ii) The risk assessment and service plan require the team to develop a specific back-up plan to address health, safety and behavioral needs while remote supports are utilized so appropriate assistance can be provided. The RS back-up plan includes how assistance is provided to the member when equipment or technology fails.

(E) **RS guidelines.** Devices or monitors are placed at locations based on the member's individual needs as documented on the member's person-centered service plan and approved by the member and involved family members and guardian, as applicable.

(i) The use of camera or video equipment in the member's bedroom, bathroom, or other private area is prohibited.

(ii) When RS involves the use of audio or video equipment that permits RS staff to view activities or listen to conversations in the residence, the member who receives the service and each person who lives with the member is fully informed of what RS entails. The member's case manager documents consent in the member's person-centered service plan.

(iii) Waiver members have the ability to turn off the remote monitoring device or equipment if they choose to do so. The RS provider educates the member regarding how to turn RS devices off and on at the start of services and as desired thereafter.

(F) **Emergency response staff.**

(i) Emergency response staff are employed by a certified ADvantage Provider with a valid OHCA SoonerCare (Medicaid) contract to provide HCBS to OKDHS HCBS waiver members.

(ii) Informal emergency response persons are unpaid family members or other interested parties who agree to become, and are approved as, an emergency response person by the member and the member's IDT.

(G) **Service limitations.** RS services are limited to twenty-four (24) hours per day. RS services are not provided simultaneously with any other in-home direct care services. However, services may be provided through a combination of remote and in-home services dependent on the member's needs.

(H) **RS service discontinuation.** The member and the member's IDT determine when it is appropriate to discontinue RS services. When RS services are terminated,

the RS provider coordinates service termination with the member's case manager to ensure a safe transition.

(20) Assistive Technology (AT) services.

(A) AT services include devices, controls, and appliances, specified in the member's person-centered service plan, which enable members to increase their abilities to perform activities of daily living or to perceive, control, or communicate with the environment in which they live.

(B) Devices may include communication technology, such as smart phones and tablets, that allow members to communicate with their providers using video chat to ensure ongoing maintenance of health and welfare.

(C) Only devices that are not covered under the SoonerCare (Medicaid) or Specialized Medical Equipment services are included in this service definition.

(D) Service codes and rates vary based on the nature of the AT device;

(E) AT services may include:

- (i) Assessment for the need of AT or auxiliary aids;
- (ii) Training the member or provider regarding use and maintenance of equipment or auxiliary aids; and
- (iii) Repair of adaptive devices; and
- (iv) Equipment provided may include:

(I) Video communication technology that allows members to communicate with providers through video communication. Video communication allows providers to assess and evaluate their members' health and welfare or other needs by enabling visualization of members and their environments. Examples include smart phones, tablets, audiovisual or virtual assistant technology, or sensors; and

(II) The cost of internet services may be augmented through the Emergency Broadband Benefit which is available to waiver members.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 14 Ok Reg 2827, eff 5-14-97 (emergency); Amended at 14 Ok Reg 3529, eff 7-23-97 (emergency); Amended at 15 Ok Reg 1528, eff 5-11-98 ; Amended at 16 Ok Reg 3627, eff 9-7-99 (emergency); Amended at 17 Ok Reg 1204, eff 5-11-00 ; Amended at 18 Ok Reg 265, eff 11-21-00 (emergency); Amended at 18 Ok Reg 501, eff 1-1-01 (emergency); Amended at 18 Ok Reg 1130, eff 5-11-01 ; Amended at 18 Ok Reg 2962, eff 5-17-01 (emergency); Amended at 19 Ok Reg 1067, eff 5-13-02 ; Amended at 19 Ok Reg 2134, eff 6-27-02 ; Amended at 20 Ok Reg 2892, eff 7-1-03 (emergency); Amended at 21 Ok Reg 2210, eff 6-25-04 ; Amended at 22 Ok Reg 2731, eff 5-4-05 (emergency); Amended at 23 Ok Reg 160, eff 7-1-05 (emergency); Amended at 23 Ok Reg 1366, eff 5-25-06 ; Amended at 24 Ok Reg 83, eff 8-2-06 (emergency); Amended at 24 Ok Reg 932, eff 5-11-07 ; Amended at 25 Ok Reg 660, eff 2-1-08 through 7-14-08 (emergency)¹; Amended at 25 Ok Reg 2685, eff 7-25-08 ; Amended at 26 Ok Reg 994, eff 5-1-09 (emergency); Amended at 27 Ok Reg 950, eff 5-13-10 ; Amended at 28 Ok Reg 1499, eff 6-25-11 ; Amended at 29 Ok Reg 192, eff 11-22-11 (emergency); Amended at 29 Ok Reg 1113, eff 6-25-12 ; Amended at 30 Ok Reg 1179, eff 7-1-13 ; Amended at 31 Ok Reg 1702, eff 9-12-14 ; Amended at 33 Ok Reg 869, eff 9-1-16 ; Amended at 34 Ok Reg 678, eff 9-1-17 ; Amended at 36 Ok Reg 893, eff 9-1-19 ; Amended at 37 Ok Reg 1512, eff 9-14-20 ; Amended at 40 Ok Reg 2222, eff 9-11-23]

Editor's Note: ¹*This emergency action expired on 7-14-08 before being superseded by a permanent action. Upon expiration of an emergency amendatory action, the last effective permanent text is reinstated. Therefore, on 7-15-08 (after the 7-14-08 expiration of the emergency action), the text of 317:30-5-763 reverted back to the permanent text that became effective 5-11-07, as was last published in the 2007 OAC Supplement, and remained as such until amended by permanent action on 7-25-08.*

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

(a) The OHCA's monitoring of the ADvantage Program is a quality assurance activity. The agency evaluates the ADvantage program on a continual basis to ensure quality, through the review of various performance measures set forth in the waiver document. The areas evaluated include:

- (1) Member eligibility determination;
- (2) Member "freedom of choice";
- (3) Member health and welfare;
- (4) ADvantage certified and SoonerCare contracted providers on the plan;
- (5) Member acceptance of the plan;
- (6) Qualified case managers;
- (7) Plan services are goal-oriented services; and,
- (8) Plan of care costs are within cost cap guidelines.

(b) Deficiencies found by the OHCA are reported to the AA for correction and/or explanation. Additionally, a quality management report is submitted to the Centers for Medicare and Medicaid Services annually.

[Source: Added at 18 Ok Reg 2962, eff 5-17-01 (emergency); Added at 19 Ok Reg 1067, eff 5-13-02 ; Amended at 25 Ok Reg 660, eff 2-1-08 through 7-14-08 (emergency)¹; Amended at 25 Ok Reg 2685, eff 7-25-08 ; Amended at 26 Ok Reg 756, eff 4-1-09 (emergency); Amended at 27 Ok Reg 963, eff 5-13-10 ; Amended at 30 Ok Reg 1179, eff 7-1-13]

Editor's Note: ¹*This emergency action expired on 7-14-08 before being superseded by a permanent action. Upon expiration of an emergency amendatory action, the last effective permanent text is reinstated. Therefore, on 7-15-08 (after the 7-14-08 expiration of the emergency action), the text of 317:30-5-763.1 reverted back to the permanent text that became effective 5-13-02, as was last published in the 2006 Edition of the OAC, and remained as such until amended by permanent action on 7-25-08.*

317:30-5-764. Reimbursement

(a) Rates for Waiver services are set in accordance with the rate-setting process by the State Plan Amendment and Rate Committee (SPARC) and approved by the Oklahoma Health Care Authority (OHCA) Board.

- (1) The rate for Nursing Facility (NF) respite is set equivalent to the rate for routine level of care NF services that require

providers having equivalent qualifications;

(2) The rate for daily units for Adult Day Health is set equivalent to the rate established by the Oklahoma Department of Human Services (OKDHS) for equivalent services provided for the OKDHS Adult Day Service Program that requires providers have equivalent qualifications.

(3) The rate for units of home-delivered meals is set equivalent to the rate established by the OKDHS for the equivalent services provided for the OKDHS Home-Delivered Meals Program that require providers having equivalent qualifications.

(4) The rates for units of ADvantage Personal Care and In-Home Respite are set equivalent to State Plan Agency Personal Care unit rate that requires providers have equivalent qualifications.

(5) The rates for Advanced Supportive/Restorative Assistance is set equivalent to 1.077 of the State Plan Agency Personal Care unit rate;

(6) Consumer-Directed Personal Assistance Services and Supports (CD-PASS) rates are determined using the Individual Budget Allocation (IBA) Expenditure Accounts Determination process for each member. The IBA Expenditure Accounts Determination process includes consideration and decisions about the items listed in (A) B (C) of this paragraph.

(A) The IBA Expenditure Accounts Determination constrains total Medicaid reimbursement for CD-PASS services to be less than expenditures for equivalent services using agency providers.

(B) The Personal Care (PSA) and Personal Care Advanced Supportive/Restorative (APSA) service unit rates are calculated by the OKDHS Aging Services (AS) during the CD-PASS service eligibility determination process. OKDHS AS sets the PSA and APSA unit rates at a level that is not less than eighty percent (80%) and not more than ninety-five percent (95%) of the comparable PSA or APSA service rates. The allocation of portions of the PSA and/or APSA rates to cover salary, mandatory taxes, and optional benefits including Worker's Compensation insurance, when available, is determined individually for each member using the CD-PASS IBA Expenditure Accounts Determination Process.

(C) The IBA Expenditure Accounts Determination process defines the level of program financial resources required to meet the member's need for CD-PASS services. When the member's need for services changes due to a change in health/disability status or a change in the level of support available from other sources to meet needs, the case manager, based upon an updated assessment, amends the person-centered service plan to increase CD-PASS service units appropriate to meet additional member need. OKDHS AS, upon favorable review, authorizes the amended person-centered service plan and updates the member's IBA. Service amendments based on changes in

member need for services do not change an existing PSA or APSA rate. The member with assistance from the Financial Management Service, reviews and revises the IBA Expenditure Accounts calculation annually or more often to the extent appropriate and necessary.

(7) Three (3) per diem reimbursement rate levels for the ADvantage assisted living services are set. Different rate per diem levels are established to adequately reimburse the provider for the provision of different levels of service to accommodate different level of member need for services-type, intensity and frequency to address member Activities of Daily Living and Instrumental Activities of Daily Living (ADL/IADL) and health care needs. Rounded to the nearest cent, the lowest level Assisted Living Services per diem rate is set equivalent to 11.636 times the State Plan Agency Personal Care unit rate; the mid-level per diem rate is set equivalent to 15.702 times the State Plan Agency Personal Care unit rate; and the highest level Assisted Living Services per diem rate is set equivalent to 21.964 times the State Plan Agency Personal Care unit rate. The specific rate level appropriate to a particular member's service is determined by Uniform Comprehensive Assessment Tool, Part III (UCAT III) assessment by the member's Advantage case manager employed by a case management agency independent of the Assisted Living Services provider. ADvantage payment is not made for twenty-four (24) hour skilled care in an assisted living center. Federal financial participation is not available for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. Separate payment is not made for ADvantage services of personal care, advanced supportive/restorative assistance, skilled nursing, Personal Emergency Response System, home-delivered meals, adult day health or environmental modifications to a member while receiving assisted living services since these services are integral to and inherent in the provision of assisted living service. However, separate payment may be made for Medicaid State Plan and/or Medicare Home Health benefits to members receiving ADvantage assisted living. Separate payment is not made for ADvantage respite to a member while receiving assisted living services since by definition assisted living services assume the responsibility for twenty-four (24) hour oversight/monitoring of the member, eliminating the need for informal support respite. The member is responsible for room and board costs; however, for an ADvantage member, the ADvantage assisted living services provider is allowed to charge a maximum for room and board that is no more than ninety (90) percent of the Supplemental Security Income (SSI) Federal Benefit Rate. When, per Oklahoma Administrative Code (OAC) 317:35-17-1(b) and 317:35-17-11, the member has a vendor payment obligation, the provider is responsible for collecting the vendor payment from the member.

(8) The maximum total annual reimbursement for a member's hospice care within a twelve (12) month period is limited to an

amount equivalent to eighty-five (85) percent of the Medicare Hospice Cap payment.

(b) The OKDHS AS approved ADvantage person-centered service plan is the basis for the Medicaid Management Information Systems (MMIS) service prior authorization, specifying the:

- (1) Service;
- (2) Service provider;
- (3) Units authorized; and
- (4) Begin and end dates of service authorization.

(c) Service time for personal care, case management services, nursing, skilled nursing, supportive/restorative assistance, and in-home respite, is documented through the use of the designated statewide Electronic Visit Verification System (EVV) when services are provided in the home.

Providers are required to use the EVV system after access to the system is made available by OKDHS. Refer to OAC 317:30-3-34(7) for additional procedures for EVV system failure or EVV system unavailability.

(d) As part of ADvantage quality assurance, provider audits evaluate whether paid claims are consistent with service plan authorizations and documentation of service provision. Evidence of paid claims not supported by service plan authorization and documentation of service provisions are given to OHCA's Program Integrity Unit for follow-up investigation.

[**Source:** Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 18 Ok Reg 2962, eff 5-17-01 (emergency); Amended at 19 Ok Reg 337, eff 11-14-01 (emergency); Amended at 19 Ok Reg 1067, eff 5-13-02 ; Amended at 20 Ok Reg 374, eff 1-1-03 (emergency); Amended at 20 Ok Reg 1920, eff 6-26-03 ; Amended at 22 Ok Reg 2731, eff 5-4-05 (emergency); Amended at 23 Ok Reg 1366, eff 5-25-06 ; Amended at 24 Ok Reg 83, eff 8-2-06 (emergency); Amended at 24 Ok Reg 932, eff 5-11-07 ; Amended at 25 Ok Reg 660, eff 2-1-08 through 7-14-08 (emergency)¹; Amended at 25 Ok Reg 2685, eff 7-25-08 ; Amended at 26 Ok Reg 994, eff 5-1-09 (emergency); Amended at 27 Ok Reg 621, eff 1-14-10 (emergency); Amended at 27 Ok Reg 1466, eff 6-11-10 ; Amended at 30 Ok Reg 1179, eff 7-1-13 ; Amended at 34 Ok Reg 678, eff 9-1-17 ; Amended at 1060 Ok Reg 9,]

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PART 87. BIRTHING CENTERS [REVOKED]

317:30-5-890. Eligible providers [REVOKED]

[**Source:** Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 30 Ok Reg 1143, eff 7-1-13 ; Amended at 34 Ok Reg 664, eff 9-1-17 ; Revoked at 37 Ok Reg 1617, eff 9-14-20]

317:30-5-890.1. Definitions [REVOKED]

[Source: Added at 30 Ok Reg 1143, eff 7-1-13 ; Revoked at 37 Ok Reg 1617, eff 9-14-20]

317:30-5-891. Coverage by category [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 30 Ok Reg 1143, eff 7-1-13 ; Revoked at 37 Ok Reg 1617, eff 9-14-20]

317:30-5-892. Reimbursement [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 17 Ok Reg 3361, eff 8-1-00 (emergency); Amended at 18 Ok Reg 1130, eff 5-11-01 ; Amended at 19 Ok Reg 2134, eff 6-27-02 ; Revoked at 37 Ok Reg 1617, eff 9-14-20]

317:30-5-893. Billing [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 32 Ok Reg 719, eff 7-1-15 (emergency); Amended at 33 Ok Reg 791, eff 9-1-16 ; Revoked at 37 Ok Reg 1617, eff 9-14-20]

PART 89. RADIOLOGICAL MAMMOGRAPHER

317:30-5-900. Eligible providers

The mammographer must be Medicare certified and have accreditation by the American College of Radiology for Mammography. Providers must have a current contract on file with the Oklahoma Health Care Authority.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95]

317:30-5-901. Coverage by category

(a) **Adults.** Medically necessary screening mammography is a covered benefit. Additional follow-up mammograms are covered when medically necessary.

(b) **Children.** Coverage for children is the same as for adults.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 14 Ok Reg 3077, eff 7-1-97 (emergency); Amended at 15 Ok Reg 1528, eff 5-11-98 ; Amended at 23 Ok Reg 2571, eff 6-25-06 ; Amended at 24 Ok Reg 303, eff 12-1-06 (emergency); Amended at 24 Ok Reg 895, eff 5-11-07]

317:30-5-902. Vocational rehabilitation [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 19 Ok Reg 2134, eff 6-27-02]

317:30-5-903. Individuals eligible for Part B of Medicare

Payment is made utilizing the Medicaid allowable for comparable services.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 19 Ok Reg 2922, eff 7-1-02 (emergency); Amended at 20 Ok Reg 1193, eff 5-27-03]

317:30-5-904. Covered procedures [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 14 Ok Reg 3077, eff 7-1-97 (emergency); Amended at 15 Ok Reg 1528, eff 5-11-98 ; Revoked at 23 Ok Reg 2571, eff 6-25-06]

317:30-5-905. Reimbursement

Reimbursement to mammographers will be based on the current allowed charge for radiologic procedures.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95]

PART 90. DIAGNOSTIC TESTING ENTITIES

317:30-5-907. Provider requirements

(a) An Independent Diagnostic Testing Facility (IDTF) is either a fixed location or mobile entity independent of a hospital or physician's office where diagnostic services are performed by licensed certified non-physician personnel under appropriate physician supervision. Diagnostic testing entities must be Medicare certified as Mobile X-ray or an IDTF and have a current contract on file with the Oklahoma Health Care Authority.

(b) An IDTF must have one or more supervising physicians who are responsible for the direct and ongoing oversight of the quality of the testing performed, the proper operation and calibration of the equipment used to perform tests and the qualifications of non-physician personnel who use the equipment.

(c) An IDTF enrolled in the SoonerCare program must comply with all applicable federal regulations, including applicable provisions of 42 CFR 410.32 and 42 CFR 410.33.

[Source: Added at 22 Ok Reg 168, eff 10-6-04 (emergency); Added at 21 Ok Reg 2494, eff 7-11-05 ; Amended at 33 Ok Reg 836, eff 9-1-16]

317:30-5-907.1. Coverage and limitations

(a) **Adults.** For IDTF services to be covered:

- (1) Services must be medically necessary;
- (2) The treating physician's order must specify the procedures to be performed and the reason for the service; and
- (3) The IDTF may not add any procedures based on internal protocols without a written order by the treating physician.

(b) **Children.** Coverage is the same as adults.

[Source: Added at 22 Ok Reg 168, eff 10-6-04 (emergency); Added at 21 Ok Reg 2494, eff 7-11-05 ; Amended at 33 Ok Reg 836, eff 9-1-16]

317:30-5-907.2. Individuals eligible for Part B of Medicare

Payment is made utilizing the Medicaid allowable for comparable services.

[Source: Added at 22 Ok Reg 168, eff 10-6-04 (emergency); Added at 21 Ok Reg 2494, eff 7-11-05]

317:30-5-907.3. Reimbursement

(a) Diagnostic procedure are reimbursable if the services were rendered to a non-hospital patient and the IDTF provided all services (professional and technical) associated with the total procedure as defined in the CPT. When separate CPT codes itemize a service by its professional and technical components, the IDTF may bill and be reimbursed for the components of the procedure it actually performed.

(b) Payment is made for the technical component on outpatient diagnostic procedures in accordance with the guidelines set forth in OAC 317:30-5-24.

[Source: Added at 22 Ok Reg 168, eff 10-6-04 (emergency); Added at 21 Ok Reg 2494, eff 7-11-05 ; Amended at 33 Ok Reg 836, eff 9-1-16]

PART 91. TUBERCULOSIS CLINIC SERVICES [REVOKED]

317:30-5-910. Eligible providers [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 24 Ok Reg 2070, eff 6-25-07]

317:30-5-911. Coverage by category [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 24 Ok Reg 2070, eff 6-25-07]

317:30-5-912. Covered services [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 19 Ok Reg 2134, eff 6-27-02]

317:30-5-913. Billing [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 24 Ok Reg 2070, eff 6-25-07]

PART 93. CASE MAAGEMENT SERVICES FOR PERSONS INFECTED WITH TUBERCULOSIS [REVOKED]

317:30-5-920. Eligible providers [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 24 Ok Reg 2070, eff 6-25-07]

317:30-5-921. Coverage by category [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 24 Ok Reg 2070, eff 6-25-07]

317:30-5-922. Billing [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 19 Ok Reg 2134, eff 6-27-02]

317:30-5-923. Reimbursement [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 19 Ok Reg 2134, eff 6-27-02 ; Revoked at 24 Ok Reg 2070, eff 6-25-07]

317:30-5-924. Documentation of records [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 24 Ok Reg 2070, eff 6-25-07]

PART 95. AGENCY PERSONAL CARE SERVICES

317:30-5-950. Eligible providers

Reimbursement for personal care is made only to agencies that are certified as home care agency providers by the Oklahoma State Department of Health and are certified by the ADvantage Administration as meeting applicable federal, state and local laws, rules and regulations. In order to be eligible for reimbursement, the home care agency must have an approved provider agreement on file with the Oklahoma Health Care Authority, per Oklahoma Administrative Code (OAC) 317:30-3-2. Service time of personal care is documented through the designated statewide Electronic Visit Verification (EVV) system when services are provided in the member's home. The home care agency is required to use

the EVV system. Refer to OAC 317:30-3-34(7) for additional procedures for EVV system failure or EVV system unavailability. Refer to OAC 317:35-17-22 for additional instructions.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 18 Ok Reg 2962, eff 5-17-01 (emergency); Amended at 19 Ok Reg 1067, eff 5-13-02 ; Amended at 26 Ok Reg 994, eff 5-1-09 (emergency); Amended at 27 Ok Reg 621, eff 1-14-10 (emergency); Amended at 27 Ok Reg 1466, eff 6-11-10 ; Amended at 35 Ok Reg 1458, eff 9-14-18 ; Amended at 1060 Ok Reg 9,]

317:30-5-951. Coverage by category

SoonerCare payment is made to agencies, on behalf of SoonerCare members, for personal care services (PC services) provided in the member's home. Personal Care services may be provided in an educational or employment setting to assist the member in achieving vocational goals identified on an approved care plan. Personal care services preventor minimize a member's physical health regression and deterioration. Tasks performed during the provision of PC services include, but are not limited to, assisting an individual in performing tasks of personal hygiene, dressing and medication. Tasks may also include meal preparation, light housekeeping, errands, and laundry directly related to the recipient's personal care needs. Personal care does not include the provision of care of a technical nature. For example, tracheal suctioning, bladder catheterization, colostomy irrigation and operation/maintenance of technical machinery is not performed as part of PC services. PC skilled nursing service is an assessment of the member's needs to determine the frequency of PC services and tasks performed, development of a PC service care plan to meet identified personal care needs, service delivery oversight and annual re-assessment and updating of care plan. It may also include more frequent re-assessment and updating of the care plan if changes in the member's needs require.

(1) **Adults.** Payment for services provided by a PC services agency is made on behalf of eligible individuals who have needs requiring the service in accordance with OAC 317:35-15-4 as determined through an assessment utilizing the Uniform Comprehensive Assessment Tool (UCAT). Before PC services can begin the individual must:

- (A) require a care plan involving the planning and administration of services delivered under the supervision of professional personnel;
- (B) have a physical impairment or combination of physical and mental impairments;
- (C) lack the ability to meet personal care needs without additional supervision or assistance, or to communicate needs to others; and
- (D) require assistance, not of a technical nature, to prevent or minimize physical health regression and deterioration.

(2) **Children.** Coverage for persons under 21 years of age is the same as for adults.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 18 Ok Reg 2962, eff 5-17-01 (emergency); Amended at 19 Ok Reg 1067, eff 5-13-02 ; Amended at 20 Ok Reg 1942, eff 6-26-03 ; Amended at 24 Ok Reg 83, eff 8-2-06 (emergency); Amended at 24 Ok Reg 932, eff 5-11-07]

317:30-5-952. Prior authorization

Eligible members receiving personal care services must have an approved care plan developed by a PC services skilled nurse. For persons receiving ADvantage Program services, the nurse works with the member's ADvantage Program Case Manager to develop the care plan. The amount and frequency of the service, to be provided to the member, is listed on the care plan. The amount and frequency of PC services is approved by the OKDHS nurse or authorized in the ADvantage Program Service Plan. At the time of a member's initial referral to a PC services agency, OKDHS/ASD authorizes PC services, skilled nursing for PC services, needs assessment and care plan development. The number of units of PC services or PC skilled nursing the member is eligible to receive is limited to the amounts approved on the care plan as authorized by OKDHS/ASD. Care plans are authorized for no more than one year from the date of care plan authorization. Services provided without prior authorization are not compensable.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 18 Ok Reg 2962, eff 5-17-01 (emergency); Amended at 19 Ok Reg 1067, eff 5-13-02 ; Amended at 20 Ok Reg 1942, eff 6-26-03 ; Amended at 20 Ok Reg 2892, eff 7-1-03 (emergency); Amended at 21 Ok Reg 2210, eff 6-25-04 ; Amended at 24 Ok Reg 83, eff 8-2-06 (emergency); Amended at 24 Ok Reg 932, eff 5-11-07 ; Amended at 26 Ok Reg 756, eff 4-1-09 (emergency); Amended at 27 Ok Reg 963, eff 5-13-10]

317:30-5-953. Billing

A billing unit for personal care services provided by a home care agency is fifteen (15) minutes of service delivery and equals a visit. Billing procedures for personal care services are contained in the Oklahoma Medicaid Management Information Systems (OKMMIS) Billing and Procedure Manual. Service time for personal care and nursing is documented through the designated statewide Electronic Visit Verification (EVV) system. Refer to OAC 317:30-3-34(7) for additional procedures for EVV system failure or EVV system unavailability.

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Amended at 19 Ok Reg 2134, eff 6-27-02 ; Amended at 20 Ok Reg 1942, eff 6-26-03 ; Amended at 24 Ok Reg 83, eff 8-2-06 (emergency); Amended at 24 Ok Reg 932, eff 5-11-07 ; Amended at 26 Ok Reg 543, eff 2-1-09 (emergency); Amended at 26 Ok Reg 1217, eff 6-25-09 ; Amended at 35 Ok Reg 1458, eff 9-14-18 ; Amended at 38 Ok Reg 1060, eff 9-1-21]

PART 97. TARGETED CASE MANAGEMENT SERVICES FOR MEMBERS UNDER TWENTY-ONE YEARS OF AGE AT RISK OF INVOLVEMENT WITH OR IN THE TEMPORARY CUSTODY OR SUPERVISION OF THE OKLAHOMA OFFICE OF JUVENILE AFFAIRS (OJA)

317:30-5-970. Eligible providers

(a) **Case management agency qualifications.** As the provider agency, the Oklahoma Office of Juvenile Affairs (OJA) must meet applicable state and federal laws governing the participation of providers in the Medicaid program. The Office of Juvenile Affairs Targeted Case Management (OJATCM) program must:

- (1) Be available to all eligible members;
- (2) Be delivered on a statewide basis with procedures that assure twenty-four (24) hour availability, the protection and safety of recipients, and continuity of services without duplication;
- (3) Ensure compliance with federal and state mandates and regulations related to serving the targeted population are met in a consistent and uniform manner;
- (4) Meet applicable state and federal laws governing the participation of providers in the Medicaid program, including, but not limited to, the ability to meet federal and state requirements for documentation billing and audits;
- (5) Demonstrate that its staff has experience working with the target population and a minimum of five (5) years' experience in providing all core elements of case management including:
 - (A) Individual strengths and needs assessment;
 - (B) Needs-based service planning;
 - (C) Service coordination and monitoring; and
 - (D) Ongoing assessment and treatment plan revision.
- (6) Have adequate administrative capacity to fulfill state and federal requirements;
- (7) Have financial management capacity and systems that provide documentation of services and costs in accordance with Generally Accepted Government Auditing Standards (GAGAS);
- (8) Have the capacity to document and maintain individual case records in accordance with state and federal requirements;
- (9) Have a minimum of five (5) years' experience in providing and meeting the case management and service needs of the target population;
- (10) Have responsibility for planning and coordinating statewide juvenile justice and delinquency prevention services in accordance with Title 10A of the Oklahoma Statutes (O.S.), Section (§) 2-2-102; and
- (11) Have the ability to evaluate the effectiveness, accessibility, and quality of targeted case management (TCM) services on a community-wide basis.

(b) **Interagency agreement.** An agreement between the Oklahoma Health Care Authority (OHCA) and OJA for TCM services must be in effect before Medicaid reimbursement can be made for compensable services.

(c) **Case manager qualifications.** A targeted case manager for the OJATCM program must:

- (1) Be employed by OJA;
- (2) Possess a minimum of a bachelor's degree in a behavioral science, or a bachelor's degree and one (1) year of professional

experience in juvenile justice or a related field;

(3) Possess knowledge of:

(A) Laws, regulations, legislation, policies, and procedures as they pertain to the State's administration of juvenile justice and the investigation of juvenile delinquency;

(B) Community resources;

(C) Human developmental stages, developmental disorders, and social work theory and practices;

(D) Adverse childhood experiences and the impact of trauma on the developing brain;

(E) The risk and protective factors of child delinquency;

(F) Solution-focused practices and the critical role protective factors play in intervention planning;

(G) Sensitivity of cultural diversity; and

(H) Clinical and counseling techniques and treatment of juvenile delinquency;

(4) Possess skills in:

(A) Crisis intervention;

(B) Gathering necessary information to determine the needs of the child;

(C) Casework management;

(D) Courtroom testimony, terminology, and procedures;

(E) Effective communication;

(F) Developing, evaluating, and modifying, as appropriate, intervention planning on an ongoing basis;

(G) Establishing and maintaining supportive relationships with children and their families;

(H) Assisting children and families to access needed resources and supports; and

(I) Working with courts and law enforcement entities; and

(5) Have the ability to access multi-disciplinary staff, when needed. This includes, at a minimum, medical professionals and a child protective services social worker.

[Source: Added at 14 Ok Reg 3686, eff 8-1-97 (emergency); Added at 15 Ok Reg 1528, eff 5-11-98 ; Amended at 37 Ok Reg 1619, eff 9-14-20]

317:30-5-971. Coverage by category

The target group includes individuals under twenty-one (21) years of age involved in, or at serious risk of involvement with, the juvenile justice system, as provided in Article II of the Oklahoma Juvenile Code. The target group includes individuals, under twenty-one (21) years of age, who have been temporarily placed in OJA custody or supervision or who are voluntarily supervised by OJA to prevent further involvement with the juvenile justice system. The target group may include individuals, under twenty-one (21) years of age, who are assessed as at risk of abuse or neglect as defined in Title 10A of the Oklahoma Statutes (O.S.), Section (§) 1-1-105. The target group does not include those who are involuntarily in secure custody of law enforcement or judicial systems, except individuals who meet Medicaid criteria for inpatient care as defined in § 435.1010 of Title 42 of the Code of Federal Regulations.

- (1) **Adults.** There is no coverage for adults age twenty-one (21) and older.
- (2) **Children.** Payment is made for services to members under the age twenty-one (21).

[Source: Added at 14 Ok Reg 3686, eff 8-1-97 (emergency); Added at 15 Ok Reg 1528, eff 5-11-98 ; Amended at 37 Ok Reg 1619, eff 9-14-20]

317:30-5-971.1. Description of targeted case management (TCM) services

(a) **Definition.** In accordance with Section (§) 440.169(b) of Title 42 of the Code of Federal Regulations (C.F.R.), TCM services are defined as services furnished to assist individuals, eligible under the Oklahoma Medicaid State Plan, in gaining access to needed medical, social, educational, and other services. TCM includes providing services that are directly related to identifying the individual's needs and care, for the purposes of helping the individual access services; identifying needs and supports to assist the individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the individual's needs [42 C.F.R. 440.169(e)]. TCM includes the following assistance:

- (1) Comprehensive assessment and periodic reassessment of an individual's needs, to determine the need for any medical, educational, social, or other services.
 - (A) All members are assessed using comprehensive, evidence-based, risk/needs assessment tools at the beginning of case assignment.
 - (B) Comprehensive, evidence-based, risk/needs assessment tools are used to measure multiple areas or domains in the lives of the members and then linking that information to case planning.
 - (C) Any area showing a moderate to high-risk/need/strength score could result in additional goals and action steps documented within the individualized treatment plan.
 - (D) In addition to the initial assessment, each member is assessed, at least once every six (6) months. Assessment activities include:
 - (i) Taking member history;
 - (ii) Identifying and documenting the member's needs; and
 - (iii) Gathering information from family members, medical providers, social workers, educators (if necessary), and other applicable sources to form a complete assessment of the member.
 - (E) Should behavior shifts or life-changing events occur prior to six (6) months, the member is reassessed and the individualized treatment service plan is adjusted to reflect identified needs. Any needed changes in services, service providers, treatment type, frequency, or duration may be adjusted at this time.

(2) Development (and periodic revision) of a specific individualized treatment service plan is based on the information collected through the assessment that:

(A) Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;

(B) Includes activities such as ensuring the active participation of the individual, and working with his or her authorized health care decision maker and others to develop those goals; and

(C) Identifies a course of action to respond to the assessed needs of the individual.

(3) Referral and related activities (such as scheduling appointments for the member) to help the individual obtain needed services, including activities that help link the member with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the treatment service plan.

(4) Monitoring and follow-up activities necessary to ensure the individualized treatment service plan is implemented and adequately addresses the individual's needs.

(A) The targeted case manager visits with the child at least once each month, face to face, and/or weekly (via telephone) to review progress as outlined within the individualized treatment service plan. The targeted case manager must visit with the parent or legal guardians monthly. The targeted case manager maintains consistent contact with the service providers to remain up to date on the child's treatment and progress.

(B) The frequency and type of visits may be adjusted or revised to better meet the needs of the child.

(C) Monitoring and follow-up activities may be conducted as frequently as necessary, including at least one (1) annual monitoring, to determine whether the following conditions are met:

(i) Services are being furnished in accordance with the member's treatment service plan;

(ii) Services in the treatment service plan are adequate; and

(iii) Changes in the needs or status of the member are reflected in the treatment service plan.

Monitoring and follow-up activities include making necessary adjustments in the treatment service plan and service arrangements with providers.

(b) **Non-covered services.** TCM does not include:

(1) Physically escorting or transporting a member to scheduled appointments or staying with the member during an appointment;

(2) Monitoring financial goals;

(3) Providing specific services such as shopping or paying bills;

and/or

- (4) Delivering bus tickets, nutritional services, money, etc.
- (c) **Non-duplication of services.** Consistent with 42 C.F.R. § 441.18(a)(4), payment for case management or TCM services shall not duplicate payments made to public agencies or private entities under the Oklahoma Medicaid State Plan or other program authorities.
- (d) **Individuals eligible for Part B of Medicare.** Case management services provided to Medicare eligible recipients are filed directly with the fiscal agent.

[Source: Added at 37 Ok Reg 1619, eff 9-14-20]

317:30-5-972. Reimbursement

- (a) Targeted case management (TCM) services will be reimbursed pursuant to the methodology described in the Oklahoma Medicaid State Plan.
- (b) The reimbursement methodology is based upon qualifying costs for the eligible population from the Cost Allocation Plan. The TCM unit rate is a prospective flat rate based on a qualifying TCM contact with the member in the target population or with some other person on behalf of the member during the claim period.

[Source: Added at 14 Ok Reg 3686, eff 8-1-97 (emergency); Added at 15 Ok Reg 1528, eff 5-11-98 ; Amended at 19 Ok Reg 2134, eff 6-27-02 ; Amended at 27 Ok Reg 808, eff 3-3-10 (emergency); Amended at 27 Ok Reg 1458, eff 6-11-10 ; Amended at 37 Ok Reg 1619, eff 9-14-20]

317:30-5-973. Billing

Billing for case management services must be submitted, ensuring no duplication of services, and in accordance with state and federal requirements, reflective of guidelines found at Oklahoma Administrative Code (OAC) 317:30-3-11, 317:30-3-11.1, and 317:30-3-20.

[Source: Added at 14 Ok Reg 3686, eff 8-1-97 (emergency); Added at 15 Ok Reg 1528, eff 5-11-98 ; Amended at 32 Ok Reg 719, eff 7-1-15 (emergency); Amended at 33 Ok Reg 791, eff 9-1-16 ; Amended at 37 Ok Reg 1619, eff 9-14-20]

317:30-5-974. Documentation of records

- (a) The Oklahoma Office of Juvenile Affairs (OJA) must maintain case records that document for all members receiving targeted case management (TCM) as follows:
- (1) The name of the member;
 - (2) The dates of the case management services;
 - (3) The name of the OJA as the provider agency (if applicable) and the person providing the case management service;
 - (4) The nature, content, units of the case management services received, and whether goals specified in the treatment service plan have been achieved;
 - (5) Whether the member has declined services in the treatment service plan;
 - (6) The need for, and occurrences of, coordination with other case managers;
 - (7) A timeline for obtaining needed services; and

- (8) A timeline for reevaluation of the plan.
- (b) All case management services rendered must be reflected by documentation in the records. All TCM units provided to the member must be documented by the case manager on the electronic case management system designated by OJA.

[Source: Added at 14 Ok Reg 3686, eff 8-1-97 (emergency); Added at 15 Ok Reg 1528, eff 5-11-98 ; Amended at 37 Ok Reg 1619, eff 9-14-20]

PART 99. CASE MANAGEMENT SERVICES FOR UNDER AGE 18 IN EMERGENCY, TEMPORARY OR PERMANENT CUSTODY OR SUPERVISION OF THE DEPARTMENT OF HUMAN SERVICES

317:30-5-990. Eligible providers

(a) **Case management agencies.** Services are provided by case management agencies established for the purpose of providing case management services. Medicaid Child Welfare Targeted Case Management (CWTCM) services must be made available to all eligible recipients and must be delivered by provider agencies on a statewide basis with procedures that assure 24 hour availability, the protection and safety of recipients, continuity of services without duplication, and compliance with federal and State mandates and regulations related to servicing the targeted population are met in a uniform and consistent manner. The agency must demonstrate that their staff has:

- (1) a minimum of five years experience in providing all core elements of case management services including:
 - (A) individualized strengths and needs assessment;
 - (B) needs-based service planning;
 - (C) service coordination and monitoring; and
 - (D) on-going assessment and treatment plan revision.
- (2) a minimum of five years experience in providing case management services that coordinate and link the community resources required by the target population.
- (3) a minimum of five years experience in meeting the case management and service needs of the target population.
- (4) an administrative capacity to insure quality of services in accordance with State and federal requirements.
- (5) a financial management capacity and system that provides documentation of services and costs.
- (6) a capacity to document and maintain individual case records in accordance with State and federal requirements.
- (7) ability to meet all State and federal laws governing the participation of providers in the State Medicaid program including, but not limited to, the ability to meet federal and State requirements for documentation, billing and audits.

(b) **Provider agreement.** A Provider Agreement between the Oklahoma Health Care Authority and the provider for CWTCM services must be in effect before reimbursement can be made for compensable services.

(c) **Qualifications of individual case managers.** A targeted case manager for the CWTCM program must:

- (1) be employed by the provider agency.
- (2) possess at minimum, a bachelor of social work degree; or a bachelor's degree and one year of experience in professional social work; or a master's degree in behavioral science.
- (3) possess knowledge of the principles and practices of:
 - (A) social work;
 - (B) laws, rules, regulations, and policies and procedures governing agency programs;
 - (C) community resources;
 - (D) human developmental stages and related dysfunctions;
 - (E) sensitivity to cultural diversity;
 - (F) emotional, physical and mental needs of clients; and
 - (G) counseling programs and services.
- (4) possess skill in:
 - (A) interviewing;
 - (B) getting clients to explore opportunities and extracting information;
 - (C) casework management;
 - (D) setting goals in cooperation with clients;
 - (E) time management;
 - (F) prioritizing and organizing needs of clients;
 - (G) courtroom testimony, terminology and procedures;
 - (H) crisis intervention;
 - (I) working with a multidisciplinary approach; and
 - (J) developing, evaluating and modifying an intervention plan on an ongoing basis.

(d) **Provider selection.** Provision of case management services must not restrict an individual's free choice of providers. Eligible recipients must have free choice of providers of case management as well as providers of other medical care under the plan.

[Source: Added at 14 Ok Reg 3711, eff 8-1-97 (emergency); Added at 15 Ok Reg 1528, eff 5-11-98]

317:30-5-991. Coverage by category

Payment is made for case management service as set forth in this Section.

- (1) **Adults.** There is no coverage for adults.
- (2) **Children.** Payment is made for services to persons under age 18 as follows:
 - (A) **Description of case management services.** The target group for CWTCM services are persons under age 18 who are in emergency, temporary or permanent custody of the Department of Human Services (DHS) or in voluntary status who are placed in out-of home care or trial adoption.
 - (i) Case management services are activities that assist the target population in gaining access to needed medical, social, educational and other

services. These services include services covered under the Oklahoma Medicaid State Plan as well as those services not covered under the State Plan.

(ii) Case management is designed to assist individuals in accessing services. The client has the right to refuse case management and cannot be restricted from services because of a refusal for Case Management Services.

(iii) Case management does not include:

(I) Physically escorting or transporting a client to scheduled appointments or staying with the client during an appointment;

(II) Monitoring financial goals;

(III) Providing specific services such as shopping or paying bills; or

(IV) Delivering bus tickets, food stamps, money, etc.

(B) **Non-Duplication of services.** To the extent any eligible recipient in the identified target population are receiving CWTCM services from another provider agency as a result of being members of other covered target groups (i.e., SoonerStart Early Intervention), the provider agency assures that case management activities are coordinated to avoid unnecessary duplication of service.

(C) **Providers.** Case management services must be provided by case management agencies.

(3) **Individuals eligible for Part B of Medicare.** Case Management Services provided to Medicare eligible recipients are filed directly with the fiscal agent.

[Source: Added at 14 Ok Reg 3711, eff 8-1-97 (emergency); Added at 15 Ok Reg 1528, eff 5-11-98]

317:30-5-992. Reimbursement

Child Welfare Targeted Case Management (CWTCM) services will be reimbursed pursuant to the methodology described in the Oklahoma Title XIX State Plan.

[Source: Added at 14 Ok Reg 3711, eff 8-1-97 (emergency); Added at 15 Ok Reg 1528, eff 5-11-98 ; Amended at 19 Ok Reg 2134, eff 6-27-02 ; Amended at 27 Ok Reg 808, eff 3-3-10 (emergency); Amended at 27 Ok Reg 1458, eff 6-11-10]

317:30-5-993. Billing

Billing for case management services is on Form HCFA-1500. Claims must be submitted in accordance with guidelines found at OAC 317:30-3-11 and 317:30-3-11.1.

[Source: Added at 14 Ok Reg 3711, eff 8-1-97 (emergency); Added at 15 Ok Reg 1528, eff 5-11-98 ; Amended at 32 Ok Reg 719, eff 7-1-15 (emergency); Amended at 33 Ok Reg 791, eff 9-1-16]

317:30-5-994. Documentation of records

All case management services rendered must be reflected by documentation in the records. All units of Medicaid CWTCM services provided are documented by the case manager on the monthly Record of Contact form.

[Source: Added at 14 Ok Reg 3711, eff 8-1-97 (emergency); Added at 15 Ok Reg 1528, eff 5-11-98]

PART 101. TARGETED CASE MANAGEMENT SERVICES FOR PERSONS WITH INTELLECTUAL DISABILITY AND/OR RELATED CONDITIONS

317:30-5-1010. Eligible providers

(a) **Eligible providers.** Services are provided by Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD) case managers.

(1) **Certification requirements.** SoonerCare Developmental Disabilities Services Division Targeted Case Management (DDSDTCM) services must be made available to all eligible members and must be delivered on a statewide basis with procedures that assure 24 hour availability, the protection and safety of members, continuity of services without duplication, and compliance with federal and State mandates and regulations related to servicing the targeted population are met in a uniform and consistent manner. A DDSDTCM case manager must:

(A) be employed by the OKDHS, DDSD.

(B) possess knowledge of:

- (i) case management methods, principles and techniques;
- (ii) types of developmental disabilities represented within the caseload;
- (iii) types of providers and services available for members;
- (iv) the behavioral sciences and allied disciplines involved in the evaluation, care and training of persons with developmental disabilities;
- (v) interviewing principles and techniques;
- (vi) counseling principles and techniques; and
- (vii) adaptive communication techniques and non-verbal communication.

(C) possess skill in:

- (i) managing a caseload;
- (ii) effectively intervening in crisis situations;
- (iii) working cooperatively and effectively with other professionals in a team situation;
- (iv) collecting and analyzing information;
- (v) making decisions relating to services provided to members;
- (vi) developing a logical and practical plan of treatment for members with developmental

- disabilities;
- (vii) evaluating the progress of members and the quality of their habilitation programs;
- (viii) communicating effectively; and
- (ix) mediating with providers and agencies to resolve problems.

(b) **Provider agreement.** A Provider Agreement between the Oklahoma Health Care Authority and the provider for DDS/DTCM services must be in effect before reimbursement can be made for compensable services.

(c) **Provider selection.** Target group consists of eligible members with developmental disabilities. Providers are limited to providers of case management services capable of ensuring that members with developmental disabilities receive needed services.

[Source: Added at 14 Ok Reg 3704, eff 8-1-97 (emergency); Added at 15 Ok Reg 1528, eff 5-11-98 ; Amended at 26 Ok Reg 2114, eff 6-25-09]

317:30-5-1010.1. Scope of service

(a) Description of targeted case management services.

(1) Case management services are services furnished to assist members, eligible under the Medicaid State Plan, in gaining access to needed medical, social, educational and other services. Case management includes the following assistance:

(A) assessment of a member to determine the need for medical, educational, social, or other services. Assessment activities include:

- (i) taking member history;
- (ii) identifying the member's needs and completing related documentation; and
- (iii) gathering information from other sources such as family members, medical providers, social workers, and educators to form a complete assessment of the member.

(B) development of an individual plan and a specific plan of care that:

- (i) are based on the information collected through the assessment;
- (ii) specify the goals and actions to address medical, social, educational, and other services needed by the member;
- (iii) include activities such as ensuring the active participation of the eligible member; and work with the member or member's authorized health care decision maker, and others to develop the goals; and
- (iv) identify a course of action to respond to the assessed needs of the eligible member.

(C) referral and related activities to help an eligible member obtain needed services including activities that help link a member with:

- (i) medical, social, educational providers; or

(ii) other programs and services capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the member.

(D) monitoring and follow-up activities include activities and contact necessary to ensure the individual plan and the plan of care are implemented and adequately address the member's needs. Activities and contact may be with the member, his or her family members, providers, other entities or individuals, and may be conducted as frequently as necessary including at least one annual monitoring to assure the following conditions are met:

- (i) services are being furnished in accordance with the member's plan of care;
- (ii) services in the plan of care are adequate; and
- (iii) if there are changes in the needs or status of the member, necessary adjustments are made to the plan of care, and to service arrangements with providers.

(2) Case management may include contact with individuals who are directly related to identifying the needs and supports for helping the eligible member to access services.

(b) Targeted Case Management Service Requirements. DDSD assures that:

- (1) case management services are provided in a manner consistent with the best interest of members and are not used to restrict a member's access to other services under the plan;
- (2) members are not compelled to receive case management services, condition receipt of case management services on the receipt of other SoonerCare services, or condition receipt of other SoonerCare services on receipt of case management services;
- (3) case management conducts activities to ensure the health and welfare of HCBS waiver members. For members who refuse case management services, these activities are completed as follows:

(A) the member develops an Individual Plan (IP) per OAC 340:100-5-50 through 340:100-5-58.

(B) the member develops a plan of care requesting authorization for services and submits it with the IP to the Developmental Disabilities Services Division (DDSD) plan of care reviewer for review and approval per OAC 340:100-3-33 and OAC 340:100-3-33.1.

(C) monthly progress reports, incident reports, OKDHS form 06HM005E, OKDHS form 06HM006E, and other documentation required to be submitted to case management are submitted to the DDSD state office program manager for case management for monitoring and follow-up per OAC 340:100-3-27.

(D) monitoring visits required by OAC 340:100-3-27 are conducted by DDSD Quality Assurance staff.

(E) the DDSD state office program manager assigns staff responsibility for maintaining the record in Client Contact

Manager (CCM), obtaining necessary documents from the member and others for continuing service eligibility, providing information regarding available HCBS Waiver providers, making referrals to other programs and identifying training available to assist the member in completing the required tasks.

(4) providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

(c) **Non-Duplication of services.** To the extent any eligible members in the identified target population are receiving case management services from another provider agency as a result of being members of other covered target groups, the provider assures that case management activities are coordinated to avoid unnecessary duplication of service.

[Source: Added at 18 Ok Reg 968, eff 3-21-01 (emergency); Added at 19 Ok Reg 1067, eff 5-13-02 ; Amended at 26 Ok Reg 2114, eff 6-25-09]

317:30-5-1011. Coverage by category

Payment is made for targeted case management service as set forth in this Section.

(1) **Adults.** Payment is made for services to persons with an intellectual disability and/or related conditions as follows:

(A) The target group for Developmental Disabilities Services Division Targeted Case Management (DDSDTCM) services are Medicaid eligible individuals:

(i) served by the Home and Community Based Waivers operated by the Department of Human Services/Developmental Disabilities Services Division (DHS/DDSD); or

(ii) residing in institutions who:

(I) have requested Home and Community Based Waiver services operated by DHS/DDSD, and

(II) receive targeted case management services during a transition period not to exceed 180 consecutive days immediately prior to entering the Waiver; or

(iii) who are being assessed for admission to the Home and Community Based Waiver operated by DHS/DDSD.

(B) Targeted case management services may be provided when the client, the client's family as appropriate, the client's legal representative and case manager have worked together to achieve a plan.

(2) **Children.** Services for children are the same as for adults.

(3) **Individuals eligible for Part B of Medicare.** Case Management Services provided to Medicare eligible recipients are filed directly with the fiscal agent.

[Source: Added at 14 Ok Reg 3704, eff 8-1-97 (emergency); Added at 15 Ok Reg 1528, eff 5-11-98 ; Amended at 18 Ok Reg 968, eff 3-21-01 (emergency); Amended at 19 Ok Reg 1067, eff 5-13-02 ; Amended at 29 Ok Reg 1076, eff 6-25-12]

317:30-5-1012. Reimbursement

(a) Reimbursement for DDSDTCM services is a unit rate based on the weekly cost per case for documented DDSDTCM services. The cost base consists of the annualized cost of case management staff including all applicable overhead and indirect service cost in accordance with the approved DHS cost allocation plan. A first year interim rate is computed by dividing the annual cost base by the projected number of units. Subsequent annual rates will include an adjustment based on previous years cost versus total billable amount. A unit of service is defined as one calendar week of targeted case management, provided that a minimum of one contact which meets the description of a targeted case management activity with or on behalf of the member has been documented during the week claimed. Payment is made on the basis of claims submitted for payment. The provider bills at the weekly unit rate for a documented unit of SoonerCare DDSDTCM services provided to each SoonerCare eligible member during the calendar week.

(b) Only one unit of DDSDTCM services may be billed for each SoonerCare eligible member per week while the member is receiving services under a DHS/DDSD HCBS Waiver or is in the transition process to receive those services. No more than twenty-six units of DDSDTCM may be provided and billed for each eligible SoonerCare member during their transition period from the institution. DHS/DDSD must provide documentation of all such transitional DDSDTCM services provided, indicating the date performed for each unit billed. In no case may DHS/DDSD bill for transitional and regular DDSDTCM services provided during the same week (i.e., if DDSD bills transitional DDSDTCM for the third week in June and the member is deinstitutionalized into the particular Waiver during the third week in June, DDSD cannot also bill for regular DDSDTCM for the third week in June). If DDSDTCM has been provided to an individual during such a transitional period but that individual dies before the placement into the community is made, decides to refuse the placement or the placement falls through, reimbursement is available.

(c) the billing week for DDSDTCM is Monday through Sunday.

[Source: Added at 14 Ok Reg 3704, eff 8-1-97 (emergency); Added at 15 Ok Reg 1528, eff 5-11-98 ; Amended at 18 Ok Reg 968, eff 3-21-01 (emergency); Amended at 19 Ok Reg 1067, eff 5-13-02 ; Amended at 29 Ok Reg 1088, eff 6-25-12]

317:30-5-1013. Billing

Billing for case management services is on Form HCFA-1500. Claims should not be submitted until Medicaid eligibility of the individual has been determined. However, a claim must be received by OHCA within 12 months of the date of service. If the eligibility of the individual has not been determined after ten months from the date of service, a claim must be submitted in order to assure that the claim is timely filed

and reimbursement from Title XIX funds can be made should the individual be determined eligible at a later date.

[Source: Added at 14 Ok Reg 3704, eff 8-1-97 (emergency); Added at 15 Ok Reg 1528, eff 5-11-98]

317:30-5-1014. Documentation of records

All case management services rendered must be reflected by documentation in the records. All units of SoonerCare DDS/DTCM services provided are documented by the case manager weekly in Client Contact Manager. The following conditions must be met in order for case management services to be reimbursed under SoonerCare.

- (1) The case manager must conduct a face-to-face interview with the member in order to determine member needs and develop approaches to meet these needs.
- (2) The case manager with a team including the member or member's representative, must develop a plan of care which is documented in the case record.
- (3) The case manager must reassess the plan of care when necessary but at a minimum annually.
- (4) The case manager must provide documentation to supplement the plan of care which includes:
 - (A) information supporting the selection of outcomes;
 - (B) information supporting the approaches selected;
 - (C) information supporting case management decisions and actions;
 - (D) documentation of communication with the member and, as appropriate, his/her representative;
 - (E) documentation of linkages with resources;
 - (F) documentation of follow-up and monitoring of the plan; and
 - (G) other factual information relevant to the case.

[Source: Added at 14 Ok Reg 3704, eff 8-1-97 (emergency); Added at 15 Ok Reg 1528, eff 5-11-98 ; Amended at 29 Ok Reg 1088, eff 6-25-12]

PART 103. QUALIFIED SCHOOLS AS PROVIDERS OF HEALTH-RELATED SERVICES

317:30-5-1020. General provisions

(a) School-based services are medically necessary health-related and rehabilitative services that are provided by a qualified school provider to a student under the age of twenty-one (21) pursuant to an Individualized Education Program (IEP), in accordance with the Individuals with Disabilities Education Act (IDEA). Payment is made to qualified school providers for delivery of school-based services, provided that such services are, among other things, medically necessary and sufficiently supported by medical records and/or other documentation, as explained below.

(b) An IEP and all relevant supporting documentation, including, but not limited to, the documentation required by Oklahoma Administrative Code (OAC) 317:30-5-1020(c), below, serves as the plan of care for consideration of reimbursement for school-based services. The plan of care must contain, among other things, the signatures, including credentials, of the provider(s) and the direct care staff delivering services under the supervision of the professional; as well as a complete, signed, and current IEP which clearly establishes the type, frequency, and duration of the service(s) to be provided, the specific place of services if other than the school (e.g., field trip, home), and measurable goals for each of the identified needs. Goals must be updated to reflect the current therapy, evaluation, or service that is being provided and billed to SoonerCare.

(1) Except for those services, referenced in OAC 317:30-5-1023(b)(2)(H), a plan of care that meets the requirements of OAC 317:30-5-1020(b), above, shall serve as a prior medical authorization for the purpose of providing medically necessary and appropriate school-based services to students.

(2) For the purposes of occupational therapy services, and services for members with speech, hearing, and language disorders, a plan of care that meets the requirements of OAC 317:30-5-1020(b), above, may also, in accordance with sections (§§) 725.2(H) and 888.4(C) of Title 59 of the Oklahoma Statutes (O.S.) serve as a valid prescription or referral for an initial evaluation and any subsequent services, as is required by Title 42 of Code of Federal Regulations (C.F.R.), § 440.110.

(3) Physical therapy services, by contrast, shall require a signed and dated prescription from the student's physician prior to that student's initial evaluation, in accordance with OAC 317:30-5-291(1). Prescriptions for school-based physical therapy must be reauthorized at least annually, and documented within Oklahoma State Department of Education's (OSDE) online IEP system, as set forth in subsection (c), below.

(c) Qualified school providers must ensure that adequate documentation is maintained within the OSDE online IEP system in order to substantiate that all school-based services billed to SoonerCare are medically necessary and comply with applicable state and federal Medicaid law. Such documentation shall include, among other things:

(1) Documentation establishing sufficient notification to a member's parents and receipt of adequate, written consent from them, prior to accessing a member's or parent's public benefits or insurance for the first time, and annually thereafter, in accordance with 34 C.F.R. § 300.154;

(2) Any referral or prescription that is required by state or federal law for the provision of school-based services, or for the payment thereof, in whole or in part, from public funds, including, but not limited to, 42 C.F.R. § 440.110. However, any prescription or referral ordered by a physician or other licensed practitioner of the healing arts who has, or whose immediate family member has, a financial interest in the delivery of the underlying service in violation of Section 1395nn, Title 42 of United States Code shall

not be valid, and services provided thereto shall not be eligible for reimbursement by the Oklahoma Health Care Authority (OHCA); (3) An annual evaluation located in or attached to the IEP that clearly demonstrates, by means of the member's diagnosis and any other relevant supporting information, that school-based services are medically necessary, in accordance with OAC 317:30-3-1(f). Evaluations completed solely for educational purposes are not compensable. Evaluations must be completed annually and updated to accurately reflect the student's current status. Any evaluation for medically necessary school-based services, including but not limited to, hearing and speech services, physical therapy, occupational therapy, and psychological therapy, must include the following information:

- (A) Documentation that supports why the member was referred for evaluation;
- (B) A diagnosis that clearly establishes and supports the need for school-based services;
- (C) A summary of the member's strengths, needs, and interests;
- (D) The recommended interventions for identified needs, including outcomes and goals;
- (E) The recommended units and frequency of services; and
- (F) A dated signature and the credentials of the professional completing the evaluation; and

(4) Documentation that establishes the medical necessity of the school-based services being provided between annual evaluations, including, for example, professional notes or updates, reports, and/or assessments that are signed, dated, and credentialed by the rendering practitioner.

(d) All claims related to school-based services that are submitted to OHCA for reimbursement must include any numeric identifier obtained from OSDE.

[Source: Added at 14 Ok Reg 3707, eff 8-1-97 (emergency); Added at 15 Ok Reg 1528, eff 5-11-98 ; Amended at 17 Ok Reg 2394, eff 6-26-00 ; Amended at 19 Ok Reg 2134, eff 6-27-02 ; Amended at 31 Ok Reg 1684, eff 9-12-14 ; Amended at 35 Ok Reg 1401, eff 9-14-18 ; Amended at 38 Ok Reg 406, eff 12-18-20 (emergency); Amended at 38 Ok Reg 985, eff 9-1-21]

317:30-5-1021. Eligible providers

(a) Eligible providers are local, regional, and state educational services agencies as defined by state law and the Individuals with Disabilities Education Act (IDEA), as most recently amended (hereinafter, "school providers"). School providers must submit a completed contract to the Oklahoma Health Care Authority (OHCA), including a Special Provisions for Schools, and must receive approval thereof prior to receiving reimbursement for school-based services.

(b) Qualified school providers must notify OHCA of all subcontractors performing Individualized Education Program (IEP) related evaluations and services in the school setting prior to services being rendered. The notification must include a copy of the agreement between the school and subcontractor and must reflect the start and ending dates of the

agreement for services. All subcontractors must be individually contracted with SoonerCare and, if rendering services, must be identified on any claim for payment as the rendering provider.

[Source: Added at 14 Ok Reg 3707, eff 8-1-97 (emergency); Added at 15 Ok Reg 1528, eff 5-11-98 ; Amended at 17 Ok Reg 2394, eff 6-26-00 ; Amended at 31 Ok Reg 1684, eff 9-12-14 ; Amended at 35 Ok Reg 1401, eff 9-14-18]

317:30-5-1022. Periodicity schedule [REVOKED]

[Source: Added at 14 Ok Reg 3707, eff 8-1-97 (emergency); Added at 15 Ok Reg 1528, eff 5-11-98 ; Amended at 31 Ok Reg 1684, eff 9-12-14 ; Amended at 35 Ok Reg 1394, eff 10-1-18 ; Revoked at 37 Ok Reg 1486, eff 9-14-20]

317:30-5-1023. Coverage by category

(a) **Adults.** There is no coverage for services rendered to adults twenty-one (21) years of age and older.

(b) **Children.** For non-Individualized Education Program (IEP) medical services that can be provided in a school setting, refer to Part 4, Early And Periodic Screening, Diagnostic and Treatment (**EPSDT**) Program/Child-Health Services, of Oklahoma Administrative Code (OAC) at 317:30-3-65 through 317:30-3-65.12. Payment is made for the following compensable services rendered by qualified school providers:

(1) **Diagnostic encounters.** Diagnostic encounters are defined as those services necessary to fully evaluate defects, physical or behavioral health illnesses, or conditions discovered by the screening. Approved diagnostic encounters may include the following:

(A) **Hearing and hearing aid evaluation.** Hearing evaluation includes pure tone air, bone, and speech audiometry. Hearing evaluations must be provided by a state-licensed audiologist as listed in OAC 317:30-5-675 (d) (1) and (2).

(B) **Audiometry test.** Audiometric test (Immittance [Impedance] audiometry or tympanometry) includes bilateral assessment of middle ear status and reflex studies (when appropriate) provided by a state-licensed audiologist as listed in OAC 317:30-5-675 (d) (1) and (2).

(C) **Ear impression (for earmold).** Ear impression (for earmold) includes taking an impression of a member's ear and providing a finished earmold, to be used with the member's hearing aid as provided by a state-licensed audiologist as listed in OAC 317:30-5-675 (d) (1) and (2).

(D) **Vision screening.** Vision screening in schools includes application of tests and examinations to identify visual defects or vision disorders. The vision screening may be performed by a registered nurse (RN) or licensed practical nurse (LPN) under the supervision of an RN. The service can be billed when a SoonerCare member has an individualized documented concern that warrants a screening. A vision examination must be provided by a

state-licensed doctor of optometry (O.D.) or licensed physician specializing in ophthalmology (M.D. or D.O.). This vision examination, at a minimum, includes diagnosis and treatment for defects in vision.

(E) **Speech-language evaluation.** Speech-language evaluation is for the purpose of identification of children or adolescents with speech or language disorders and the diagnosis and appraisal of specific speech and language services. Speech-language evaluations must be provided by a fully licensed speech-language pathologist as listed in OAC 317:30-5-675 (a) (1) through (3).

(F) **Physical therapy evaluation.** Physical therapy evaluation includes evaluating the student's ability to move throughout the school and to participate in classroom activities and the identification of movement dysfunction and related functional problems. It must be provided by a fully licensed physical therapist as listed in OAC 317:30-5-290.1 (a) (1) and (2). Physical therapy evaluations must adhere to guidelines found at OAC 317:30-5-291.

(G) **Occupational therapy evaluation.** Occupational therapy evaluation services include determining what therapeutic services, assistive technology, and environmental modifications a student requires for participation in the special education program and must be provided by a fully licensed occupational therapist as listed in OAC 317:30-5-295 (a) (1) and (2). Occupational therapy evaluations must adhere to guidelines found at OAC 317:30-5-296.

(H) **Evaluation and testing.** Evaluation and testing by psychologists and certified school psychologists are for the purpose of assessing emotional, behavioral, cognitive, or developmental issues that are affecting academic performance and for determining recommended treatment protocol. Evaluation or testing for the sole purpose of academic placement (e.g., diagnosis of learning disorders) is not a compensable service. These evaluations and tests must be provided by a state-licensed, board-certified psychologist or a certified school psychologist certified by the State Department of Education (SDE).

(2) **Child-guidance treatment encounter.** A child-guidance treatment encounter may occur through the provision of individual, family, or group treatment services to children and adolescents who are identified as having specific disorders or delays in development, emotional or behavioral problems, or disorders of speech, language, or hearing. These types of encounters are initiated following the completion of a diagnostic encounter and subsequent development of a treatment plan, or as a result of an IEP and may include the following:

(A) **Hearing and vision services.** Hearing and vision services may include provision of habilitation activities,

such as: auditory training; aural and visual habilitation training including Braille, and communication management; orientation and mobility; and counseling for vision and hearing losses and disorders. Services must be provided by or under the direct guidance of one (1) of the following individuals practicing within the scope of his or her practice under state law:

(i) State-licensed audiologist as listed in OAC 317:30-5-675 (d) (1) and (2).

(ii) Fully licensed, speech-language pathologist as listed in OAC 317:30-5-675 (a) (1) through (3).

(iii) Certified orientation and mobility specialists.

(B) Speech-language therapy services. Speech-language therapy services include provisions of speech and language services for the habilitation or prevention of communicative disorders. Speech-language therapy services must be provided by or under the direct guidance and supervision of a fully licensed speech-language pathologist within the scope of his or her practice under state law as listed in OAC 317:30-5-675 (a) (1) through (3).

(C) Physical therapy services. Physical therapy services are provided for the purpose of preventing or alleviating movement dysfunction and related functional problems that adversely affect the member's education. Physical therapy services must adhere to guidelines found at OAC 317:30-5-291 and must be provided by or under the direct guidance and supervision of a fully licensed physical therapist; services may also be provided by a licensed physical therapy assistant who has been authorized by the Board of Examiners working under the supervision of a fully licensed physical therapist.

(D) Occupational therapy services. Occupational therapy may include provision of services to improve, develop, or restore impaired ability to function independently. Occupational therapy services must be provided by or under the direct guidance and supervision of a fully licensed occupational therapist; services may also be provided by a licensed occupational therapy assistant who has been authorized by the Board of Examiners, working under the supervision of a licensed occupational therapist.

(E) Nursing services. Nursing services may include provision of services to protect the health status of children and adolescents, correct health problems and assist in removing or modifying health-related barriers, and must be provided by a RN or LPN under supervision of a RN. Services include medically necessary procedures rendered at the school site, such as catheterization, suctioning, tube feeding, and administration and monitoring of medication.

(F) **Counseling services.** All services must be for the direct benefit of the member. Counseling services must be provided by a state-licensed social worker, a state-licensed professional counselor, a state-licensed psychologist or SDE-certified school psychologist, a state-licensed marriage and family therapist, or a state-licensed behavioral health practitioner, or under Board supervision to be licensed in one (1) of the above-stated areas.

(G) **Assistive technology.** Assistive technology is the provision of services that help to select a device and assist a student with disability(ies) to use an assistive technology device, including coordination with other therapies and training of member and caregiver. Services must be provided by a:

- (i) Fully licensed speech-language pathologist as listed in OAC 317:30-5-675 (a) (1) through (3);
- (ii) Fully licensed physical therapist as listed in OAC 317:30-5-290.1 (a) (1) and (2); or
- (iii) Fully licensed occupational therapist as listed in OAC 317:30-5-295 (a) (1) and (2).

(H) **Personal care.** Provision of personal care services (PCS) allow students with disabilities to safely attend school. Services include, but are not limited to: dressing, eating, bathing, assistance with transferring and toileting, positioning, and instrumental activities of daily living such as preparing meals and managing medications. PCS also includes assistance while riding a school bus to handle medical or physical emergencies. Services must be provided by registered paraprofessionals that have completed training approved or provided by SDE, or personal care assistants, including LPNs, who have completed on-the-job training specific to their duties. PCS does not include behavioral monitoring. Paraprofessionals are not allowed to administer medication, nor are they allowed to assist with or provide therapy services to SoonerCare members. Tube feeding of any type may only be reimbursed if provided by a RN or LPN. Catheter insertion and catheter/ostomy care may only be reimbursed when done by a RN or LPN. All PCS must be prior authorized.

(I) **Therapeutic behavioral services (TBS).** Services are goal-directed activities for each client to restore, retain and improve the self-help, socialization, communication, and adaptive skills necessary to reside successfully in home and community-based settings. It also includes problem identification and goal setting, medication support, restoring function, and providing support and redirection when needed. TBS activities are behavioral interventions to complement more intensive behavioral health services and may include the following components: basic living and self-help skills; social skills;

communication skills; organization and time management; and transitional living skills. This service must be provided by a behavioral health school aide (BHSA) who has a high school diploma or equivalent and has successfully completed training approved by the SDE, and in collaboration with the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS), along with corresponding continuing education. BHSA must be supervised by a bachelor's level individual with a special education certification. BHSA must have Cardiopulmonary resuscitation (CPR) and first aid certification. Six (6) additional hours of related continuing education are required per year.

(c) Members eligible for Part B of Medicare. EPSDT school health-related services provided to Medicare eligible members are billed directly to the fiscal agent.

[Source: Added at 14 Ok Reg 3707, eff 8-1-97 (emergency); Added at 15 Ok Reg 1528, eff 5-11-98 ; Amended at 16 Ok Reg 1927, eff 6-11-99 ; Amended at 17 Ok Reg 2394, eff 6-26-00 ; Amended at 18 Ok Reg 2579, eff 6-25-01 ; Amended at 27 Ok Reg 706, eff 2-4-10 through 7-14-10 (emergency); Amended at 27 Ok Reg 2387, eff 7-15-10 (emergency); Amended at 28 Ok Reg 1431, eff 6-25-11 ; Amended at 29 Ok Reg 1098, eff 6-25-12 ; Amended at 31 Ok Reg 1684, eff 9-12-14 ; Amended at 35 Ok Reg 1401, eff 9-14-18 ; Amended at 37 Ok Reg 1486, eff 9-14-20 ; Amended at 38 Ok Reg 411, eff 2-1-21 (emergency); Amended at 38 Ok Reg 1006, eff 9-1-21 ; Amended at 39 Ok Reg 1425, eff 9-12-22]

317:30-5-1024. Periodic screening examination [REVOKED]

[Source: Added at 14 Ok Reg 3707, eff 8-1-97 (emergency); Added at 15 Ok Reg 1528, eff 5-11-98 ; Revoked at 37 Ok Reg 1486, eff 9-14-20]

317:30-5-1025. Interperiodic screening examination [REVOKED]

[Source: Added at 14 Ok Reg 3707, eff 8-1-97 (emergency); Added at 15 Ok Reg 1528, eff 5-11-98 ; Amended at 31 Ok Reg 1684, eff 9-12-14 ; Revoked at 37 Ok Reg 1486, eff 9-14-20]

317:30-5-1026. Reporting of suspected abuse/neglect

Instances of child abuse and/or neglect are to be reported in accordance with state law, including, but not limited to, Section (§) 1-2-101 of Title 10A of the Oklahoma Statutes and 43A O.S. § 10-104. Any person suspecting child abuse or neglect shall immediately report it to the Oklahoma Department of Human Services (OKDHS) hotline, at 1-800-522-3511; any person suspecting abuse, neglect, or exploitation of a vulnerable adult shall immediately report it to the local DHS County Office, municipal or county law enforcement authorities, or, if the report occurs after normal business hours, the OKDHS hotline. Health care professionals who are requested to report incidents of domestic abuse by adult victims with legal capacity shall promptly make a report to the nearest law enforcement agency, per 22 O.S. § 58.

[Source: Added at 14 Ok Reg 3707, eff 8-1-97 (emergency); Added at 15 Ok Reg 1528, eff 5-11-98 ; Amended at 26 Ok Reg 2081, eff 6-25-09 ; Amended at 37 Ok Reg 1486, eff 9-14-20]

317:30-5-1027. Billing

Each service has a specified unit of service (unit) for billing purposes which represents the actual time spent providing a direct service. Direct service must be face-to face with the child. There is no reimbursement for time reviewing/completing paperwork and/or documentation related to the service or for staff travel to/from the site of service, unless otherwise specified.

(1) Most units of service are time-based, meaning that the service must be of a minimum duration in order to be billed. A unit of service that is time-based is continuous minutes; the time cannot be aggregated throughout the day.

(2) There are no minimum time requirements for evaluation services, for which the unit of service is generally a completed evaluation. The only exception is the evaluation and testing (OAC 317:30-5-1023(b)(1)(H), which is billed in hourly increments.

[Source: Added at 14 Ok Reg 3707, eff 8-1-97 (emergency); Added at 15 Ok Reg 1528, eff 5-11-98 ; Amended at 16 Ok Reg 1927, eff 6-11-99 ; Amended at 17 Ok Reg 2394, eff 6-26-00 ; Amended at 18 Ok Reg 3633, eff 5-22-01 (emergency); Amended at 18 Ok Reg 2579, eff 6-25-01 ; Amended at 19 Ok Reg 1067, eff 5-13-02 ; Amended at 19 Ok Reg 2134, eff 6-27-02 ; Amended at 27 Ok Reg 706, eff 2-4-10 through 7-14-10 (emergency); Amended at 27 Ok Reg 2387, eff 7-15-10 (emergency); Amended at 28 Ok Reg 1431, eff 6-25-11 ; Amended at 29 Ok Reg 1098, eff 6-25-12 ; Amended at 31 Ok Reg 1684, eff 9-12-14 ; Amended at 34 Ok Reg 696, eff 9-1-17 ; Amended at 37 Ok Reg 1486, eff 9-14-20]

317:30-5-1028. Billing [REVOKED]

[Source: Added at 14 Ok Reg 3707, eff 8-1-97 (emergency); Added at 15 Ok Reg 1528, eff 5-11-98 ; Amended at 17 Ok Reg 2394, eff 6-26-00 ; Revoked at 19 Ok Reg 2134, eff 6-27-02]

PART 104. SCHOOL-BASED CASE MANAGEMENT SERVICES

317:30-5-1030. Eligible providers

(a) **Case management providers.** Services are provided by case managers certified by the State Department of Education as meeting the requirements for providing case management. SoonerCare School-Based Targeted Case Management (SBTCM) services must be made available to all eligible members and must be delivered on a statewide basis with procedures that ensure continuity of service without duplication and in compliance with federal and state mandates and regulations related to servicing the targeted population in a uniform and consistent manner. The case managers must be certified by the single state Medicaid agency as meeting the following:

(1) a minimum of five (5) years experience in meeting the case management and service needs of the target population.

(2) a minimum of five (5) years experience in providing all core elements of case management services, including:

- (A) individualized strengths and needs assessment;
- (B) needs-based service planning;
- (C) service coordination, monitoring and advocacy;
- (D) service plan review; and
- (E) crisis assistance planning.

(3) a minimum of five (5) years experience in developing and implementing Individualized Education Programs (IEP) and/or Individualized Family Service Plans (IFSP) and in meeting the requirements of the IDEA, in accordance with State and Federal law. Each IEP and/or IFSP is dependent upon the needs of the individual student as determined by consultation that may include any or all of the professions in (A) through (F) of this paragraph. Those providing input must meet state or national licensure, registration or certification requirements of the profession in which they practice and include:

- (A) special education,
- (B) school psychologist,
- (C) occupational therapist,
- (D) physical therapist,
- (E) speech language specialist, or
- (F) school counselor and other specialists as identified.

(4) a demonstrated ability to collaborate with public and private services providers.

(5) experience in providing and coordinating education support services, including but not limited to Student Assistance, Special Education, Psychology and Counseling Services.

(6) adequate administrative capacity to fulfill state and federal requirements.

(7) a financial management capacity and system that provides documentation of services and costs.

(8) a capacity to document and maintain individual case records in accordance with state and federal requirements.

(9) a demonstrated ability to meet all state and federal laws governing participation of providers in the SoonerCare program including, but not limited to, the ability to meet federal and state requirements for documentation, billing and audits.

(b) Provider agreement. A Provider Agreement between the Oklahoma Health Care Authority and the providers for case management services must be in effect before reimbursement can be made for compensable services.

(c) Qualifications of individual case managers. A targeted case manager for the SBTCM program must:

- (1) be employed by the school or their contractor;
- (2) possess an appropriate certificate, or meet other comparable requirements as applicable to the profession or discipline in which a person is providing special education, early intervention or related services, in accordance with the requirements of the Oklahoma State Department of Education; or
- (3) be licensed, certified or registered as a health care professional in the State, and meet the qualifications for related services staff under the most current provisions of Part B or Part C of the Individuals with Disabilities Education Act.

(d) Provider selection. Provision of case management services must not restrict an individual's free choice of providers. Eligible members must have free choice of the providers of other medical care under the plan.

[Source: Added at 16 Ok Reg 1927, eff 6-11-99 ; Amended at 17 Ok Reg 2399, eff 6-26-00 ; Amended at 31 Ok Reg 1684, eff 9-12-14]

317:30-5-1031. Coverage by category

(a) Payment is made for case management services to children as set forth in this Section.

(1) **Description of case management services.** The target group for case management services is individuals 0-21 who are receiving services pursuant to an Individualized Education Program (IEP), an Individualized Family Service Plan (IFSP), a Section 504 Accommodation Plan, or an Individualized Health Service Plan (IHSP), and who have a disability or are medically at risk. A disability is defined as a physical or mental impairment that substantially limits one or more major life activities. Medically at risk refers to individuals who have a diagnosable physical or mental condition that has a high probability of impairing cognitive, emotional, neurological, social or physical development.

(A) Services are provided to assist the target population in gaining access to needed medical, social, educational, and other services. Major components of the service include:

- (i) Individualized needs assessment
- (ii) Needs-based service planning;
- (iii) Service coordination, monitoring and advocacy;
- (iv) Services plan review; and
- (v) Crisis assistance planning.

(B) Case record documentation of the service components listed in (1) of this subsection is included as a case management activity. The client has the right to refuse case management and cannot be restricted from services because of a refusal for Case Management Services.

(C) Case management does not include:

- (i) Program activities of the agency itself that do not meet the definition of case management.
- (ii) Administrative activities necessary for the operation of the agency providing case management services other than the overhead costs directly attributable to targeted case management.
- (iii) Diagnostic, treatment or instructional services, including academic testing.
- (iv) Services that are an integral part of another service already reimbursed by SoonerCare.
- (v) Activities that are an essential part of SoonerCare administration, such as outreach, intake processing, eligibility determination or claims processing.

(2) **Non-duplication of services.** To the extent any eligible members in the identified targeted population are receiving TCM

services from another provider agency as a result of being members of other covered targeted groups, the providers assures that case management activities are coordinated to avoid unnecessary duplication of service. To the extent any of the services required by the member are a SoonerCare covered benefit of a managed care organization of which the client is a member, the provider will assure that timely referrals are made and that coordination of care occurs.

(3) **Providers.** Case management services must be provided by the schools or their contractors.

(b) **Individuals eligible for Part B of Medicare.** Case Management Services provided to Medicare eligible members are filed directly with the fiscal agent.

[Source: Added at 16 Ok Reg 1927, eff 6-11-99 ; Amended at 19 Ok Reg 63, eff 9-1-01 (emergency); Amended at 19 Ok Reg 2127, eff 6-27-02 ; Amended at 31 Ok Reg 1684, eff 9-12-14]

317:30-5-1032. Reimbursement

(a) Reimbursement for SBTCM services is a unit rate based on the analysis of the average annual costs of providing case management services by participating providers. A unit of service is defined as each completed 10 minute increment that meets the description of case management activity with, or on behalf of the individual, his or her parent(s) or legal guardian.

(b) Payment will be made on the basis of claims submitted for payment. The provider will bill for the unit rate for each documented unit of SoonerCare SBTCM service provided to each SoonerCare eligible individual.

[Source: Added at 16 Ok Reg 1927, eff 6-11-99 ; Amended at 31 Ok Reg 1684, eff 9-12-14]

317:30-5-1033. Billing

Claims should not be submitted until SoonerCare eligibility of the individual has been determined. However, a claim must be received by OHCA within six (6) months of the date of service. If the eligibility of the individual has not been determined after four (4) months from the date of service, a claim should be submitted in order to assure that the claim is filed and reimbursement can be made should the individual be determined eligible at a later date.

[Source: Added at 16 Ok Reg 1927, eff 6-11-99 ; Amended at 19 Ok Reg 2134, eff 6-27-02 ; Amended at 31 Ok Reg 1684, eff 9-12-14 ; Amended at 34 Ok Reg 696, eff 9-1-17]

317:30-5-1034. Documentation of records

All case management services rendered must be reflected by documentation in the records. The case manager documents all units of SoonerCare SBTCM services provided on the service record form.

[Source: Added at 16 Ok Reg 1927, eff 6-11-99 ; Amended at 31 Ok Reg 1684, eff 9-12-14]

PART 105. RESIDENTIAL BEHAVIORAL MANAGEMENT SERVICES IN GROUP SETTINGS

317:30-5-1040. Organized health care delivery system

The OHCA recognizes an Organized Health Care Delivery System (OHCDS) as an entity with an identifiable component within its mission which is organized for the purpose of delivering health care. The entity must furnish at least one service covered by the Oklahoma Medicaid State Plan itself (i.e. through its own employees). Those employees who furnish each service must meet the State's minimum qualifications for its provision. So long as the entity continues to furnish at least one service itself, it may contract with other qualified providers to furnish Medicaid covered services.

[Source: Added at 15 Ok Reg 538, eff 11-5-97 (emergency); Added at 15 Ok Reg 1528, eff 5-11-98 ; Amended at 27 Ok Reg 623, eff 1-14-10 through 7-14-10 (emergency)¹]

Editor's Note: ¹*This emergency action expired without being superseded by a permanent action. Upon expiration of an emergency amendatory action, the last effective permanent text is reinstated. Therefore, on 7-15-10 (after the 7-14-10 expiration of this emergency action), the text of 317:30-5-1040 reverted back to the permanent text that became effective 5-11-98, as was last published in the 2006 Edition of the OAC.*

317:30-5-1041. Eligible providers

Payment is made for Residential Behavior Management Services (RBMS) in group settings to any Organized Health Care Delivery System (OHCDS) that is a child placing agency, that has a statutory authority for the care of children in the custody of the State of Oklahoma and which enters into a contract with the State Medicaid program. The OHCDS must certify to the Oklahoma Health Care Authority (OHCA) that all direct providers of services (whether furnished through its own employees or under contract) meet the minimum program qualifications. RBMS are covered only for those beds contracted by the OHCDS.

[Source: Added at 15 Ok Reg 538, eff 11-5-97 (emergency); Added at 15 Ok Reg 1528, eff 5-11-98 ; Amended at 27 Ok Reg 623, eff 1-14-10 through 7-14-10 (emergency)¹; Amended at 36 Ok Reg 908, eff 9-1-19]

Editor's Note: ¹*This emergency action expired without being superseded by a permanent action. Upon expiration of an emergency amendatory action, the last effective permanent text is reinstated. Therefore, on 7-15-10 (after the 7-14-10 expiration of this emergency action), the text of 317:30-5-1041 reverted back to the permanent text that became effective 5-11-98, as was last published in the 2006 Edition of the OAC and republished in the 2011 and 2016 Editions of the OAC, and remained as such until amended by permanent action on 9-1-19.*

317:30-5-1042. Memorandum of agreement

A Memorandum of Agreement between the Oklahoma Health Care Authority (OHCA) and the Organized Health Care Delivery System (OHCDS) must be in effect before reimbursement can be made for compensable services. The agreement outlines the contractual and subcontractual requirements for reimbursement. This agreement provides that the OHCDS is responsible for the Medicaid state share required for federal financial participation for all Residential Behavior Management Services (RBMS) provided to custody children in residential group homes.

[**Source:** Added at 15 Ok Reg 538, eff 11-5-97 (emergency); Added at 15 Ok Reg 1528, eff 5-11-98 ; Amended at 27 Ok Reg 623, eff 1-14-10 through 7-14-10 (emergency)¹; Amended at 36 Ok Reg 908, eff 9-1-19]

Editor's Note: ¹*This emergency action expired without being superseded by a permanent action. Upon expiration of an emergency amendatory action, the last effective permanent text is reinstated. Therefore, on 7-15-10 (after the 7-14-10 expiration of this emergency action), the text of 317:30-5-1042 reverted back to the permanent text that became effective 5-11-98, as was last published in the 2006 Edition of the OAC and republished in the 2011 and 2016 Editions of the OAC, and remained as such until amended by permanent action on 9-1-19.*

317:30-5-1043. Coverage by category

(a) **Adults.** Residential Behavioral Management Services (RBMS) in group settings are not covered for adults.

(b) **Children.** RBMS in group settings are covered for children as set forth in this subsection.

(1) **Description.** RBMS are provided by Organized Health Care Delivery Systems (OHCDS) for children in the care and custody of the State who have special psychological, behavioral, emotional and social needs that require more intensive care than can be provided in a family or foster home setting. The behavior management services are provided in the least restrictive environment and within a therapeutic milieu. The group setting is restorative in nature, allowing children with emotional and psychological problems to develop the necessary control to function in a less restrictive setting. RBMS are reimbursed in accordance with established rate methodology as described in the Oklahoma Medicaid State Plan. It is expected that RBMS in group settings are an all-inclusive array of treatment services provided in one (1) day. In the case of a child who needs additional specialized services, under the Rehabilitation Option or by a psychologist, prior authorization by the OHCA or designated agent is required. Only specialized rehabilitation or psychological treatment services to address unique, unusual or severe symptoms or disorders will be authorized. If additional services are approved, the OHCDS collaborates with the provider of such

services as directed by the OHCA or its agent. Any additional specialized behavioral health services provided to children in state custody are funded in the normal manner. The OHCDS must provide concurrent documentation that these services are not duplicative. The OHCDS determines the need for RBMS.

(2) **Medical necessity criteria.** The following medical necessity criteria must be met for RBMS.

(A) Any Diagnostic and Statistical Manual of Mental Disorders (DSM) primary diagnosis, with the exception of V codes, with a detailed description of the symptoms supporting the diagnosis. A detailed description of the child's emotional, behavioral and psychological condition must be on file.

(B) The child is medically stable and not actively suicidal or homicidal and not in need of substance abuse detoxification services.

(C) It has been determined by the OHCDS that the current disabling symptoms could not have been or have not been manageable in a less intensive treatment program.

(D) Documentation that the child's presenting emotional and/or behavioral problems prevent the child from living in a traditional family home. The child requires the availability of twenty-four (24) hour crisis response/behavior management and intensive clinical interventions from professional staff.

(E) The agency which has permanent or temporary custody of the child agrees to active participation in the child's treatment needs and planning.

(F) All of the medical necessity criteria must also be met for continued stay in residential group settings.

(3) **Treatment components.**

(A) **Individual plan of care development.** A comprehensive individualized plan of care for each resident shall be formulated by the provider agency staff within thirty (30) days of admission, for intensive treatment services (ITS) level within seventy-two (72) hours, with documented input from the agency which has permanent or temporary custody of the child and when possible, the parent. This plan must be revised and updated at least every three (3) months, every seven (7) days for ITS, with documented involvement of the agency which has permanent or temporary custody of the child. Documented involvement can be written approval of the individual plan of care by the agency which has permanent or temporary custody of the child and indicated by the signature of the agency case worker or liaison on the individual plan of care. It is acceptable in circumstances where it is necessary to fax a service plan to someone for review and then have him/her fax back his/her signature; however, the provider obtains the original signature for the clinical file within thirty (30) days. No stamped or

Xeroxed signatures are allowed. An individual plan of care is considered inherent in the provision of therapy and is not covered as a separate item of behavior management services. The individual plan of care is individualized taking into account the child's age, history, diagnosis, functional levels, and culture. It includes appropriate goals and time limited and measurable objectives. Each member's individual plan of care must also address the provider agency's plans with regard to the provision of services in each of the following areas:

- (i) Group therapy;
- (ii) Individual therapy;
- (iii) Family therapy;
- (iv) Alcohol and other drug counseling;
- (v) Basic living skills redevelopment;
- (vi) Social skills redevelopment;
- (vii) Behavior redirection; and
- (viii) The provider agency's plan to access appropriate educational placement services. (Any educational costs are excluded from calculation of the daily rate for behavior management services.)

(B) **Individual therapy.** The provider agency must provide individual therapy on a weekly basis with a minimum of one (1) or more sessions totaling one (1) hour or more of treatment per week to children and youth receiving RBMS in group homes. Individual therapy must be age appropriate and the techniques and modalities employed relevant to the goals and objectives of the individual's plan of care. Individual counseling is a face-to-face, one-to-one service, and must be provided in a confidential setting.

(C) **Group therapy.** The provider agency must provide group therapy to children and youth receiving RBMS. Group therapy must be a face-to-face interaction, age appropriate and the techniques and modalities employed relevant to the goals and objectives of the individual's plan of care. The minimum expected occurrence would be one (1) hour per week in group homes. Group size should not exceed six (6) members and group therapy sessions must be provided in a confidential setting. Thirty (30) minutes of individual therapy may be substituted for one (1) hour of group therapy.

(D) **Family therapy.** Family therapy is a face-to-face interaction between the therapist/counselor and family, to facilitate emotional, psychological or behavioral changes and promote successful communication and understanding. The provider agency must provide family therapy as indicated by the resident's individual plan of care. The agency must work with the caretaker to whom the resident will be discharged, as identified by the OHCDs custody worker. The agency must seek to support

and enhance the child's relationships with family members (nuclear and appropriate extended), if the custody plan for the child indicates family reunification. The RBMS provider must also seek to involve the child's parents in treatment team meetings, plans and decisions and to keep them informed of the child's progress in the program. Any service provided to the family must have the child as the focus.

(E) **Alcohol and other drug abuse treatment education, prevention, therapy.** The provider agency must provide alcohol and other drug abuse treatment for residents who have emotional or behavioral problems related to substance abuse/chemical dependency, to begin, maintain and enhance recovery from alcoholism, problem drinking, drug abuse, drug dependency addiction or nicotine use and addiction. This service is considered ancillary to any other formal treatment program in which the child participates for treatment and rehabilitation. For residents who have no identifiable alcohol or other drug use, abuse, or dependency, age appropriate education and prevention activities are appropriate. These may include self-esteem enhancement, violence alternatives, communication skills or other skill development curriculums.

(F) **Basic living skills redevelopment.** The provider agency must provide goal-directed activities designed for each resident to restore, retain, and improve those basic skills necessary to independently function in a family or community. Basic living skills redevelopment is age appropriate and relevant to the goals and objectives of the individual plan of care. This may include, but is not limited to food planning and preparation, maintenance of personal hygiene and living environment, household management, personal and household shopping, community awareness and familiarization with community resources, mobility skills, job application and retention skills.

(G) **Social skills redevelopment.** The provider agency must provide goal-directed activities designed for each resident to restore, retain and improve the self-help, communication, socialization, and adaptive skills necessary to reside successfully in home and community based settings. These are age appropriate, culturally sensitive and relevant to the goals of the individual plan of care. For ITS level of care, the minimum skill redevelopment per day is three (3) hours. Any combination of basic living skills and social skills redevelopment that is appropriate to the need and developmental abilities of the child is acceptable.

(H) **Behavior redirection.** The provider agency must be able to provide behavior redirection management by agency staff as needed twenty-four (24) hours a day, seven

(7) days per week. The agency must ensure staff availability to respond in a crisis to stabilize residents' behavior and prevent placement disruption. In addition, ITS group homes will be required to provide crisis stabilization interaction and treatment for new residents twenty-four (24) hours a day, seven (7) days a week.

(4) **Providers.** For eligible RBMS agencies to bill the OHCA for services provided by their staff for behavior management therapies (individual, group, family) as of July 1, 2007, providers must have the following qualifications:

(A) Be licensed in the state in which the services are delivered as a licensed psychologist, social worker (clinical specialty only), professional counselor, marriage and family therapist, or behavioral practitioner, alcohol and drug counselor or under Board approved supervision to be licensed in one (1) of the above stated areas; or

(B) Be licensed as an advanced practice registered nurse (APRN) certified in a psychiatric mental health specialty, and licensed as a registered nurse (RN) with a current certification of recognition from the Board of Nursing in the state in which services are provided; and

(C) Demonstrate a general professional or educational background in the following areas:

(i) Case management, assessment and treatment planning;

(ii) Treatment of victims of physical, emotional, and sexual abuse;

(iii) Treatment of children with attachment disorders;

(iv) Treatment of children with hyperactivity or attention deficit disorders;

(v) Treatment methodologies for emotionally disturbed children and youth;

(vi) Normal childhood development and the effect of abuse and/or neglect on childhood development;

(vii) Treatment of children and families with substance abuse and chemical dependency disorders;

(viii) Anger management; and

(ix) Crisis intervention.

(D) Staff providing basic living skills redevelopment, social skills redevelopment, and alcohol and other substance abuse treatment, must meet one (1) of the following areas:

(i) Bachelor's or master's degree in a behavioral health related field including but not limited to, psychology, sociology, criminal justice, school guidance and counseling, social work, occupational therapy, family studies, alcohol and drug; or

(ii) Currently licensed and in good standing as an RN in the state in which services are provided; or

(iii) Certification as an alcohol and drug counselor to provide substance abuse rehabilitative treatment to those with alcohol and/or other drug dependencies or addictions as a primary or secondary DSM diagnosis; or
(iv) Current certification as a behavioral health case manager from the Oklahoma Department of Mental Health and Substance Abuse (ODMHSAS) and meets OHCA requirements to perform case management services, as described in Oklahoma Administrative Code (OAC) 317:30-5-240 through 317:30-5-249.

(E) Staff providing behavior redirection services must have current certification and required updates in nationally recognized behavior management techniques, such as Controlling Aggressive Patient Environment (CAPE) or MANDT. Additionally, staff providing these services must receive initial and ongoing training in at least one (1) of the following areas:

- (i) Trauma-informed methodology;
- (ii) Anger management;
- (iii) Crisis intervention;
- (iv) Normal child and adolescent development and the effect of abuse;
- (v) Neglect and/or violence on such development;
- (vi) Grief and loss issues for children in out of home placement;
- (vii) Interventions with victims of physical, emotional and sexual abuse;
- (viii) Care and treatment of children with attachment disorders;
- (ix) Care and treatment of children with hyperactive, or attention deficit, or conduct disorders;
- (x) Care and treatment of children, youth and families with substance abuse and chemical dependency disorders;
- (xi) Passive physical restraint procedures; or
- (xii) Procedures for working with delinquents or the Inpatient Mental Health and Substance Abuse Treatment of Minors Act.

(F) In addition, behavior management staff must have access to consultation with an appropriately licensed mental health professional.

[Source: Added at 15 Ok Reg 538, eff 11-5-97 (emergency); Added at 15 Ok Reg 703, eff 11-12-97 (emergency); Added at 15 Ok Reg 1528, eff 5-11-98 ; Amended at 60 Ok Reg 55, eff 9-11-98 (emergency); Amended at 16 Ok Reg 159, eff 10-14-98 (emergency); Amended at 16 Ok Reg 691, eff 12-31-98 (emergency); Amended at 16 Ok Reg 1429, eff 5-27-99 ; Amended at 18 Ok Reg 492, eff 1-1-01 (emergency); Amended at 18 Ok Reg 1130, eff 5-11-01 ; Amended at 21 Ok Reg 415, eff 1-1-04 (emergency); Amended at 21 Ok Reg 2230, eff 6-25-04 ; Amended at 23 Ok Reg 2572, eff 6-25-06 ; Amended at 24 Ok Reg 2862, eff 7-1-07 (emergency); Amended at 25 Ok Reg 1200, eff 5-25-08 ; Amended at 27 Ok Reg 623, eff 1-14-10 through 7-14-10 (emergency)¹; Amended at 33 Ok Reg 804, eff

9-1-16 ; Amended at 36 Ok Reg 908, eff 9-1-19 ; Amended at 37 Ok Reg 1512, eff 9-14-20]

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317:30-5-1044. Payment rates

A per diem rate is established for each residential level of care in which behavior management services are provided. The payment is an all-inclusive daily rate for all behavior management services provided under the auspices of the Organized Health Care Delivery System (OHCDS). Room and board costs, educational costs and related administrative costs are not reimbursable and are excluded from the calculation of the daily rate. Residential Behavioral Management Services (RBMS) are limited to a maximum of one (1) service per day per eligible recipient.

[**Source:** Added at 15 Ok Reg 538, eff 11-5-97 (emergency); Added at 15 Ok Reg 1528, eff 5-11-98 ; Amended at 18 Ok Reg 492, eff 1-1-01 (emergency); Amended at 18 Ok Reg 1130, eff 5-11-01 ; Amended at 19 Ok Reg 2134, eff 6-27-02 ; Amended at 27 Ok Reg 623, eff 1-14-10 through 7-14-10 (emergency)¹; Amended at 36 Ok Reg 908, eff 9-1-19]

Editor's Note: ¹*This emergency action expired without being superseded by a permanent action. Upon expiration of an emergency amendatory action, the last effective permanent text is reinstated. Therefore, on 7-15-10 (after the 7-14-10 expiration of this emergency action), the text of 317:30-5-1044 reverted back to the permanent text that became effective 6-27-02, as was last published in the 2006 Edition of the OAC and republished in the 2011 and 2016 Editions of the OAC, and remained as such until amended by permanent action on 9-1-19.*

317:30-5-1045. Billing

- (a) Billing is on the HCFA-1500.
- (b) Claims must be submitted in accordance with guidelines found at OAC 317:30-3-11 and 317:30-3-11.1.

[**Source:** Added at 15 Ok Reg 538, eff 11-5-97 (emergency); Added at 15 Ok Reg 1528, eff 5-11-98 ; Amended at 27 Ok Reg 623, eff 1-14-10 through 7-14-10 (emergency)¹; Amended at 32 Ok Reg 719, eff 7-1-15 (emergency); Amended at 33 Ok Reg 791, eff 9-1-16]

Editor's Note: ¹*This emergency action expired without being superseded by a permanent action. Upon expiration of an emergency amendatory action, the last effective permanent text is reinstated. Therefore, on 7-15-10 (after the 7-14-10 expiration of this emergency*

action), the text of 317:30-5-1045 reverted back to the permanent text that became effective 5-11-98, as was last published in the 2006 Edition of the OAC, and remained as such until amended again by emergency action on 7-1-15.

317:30-5-1046. Documentation of records and records review

(a) The Organized Health Care Delivery System (OHCDS) and the facilities with whom it contracts must maintain appropriate records system. Current individual plans of care, case files, and progress notes are maintained in the facilities' files during the time the child or youth is receiving services. All services rendered must be reflected by documentation in the case records.

(b) The Oklahoma Health Care Authority (OHCA) and the Centers for Medicare and Medicaid Services (CMS) may evaluate through inspection or other means, the quality, appropriateness and timeliness of services provided by the OHCDS or facilities with whom it contracts.

(c) All Residential Behavioral Management Services (RBMS) in group settings must be reflected by documentation in the patients' records. Individual, group, family, and alcohol and other drug counseling and social and basic living skills development services must include all of the following:

- (1) Date;
- (2) Start and stop time for each session;
- (3) Signature of the therapist/staff providing service;
- (4) Credentials of therapist/staff providing service;
- (5) Specific problem(s) addressed (problem must be identified on individualized plan of care);
- (6) Methods used to address problem(s);
- (7) Progress made toward goals;
- (8) Patient response to the session or intervention; and
- (9) Any new problem(s) identified during the session.

[Source: Added at 15 Ok Reg 538, eff 11-5-97 (emergency); Added at 15 Ok Reg 1528, eff 5-11-98 ; Amended at 18 Ok Reg 492, eff 1-1-01 (emergency); Amended at 18 Ok Reg 1130, eff 5-11-01 ; Amended at 21 Ok Reg 415, eff 1-1-04 (emergency); Amended at 21 Ok Reg 2230, eff 6-25-04 ; Amended at 24 Ok Reg 2862, eff 7-1-07 (emergency); Amended at 25 Ok Reg 1200, eff 5-25-08 ; Amended at 27 Ok Reg 623, eff 1-14-10 through 7-14-10 (emergency)¹; Amended at 36 Ok Reg 908, eff 9-1-19]

Editor's Note: ¹*This emergency action expired without being superseded by a permanent action. Upon expiration of an emergency amendatory action, the last effective permanent text is reinstated. Therefore, on 7-15-10 (after the 7-14-10 expiration of this emergency action), the text of 317:30-5-1046 reverted back to the permanent text that became effective 5-25-08, as was last published in the 2009 OAC Supplement and republished in the 2010 OAC Supplement and the 2011 and 2016 Editions of the OAC, and remained as such until amended by permanent action on 9-1-19.*

317:30-5-1047. Confidentiality of information

In accordance with the provisions of 42 CFR 431, Subpart F, the OHCDS and the facilities with whom it contracts must safeguard

information about the client.

[Source: Added at 15 Ok Reg 538, eff 11-5-97 (emergency); Added at 15 Ok Reg 1528, eff 5-11-98 ; Amended at 27 Ok Reg 623, eff 1-14-10 through 7-14-10 (emergency)¹]

Editor's Note: ¹*This emergency action expired without being superseded by a permanent action. Upon expiration of an emergency amendatory action, the last effective permanent text is reinstated. Therefore, on 7-15-10 (after the 7-14-10 expiration of this emergency action), the text of 317:30-5-1047 reverted back to the permanent text that became effective 5-11-98, as was last published in the 2006 Edition of the OAC.*

PART 108. NUTRITION SERVICES

317:30-5-1075. Eligible providers

Payment is made for compensable services to dietitians licensed in the state where they practice. Each dietitian must have a current contract with the Oklahoma Health Care Authority (OHCA).

[Source: Added at 17 Ok Reg 2401, eff 6-26-00]

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 (6) hours of medically necessary nutritional counseling per year by a licensed registered dietitian. All services must be prescribed by a physician, physician assistant (PA), advanced practice registered nurse (APRN), or certified nurse midwife (CNW), 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.** Payment is made for medically necessary nutritional counseling as described above for adults. Nutritional services for the treatment of obesity may be covered for children as part of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. Additional services which are deemed medically necessary and allowable under federal regulations may be covered by the EPSDT benefit found at OAC 317:30-3-65 through 317:30-3-65.12.

(3) **Home and community-based services (HCBS) waiver for the intellectually disabled.** All providers participating in the HCBS waiver for the intellectually disabled program must have a separate contract with the Oklahoma Health Care Authority (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 (6) 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 (2) hours of class time. Thereafter, four (4) 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 six (6) weeks after delivery. All services must be prescribed by a physician, PA, APRN, or CNM 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.

[Source: Added at 17 Ok Reg 2401, eff 6-26-00 ; Amended at 19 Ok Reg 2922, eff 7-1-02 (emergency); Amended at 20 Ok Reg 1193, eff 5-27-03 ; Amended at 24 Ok Reg 678, eff 2-1-07 (emergency); Amended at 24 Ok Reg 2094, eff 6-25-07 ; Amended at 26 Ok Reg 254, eff 12-1-08 (emergency); Amended at 26 Ok Reg 1059, eff 5-11-09 ; Amended at 28 Ok Reg 1477, eff 6-25-11 ; Amended at 29 Ok Reg 1076, eff 6-25-12 ; Amended at 34 Ok Reg 612, eff 9-1-17 ; Amended at 36 Ok Reg 1099, eff 7-1-19 (emergency); Amended at 37 Ok Reg 514, eff 1-6-20 (emergency); Amended at 37 Ok Reg 1492, eff 9-14-20]

317:30-5-1077. Procedure codes and claim form [REVOKED]

[Source: Added at 17 Ok Reg 2401, eff 6-26-00 ; Revoked at 19 Ok Reg 2134, eff 6-27-02]

PART 109. DIABETES SELF-MANAGEMENT EDUCATION AND SUPPORT

317:30-5-1080. Definitions

The following words or terms, when used in this Part, shall have the following meaning, unless the context clearly indicates otherwise:

"ADA" means American Diabetes Association.

"ADCES" means the Association of Diabetes Care and Education Specialists.

"BC-ADM" means Board-certified advanced diabetes management.

"CDCES" means certified diabetes care and education specialist.

"DSMES" means diabetes self-management education and support.

"OAC" means Oklahoma Administrative Code.

"OHCA" means Oklahoma Health Care Authority.

"Qualified non-physician provider" means a physician assistant or advanced practice registered nurse.

[Source: Added at 37 Ok Reg 521, eff 1-6-20 (emergency); Added at 37 Ok Reg 1543, eff 9-14-20 ; Amended at 38 Ok Reg 747, eff 4-14-21 (emergency); Amended at 39 Ok Reg 1493, eff 9-12-22]

317:30-5-1081. Eligible providers and requirements

(a) In order to receive Medicaid reimbursement for DSMES services, providers or provider groups must:

(1) Be working under an accredited DSMES program that meets the quality standards of one (1) of the following accreditation organizations:

- (A) The ADA; or
- (B) The ADCES.

(2) Be fully contracted with SoonerCare as a "diabetes educator". Eligible DSMES providers include:

- (A) A registered dietician (RD) who is:
 - (i) Licensed and in good standing in the state in which s/he practices.
 - (ii) Has training and experience pertinent to diabetes self-management education and support verified by the OHCA Pharmacy Services unit.
- (B) A registered nurse (RN) who is:
 - (i) Licensed and in good standing in the state in which s/he practices.
 - (ii) Has training and experience pertinent to diabetes self-management education and support verified by the OHCA Pharmacy Services unit.
- (C) A pharmacist who is:
 - (i) Licensed and in good standing in the state in which s/he practices.
 - (ii) Has training and experience pertinent to diabetes self-management education and support verified by the OHCA Pharmacy Services unit.
- (D) A health care provider, as defined in Section 3090.2 of Title 63 of the Oklahoma Statutes, who holds a certification as a:
 - (i) CDCES; or
 - (ii) BC-ADM.

(b) All DSMES programs must adhere to the national standards for diabetes self-management education.

(1) Each DSMES program must include at least one (1) of the eligible providers listed above in OAC 317:30-5-1081 (a) (2) (A) B (D).

(2) All members of the instructional team must complete the nationally recommended annual continuing education hours for diabetes management.

[Source: Added at 37 Ok Reg 521, eff 1-6-20 (emergency); Added at 37 Ok Reg 1543, eff 9-14-20 ; Amended at 38 Ok Reg 747, eff 4-14-21 (emergency); Amended at 39 Ok Reg 1493, eff 9-12-22]

317:30-5-1082. Scope of services

(a) **General provisions.** The OHCA covers medically necessary DSMES services when all the following criteria are met:

(1) The member has been diagnosed with diabetes by a physician or qualified non-physician provider working within the scope of

his/her licensure;

(2) The services have been ordered by a physician or qualified non-physician provider who is actively managing the member's diabetes;

(3) The services are provided by a qualified DSMES provider [Refer to OAC 317:30-5-1081(a)(2)]; and

(4) The program meets the current ADA or ADCES training standards.

(b) **Training.** DSMES services shall provide one (1) initial assessment per lifetime. Initial DSMES shall be comprised of up to ten (10) hours [can be performed in any combination of thirty (30) minute increments] of diabetes training within a consecutive twelve (12) month period beginning with the initial training date, including:

(1) One (1) hour of individual instruction, consisting of face-to-face encounters between the diabetes educator and the member; and

(2) Nine (9) hours of group instruction.

(c) **Follow-up DSMES.** After the first twelve (12) month period has concluded, members shall only be eligible for two (2) hours of individual or group DSMES instruction per calendar year.

[Source: Added at 37 Ok Reg 521, eff 1-6-20 (emergency); Added at 37 Ok Reg 1543, eff 9-14-20 ; Amended at 38 Ok Reg 747, eff 4-14-21 (emergency); Amended at 39 Ok Reg 1493, eff 9-12-22]

317:30-5-1083. Coverage by category

The purpose of DSMES services must be to provide the member with the knowledge, skill, and ability necessary for diabetes self-care.

(1) **Adults.** Payment is made for medically necessary DSMES provided by eligible providers described in OAC 317:30-5-1081. Refer to OAC 317:30-5-1082 for units of DSMES training allowed.

(2) **Children/adolescents.** Payment is made for medically necessary DSMES for members under twenty-one (21) years of age provided by eligible providers described in OAC 317:30-5-1081. DSMES coverage for children is the same as for adults. Additional DSMES services may be covered under EPSDT provisions if determined to be medically necessary.

[Source: Added at 37 Ok Reg 521, eff 1-6-20 (emergency); Added at 37 Ok Reg 1543, eff 9-14-20 ; Amended at 38 Ok Reg 747, eff 4-14-21 (emergency); Amended at 39 Ok Reg 1493, eff 9-12-22]

317:30-5-1084. Reimbursement methodology

SoonerCare shall provide reimbursement for DSMES services as follow:

(1) Payment shall be made to fully-contracted providers. If the rendering provider operates through an enrolled SoonerCare provider, or is contracted to provide services by an enrolled SoonerCare provider, payment may be made to that enrolled SoonerCare provider.

(2) Reimbursement for DSMES services is only made on a fee-for-service basis. The maximum allowable fee for a unit of service has been determined by OHCA to be a reasonable fee, consistent with

efficiency, economy, and quality of care. Payment for covered services is the lower of the provider's actual billed charges, consistent with the provider's usual and customary charge to the general public for the service, or the maximum allowable per unit of service.

[Source: Added at 37 Ok Reg 521, eff 1-6-20 (emergency); Added at 37 Ok Reg 1543, eff 9-14-20 ; Amended at 38 Ok Reg 747, eff 4-14-21 (emergency); Amended at 39 Ok Reg 1493, eff 9-12-22]

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

317:30-5-1085. General provisions

(a) Indian Health Services (IHS) provide health care to Certificate of Degree of Indian Blood (CDIB) eligible American Indian and Alaska Natives (AI/AN). The IHS is a division of the Department of Health and Human Services that administers a system of hospitals and Indian health outpatient services. Urban Indian Clinics are considered facilities of the IHS. Under the Indian Self-Determination Act, Public Law 93-638, as amended, Tribes may also provide health care to IHS eligible AI/ANs.

(b) The rules at OAC 317:30-3 apply to IHS, Tribal, and Urban Indian facilities. Additionally, unless otherwise stated, all other SoonerCare rules apply to IHS, Tribal, and Urban Indian facilities.

[Source: Added at 23 Ok Reg 2575, eff 6-25-06 ; Amended at 25 Ok Reg 2698, eff 7-25-08 ; Amended at 33 Ok Reg 837, eff 9-1-16]

317:30-5-1086. Eligible I/T/U providers

Indian Health Services, Tribal Programs, and Urban Indian Clinics (I/T/US) are considered eligible for participation in the SoonerCare Program. To receive SoonerCare reimbursement, an I/T/U must be contracted as a provider with the Oklahoma Health Care Authority and appear on the IHS maintained listing of IHS-operated and Indian health care facilities under a 638 agreement. OHCA recognizes that I/T/US are the payer of last resort, and are not considered creditable health insurance. It is the sole responsibility of the facility to petition IHS for placement on the list of facilities operating under a 638 agreement.

[Source: Added at 23 Ok Reg 2575, eff 6-25-06 ; Amended at 25 Ok Reg 2698, eff 7-25-08 ; Amended at 33 Ok Reg 837, eff 9-1-16]

317:30-5-1087. Terms and definitions

The following words and terms, when used in this Part, have the following meaning, unless the context clearly indicates otherwise:

- (1) **"American Indian/Alaska Native (AI/AN)"** means an individual of Native American descent who has or is eligible for a Certificate of Degree of Indian Blood (CDIB) card.
- (2) **"Behavioral Health services"** means professional medical services for the treatment of a mental health and/or substance

use disorder.

(3) **"CFR"** means the Code of Federal Regulations.

(4) **"CMS"** means the Centers for Medicare and Medicaid Services.

(5) **"Encounter"** means a face to face contact between a health care professional and an IHS eligible SoonerCare member for the provision of medically necessary Title XIX or Title XXI covered services through an IHS or Tribal 638 facility or an urban Indian clinic within a 24-hour period ending at midnight, as documented in the patient's record.

(6) **"Licensed Behavioral Health Professional (LBHP)"** means a licensed psychologist, licensed clinical social worker(LCSW), licensed marital and family therapist (LMFT), licensed professional counselor (LPC), licensed behavioral practitioner (LBP) or licensed alcohol and drug counselor (LADC).

(7) **"OHCA"** means the Oklahoma Health Care Authority.

(8) **"OMB rate"** means the Medicaid reimbursement rate negotiated between CMS and IHS. Inpatient and outpatient Medicaid reimbursement rates for I/T/Us are published annually in the Federal Register or Federal Register Notices. The outpatient rate is also known as the I/T/U encounter rate. The encounter rate is available only to I/T/U facilities that appear on the IHS maintained listing of IHS-operated and Indian health care facilities operating under a 638 agreement. It is the sole responsibility of the facility to petition IHS for placement on this list.

(9) **"Physician"** means a doctor of medicine or osteopathy legally authorized to practice medicine and surgery or who is a licensed physician employed by the Federal Government in an IHS facility or who provides services in a 638 Tribal Facility.

(10) **"State Administering Agency (SAA)"** is the Oklahoma Health Care Authority.

(11) **"638 Tribal Facility"** is a facility that is operated by a tribe or tribal organization and funded by Title I or Title III of the Indian Self Determination and Education Assistance Act (Public Law 93-638).

[Source: Added at 23 Ok Reg 2575, eff 6-25-06 ; Amended at 25 Ok Reg 2698, eff 7-25-08 ; Amended at 33 Ok Reg 837, eff 9-1-16 ; Amended at 34 Ok Reg 674, eff 9-1-17]

317:30-5-1088. I/T/U provider participation requirements

(a) I/T/US must directly employ the services of legally credentialed professional staff that are authorized within their scope of practice under state law to provide the services for which claims are submitted to SoonerCare; or I/T/U Physicians may meet all requirements for employment by the Federal Government as a physician and be employed by the Federal Government in an IHS facility or affiliated with a 638 Tribal Facility.

(b) The facility is required to contract with OHCA all professional staff employed by the I/T/U. Participating I/T/Us are required to submit contracts for all practitioners working within the facility via Oklahoma's

Electronic Provider Enrollment (EPE) web-based system. The reimbursement for services rendered at or on behalf of the I/T/U will be made to the facility.

(c) Only professional staff listed as eligible providers in OAC 317:30-5 are recognized by OHCA.

[Source: Added at 23 Ok Reg 2575, eff 6-25-06 ; Amended at 25 Ok Reg 2698, eff 7-25-08 ; Amended at 33 Ok Reg 837, eff 9-1-16]

317:30-5-1089. I/T/U multiple sites

(a) I/T/US may contract as a PCP/CM under SoonerCare Choice (See OAC 317:25-7-5).

(b) I/T/US are required to contract with all facilities affiliated or owned by the I/T/U to be eligible for SoonerCare reimbursement.

[Source: Added at 23 Ok Reg 2575, eff 6-25-06 ; Amended at 33 Ok Reg 837, eff 9-1-16]

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

(a) 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 (FFS) contract. The services will be reimbursed at the FFS rate, and will be subject to any limitations, restrictions, or prior authorization requirements. Examples of these services include, but are not limited to:

- (1) Durable medical equipment [refer to Oklahoma Administrative Code (OAC) 317:30-5-210];
- (2) Eyeglasses (refer to OAC 317:30-5-431, 317:30-5-432.1 and 317:30-5-451);
- (3) Transportation by ambulance (refer to OAC 317:30-5-335);
- (4) Home health (refer to OAC 317:30-5-546);
- (5) Inpatient practitioner services (refer to OAC 317:30-5-1100);
- (6) Non-emergency transportation (refer to OAC 317:30-5-326 through 317:30-5-327.9);
- (7) Behavioral health case management (refer to OAC 317:30-5-241.6);
- (8) Psychosocial rehabilitative services (refer to OAC 317:30-5-241.3);
- (9) Psychiatric residential treatment facility services (refer to OAC 317:30-5-95 through 317:30-5-97);
- (10) Applied behavior analysis (ABA) (refer to OAC 317:30-5-310 through 317:30-5-316); and
- (11) Diabetes self-management education and support (DSMES) (refer to OAC 317:30-5-1080 through 317:30-5-1084).

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

(c) Providers may bill for antepartum and postpartum visits, and a cesarean or vaginal delivery as individual encounters, or a provider can bill the packaged/bundled rate for total obstetrical care (OB) (which includes antepartum/postpartum visits and delivery). Providers may not bill for both antepartum/postpartum visits and a packaged/bundled rate for total OB care for the same episode of care. Refer to OAC 317:30-5-22 for more detailed obstetrical care policy.

[Source: Added at 23 Ok Reg 2575, eff 6-25-06 ; Amended at 25 Ok Reg 2698, eff 7-25-08 ; Amended at 26 Ok Reg 249, eff 1-1-09 (emergency); Amended at 26 Ok Reg 1053, eff 5-11-09 ; Amended at 33 Ok Reg 837, eff 9-1-16 ; Amended at 34 Ok Reg 346, eff 12-29-16 (emergency); Amended at 34 Ok Reg 674, eff 9-1-17 ; Amended at 36 Ok Reg 1099, eff 7-1-19 (emergency); Amended at 37 Ok Reg 514, eff 1-6-20 (emergency); Amended at 37 Ok Reg 1492, eff 9-14-20 ; Amended at 38 Ok Reg 747, eff 4-14-21 (emergency); Amended at 39 Ok Reg 1493, eff 9-12-22]

317:30-5-1091. Definition of I/T/U services

- (a) As described in 42 CFR 136.11(a), the I/T/U services may include hospital and medical care, dental care, public health nursing, preventive care (including immunizations).
- (b) Further, 42 CFR 136.11(c) allows that the scope and availability of I/T/U services will depend upon the resources of the facility.
- (c) I/T/U services may be covered when furnished to a patient at the clinic or other location, including a mobile clinic, or the patient's place of residence. Provider contracts must meet the provider participation requirements found at OAC 317:30-5-1096.
- (d) I/T/U outpatient encounters include but are not limited to:
- (1) Physicians' services and supplies incidental to a physician's services;
 - (2) Within limitations as to the specific services furnished, a doctor of dentistry or oral surgery, a doctor of optometry, or a doctor of podiatry [Refer to Section 1861(r) of the Act for specific limitations];
 - (3) Services of advanced practice nurses (APNs), physician assistants (PAs), certified nurse midwives (CNMs), or specialized advanced practice nurse practitioners;
 - (4) Services and supplies incidental to the services of APNs and PAs (including services furnished by certified nurse midwives);
 - (5) Public health nursing services, within the scope of their licensure, include but are not limited to services in the following areas:
 - (A) Phlebotomy;
 - (B) Wound care;
 - (C) Public health education;
 - (D) Administration of immunizations;
 - (E) Administration of medication;
 - (F) Child health screenings meeting EPSDT criteria;
 - (G) Smoking and Tobacco Use Cessation Counseling;
 - (H) Prenatal, newborn and postpartum assessments, including case management services for first time mothers; and
 - (I) General health assessments and management of conditions such as tuberculosis, diabetes and

hypertension.

- (6) Visiting nurse services to the homebound;
- (7) Behavioral health professional services and services and supplies incidental to the services of LBHPs; and
- (8) Dental services.

[Source: Added at 23 Ok Reg 2575, eff 6-25-06 ; Amended at 25 Ok Reg 2698, eff 7-25-08 ; Amended at 26 Ok Reg 3025, eff 7-21-09 (emergency); Amended at 27 Ok Reg 931, eff 5-13-10 ; Amended at 28 Ok Reg 16, eff 8-13-10 (emergency); Amended at 28 Ok Reg 1435, eff 6-25-11 ; Amended at 33 Ok Reg 837, eff 9-1-16]

317:30-5-1092. Services and supplies incidental to I/T/U outpatient encounters

Services and supplies incidental to the service of a physician, physician assistant, advanced practice nurse, clinical psychologist, or clinical social worker may be covered if the service or supply is:

- (1) of a type commonly furnished in physicians' offices;
- (2) of a type commonly rendered either without charge or included in the I/T/U's bill;
- (3) furnished as an incidental, although integral, part of professional services furnished by a physician, nurse practitioner, physician assistant, nurse midwife, or specialized nurse practitioner;
- (4) furnished under the direct, personal supervision of a nurse practitioner, physician assistant, nurse midwife, specialized nurse practitioner or a physician; and
- (5) in the case of a service, furnished by a member of the I/T/U's health care staff who is an employee of the clinic.

[Source: Added at 23 Ok Reg 2575, eff 6-25-06]

317:30-5-1093. I/T/U visiting nurses services

(a) Visiting nurse services may be covered if:

- (1) The services are rendered to a homebound individual who is permanently or temporarily confined to his or her place of residence because of a medical or health condition. The individual may be considered homebound if he or she leaves the place of residence infrequently. For this purpose, place of residence does not include a hospital or long term care facility; and
- (2) The services are furnished by a registered nurse, licensed practical nurse, or licensed vocational nurse who is employed by, and receives compensation for the services from the I/T/U; and
- (3) The services are furnished under a written plan of treatment that is:
 - (A) established and reviewed at least every 60 days by a supervising physician of the I/T/U or established by a nurse practitioner, physician assistant, nurse midwife, or specialized nurse practitioner and reviewed at least every 60 days by a supervising physician; and
 - (B) signed by the nurse practitioner, physician assistant, nurse midwife, specialized nurse practitioner, or the

supervising physician of the clinic.

- (b) The nursing care covered in this Section includes:
- (1) Services that must be performed by a registered nurse, licensed practical nurse, or licensed vocational nurse if the safety of the patient can be assured in the home and the medically desired results achieved; and
 - (2) Personal care services, to the extent covered under Medicare as home health services. These services include helping the patient to bathe, to get in and out of bed, to exercise and to take medications.
- (c) This benefit does not cover household and housekeeping services or other services that would constitute custodial care.

[Source: Added at 23 Ok Reg 2575, eff 6-25-06 ; Amended at 25 Ok Reg 2698, eff 7-25-08 ; Amended at 33 Ok Reg 837, eff 9-1-16]

317:30-5-1094. Behavioral health services provided at I/T/Us

(a) **Inpatient behavioral health.** Services are covered when provided in accordance with a documented individualized service plan developed to treat the identified behavioral health needs.

(1) Inpatient psychiatric service providers must meet the requirements and applicable limitations, restrictions, or prior authorization requirements set forth in Oklahoma Administrative Code (OAC) 317:30-5-95 through 317:30-5-97.

(2) The provision of inpatient psychiatric services by Indian Health Services (IHS) facilities are reimbursed at the OMB inpatient encounter rate. Inpatient psychiatric services provided by non-IHS facilities are reimbursed at the established per diem or DRG rate.

(b) **Outpatient behavioral health.** Services are covered when provided in accordance with a documented individualized service plan developed to treat the identified mental health needs and/or SUD. Outpatient behavioral health services are reimbursed at the I/T/U outpatient encounter rate unless otherwise noted in the section.

(1) A full description of services may be found at OAC 317:30-5-241 and 317:30-5-241.5(d), 317:30-5-241.7. Services may include, but are not limited to:

- (A) Mental health and/or substance use assessment/evaluation and testing;
- (B) Service plan development;
- (C) Crisis intervention services;
- (D) Medication training and support;
- (F) Individual/interactive psychotherapy;
- (G) Group psychotherapy;
- (H) Family psychotherapy;
- (I) Medication-assisted treatment (MAT) services and/or medication; and
- (J) Peer recovery support specialist (PRSS) services.

(2) In order to support access to behavioral health services, these services may be provided in settings outside of the I/T/U. Offsite services must take place in a confidential setting.

(3) For the provision of behavioral health related case management services, I/T/U facilities must be fully contracted with the Oklahoma Health Care Authority (OHCA) as an outpatient behavioral health agency. The provision of these services is considered to be outside of the I/T/U encounter and will be paid at the current FFS rate. Contracted behavioral health case management providers must comply with the requirements found at OAC 317:30-5-241.6 and are responsible for obtaining all necessary prior authorizations, if needed.

(4) For the provision of psychosocial rehabilitation services, I/T/U facilities must be fully contracted with the OHCA as an outpatient behavioral health agency. The provision of these services is considered to be outside of the I/T/U encounter and will be paid at the current FFS rate. Contracted psychosocial rehabilitation service providers must comply with the requirements found at OAC 317:30-5-241.3 and are responsible for obtaining all necessary prior authorizations, if needed.

(5) Services provided by behavioral health practitioners, such as, licensed clinical social workers (LCSW), licensed marital and family therapists (LMFT), licensed professional counselors (LPC), licensed behavioral health practitioners (LBHP), licensed alcohol and drug counselors (LADC), and licensure candidates are not eligible for direct reimbursement as practitioners. Services provided by the aforementioned practitioners are compensable only when billed by their OHCA-contracted employer and when provided in those clinical settings in which they are currently approved to render services. Licensure candidates must meet the requirements contained in OAC 317:30-5-240.3.

(6) Behavioral health services must be billed on an appropriate claim form using the appropriate procedure code and guidelines. The time indicated on the claim form must be the time actually spent with the member.

(c) **Residential substance use disorder (SUD).** For the provision of residential SUD treatment services, I/T/U facilities must be contracted as SoonerCare providers and meet the requirements found at OAC 317:30-5-95.43 through 317:30-5-95.49. Residential SUD treatment services will be reimbursed at the OMB outpatient encounter rate.

[Source: Added at 23 Ok Reg 2575, eff 6-25-06 ; Amended at 25 Ok Reg 2698, eff 7-25-08 ; Amended at 33 Ok Reg 837, eff 9-1-16 ; Amended at 34 Ok Reg 674, eff 9-1-17 ; Amended at 35 Ok Reg 1459, eff 9-14-18 ; Amended at 38 Ok Reg 1062, eff 9-1-21 ; Amended at 40 Ok Reg 2194, eff 9-11-23]

317:30-5-1095. I/T/U services not compensable under outpatient encounters

I/T/U services that are not compensable under outpatient encounters include:

(1) group or mass information programs, health education classes, or group education activities, including media productions and publications;

(2) vaccines covered by the Vaccines for Children program [refer to Oklahoma Administrative Code 317:30-5-14(a)(1)];

- (3) group or sports physicals and medical reports;
- (4) drug samples or other prescription drugs provided to the clinic free of charge;
- (5) administrative medical examinations and report services; and
- (6) gauze, band-aids, or other disposable products used during an office visit; and
- (7) billing global obstetrical care when performing a cesarean or vaginal delivery only.

[Source: Added at 23 Ok Reg 2575, eff 6-25-06 ; Amended at 25 Ok Reg 2698, eff 7-25-08 ; Amended at 33 Ok Reg 837, eff 9-1-16 ; Amended at 37 Ok Reg 1624, eff 9-14-20]

317:30-5-1096. Off-site services

I/T/U covered services provided off-site or outside of the I/T/U setting, including but not limited to hospice services, mobile clinics, or places of residence, are compensable at the OMB rate when billed by an I/T/U that has been designated as a Federally Qualified Health Center. The I/T/U must meet provider participation requirements listed in OAC 317:30-5-1088. I/T/U off-site services may be covered if the services rendered were within the provider's scope of practice and are of the same integrity of services rendered at the I/T/U facility.

[Source: Added at 23 Ok Reg 2575, eff 6-25-06 ; Amended at 25 Ok Reg 2698, eff 7-25-08 ; Amended at 33 Ok Reg 837, eff 9-1-16 ; Amended at 35 Ok Reg 231, eff 1-1-18 (emergency); Amended at 35 Ok Reg 1407, eff 9-14-18 ; Amended at 40 Ok Reg 2192, eff 9-11-23]

317:30-5-1097. Billable I/T/U encounters

I/T/U encounters that are billed to the OHCA must meet the definition listed in OAC 317:30-5-1099 and are limited to medically necessary State Plan services covered by OHCA. These services include ambulatory services included in the State Plan under Title XIX or Title XXI of the Social Security Act.

[Source: Added at 23 Ok Reg 2575, eff 6-25-06]

317:30-5-1098. I/T/U outpatient encounters

(a) I/T/U outpatient encounters that are billed to the OHCA must meet the definition in this Section and are limited to services covered by the OHCA. These services include health services included in the State Plan under Title XIX or Title XXI of the Social Security Act.

(1) An I/T/U encounter means a face to face or telehealth contact between a health care professional and an IHS eligible SoonerCare member for the provision of medically necessary Title XIX or Title XXI covered services through an IHS or Tribal 638 facility or an urban Indian clinic within a 24-hour period ending at midnight, as documented in the patient's record.

(2) An I/T/U outpatient encounter means outpatient services that may be covered when furnished to a patient by a contracted SoonerCare provider employed by the I/T/U facility and rendered at the I/T/U facility or other location, including the patient's place of residence.

(b) The following services may be considered reimbursable encounters subject to the limitations of the Oklahoma State Plan and include any related medical supplies provided during the course of the encounter:

- (1) Medical;
- (2) Diagnostic;
- (3) Behavioral Health services [refer to OAC 317:30-5-1094];
- (4) Dental, Medical and Mental Health Screenings;
- (5) Vision;
- (6) Physical Therapy;
- (7) Occupational Therapy;
- (8) Podiatry;
- (9) Speech;
- (10) Hearing;
- (11) Visiting Nurse Service [refer to OAC 317:30-5-1093];
- (12) Smoking and Tobacco Use Cessation Counseling;
- (13) Other Title XIX or XXI services as allowed under OHCA's SoonerCare State Plan and OHCA Administrative Rules;
- (14) Drugs or medication treatments provided during a clinic visit are part of the encounter rate. For example, a member has come into the clinic with high blood pressure and is treated at the clinic with a hypertensive drug or drug sample. Drug samples are included in the encounter rate. Prescription drugs are reimbursed pursuant to OAC 317:30-5-78(b)(4)(B).
- (15) Encounters with a registered professional nurse or a licensed practical nurse and related medical supplies (other than drugs and biologicals) furnished on a part-time or intermittent basis to home-bound members; and
- (16) I/T/U Multiple Outpatient Encounters.

(A) OHCA will cover one medically necessary outpatient medical encounter per member per day unless if due to an emergency, the same member returns on the same day for a second visit with a different diagnosis. Then, a second encounter is allowed.

(B) OHCA will cover one dental encounter per member per day regardless of how many procedures are done or how many providers are seen unless if due to an emergency, the same member returns on the same day for a second visit and has a different diagnosis. Then, a second encounter is allowed.

(C) OHCA will cover one behavioral health professional outpatient encounter per member per day unless if due to an emergency, the same member returns on the same day for a second visit and has a different diagnosis. Then, a second encounter is allowed.

(D) Each service must have distinctly different diagnoses in order to meet the criteria for multiple I/T/U outpatient encounters.

(c) More than one outpatient visit with a medical professional within a 24-hour period for distinctly different diagnoses may be reported as two encounters. This does not imply that if a member is seen at a single office visit with multiple problems that multiple encounters can be billed. For

example, a member comes to the clinic in the morning for an immunization, and in the afternoon, the member falls and breaks an arm. This would be considered multiple medical encounters and can be billed as two encounters. However, a member who comes to the I/T/U facility for a diabetic wellness screening and is then referred to a podiatrist within the clinic for diabetes-related follow-up on the same date of service would not be considered a distinctly different diagnosis and can only be billed as a single encounter.

(d) The following services may be considered as separate or multiple encounters when two or more services are provided on the same date of service with distinctly different diagnoses:

- (1) Medical Services;
- (2) Dental Services;
- (3) Mental Health and addiction services with similar diagnoses can only be billed as one encounter. In addition, if the member is also seen for a medical office visit with a mental health or addiction diagnosis, then it is considered a single encounter;
- (4) Physical or occupational therapy (PT/OT). If this service is also performed on the same date of service as the medical encounter that determined the need for PT/OT (initial referral), then it is considered a single encounter;
- (5) Administration of immunizations. If no other medical office visit occurs on the same date of services; and
- (6) Tobacco cessation limited to state plan services. If no other medical or addiction encounter occurs on the same date of service.

(e) I/T/U outpatient encounters for IHS eligible SoonerCare members whether medical, dental, or behavioral health, are not subject to prior authorization. Other State Plan covered services that the I/T/U facility chooses to provide but which are not part of the I/T/U encounter are subject to all applicable SoonerCare regulations which govern the provision and coverage for that service.

[Source: Added at 23 Ok Reg 2575, eff 6-25-06 ; Amended at 25 Ok Reg 2698, eff 7-25-08 ; Amended at 28 Ok Reg 16, eff 8-13-10 (emergency); Amended at 28 Ok Reg 1435, eff 6-25-11 ; Amended at 33 Ok Reg 837, eff 9-1-16 ; Amended at 34 Ok Reg 346, eff 12-29-16 (emergency); Amended at 34 Ok Reg 674, eff 9-1-17]

317:30-5-1099. I/T/U service limitations and requirements

Service limitations governing the provision of all Oklahoma SoonerCare services will apply pursuant to Chapter 30 of the OHCA rules. In addition, the following limitations and requirements apply to services provided by I/T/U facilities:

- (1) **Multiple encounters.** An I/T/U facility may bill for more than one encounter per twenty-four (24) hour period under certain conditions.
- (2) **Behavioral Health services.** Behavioral Health Services are limited to those services furnished to members at or on behalf of the I/T/U facility.
- (3) **Laboratory procedures.** Laboratory procedures performed by an I/T/U outpatient facility (not an independently certified

enrolled laboratory) on the same date of service are considered part of the health care practitioner's service and are included in the I/T/U encounter.

(4) **Obstetrical services.** For OB services provided to a member before, during, and/or after the same pregnancy, ITUs may not bill for individual encounters and the package/bundled rate. Providers may only either:

- (A) bill for antepartum visits, postpartum visits, and/or a cesarean or vaginal delivery as individual encounter; or
- (B) bill the packaged/bundled rate for total care obstetrics, (which includes antepartum and postpartum visits and delivery). Refer to Oklahoma Administrative Code 317:30-5-22 for more detailed obstetrical care policy.

[Source: Added at 23 Ok Reg 2575, eff 6-25-06 ; Amended at 25 Ok Reg 2698, eff 7-25-08 ; Amended at 33 Ok Reg 837, eff 9-1-16 ; Amended at 37 Ok Reg 1624, eff 9-14-20]

317:30-5-1100. Inpatient care provided by IHS facilities

Inpatient practitioner services are separately contracted and paid at a fee-for-service rate. Each individual inpatient practitioner must be contracted with SoonerCare and attached to a SoonerCare contracted medical group. The Inpatient hospital per diem rate for inpatient medical care provided by IHS facilities is published annually in the Federal Register or Federal Register Notices. In order to receive the inpatient hospital per diem rate, the IHS or Tribal 638 facility must:

- (1) be contracted as a provider with the Oklahoma Health Care Authority; and
- (2) appear on the IHS maintained listing of IHS-operated and Indian health care facilities operating under a 638 agreement. It is the sole responsibility of the facility to petition IHS for placement on this list.

[Source: Added at 25 Ok Reg 2698, eff 7-25-08 ; Amended at 33 Ok Reg 837, eff 9-1-16]

317:30-5-1101. I/T/U Shared Savings Program

(a) **Description.** In accordance with state and federal law, the I/T/U Shared Savings Program is a program that direct the reinvestment of any savings to the Oklahoma Health Care Authority (OHCA) generated by enhanced federal matching authorized under Section 1905(b) of the Social Security Act at a rate of one hundred percent (100%) for covered services received through participating Indian Health Service, Tribal and Urban Indian (I/T/U) facilities.

- (1) **Eligibility.** Authorized services provided by a non-I/T/U Medicaid provider to an American Indian or Alaska Native (AI/AN) Medicaid member as a result of a referral from an I/T/U facility provider may be eligible for the enhanced federal matching rate of one hundred percent (100%).
- (2) **Distribution criteria.** OHCA will distribute up to fifty percent (50%) of any savings that result from the I/T/U Shared Savings Program to the referring I/T/U, but only after administrative costs

incurred by OHCA in implementing the program have been fully satisfied. Distributions issued will ensure the following:

- (A) Distributions to participating I/T/U facilities will be used to increase care coordination and to support health care initiatives for AI/AN populations;
- (B) OHCA will deposit any shared savings that remain after administrative costs have been fully paid, and after distributions have been made to participating I/T/U facilities, into the I/T/U Shared Savings Revolving Fund for the purpose of increasing Medicaid provider rates;
- (C) Monies in the fund will not be used to replace other general revenues appropriated and funded by the Oklahoma Legislature or other revenues used to support Medicaid; or
- (D) OHCA will make distributions on a quarterly basis to participating I/T/U facilities based on claims data. The calculation will include the paid claims from the non-I/T/U provider that a member was referred to by an I/T/U. The referring ITU provider will need to be listed on the claim, and there must be an active Care Coordination Agreement (CCA) on file with OHCA. A CCA must be executed between the I/T/U facility and the non-I/T/U provider. A CCA must include, but not limited to the following:
 - (i) The I/T/U facility provider providing a request for specific services by electronic or other verifiable means and relevant information about the practitioner's member to the non-I/T/U provider;
 - (ii) The non-I/T/U provider sending information about the care the non-I/T/U provider provides to the patient including the results of any screening, diagnostic or treatment procedures, to the I/T/U facility provider;
 - (iii) The I/T/U facility provider continuing to assume responsibility for the member's care by assessing the information and taking appropriate action including, when necessary, furnishing or requesting additional services; and
 - (iv) The I/T/U facility incorporating the member's information in the medical record through the statewide health information exchange or other agreed-upon means.

(b) I/T/U Shared Savings Revolving Fund. A revolving fund for OHCA will be designated as the "I/T/U Shared Savings Revolving Fund". All monies accruing to the credit of the fund will be budgeted and expended by OHCA and will consist of:

- (1) All monies received by OHCA as pursuant to Title 63 Section 5061.2 of the Oklahoma Statutes, and as otherwise specified or authorized by other state and federal laws;
- (2) All monies accruing to the credit of the fund are appropriated and will be budgeted and expended by OHCA to increase

Medicaid provider rates, unless otherwise provided by state and federal law; and

(3) Expenditures from the fund will be made upon warrants issued by the State Treasurer against claims filed as prescribed by law with the Director of the Office of Management and Enterprise Services (OMES) for approval and payment.

(c) **Report Criteria.** An annual report will be prepared by the OHCA's Chief Financial Officer (CFO) and will be submitted to the Governor, the President Pro Tempore of the Senate, and the Speaker of the House of Representatives no later than thirty (30) days following the end of each state fiscal year. The annual report will account for:

(1) The savings realized by the OHCA as a result of the I/T/U Shared Savings Program;

(2) The administrative costs incurred by the OHCA as a result of the I/T/U Shared Savings Program;

(3) The monies distributed to participating I/T/U facilities as a result of I/T/U Shared Savings Program including, but not limited to, a summary of all specific distributions;

(4) The balance of savings realized by the OHCA as a result of the I/T/U Shared Savings Program and accruing to the credit of the fund after payment of administrative costs and distributions to participating I/T/U facilities and

(5) The monies expended on increasing Medicaid provider rates including, but not limited to, identification of the types of providers affected and the percentage by which the providers' rates were increased.

[Source: Added at 39 Ok Reg 422, eff 12-21-21 (emergency); Added at 39 Ok Reg 1496, eff 9-12-22]

PART 112. PUBLIC HEALTH CLINIC SERVICES

317:30-5-1150. General

Public Health Clinic services consist of primary and preventive health care, related diagnostic services, and/or dental services. County health departments (CHDs) and City-County Health Departments (CCHDs) may participate as providers in the SoonerCare program as Public Health Clinics. The Statutory basis for their participation is pursuant to 42 CFR 431.615 (Relations with State Health and Vocational Rehabilitation Agencies and Title V Grantees), thereby implementing Sec. 1902(a)(11) and (22)(C) of the Social Security Act. The CHD Clinics are administered by the Oklahoma State Department of Health (OSDH) for the purpose of providing public health services.

[Source: Added at 24 Ok Reg 2070, eff 6-25-07]

317:30-5-1151. Eligible providers

To be eligible for reimbursement, a CHD or the OSDH (on behalf of the CHDs) or CCHD, must complete a provider contract with the Oklahoma Health Care Authority (OHCA). The CHD or CCHD clinic must

have a licensed physician on staff or physician supervising the services. The supervising physician must be available at all times in person or by direct telecommunication for advice and assistance on patient referrals or emergencies. Clinic services must be provided in accordance with 42 CFR 440.90.

[Source: Added at 24 Ok Reg 2070, eff 6-25-07]

317:30-5-1152. Provider participation requirements

(a) OSDH and or/ CHD or CCHD must employ or contract the services of professional staff that are authorized within their scope of practice under state law to provide the services for which claims are submitted to the OHCA.

(b) The OSDH and CCHDs are required to submit a list of names of all practitioners who are working within the CHD and not individually enrolled with the OHCA when requested by the OHCA or it's designated agent.

[Source: Added at 24 Ok Reg 2070, eff 6-25-07]

317:30-5-1153. Physician

Physicians who perform services in Oklahoma, but who are not licensed in Oklahoma may provide services for the CHD/CCHD if they are commissioned medical officers of the Public Health Service or Armed Services of the United States, on active duty, and acting within the scope of their Public Health Service or military responsibilities.

[Source: Added at 24 Ok Reg 2070, eff 6-25-07]

317:30-5-1154. County health department (CHD) and city-county health department (CCHD) services/limitations

CHD/CCHD service limitations are:

- (1) Child-guidance services (refer to Oklahoma Administrative Code (OAC)317:30-5-1023).
- (2) Dental services (refer to OAC 317:30-3-65.4(7) for specific coverage).
- (3) Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services , including blood lead testing and follow-up services (refer to OAC 317:30-3-65 through 317:30-3-65.12 for specific coverage).
- (4) Environmental investigations.
- (5) Family planning and SoonerPlan family planning services (refer to OAC 317:30-5-12 for specific coverage guidelines).
- (6) Immunizations (adult and child).
- (7) Blood lead testing (refer to OAC 317:30-3-65.4 for specific coverage).
- (8) Newborn hearing screening.
- (9) Newborn metabolic screening.
- (10) Maternity services (refer to OAC 317:30-5-22 for specific coverage).

- (11) Public health nursing services.
- (12) Tuberculosis case management and directly observed therapy.
- (13) Laboratory services.
- (14) Targeted case management.

[Source: Added at 24 Ok Reg 2070, eff 6-25-07 ; Amended at 29 Ok Reg 1085, eff 6-25-12 ; Amended at 36 Ok Reg 1099, eff 7-1-19 (emergency); Amended at 37 Ok Reg 514, eff 1-6-20 (emergency); Amended at 37 Ok Reg 1492, eff 9-14-20]

317:30-5-1155. Immunizations

- (a) Immunizations are administered in accordance with Centers for Disease Control, Advisory Committee on Immunization Practices.
- (b) The Vaccines for Children (VFC) program offers free vaccines to qualified health care providers for children 18 years of age and under who are SoonerCare members, American Indian or Alaska Native, uninsured, or under insured. The Oklahoma State Department of Health administers this program.

[Source: Added at 24 Ok Reg 2070, eff 6-25-07]

317:30-5-1156. Environmental lead investigations

Environmental inspections are provided through the Oklahoma State Department of Health (OSDH) upon notification from laboratories or providers and reimbursed through the Oklahoma SoonerCare program. The OCLPPP schedules an environmental inspection to identify the source of the lead for children who have a persistent blood lead level 15 ug/dL or greater. After the results of the environmental inspection have been received, the OHCA and OCLPPP continue case management activities until two consecutive blood lead measurements equal to or below 10 ug/dL have been achieved. A qualified investigator must be certified, accredited or granted approval by the Oklahoma Department of Environmental Quality to perform environmental lead testing.

[Source: Added at 24 Ok Reg 2070, eff 6-25-07]

317:30-5-1157. Newborn screening

- (a) The newborn hearing screening is for the purpose of testing all newborns for hearing impairments to alleviate the adverse effects of hearing loss or speech and language development. The screening is a test or battery of tests administered to determine the need for an in-depth hearing diagnostic evaluation. Payment for the initial screening is included in the inpatient facility payment. Follow-up screening is covered if the child has not been seen by his/her PCP/CM.
- (b) The newborn metabolic screening is for the purpose of testing all newborns born in Oklahoma for disorders as determined by the OSDH Board of Health. Short-term and long-term follow-up services are provided in conjunction with the laboratory testing.

[Source: Added at 24 Ok Reg 2070, eff 6-25-07]

317:30-5-1158. Public health nursing services

(a) Public health nursing services must be performed at a main clinic site, satellite clinic or mobile clinic site that is open to the public, or a member's home.

(b) Clinic visits may include but are not limited to services in the following areas:

- (1) health promotion and counseling;
- (2) medication management;
- (3) nursing assessment, treatment and diagnostic testing;
- (4) home visits;
- (5) nursing treatments;
- (6) immunizations;
- (7) administration of injectable medications;
- (8) medication management and the direct observation of the intake of prescribed drugs to treat tuberculosis (TB); and
- (9) case management for TB, first time mothers and their infant children, and high risk pregnant women.

[Source: Added at 24 Ok Reg 2070, eff 6-25-07]

317:30-5-1159. Tuberculosis

The purpose of the Tuberculosis program is to identify and treat clients with tuberculosis, insure appropriate measures are taken to prevent the occurrence and transmission of tuberculosis, analyze tuberculosis related data for program planning and evaluation, and ultimately eliminate tuberculosis in Oklahoma. Payment is made for tuberculosis clinic services pursuant to (1) - (7) of this Section.

(1) **Nursing visit - regular with disease.** Nursing visit - regular with disease requires an initial intensive interview by Health Department personnel for gathering clinical and epidemiologic data and administration of a tuberculosis skin test.

(A) The nursing visit in this paragraph includes:

- (i) one x-ray every two months;
- (ii) a monthly blood test;
- (iii) one series (3 samples) of sputum tests every two months;
- (iv) monitoring of side effects; and
- (v) provision of medication.

(B) Notification and consultation with the Tuberculosis Control Officer must be established and maintained during the treatment regimen as required by State law.

(C) The nursing visit in this paragraph is appropriate for a patient with the disease of tuberculosis that is drug susceptible and a treatment regimen of six to 12 months is prescribed.

(2) **Nursing visit - multi-drug resistant with disease.** A nursing visit - multi-drug resistant with disease requires an initial intensive interview by Health Department personnel for gathering clinical and epidemiologic data and administration of a tuberculosis skin test.

- (A) This nursing visit in this paragraph includes:
- (i) one x-ray every two months;
 - (ii) a monthly blood test;
 - (iii) one series (3 samples) of sputum tests each month;
 - (iv) monitoring of side effects; and
 - (v) provision of medication.

(B) Notification and consultation with the Tuberculosis Control Officer must be established and maintained during the treatment regimen as required by State law.

(C) The nursing visit in this paragraph is appropriate for a patient with the disease of tuberculosis that is multi-drug resistant and a treatment regimen of 18 to 24 months has been prescribed.

(3) Nursing visit - regular preventive therapy with infection.

A nursing visit - regular preventive therapy with infection requires an initial intensive interview by Health Department personnel for gathering clinical and epidemiologic data and administration of a tuberculin skin test.

- (A) The nursing encounter in this paragraph includes:
- (i) one x-ray every three months;
 - (ii) four blood tests in six months;
 - (iii) one series (3 samples) of sputum tests;
 - (iv) monitoring of side effects; and
 - (v) provision of medication.

(B) Notification and consultation with the Tuberculosis Control Officer must be established and maintained during the treatment regimen as required by State law.

(C) The nursing visit in this paragraph is appropriate for a patient with an infection of drug susceptible tuberculosis and a treatment regimen of 12 months has been prescribed.

(4) Nursing visit - multi-drug resistant preventive therapy with infection. A nursing visit - multi-drug resistant preventive therapy with infection requires an initial intensive interview by Health Department personnel for gathering clinical and epidemiologic data and administration of a tuberculin skin test.

- (A) The nursing visit in this paragraph includes:
- (i) one x-ray every two months;
 - (ii) eight blood tests in 12 months;
 - (iii) two series (6 samples) of sputum tests each 12 months;
 - (iv) monitoring of side effects; and
 - (v) provision of medication.

(B) Notification and consultation with Tuberculosis Control Officer must be established and maintained during the treatment regimen as required by State law.

(C) The nursing visit in this paragraph is appropriate for a patient with a multi-drug resistant tuberculosis infection and a treatment regimen of 12 months has been prescribed.

(5) **Nursing visit - other.** A nursing visit - other - requires an interview by Health Department personnel for gathering clinical data. This nursing visit may include an x-ray, blood test, sputum sample and monitoring of side effects. It does not include medication. Consultation with the Tuberculosis Control Officer may be required. This visit may be appropriate for either a patient with a tuberculosis infection or disease if the patient is continuing to experience symptoms or on orders of a physician.

(6) **Screening.** In a TB screening, Health Department personnel perform tuberculin skin testing of contacts to all TB cases and suspects, high risk population groups and nursing home residents. Tuberculin skin testing is always done at least one time. For negative skin tests, a two-step boosted skin test one to two weeks later will be performed and repeated three months later for contact individuals with a negative boosted skin test.

(7) **Direct Observed Therapy (DOT).** The DOT provider delivers medication to the patient and observes and records the patient's ingestion of medication. Visits may be as frequent as three times a day, seven days a week. The DOT provider is responsible for monitoring side effects of medication and the collection of sputum samples.

[Source: Added at 24 Ok Reg 2070, eff 6-25-07]

317:30-5-1160. Public health nursing services for first time mothers and their infants/children (Children's First program)

(a) The purpose of the Children's First program is to make home visits to low income, first time parents teaching them about pregnancy, nutrition, fetal development and how to care for themselves and their baby after delivery. A first time mother is:

- (1) a woman who is expecting her first live birth, has never parented and plans on parenting this child;
- (2) a woman who is expecting her first live birth, has never parented and is contemplating placing the child for adoption;
- (3) a woman who has been pregnant, but has not delivered a child due to abortion or miscarriage;
- (4) a woman who is expecting her first live birth, but has parented stepchildren or younger siblings;
- (5) a woman who has delivered a child, but her parental rights were legally terminated within the first few months of that child's life; or
- (6) a woman who has delivered a child, but the child died within the first few months of life.

(b) The pregnant woman must enter the program prior to the 28th week of gestation. Services may be provided until the infant's/child's second birthday.

(c) Reimbursement is limited to one nursing service per day provided during the pre and postnatal period of the first time mother and for the first two years of the infant's/child's life. Public health nurse clinic services are limited to five services per month per eligible member/child.

[Source: Added at 24 Ok Reg 2070, eff 6-25-07]

317:30-5-1161. Targeted case management

(a) Case management is a set of interrelated activities under which responsibility for locating, coordinating and monitoring appropriate services for an individual rests with a specific person within the case management agency. Services under case management are not comparable in amount duration and scope.

(b) Case management is designed to assist a individual in gaining access to needed medical, social, educational and other services essential to meeting basic human needs, and is not restrictive in nature.

(c) Major components of the services include working with the individual in the use of basic community resources, referral, linkage and advocacy.

(d) In order to ensure that case management services are not duplicated by other staff, case management activities will be provided in accordance with a comprehensive individualized treatment/service plan. The development of this plan includes clinical staff participation, thus ensuring that staff knows a client has a case manager.

(e) Case management services for first time mothers must provide necessary coordination with providers of non-medical services, such as nutrition, psycho social or health education programs, when services provided by these entities are needed. The case manager coordinates these services with needed medical services. The purpose of case

management services for first time mothers and their infants/children is to:

- (1) assist first time mothers and their infants/children in gaining access to needed medical, social, educational and other services;
 - (2) encourage the use of appropriate medical providers; and
 - (3) discourage over utilization or duplication of services.
- (f) Targeted case management does not include:
- (1) SoonerCare eligibility determinations and re-determinations;
 - (2) SoonerCare intake processing;
 - (3) SoonerCare preadmission screening for inpatient care;
 - (4) Prior Authorization for SoonerCare services and utilization review;
 - (5) SoonerCare outreach;
 - (6) physically escorting or transporting a member to scheduled appointments or staying with a member during an appointment;
 - (7) monitoring financial goals;
 - (8) providing specific services such as shopping or payment of bills; or
 - (9) delivering bus tickets, food stamps, money, etc.

[Source: Added at 24 Ok Reg 2070, eff 6-25-07]

PART 113. LIVING CHOICE PROGRAM

317:30-5-1200. Benefits for members age 65 or older with disabilities or long-term illnesses

- (a) Living Choice program participants age 65 or older with disabilities or long-term illnesses may receive a range of necessary medical and home and community based services for one year after moving from an institutional setting. The one year period begins the day the member occupies a qualified residence in the community. Once this transition period is complete, the member receives 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 (26) 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) extended duty nursing;
- (10) home delivered meals;
- (11) hospice care;
- (12) medically necessary prescription drugs;
- (13) personal care as described in Part 95 of this Chapter;
- (14) Personal Emergency Response System (PERS);
- (15) self-direction;
- (16) transition coordination;
- (17) community transition services as described in OAC 317:30-5-1205;
- (18) dental services (up to \$1,000 per person annually);
- (19) nutrition evaluation and education services;
- (20) agency companion services;
- (21) pharmacological evaluations;
- (22) vision services including eye examinations and eyeglasses;
- (23) non-emergency transportation;
- (24) family training services;
- (25) assisted living services; and
- (26) SoonerCare compensable medical services.

[Source: Added at 26 Ok Reg 258, eff 12-1-08 (emergency); Added at 26 Ok Reg 1069, eff 5-11-09 ; Amended at 30 Ok Reg 1193, eff 7-1-13]

317:30-5-1201. Benefits for members with intellectual disabilities

(a) Living Choice program participants with intellectual disabilities 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 receives 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 intellectual disabilities 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.

[Source: Added at 26 Ok Reg 258, eff 12-1-08 (emergency); Added at 26 Ok Reg 1069, eff 5-11-09 ; Amended at 29 Ok Reg 1102, eff 6-25-12]

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

(a) Living Choice program participants with physical disabilities 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 receives 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 (32) 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) Self-Direction;
- (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;
- (31) assisted living services; and
- (32) SoonerCare compensable medical services.

[Source: Added at 26 Ok Reg 258, eff 12-1-08 (emergency); Added at 26 Ok Reg 1069, eff 5-11-09 ; Amended at 30 Ok Reg 1193, eff 7-1-13]

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

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

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

(b) Institution Transition Case Management services are billed per 15-minute unit of service using the appropriate HCPC and modifier associated with the location of residence of the member served. A unique modifier code is used to distinguish Institution Transition Case Management services from regular Case Management services. The services are billed effective the date of transition into Living Choice and the provider records document actual time and date of services provided.

(c) 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 Program Integrity unit. Erroneous or invalidated claims identified through post payment reviews are recouped from the provider.

(d) Claims may not be filed until the services are rendered.

[Source: Added at 26 Ok Reg 258, eff 12-1-08 (emergency); Added at 26 Ok Reg 1069, eff 5-11-09 ; Amended at 30 Ok Reg 1193, eff 7-1-13]

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. The Oklahoma State Department of Health (OSDH) is 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.

[Source: Added at 26 Ok Reg 258, eff 12-1-08 (emergency); Added at 26 Ok Reg 1069, eff 5-11-09]

317:30-5-1205. Community transition services

(a) Community transition services are one-time set-up expenses for members who transition from a nursing facility or public ICF/MR to a home in the community.

(b) Each member who transitions 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 for 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.

[Source: Added at 26 Ok Reg 258, eff 12-1-08 (emergency); Added at 26 Ok Reg 1069, eff 5-11-09]

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.

[Source: Added at 26 Ok Reg 258, eff 12-1-08 (emergency); Added at 26 Ok Reg 1069, eff 5-11-09]

317:30-5-1207. Benefits for members ages sixteen (16) through eighteen (18) in a psychiatric residential treatment facility

- (a) Living Choice program participants, ages sixteen (16) through eighteen (18), may receive a range of necessary home and community based services for one (1) year after transitioning to the community from a psychiatric residential treatment facility (PRTF) setting. In order to be eligible for the Living Choice program, the member must:
 - (1) Have been in a PRTF facility for ninety (90) or more days during an episode of care; and
 - (2) Meet Level 3 criteria on the Individual Client Assessment Record; or
 - (3) Meet the criteria for Serious Emotional Disturbance as defined in OAC 317:30-5-240.1; or
 - (4) Show critical impairment on a caregiver rated Ohio Scales (score of 25 and above on the Problems Subscale or a score of 44 and below on the Functioning Subscales).
- (b) Services must be billed using the appropriate Healthcare Common Procedure Code System and must be medically necessary.
- (c) All services must be necessary for the individual to live successfully in the community, must be documented in the individual care plan and require prior authorization.

(d) Services that may be provided to members transitioning from a PRTF are found in OAC 317:30-5-241.6(1)(B).

(e) Reimbursement will be for a monthly care coordination payment upon successful submission of a claim for one (1) or more of the covered services listed in OAC 317:30-5-96.3(e)(2).

[Source: Added at 35 Ok Reg 5, eff 8-10-17 (emergency); Added at 35 Ok Reg 1408, eff 9-14-18 ; Amended at 38 Ok Reg 1039, eff 10-1-21]

SUBCHAPTER 7. BILLING AND INQUIRIES [REVOKED]

317:30-7-1. Preparation of claims forms [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 13 Ok Reg 4055, eff 9-17-96 (emergency); Revoked at 14 Ok Reg 1780, eff 5-27-97]

317:30-7-2. Remittance statement [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 13 Ok Reg 4055, eff 9-17-96 (emergency); Revoked at 14 Ok Reg 1780, eff 5-27-97]

317:30-7-3. Electronic billing [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 13 Ok Reg 4055, eff 9-17-96 (emergency); Revoked at 14 Ok Reg 1780, eff 5-27-97]

317:30-7-4. Medicare crossover claims [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 13 Ok Reg 4055, eff 9-17-96 (emergency); Revoked at 14 Ok Reg 1780, eff 5-27-97]

317:30-7-5. Claim status inquiries [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 13 Ok Reg 4055, eff 9-17-96 (emergency); Revoked at 14 Ok Reg 1780, eff 5-27-97]

317:30-7-6. Policy questions [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 13 Ok Reg 4055, eff 9-17-96 (emergency); Revoked at 14 Ok Reg 1780, eff 5-27-97]

317:30-7-7. Medicaid provider file changes [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 13 Ok Reg 4055, eff 9-17-96 (emergency); Revoked at 14 Ok Reg 1780, eff 5-27-97]

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317:30-7-8. Claim adjustments [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 13 Ok Reg 4055, eff 9-17-96 (emergency); Revoked at 14 Ok Reg 1780, eff 5-27-97]

317:30-7-9. Inquiry instructions/addresses for filing claims [REVOKED]

[Source: Added at 12 Ok Reg 751, eff 1-5-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3131, eff 7-27-95 ; Revoked at 13 Ok Reg 4055, eff 9-17-96 (emergency); Revoked at 14 Ok Reg 1780, eff 5-27-97]

APPENDIX A. RISK LEVELS FOR PROVIDERS

Figure 1

Low Risk Provider Types	
41	Adult Day Services
09	Advance Practice Nurse
46	Advantage Home Delivered Meals
39	Agency Companion- DDSD
02	Ambulatory Surgical Center
60	Anesthesiologist Assistant
44	Architectural Modification
36	Assisted Living Services
20	Audiologist
47	Birth Center
21	Case Management Agency- DDSD
15	Chiropractor
08	Clinic/Group
58	Community Transition Services
27	Dentist
39	Direct Support Services- DDSD
42	Employee Training Specialist
11	Family Training Services- DDSD
08	Federally Qualified Health Center
30	Free Standing Dialysis Clinic
50	Group Home-DDSD
39	Habilitation Training- DDSD
43	Homemaker Services
01	Hospital
63	Inpatient Psychiatric Facility
01	I/T/U Hospital
08	I/T/U Outpatient Clinic
03	Nursing Facility
03	Nursing Facility- Extended Respite
Varies	Medicare Crossover Providers
16	Nurse
23	Nutritionist
17	Occupational Therapy Business-DDSD
19	Optician
18	Optometrist
36	Personal Care
24	Pharmacy
31/52	Physician
10	Physician Assistant
14	Podiatrist
13	Public Health Agency
38	Respite Care
37	Room and Board
8	Rural Health Clinic

Figure 2

Moderate Risk Provider Types	
26	Ambulance Services
53	Behavioral Health Practitioner- Under Supervision
06	Hospice
29	Independent Diagnostic Testing Facility/Mobile X-ray
28	Independent Laboratory
53	Licensed Behavioral Health Practitioner
11	Outpatient Behavioral Health Agency Services
11	Paraprofessionals – Behavioral Health
17	Physical Therapists Group and/or Individual
25	Revalidating DME/Medical Supplies
05	Revalidating Home Health Agencies
High Risk Provider Types	
25	Newly Enrolling DME/Medical Supplies
05	Newly Enrolling Home Health Agencies

[Source: Added at 36 Ok Reg 858, eff 9-1-19]

CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY

[**Authority:** Federal Social Security Act, Title XIX; Immigration and Reform Act of 1936; 42 CFR, §§ 440.167, 440.181, and 440.155; P.L. 111-148 and 111-152; 10 O.S., §§ 175.1, 1415, and 1417; 56 O.S., §§ 28.1 et seq., 161 et seq., 162, 164, 175, 177, and 1025.1 through 1025.3; 63 O.S., §§ 5003 through 5016]
[**Source:** Codified 7-27-95]

SUBCHAPTER 1. GENERAL PROVISIONS

317:35-1-1. Purpose

The purpose of this Chapter is to provide the rules for the Oklahoma Health Care Authority's (OHCA) Title XIX (Medicaid) and Title XXI (CHIP) programs for adults and children. The Authority provides payment for medical services to adults and children, within the scope of the program, on behalf of individuals who meet the eligibility requirements for Title XIX (Medicaid) or Title XXI (CHIP).

[**Source:** Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 30 Ok Reg 1209, eff 7-1-13]

317:35-1-2. Definitions

The following words and terms, when used in this Chapter, have the following meaning, unless the context clearly indicates otherwise:

"Acute Care Hospital" means an institution that meets the requirements defined in Section (§) 440.10 of Title 42 of the Code of Federal Regulations (C.F.R.) and:

- (A) Is maintained primarily for the care and treatment of patients with disorders other than mental diseases;
- (B) Is formally licensed or formally approved as a hospital by an officially designated authority for state standard setting; and
- (C) Meets the requirements for participation in Medicare as a hospital.

"Adult" means an individual twenty-one (21) years of age or older, unless otherwise specified by statute, regulation, and/or policy adopted by the Oklahoma Health Care Authority (OHCA). For eligibility criteria policy for children and adults, please refer to Oklahoma Administrative Code (OAC) 317:35-5-2.

"ADvantage Administration (AA)" means the Oklahoma Department of Human Services (OKDHS) which performs certain administrative functions related to the ADvantage Waiver.

"Aged" means an individual whose age is established as sixty-five (65) years or older.

"Agency partner" means an agency or organization contracted with the OHCA that will assist those applying for services.

"Aid to Families with Dependent Children (AFDC)" means the group of low-income families with children described in Section 1931 of the Social Security Act. The Personal Responsibility and Work Opportunity Act of 1996 established the new eligibility group of low-

income families with children and linked eligibility income and resource standards and methodologies and the requirement for deprivation for the new group to the State plan for AFDC in effect on July 16, 1996. Oklahoma has elected to be less restrictive for all SoonerCare members related to AFDC. Children covered under Section 1931 are related to the children's group, and adults covered under Section 1931 are related to the parent and caretaker relative group. The Modified Adjusted Gross Income (MAGI) methodology is used to determine eligibility for these groups.

"Alien" is synonymous with the word "noncitizen" and means an individual who does not have United States citizenship and is not a United States national.

"Area nurse" means a registered nurse in the OKDHS Aging Services Division, designated according to geographic areas who evaluates the Uniform Comprehensive Assessment Tool (UCAT) and determines medical eligibility for Personal Care, ADvantage Waiver, and Nursing Facility services. The area nurse also approves care plan and service plan implementation for Personal Care services.

"Area nurse designee" means a registered nurse selected by the area nurse who evaluates the UCAT and determines medical eligibility for Personal Care, ADvantage Waiver, and Nursing Facility services.

"Authority" means the OHCA.

"Blind" means an individual who has central visual acuity of 20/200 or less in the better eye with the use of a correcting lens.

"Board" means the OHCA Board.

"Buy-in" means the procedure whereby the OHCA pays the member's Medicare premium.

(A) **"Part A Buy-in"** means the procedure whereby the OHCA pays the Medicare Part A premium for individuals determined eligible as Qualified Medicare Beneficiaries Plus (QMBP) who are enrolled in Part A and are not eligible for premium free enrollment as explained under Medicare Part A. This also includes individuals determined to be eligible as Qualified Disabled and Working Individuals (QDWI).

(B) **"Part B Buy-in"** means the procedure whereby the OHCA pays the Medicare Part B premium for categorically needy individuals who are eligible for Part B Medicare. This includes individuals who receive TANF or the State Supplemental Payment to the Aged, Blind or Disabled, and those determined to be Qualified Medicare Beneficiary Plus (QMBP), Specified Low Income Medicare Beneficiaries (SLMB) or Qualifying Individual-1 (QI-1). Also included are individuals who continue to be categorically needy under the PICKLE amendment and those who retain eligibility after becoming employed.

"Caretaker relative" means a person other than the biological or adoptive parent with whom the child resides who meets the specified degree of relationship within the fifth degree of kinship.

"Case management" means the activities performed for members to assist them in accessing services, advocacy and problem solving

related to service delivery.

"Categorically needy" means that income and, when applicable, resources are within the standards for the category to which the individual is related.

"Categorically related" or **"related"** means the individual meets basic eligibility requirements for an eligibility group.

"Certification period" means the period of eligibility extending from the effective date of certification to the date of termination of eligibility or the date of the next periodic redetermination of eligibility.

"Child" means an individual under twenty-one (21) years of age, unless otherwise specified by statute, regulation, and/or policy adopted by the OHCA. For eligibility criteria policy for children and adults, please refer to OAC 317:35-5-2.

"County" means the Oklahoma OKDHS' office or offices located in each county within the State.

"Custody" means the custodial status, as reported by OKDHS.

"Deductible/Coinsurance" means the payment that must be made by or on behalf of an individual eligible for Medicare before Medicare payment is made. The coinsurance is that part of the allowable medical expense not met by Medicare, which must be paid by or on behalf of an individual after the deductible has been met.

(A) For Medicare Part A (Hospital Insurance), the deductible relates to benefits for inpatient services while the patient is in a hospital or nursing facility. After the deductible is met, Medicare pays the remainder of the allowable cost.

(B) For Medicare Part B (Medical Insurance), the deductible is an annual payment that must be made before Medicare payment for medical services. After the deductible is met, Medicare pays eighty percent (80%) of the allowable charge. The remaining twenty percent (20%) is the coinsurance.

"Disabled" means an individual who is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or which has lasted (or can be expected to last) for a continuous period of not less than twelve (12) months.

"Disabled child" means for purposes of Medicaid Recovery a child of any age who is blind, or permanently and totally disabled according to standards set by the Social Security Administration.

"Estate" means all real and personal property and other assets included in the member's estate as defined in Title 58 of the Oklahoma Statutes.

"Expansion adult" means an individual defined by 42 Code of Federal Regulations (C.F.R.) § 435.119 who is age nineteen (19) or older and under sixty-five (65), at or below 133 percent of the federal poverty level (FPL), and who are not related to the aged, blind, or disabled.

"Gatekeeping" means the performance of a comprehensive assessment by the OKDHS nurse utilizing the UCAT for the determination of medical eligibility, care plan development, and the determination of Level of Care for Personal Care, ADvantage Waiver and

Nursing Facility services.

"Ineligible Spouse" means an individual who is not eligible for Supplemental Security Income (SSI) but is the husband or wife of someone who is receiving SSI.

"Lawfully present" means a noncitizen in the United States who is considered to be in lawful immigration status or class.

"Lawfully residing" means the individual is lawfully present in the United States and also meets Medicaid residency requirements.

"Local office" means the Oklahoma OKDHS' office or offices located in each county within the State.

"LOCEU" means the Oklahoma Health Care Authority's Level of Care Evaluation Unit.

"MAGI eligibility group" means an eligibility group whose financial eligibility is determined through the Modified Adjusted Gross Income (MAGI) methodology. The groups subject to MAGI are defined in 42 C.F.R. § 436.603 and listed in OAC 317:35-6-1.

"Modified Adjusted Gross Income (MAGI)" means the financial eligibility determination methodology established by the Patient Protection and Affordable Care Act (PPACA) in 2009.

"Medicare" means the federally funded health insurance program also known as Title XVIII of the Social Security Act. It consists of four (4) separate programs. Part A is Hospital Insurance, Part B is Medical Insurance, Part C is Medicare Advantage Plans, and Part D is Prescription Drug Coverage.

(A) **"Part A Medicare"** means Hospital Insurance that covers services for inpatient services while the patient is in a hospital or nursing facility. Premium free enrollment is provided for all persons receiving Old Age, Survivors, and Disability Insurance (OASDI) or Railroad Retirement income who are age sixty-five (65) or older and for those under age sixty-five (65) who have been receiving disability benefits under these programs for at least twenty-four (24) months.

(i) Persons with end-stage renal disease who require dialysis treatment or a kidney transplant may also be covered.

(ii) Those who do not receive OASDI or Railroad Retirement income must be age sixty-five (65) or over and pay a large premium for this coverage. Under Authority rules, these individuals are not required to enroll for Part A to be eligible for SoonerCare benefits as categorically needy. They must, however, enroll for Medicare Part B. Individuals eligible as a QMBP or as a QDWI under Medicaid are required to enroll for Medicare Part A. The Authority will pay Part A premiums for QMBP individuals who do not qualify for premium free Part A and for all QDWI's.

(B) **"Part B Medicare"** means Supplemental Medical Insurance that covers physician and related medical services other than inpatient or nursing facility care.

Individuals eligible to enroll in Medicare Part B are required to do so under OHCA policy. A monthly premium is required to keep this coverage in effect.

"Minor child" means a child under the age of eighteen (18).

"Noncitizen" is synonymous with the word "alien" and means an individual who does not have United States citizenship and is not a United States national.

"Nursing Care" for the purpose of Medicaid Recovery is care received in a nursing facility, an intermediate care facility for individuals with intellectual disabilities (ICF/IIDs) or other medical institution providing nursing and convalescent care, on a continuing basis, by professional personnel who are responsible to the institution for professional medical services.

"OCSS" means the OKDHS' Oklahoma Child Support Services (formerly Child Support Enforcement Division).

"OHCA" means the Oklahoma Health Care Authority.

"OHCA Eligibility Unit" means the group within the OHCA that assists with the eligibility determination process.

"OKDHS" means the Oklahoma Department of Human Services which is also referenced in rules as Department of Human Services (DHS) and Office of Human Services (OHS).

"OKDHS nurse" means a registered nurse in the OKDHS Aging Services Division who meets the certification requirements for UCAT Assessor and case manager, and who conducts the uniform assessment of individuals utilizing the UCAT for the purpose of medical eligibility determination. The OKDHS nurse also develops care plans and service plans for Personal Care services based on the UCAT.

"Qualified Disabled and Working Individual (QDWI)" means individuals who have lost their Title II OASDI benefits due to excess earnings but have been allowed to retain Medicare coverage.

"Qualified Medicare Beneficiary Plus (QMBP)" means certain aged, blind or disabled individuals who may or may not be enrolled in Medicare Part A, meet the Medicaid QMBP income and resource standards and meet all other Medicaid eligibility requirements.

"Qualifying Individual" means certain aged, blind or disabled individuals who are enrolled in Medicare Part A, meet the Medicaid Qualifying Individual income and resource standards and meet all other Medicaid eligibility requirements.

"Qualifying Individual-1" means a Qualified Individual who meets the Qualifying Individual-1 income and resource standards.

"Reasonably compatible" means that there is no significant discrepancy between information declared by a member or applicant and other information available to the agency. More specific policies and procedures for determining whether a declaration is reasonably compatible are detailed in Oklahoma's Verification Plan.

"Recipient lock-in" means when a member is restricted to one primary physician and/or one pharmacy. It occurs when the OHCA determines that a SoonerCare member has used multiple physicians and/or pharmacies in an excessive manner over a twelve (12) month period.

"Scope" means the covered medical services for which payment is made to providers on behalf of eligible individuals. The OHCA Provider Manual (OAC 317:30) contains information on covered medical services.

"Specified Low Income Medicare Beneficiaries (SLMB)" means individuals who, except for income, meet all of the eligibility requirements for QMBP eligibility and are enrolled in Medicare Part A.

"TEFRA" means the Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97-248). TEFRA provides coverage to certain disabled children living in the home who would qualify for SoonerCare if residents of nursing facilities, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs), or inpatient acute care hospital stays are expected to last not less than sixty (60) days.

"Worker" means the OHCA or OKDHS worker responsible for assisting in eligibility determinations.

[**Source:** Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 13 Ok Reg 911, eff 8-1-95 (emergency); Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 13 Ok Reg 2537, eff 6-27-96 ; Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 15 Ok Reg 544, eff 12-1-97 (emergency); Amended at 15 Ok Reg 1554, eff 5-11-98 ; Amended at 15 Ok Reg 3679, eff 5-18-98 (emergency); Amended at 16 Ok Reg 60, eff 9-11-98 (emergency); Amended at 16 Ok Reg 1438, eff 5-27-99 ; Amended at 17 Ok Reg 2410, eff 6-26-00 ; Amended at 18 Ok Reg 114, eff 11-1-00 (emergency); Amended at 18 Ok Reg 1139, eff 5-11-01 ; Amended at 19 Ok Reg 136, eff 9-1-01 (emergency); Amended at 19 Ok Reg 2149, eff 6-27-02 ; Amended at 20 Ok Reg 2775, eff 7-1-03 (emergency); Amended at 21 Ok Reg 2234, eff 6-25-04 ; Amended at 22 Ok Reg 2494, eff 7-11-05 ; Amended at 23 Ok Reg 268, eff 9-1-05 (emergency); Amended at 23 Ok Reg 1378, eff 5-25-06 ; Amended at 26 Ok Reg 758, eff 4-1-09 (emergency); Amended at 27 Ok Reg 711, eff 2-4-10 (emergency); Amended at 27 Ok Reg 1471, eff 6-11-10 ; Amended at 30 Ok Reg 1209, eff 7-1-13 ; Amended at 32 Ok Reg 1118, eff 8-27-15 ; Amended at 37 Ok Reg 1625, eff 9-14-20 ; Amended at 38 Ok Reg 799, eff 7-1-21 (emergency); Amended at 39 Ok Reg 436, eff 12-21-21 (emergency); Amended at 39 Ok Reg 1534, eff 9-12-22 ; Amended at 41 Ok Reg, Number 14, effective 3-8-24 (emergency)]

317:35-1-3. Legal bases

The Federal legal base of the Medical Assistance program is vested in Titles XIX and XXI of the Federal Social Security Act. The State Legal base is vested in 56 O.S. 1981, Sec. 328 et seq.

[**Source:** Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 30 Ok Reg 1209, eff 7-1-13]

SUBCHAPTER 3. COVERAGE AND EXCLUSIONS

317:35-3-1. Reimbursement

(a) **Payment eligibility.** In order for the Authority to make payment for SoonerCare services, the individual must be determined eligible to have such payment made by:

- (1) having eligibility previously determined, or
- (2) making application for SoonerCare at the time the medical services is requested, and having eligibility determined at that time.

(b) **Member lock-in.** SoonerCare members who have demonstrated utilization above the statistical norm, during a 6-month period, may be "locked-in" to a prescriber and/or one pharmacy for medications classified as controlled dangerous substances. If OHCA has determined

that SoonerCare has been over-utilized, the member is notified, by letter, of the need to select a prescriber and/or pharmacy and of their opportunity for a fair hearing. If the member does not select a prescriber or pharmacy, one is selected for her/him. "Locked-in" members may obtain emergency services from a physician and/or an emergency room facility in the event of a medical emergency.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 20 Ok Reg 646, eff 2-1-03 (emergency); Amended at 20 Ok Reg 1943, eff 6-26-03 ; Amended at 20 Ok Reg 2775, eff 7-1-03 (emergency); Amended at 21 Ok Reg 2234, eff 6-25-04 ; Amended at 32 Ok Reg 1125, eff 8-27-15]

317:35-3-2. SoonerCare transportation and subsistence [REVOKED]

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 13 Ok Reg 911, eff 8-1-95 (emergency); Amended at 13 Ok Reg 2537, eff 6-27-96 ; Amended at 14 Ok Reg 779, eff 11-25-96 (emergency); Amended at 14 Ok Reg 538, eff 12-24-96 (emergency); Amended at 14 Ok Reg 787, eff 1-24-97 (emergency); Amended at 14 Ok Reg 1805, eff 5-27-97 ; Amended at 15 Ok Reg 1117, eff 1-6-98 (emergency); Amended at 15 Ok Reg 1559, eff 5-11-98 ; Amended at 15 Ok Reg 3679, eff 5-18-98 (emergency); Amended at 16 Ok Reg 60, eff 9-11-98 (emergency); Amended at 16 Ok Reg 162, eff 10-14-98 (emergency); Amended at 16 Ok Reg 1438, eff 5-27-99 ; Amended at 16 Ok Reg 3363, eff 6-1-99 (emergency); Amended at 16 Ok Reg 3502, eff 7-16-99 (emergency); Amended at 17 Ok Reg 231, eff 9-7-99 (emergency); Amended at 17 Ok Reg 1212, eff 5-11-00 ; Amended at 17 Ok Reg 3517, eff 8-1-00 (emergency); Amended at 18 Ok Reg 114, eff 11-1-00 (emergency); Amended at 18 Ok Reg 269, eff 10-7-00 (emergency); Amended at 18 Ok Reg 506, eff 1-1-01 (emergency); Amended at 18 Ok Reg 784, eff 1-23-01 (emergency); Amended at 18 Ok Reg 1139, eff 5-11-01 ; Amended at 20 Ok Reg 2775, eff 7-1-03 (emergency); Amended at 20 Ok Reg 2901, eff 7-1-03 (emergency); Amended at 21 Ok Reg 2234, eff 6-25-04 ; Amended at 23 Ok Reg 817, eff 3-9-06 (emergency); Amended at 23 Ok Reg 2580, eff 6-25-06 ; Amended at 24 Ok Reg 93, eff 8-2-06 (emergency); Amended at 24 Ok Reg 943, eff 5-11-07 ; Amended at 24 Ok Reg 2115, eff 6-25-07 ; Amended at 29 Ok Reg 1147, eff 6-25-12 ; Amended at 30 Ok Reg 1244, eff 7-1-13 ; Amended at 32 Ok Reg 1126, eff 8-27-15 ; Revoked at 38 Ok Reg 1066, eff 9-1-21]

317:35-3-3. Prior authorization requirements [REVOKED]

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 779, eff 11-25-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 18 Ok Reg 506, eff 1-1-01 (emergency); Amended at 18 Ok Reg 1139, eff 5-11-01 ; Revoked at 35 Ok Reg 1460, eff 9-14-18]

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME

PART 1. DETERMINATION OF QUALIFYING CATEGORICAL RELATIONSHIPS

317:35-5-1. Scope and applicability

The provisions in this Part apply to all individuals requesting medical services within the scope of the SoonerCare Program.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 18 Ok Reg 114, eff 11-1-00 (emergency); Amended at 18 Ok Reg 1139, eff 5-11-01 ; Amended at 20 Ok Reg 2775, eff 7-1-03 (emergency); Amended at 21 Ok Reg 2234, eff 6-25-04 ; Amended at 30 Ok Reg 1209, eff 7-1-13]

317:35-5-2. Categorically related programs

(a) In order to be eligible for SoonerCare, an individual must first meet the description of a member eligibility group.

(1) For individuals related to the aged, blind, or disabled groups, categorical relationship is established using the same definitions of age, disability, and blindness as used by the Social Security Administration (SSA) in determining eligibility for Supplemental Security Income (SSI) or SSA benefits.

(2) If the individual is a SSA/SSI recipient in current payment status (including presumptive eligibility), a Temporary Assistance for Needy Families (TANF) recipient, an adoption assistance or kinship guardianship assistance recipient, or is under age nineteen (19), categorical relationship is automatically established.

(3) For individuals related to expansion adults the categorical relationship is established and defined by 42 Code of Federal Regulations (C.F.R.) § 435.119.

(4) Categorical relationship to the pregnancy group is established when the determination is made by medical evidence that the individual is or has been pregnant. Verification of pregnancy is only required if the individual's declaration that she is pregnant is not reasonably compatible with other information available to the agency. Pregnancy-related services include all medical services provided within the scope of the program during the prenatal, delivery and postpartum periods for women in this pregnancy group; see Subchapter 22 of this Chapter for services for unborn children covered under Title XXI.

(5) For an individual age nineteen (19) or over to be related to the parent and caretaker relative group, the individual must have a minor dependent child.

(6) For an individual to be related to the former foster care children group, the individual must have been receiving Medicaid benefits as a foster care child in Oklahoma or another state when he/she attained the age of eighteen (18), or aged out of foster care, until he/she reaches the age of twenty-six (26). If the individual aged out of foster care in a state other than Oklahoma, the date of ageing out had to occur on January 1, 2023, or later, and the individual must now be residing in Oklahoma. There is no income or resource test for the former foster care children group.

(7) Categorical relationship to refugee services is established in accordance with OAC 317:35-5-25.

(8) Categorical relationship for the Breast and Cervical Cancer (BCC) treatment program is established in accordance with Subchapter 21 of this Chapter.

(9) Categorical relationship for the SoonerPlan family planning program is established in accordance with OAC 317:35-5-8.

(10) Categorical relationship for pregnancy related benefits covered under Title XXI is established in accordance with Subchapter 22 of the Chapter. Benefits for pregnancies covered under Title XXI medical services are provided within the scope of

the program during the prenatal, delivery and postpartum care when included in the global delivery payment.

(b) To be eligible for SoonerCare benefits, an individual must be related to one (1) of the following eligibility groups and as defined above in this Section:

- (1) Aged;
- (2) Disabled;
- (3) Blind;
- (4) Pregnancy;
- (5) Children, including newborns deemed eligible;
- (6) Parents and caretaker relatives;
- (7) Refugee;
- (8) BCC treatment program;
- (9) SoonerPlan family planning program;
- (10) Benefits for pregnancies covered under Title XXI;
- (11) Former foster care children; or
- (12) Expansion adults.

(c) The Authority may provide SoonerCare to reasonable categories of individuals under age twenty-one (21).

(1) Individuals eligible for SoonerCare benefits include individuals between the ages of nineteen (19) and twenty-one (21):

(A) For whom a public agency is assuming full or partial financial responsibility who are in custody as reported by Oklahoma Human Services (OKDHS) and in foster homes, private institutions or public facilities; or

(B) In adoptions subsidized in full or in part by a public agency; or

(C) Individuals under age twenty-one (21) receiving active treatment as inpatients in public psychiatric facilities or programs if inpatient psychiatric services for individuals under age twenty-one (21) are provided under the State Plan and the individuals are supported in full or in part by a public agency; or

(2) Individuals eligible for SoonerCare benefits include individuals between the ages of eighteen (18) and twenty-one (21) if they are in custody as reported by OKDHS on their eighteenth (18th) birthday and living in an out-of-home placement.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 13 Ok Reg 911, eff 8-1-95 (emergency); Amended at 13 Ok Reg 2537, eff 6-27-96 ; Amended at 19 Ok Reg 136, eff 9-1-01 (emergency); Amended at 19 Ok Reg 2149, eff 6-27-02 ; Amended at 22 Ok Reg 1012, eff 4-1-05 (emergency); Amended at 22 Ok Reg 2518, eff 7-11-05 ; Amended at 23 Ok Reg 275, eff 9-1-05 (emergency); Amended at 23 Ok Reg 1387, eff 5-25-06 ; Amended at 25 Ok Reg 430, eff 1-1-08 (emergency); Amended at 25 Ok Reg 1227, eff 5-25-08 ; Amended at 27 Ok Reg 1481, eff 6-11-10 ; Amended at 29 Ok Reg 1149, eff 6-25-12 ; Amended at 30 Ok Reg 1209, eff 7-1-13 ; Amended at 33 Ok Reg 892, eff 9-1-16 ; Amended at 34 Ok Reg 196, eff 11-22-16 (emergency); Amended at 34 Ok Reg 719, eff 9-1-17 ; Amended at 35 Ok Reg 1464, eff 9-14-18 ; Amended at 38 Ok Reg 799, eff 7-1-21 (emergency); Amended at 39 Ok Reg 1544, eff 9-12-22 ; Amended at 40 Ok Reg 378, eff 11-4-22 (emergency); Amended at 40 Ok Reg 2250, eff 9-11-23]

317:35-5-3. Determining categorical relationship to the aged

An individual is categorically related to the aged when his/her age is established as 65 years or older. The individual meets the condition of

categorical relationship for the entire month in which his/her 65th birthday occurs. Age as determined by SSA is sufficient to establish categorical relationship.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95]

317:35-5-4. Determining categorical relationship to the disabled

An individual is related to disability if he/she is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or which has lasted (or can be expected to last) for a continuous period of not less than twelve (12) months.

(1) **Determination of categorical relationship to the disabled by Social Security Administration (SSA).** The procedures outlined in (A) through (G) of this paragraph are applicable when determining categorical relationship based on a SSA disability decision:

(A) **Already determined eligible for Social Security disability benefits.** If the applicant states he/she is already receiving Social Security benefits on the basis of disability, the information is verified by seeing the applicant's notice of award or the Social Security benefit check. If the applicant states an award letter approving Social Security disability benefits has been received but a check has not been received, this information is verified by seeing the award letter. Such award letter or check establishes categorical relationship. The details of the verification used are recorded in the case record.

(B) **Already determined eligible for Supplemental Security Income (SSI) on disability.** If the applicant, under age sixty-five (65), states he/she is already receiving SSI on the basis of his/her disability (or that a written notice of SSI eligibility on disability has been received but has not yet received a check) this information is verified by seeing the written notice or check. If neither are available, the county clears on the terminal system for the Supplemental Data Exchange (SDX) record. The SDX record shows, on the terminal, whether the individual has been approved or denied for SSI. If the individual has been approved for such benefits, the county uses this terminal clearance to establish disability for categorical relationship. The details of the verification used are recorded in the case record.

(C) **Pending SSI/SSA application or has never applied for SSI.** If the applicant says he/she has a pending SSI/SSA application, an SDX record may not appear on the terminal. Therefore, it is requested that the applicant bring the notice regarding the action taken on his/her SSI/SSA application to the county office as soon as it is received. The other conditions of eligibility are established

while awaiting the SSI/SSA decision. When the SSI/SSA notice is presented, the details of the verification are recorded in the case record and the indicated action is taken on the Title XIX application. If the applicant says he/she has never applied for SSI/SSA but appears potentially eligible from the standpoint of unearned income and has an alleged disability which would normally be expected to last for a period of twelve (12) months, he/she is referred to the SSA office to make SSI/SSA application immediately following the filing of the Title XIX application.

(D) **Already determined ineligible for SSI.** If the applicant says he/she has been determined ineligible for SSI, the written notice of ineligibility from SSA is requested to determine if the denial was based on failure to meet the disability definition. If the SSI notice shows ineligibility was due to not meeting the disability definition, and the applicant says the medical condition has not worsened since the SSI denial, the Title XIX application is denied for the same reason. If written notice is not available, the SDX record on the terminal system is used. This record shows whether the individual has been determined eligible or ineligible for SSI. If he/she has been determined ineligible, the payment status code for ineligibility is shown. The definition of this code is found on OKDHS Appendix Q in order to determine the reason for SSI ineligibility. If the reason for SSI ineligibility was based on failure to meet the disability definition, the Title XIX application is denied for the same reason and the details of the verification are recorded in the case record. If the reason for SSI ineligibility was based on some reason other than failure to meet the disability definition (and therefore, a determination of disability was not made), the Level of Care Evaluation Unit (LOCEU) must determine categorical relationship. In any instance in which an applicant who was denied SSI on "disability" states the medical condition has worsened since the SSI denial, he/she is referred to the SSA office to reapply for SSI immediately following the filing of the Title XIX application.

(E) **Already determined ineligible for Social Security disability benefits.** If the applicant says he/she has been determined ineligible for Social Security disability benefits, he/she is requested to provide written notice of ineligibility to determine if the denial was based on failure to meet the disability definition. If the SSA notice shows ineligibility was due to not meeting the disability definition, and the applicant says the medical condition has not worsened since the denial, the Title XIX application is denied for the same reason. The details of the verification used are recorded in the case record. If

the written notice is not available, third party query procedure (TPQY) is used to verify the denial and the reason for ineligibility. If the reason for ineligibility was based on failure to meet the disability definition, the Title XIX application is denied for the same reason and the details of the verification are recorded in the case record. If the reason for ineligibility was based on some reason other than failure to meet the disability definition (and a determination of disability was, thus, not made), the LOCEU must determine categorical relationship. In any instance in which an applicant who was denied Social Security benefits on disability states the medical condition has worsened since the denial, he/she is referred to the SSA office to reapply immediately following the filing of the Title XIX application.

(F) Determined retroactively eligible for SSA/SSI due to appeal. If an individual becomes retroactively eligible for SSA/SSI due to a decision on an appeal, categorical relationship is established as of the effective date of the retroactive disability decision. Payment will be made for medical services only if the claim is received timely, per Oklahoma Administrative Code (OAC) 317:30-3-11. After the submission of a timely claim, a claim may be resubmitted, per OAC 317:30-3-11.1. If the effective date of the retroactive disability decision does not cover the period of the medical service because the SSA/SSI application was made subsequent to the service, a medical social summary with pertinent medical information is sent to the LOCEU for a categorical relationship decision for the time period of the medical service.

(G) SSA/SSI appeal with benefits continued. A Title XIX recipient who has filed an appeal due to SSA's determination that he/she is no longer disabled may continue to receive SSA benefits. The recipient has the option to have Title XIX benefits continued until the appeal decision has been reached. After the decision has been reached, the appropriate case action is taken. If SSA's decision is upheld, an overpayment referral is submitted for any Title XIX benefits the recipient received beginning with the month that SSA/SSI determined the recipient did not meet disability requirements.

(H) Applicant deceased. Categorical relationship to the disabled is automatically established if an individual dies while receiving a medical service or dies as a result of an illness for which he/she was hospitalized if death occurs within two (2) months after hospital release. The details of the verification used are recorded in the case record.

(2) Determination of categorical relationship to the disabled by the LOCEU.

(A) A disability decision from the LOCEU to determine categorical relationship to the disabled is required only

when SSA makes a disability decision effective after medical services were received or when the SSA will not make a disability decision. The LOCEU is advised of the basis for the referral. SSA does not make disability decisions on individuals who:

- (i) have been determined ineligible by SSA on some condition of eligibility other than disability,
- (ii) have unearned income in excess of the SSI standard and, therefore, are not referred to SSA, or
- (iii) do not have a disability which would normally be expected to last twelve (12) months but the applicant disagrees.

(B) A disability decision from the LOCEU is not required if the disability obviously will not last twelve (12) months and the individual agrees with the short term duration. The case record is documented to show the individual agrees with the short term duration.

(C) The local DHS office is responsible for submitting a medical social summary on DHS form ABCDM-80-D 08MA022E with pertinent medical information substantiating or explaining the individual's physical and mental condition. The medical social summary should include relevant social information such as the worker's personal observations, details of the individual's situation including date of onset of the disability, and the reason for the medical decision request. The worker indicates the beginning date for the categorical relationship to disability. Medical information submitted might include physical exam results, psychiatric, lab, and x-ray reports, hospital admission and discharge summaries, and/or doctors' notes and statements. Copies of medical and hospital bill and DHS Form 08MA005E are not normally considered pertinent medical information by themselves. Current (less than ninety (90) days old) medical information is required for the LOCEU to make a decision on the client's current disability status. If existing medical information cannot be obtained without cost to the client, the county administrator authorizes either payment for existing medical information or one general physical examination by a medical or osteopathic physician of the client's choice. The physician cannot be in an intern, residency or fellowship program of a medical facility, or in the full-time employment of Veterans Administration, Public Health Service or other Agency. Such examination is authorized by use of DHS form 08MA016E, Authorization for Examination and Billing. The DHS worker sends the 08MA016E and DHS form 08MA080E, Report of Physician's Examination, to the physician who will be completing the exam.

(3) Responsibility of Medical Review Team in the LOCEU.

The responsibilities of the Medical Review Team in the LOCEU

include:

(A) The decision as to whether the applicant is related to Aid to the Disabled.

(B) The effective date (month and year) of eligibility from the standpoint of disability. (This date may be retroactive for any medical service provided on or after the first day of the third month prior to the month in which the application was made.)

(C) A request for additional medical and/or social information when additional information is necessary for a decision.

(D) When the LOCEU has made a determination of categorical relationship to disability and SSA later renders a different decision, the Oklahoma Health Care Authority (OHCA) uses the effective date of the SSA approval or denial as their date of disability approval or denial. No overpayment will occur based solely on the SSA denial superseding the LOCEU approval.

(E) Public Law 97-248, the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, provides coverage to certain disabled children living in the home if they would qualify for Medicaid as residents of nursing facilities, ICF/IIDs, or inpatient acute care hospital stays expected to last not less than sixty (60) days. In addition to disability, LOCEU determines the appropriate level of care and cost effectiveness.

(4) Determination of categorical relationship to the disabled based on Tuberculosis (TB) infection. Categorical relationship to disability is established for individuals with a diagnosis of TB. An individual is related to disability for TB related services if he/she has verification of an active TB infection established by a medical practitioner.

(5) Determination of categorical relationship to the disabled for TEFRA. Section 134 of TEFRA allows states, at their option, to make Medicaid benefits available to children, under nineteen (19) years of age, living at home who are disabled as defined by the SSA, even though these children would not ordinarily be eligible for SSI benefits because of the deeming of parental income or resources. Under TEFRA, a child living at home who requires the level of care provided in an acute care hospital (for a minimum of sixty (60) days), nursing facility or intermediate care facility for individuals with intellectual disabilities, is determined eligible using only his/her income and resources as though he/she were institutionalized.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 18 Ok Reg 2587, eff 6-25-01 ; Amended at 22 Ok Reg 2494, eff 7-11-05 ; Amended at 29 Ok Reg 1153, eff 6-25-12 ; Amended at 32 Ok Reg 1118, eff 8-27-15 ; Amended at 36 Ok Reg 921, eff 9-1-19 ; Amended at 39 Ok Reg 1553, eff 9-12-22]

317:35-5-4.1. Special level of care and cost effectiveness application procedures for Tax Equity and Fiscal Responsibility Act (TEFRA)

(a) In order for a child to be eligible for TEFRA, he/she must require a level of care provided in an acute care hospital for a minimum of sixty (60) days, or a nursing facility (NF) or intermediate care facility for individuals with intellectual disabilities (ICF/IID) for a minimum of thirty (30) days. It must also be appropriate to provide care to the child at home. The level of care determination is made by LOCEU. The level of care certification period may be for any number of months that the LOCEU determines appropriate. At the time of application, an assessment form is provided to the applicant for completion by the child's physician. Once completed by the physician and returned to the Oklahoma Health Care Authority, the assessment form is forwarded to the LOCEU along with the request for a disability determination (if needed).

(b) The estimated cost of caring for the child at home must not exceed the estimated cost of treating the child within an institution at the appropriate level of care, i.e., hospital, NF, or ICF/IID. The initial cost analysis is established by LOCEU based on the information provided by the TEFRA-1 Assessment form and medical information used in the relationship to disability determination.

(c) The level of care determination and cost effectiveness analysis are reported by LOCEU annually.

[Source: Added at 22 Ok Reg 2494, eff 7-11-05 ; Amended at 32 Ok Reg 1118, eff 8-27-15 ; Amended at 36 Ok Reg 921, eff 9-1-19]

317:35-5-4.2. Determining nursing facility level of care for TEFRA children

In order to determine nursing facility level of care for TEFRA children:

(1) The child must be age 18 years or younger and expected to meet the following criteria for a minimum of 30 days.

(A) The child must:

(i) have a long-term medical or physical condition which significantly diminishes his/her functional capacity;

(ii) require health-related services that are so inherently complex that it can only be safely and effectively provided by technical or professional medical personnel, such as a registered nurse, licensed practical nurse, etc., and are ordinarily provided in a nursing facility. Without these services, the child is at risk of being institutionalized within a nursing facility; and

(iii) the services needed are above general supervision but can be provided safely in the child's home. The services are usually required 24 hours per day and are ordinarily provided in a

nursing facility inpatient basis (see 42 CFR 409.31-409.34 for the types of services and service frequencies that would be normally considered as nursing facility level of care).

- (B) The service(s) needed has been ordered by a physician.
- (2) The services needed by the child must be greater than the services provided by an ICF/IID and less than those provided in a hospital.

[Source: Added at 32 Ok Reg 1118, eff 8-27-15]

317:35-5-4.3. Determining acute hospital level of care for TEFRA children

In order to determine acute hospital level of care for TEFRA children:

- (1) The child must be age 18 years or younger and expected to meet the following criteria for at least 60 days.
 - (A) The child must need services that:
 - (i) are ordinarily provided in a hospital setting for the care and treatment of inpatients; and
 - (ii) are provided in a hospital that is maintained primarily for the care and treatment of patients with disorders other than mental health diagnosis.
 - (B) The service(s) needed has been ordered by, and is provided under the direction of, a physician.
- (2) The services needed by the child must be greater than the services provided by an ICF/IID and a nursing facility.

[Source: Added at 32 Ok Reg 1118, eff 8-27-15]

317:35-5-5. Determining categorical relationship to the blind

An individual is related to the blind if he/she has central visual acuity of 20/200 or less in the better eye with the use of a correcting lens. When the limitation in the fields of vision is such that the widest diameter of the visual field subtends an angle no greater than 20 degrees, central visual acuity is 20/200 or less. If the individual is to be related to the blind, the exact procedures are followed as are outlined for the disabled. Exception: If a decision on blindness is to be made and current medical information regarding degree of vision is not available to the local office, the individual is referred to an ophthalmologist or optometrist, with payment authorized by the local office, for an examination or existing current medical information. Upon receipt, the local office routes the medical information and the Medical Social Summary to the LOCEU where the decision on blindness is made.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 18 Ok Reg 2587, eff 6-25-01]

317:35-5-6. Determining categorical relationship to pregnancy-related services

(a) For applications made prior to January 1, 2014, categorical relationship to pregnancy-related services can be established by determining through medical evidence that the individual is currently or has been pregnant. Pregnancy must be verified by providing medical proof of pregnancy within thirty (30) days of application submission. OKDHS form 08MA005E, Notification of Needed Medical Services, is not required but will be accepted as medical verification. If proof of pregnancy is not provided within thirty (30) days of application submission, SoonerCare benefits will be closed for the pregnant woman at the end of the thirty (30) day period. The expected date of delivery must be established either by information from the applicant's physician or certified nurse midwife or the member's statement.

(b) Effective January 1, 2014, women who are pregnant, including twelve (12) months postpartum, are related to the pregnant women group. Pregnancy does not have to be verified unless the declaration that an applicant or member is pregnant is not reasonably compatible with other information available to the agency. The individual must also provide the expected date of delivery.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 27 Ok Reg 711, eff 2-4-10 (emergency); Amended at 27 Ok Reg 1471, eff 6-11-10 ; Amended at 28 Ok Reg 1532, eff 6-25-11 ; Amended at 30 Ok Reg 1209, eff 7-1-13 ; Amended at 40 Ok Reg 657, eff 2-21-23 (emergency); Amended at 40 Ok Reg 2252, eff 9-11-23]

317:35-5-6.1. Determining categorical relationship for pregnancy related services covered under Title XXI

(a) For applications made prior to January 1, 2014, categorical relationship for pregnancy related benefits covered under Title XXI is determined in accordance with OAC 317:35-22-1 and through medical evidence that the individual is currently or has recently been pregnant and may qualify for pregnancy related services. Pregnancy must be verified by providing medical proof of pregnancy within 30 days of application submission. OKDHS form 08MA005E, Notification of Needed Medical Services, is not required but will be accepted as medical verification. If proof of pregnancy is not provided within 30 days of application submission, SoonerCare benefits will be closed for the pregnant woman at the end of the thirty day period. The applicant must be residing in the State of Oklahoma with the intent to remain at the time the medical service is received. The expected date of delivery must be established either by information from the applicant's physician or other qualified practitioner.

(b) Effective January 1, 2014, relationship to the pregnancy-related services group under Title XXI is determined in accordance with OAC 317:35-22-1. Pregnancy does not have to be verified unless the declaration that an applicant or member is pregnant is not reasonably compatible with other information available to the agency. The individual must also provide the expected date of delivery.

[Source: Added at 25 Ok Reg 430, eff 1-1-08 (emergency); Added at 25 Ok Reg 1227, eff 5-25-08 ; Amended at 27 Ok Reg 711, eff 2-4-10 (emergency); Amended at 27 Ok Reg 1471, eff 6-11-10 ; Amended at 28 Ok Reg 1532, eff 6-25-11 ; Amended at 30 Ok Reg 1209, eff 7-1-13]

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

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

(b) **Requirement for referral to the Oklahoma Child Support Services Division (OCSS).** As a condition of eligibility, when both the parent or caretaker and minor child(ren) are receiving SoonerCare and a parent is absent from the home, the parent or caretaker relative must agree to cooperate with OCSS. However, cooperation with OCSS is not required in the following instances:

- (1) OCSS made a good cause determination that cooperation is not in the best interest of the child;
- (2) The child is eligible for health care services through the Indian Health Service and the child support case was or would have been opened because of a Medicaid referral based solely on health care services provided through an Indian Health Program, in accordance with Section 533.152 of Title of the Code of Federal Regulations; or
- (3) The SoonerCare application is only for child(ren) and/or pregnant women.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 13 Ok Reg 911, eff 8-1-95 (emergency); Amended at 13 Ok Reg 2537, eff 6-27-96 ; Amended at 17 Ok Reg 2410, eff 6-26-00 ; Amended at 19 Ok Reg 136, eff 9-1-01 (emergency); Amended at 19 Ok Reg 2149, eff 6-27-02 ; Amended at 21 Ok Reg 2234, eff 6-25-04 ; Amended at 23 Ok Reg 268, eff 9-1-05 (emergency); Amended at 23 Ok Reg 1378, eff 5-25-06 ; Amended at 27 Ok Reg 1481, eff 6-11-10 ; Amended at 30 Ok Reg 1209, eff 7-1-13 ; Amended at 31 Ok Reg 73, eff 9-24-13 (emergency); Amended at 31 Ok Reg 1720, eff 9-12-14 ; Amended at 35 Ok Reg 1464, eff 9-14-18 ; Amended at 38 Ok Reg 444, eff 12-18-20 (emergency); Amended at 38 Ok Reg 1071, eff 9-1-21]

317:35-5-8. Determining categorical relationship for the SoonerPlan Family Planning Program

All non-pregnant women and men ages 19 and older, regardless of pregnancy or paternity history, who are otherwise ineligible for SoonerCare are categorically related to the SoonerPlan Family Planning Program. If eligible for SoonerCare benefits, the individual can choose to enroll only in SoonerPlan with the option of applying for SoonerCare at any time.

[Source: Added at 22 Ok Reg 1012, eff 4-1-05 (emergency); Added at 22 Ok Reg 2518, eff 7-11-05 ; Amended at 25 Ok Reg 128, eff 10-1-07 (emergency); Amended at 25 Ok Reg 1227, eff 5-25-08 ; Amended at 29 Ok Reg 1149, eff 6-25-12 ; Amended at 30 Ok Reg 1209, eff 7-1-13]

317:35-5-9. Determining the categorical relationship to expansion adults

(a) To be eligible for SoonerCare under expansion adults, individuals shall meet the following requirements:

- (1) Are age nineteen (19) years or older, and under age sixty-five (65);
- (2) Are not pregnant;
- (3) Are not entitled to or enrolled for Medicare benefits under part A or B;
- (4) Are not eligible for SoonerCare in another mandatory eligibility group under Oklahoma's Medicaid State Plan;
- (5) Have household income that is at or below 133 percent of the federal poverty level (FPL) for their household size; and
- (6) Meet general SoonerCare program eligibility requirements described in Oklahoma Administrative Code (OAC) 317:35, including but not limited to citizenship and residence requirements.

(b) An individual whose household's modified adjusted gross income (MAGI) exceeds the income standard for participation under the parent and caretaker relative group, including those eligible for transitional medical assistance per 317:35-6-64.1, may participate in expansion adults if:

- (1) The individual resides with and assumes primary responsibility for the care of a child under nineteen (19) years of age; and
- (2) The child is enrolled in SoonerCare or other minimum essential coverage, as described by the Affordable Care Act.

[Source: Added at 38 Ok Reg 799, eff 7-1-21 (emergency); Added at 39 Ok Reg 1544, eff 9-12-22]

PART 3. NON-MEDICAL ELIGIBILITY REQUIREMENTS

317:35-5-25. Citizenship/noncitizen status and identity verification requirements

(a) **Citizenship/noncitizen status and identity verification requirements.** Verification of citizenship/noncitizen status and identity is required for all adults and children approved for SoonerCare. An exception is individuals who are initially eligible for SoonerCare as deemed newborns; according to Section 1903(x) of the Social Security Act, they will not be required to further document citizenship or identity at any subsequent SoonerCare eligibility redetermination. They are considered to have provided satisfactory documentation of citizenship and identity by virtue of being born in the United States.

- (1) The types of acceptable evidence that verify identity and citizenship include:
 - (A) United States (U.S.) passport;
 - (B) Certificate of Naturalization issued by U.S. Citizenship & Immigration Services (USCIS)(Form N-550 or N-570);
 - (C) Certificate of Citizenship issued by USCIS (Form N-560 or N-561);
 - (D) Copy of the Medicare card or printout of a Beneficiary Earnings and Data Exchange (BENDEX) or State Data

Exchange (SDX) screen showing receipt of Medicare benefits, Supplemental Security Income or disability benefits from the Social Security Administration; or (E) Tribal membership card or Certificate of Degree of Indian Blood (CDIB) card, with a photograph of the individual.

(2) The types of acceptable evidence that verify citizenship but require additional steps to obtain satisfactory evidence of identity are listed in subparagraphs (A) and (B). Subparagraph (A) lists the most reliable forms of verification and is to be used before using items listed in (B). Subparagraph (B) lists those verifications that are less reliable forms of verification and are used only when the items in (A) are not attainable.

(A) Most reliable forms of citizenship verification are:

- (i) A U.S. public Birth Certificate showing birth in one (1) of the fifty (50) states, the District of Columbia, Puerto Rico (on or after 1/13/1941), Guam (on or after 4/10/1899), the U.S. Virgin Islands (on or after 1/17/1917), American Samoa, Swain's Island, or the Northern Mariana Islands after 11/4/1986. For Puerto Ricans whose eligibility is being determined for the first time on or after October 1, 2010 and using a birth certificate to verify citizenship, the birth certificate must be a certified birth certificate issued by Puerto Rico on or after July 1, 2010;
- (ii) A Consular Report of Birth Abroad of a U.S. citizen issued by the Department of Homeland Security or a Certification of Birth issued by the State Department (Form FS-240, FS-545 or DS-1350);
- (iii) A U.S. Citizen Identification Card (Form I-179 or I-197);
- (iv) A Northern Mariana Identification Card (Form I-873) (Issued by the former INS to a collectively naturalized citizen of the U.S. who was born in the Northern Mariana Islands before 11/3/1986);
- (v) An American Indian Card issued by the Department of Homeland Security with the classification code "KIC" (Form I-872);
- (vi) A final adoption decree showing the child's name and U.S. place of birth;
- (vii) Evidence of U.S. Civil Service employment before 6/1/1976;
- (viii) An Official U.S. Military Record of Service showing a U.S. place of birth (for example a DD-214);
- (ix) Tribal membership card or Certificate of Degree of Indian Blood (CDIB) card, without a photograph of the individual, for Native Americans;
- (x) Oklahoma voter registration card;

- (xi) Other acceptable documentation as approved by OHCA; or
- (xii) Other acceptable documentation to the same extent as described and communicated by the United States Citizenship and Immigration Service (USCIS) from time to time.

(B) Other less reliable forms of citizenship verification are:

- (i) An extract of a hospital record on hospital letterhead established at the time of the person's birth that was created five (5) years before the initial application date and that indicates a U.S. place of birth. For children under sixteen (16) the evidence must have been created near the time of birth or five (5) years before the date of application;
- (ii) Life, health, or other insurance record showing a U.S. place of birth that was created at least five (5) years before the initial application date and that indicates a U.S. place of birth;
- (iii) Federal or state census record showing U.S. citizenship or a U.S. place of birth (generally for persons born 1900 through 1950). The census record must also show the applicant's/member's age; or
- (iv) One (1) of the following items that show a U.S. place of birth and was created at least five (5) years before the application for SoonerCare. This evidence must be one (1) of the following and show a U.S. place of birth:

- (I) Seneca Indian tribal census record;
- (II) Bureau of Indian Affairs tribal census records of the Navajo Indians;
- (III) U.S. State Vital Statistics official notification of birth registration;
- (IV) An amended U.S. public birth record that is amended more than five (5) years after the person's birth; or
- (V) Statement signed by the physician or midwife who was in attendance at the time of birth.

(3) Acceptable evidence of identity that must accompany citizenship evidence listed in (A) and (B) of paragraph (2) of this subsection includes:

- (A) A driver's license issued by a U.S. state or territory with either a photograph of the individual or other identifying information such as name, age, sex, race, height, weight, or eye color;
- (B) A school identification card with a photograph of the individual;
- (C) An identification card issued by federal, state, or local government with the same information included on

driver's licenses;

(D) A U.S. military card or draft record;

(E) A U.S. military dependent's identification card;

(F) A Native American Tribal document including Certificate of Degree of Indian Blood, or other U.S.

American Indian/Alaska Native Tribal document with a photograph of the individual or other personal identifying information;

(G) A U.S. Coast Guard Merchant Mariner card;

(H) A state court order placing a child in custody as reported by the OKDHS;

(I) For children under sixteen (16), school records may include nursery or daycare records;

(J) If none of the verification items on the list are available, an affidavit may be used for children under sixteen (16).

An affidavit is only acceptable if it is signed under penalty of perjury by a parent or guardian stating the date and place of the birth of the child and cannot be used if an affidavit for citizenship was provided.

(b) Reasonable opportunity to obtain verification.

(1) The state provides Medicaid to citizens and nationals of the United States and certain noncitizens, including during a reasonable opportunity period pending verification of citizenship, national status, or immigration status. The reasonable opportunity period begins on the date the notice of reasonable opportunity is received by the individual and extends at minimum ninety (90) days. Receipt by the individual is deemed to occur five (5) days after the date on the notice, unless the individual shows that the notice was not received in the five-day period. The state provides an extension of the reasonable opportunity period if the individual subject to verification is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the state needs more time to complete the verification process. The state begins to furnish benefits to otherwise eligible individuals on the date of application containing the declaration of citizenship or immigration status and throughout the reasonable opportunity period.

(2) The following methods of verification are the least reliable forms of verification and should only be used as a last resort:

(A) Institutional admission papers from a nursing facility, skilled care facility or other institution. Admission papers generally show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth;

(B) Medical (clinic, doctor, or hospital) record created at least five (5) years before the initial application date that indicates a U.S. place of birth. For children under the age of sixteen (16), the document must have been created near the time of birth. Medical records generally show biographical information for the person including place of

birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth. An immunization record is not considered a medical record for purposes of establishing U.S. citizenship;

(C) Written affidavit. Affidavits are only used in rare circumstances. If the verification requirements need to be met through affidavits, the following rules apply:

(i) There must be at least two (2) affidavits by two (2) individuals who have personal knowledge of the event(s) establishing the applicant's/member's claim of citizenship;

(ii) At least one (1) of the individuals making the affidavit cannot be related to the applicant/member;

(iii) In order for the affidavit to be acceptable, the persons making them must be able to provide proof of their own citizenship and identity;

(iv) If the individual(s) making the affidavit has information which explains why evidence establishing the applicant's/member's claim of citizenship does not exist or cannot be readily obtained, the affidavit must contain this information as well;

(v) The State must obtain a separate affidavit from the applicant/member or other knowledgeable individual (guardian or representative) explaining why the evidence does not exist or cannot be obtained; and

(vi) The affidavits must be signed under penalty of perjury.

(c) **Noncitizen eligibility.** SoonerCare services are provided as described to the defined groups as indicated in this subsection if they meet all other factors of eligibility, including but not limited to residency requirements, and if the relevant noncitizen status is verifiable by federally approved means.

(1) **Unauthorized resident noncitizen.** An unauthorized resident noncitizen is a foreign-born individual who is not lawfully present in the United States, regardless of having had authorization during a prior period. Unauthorized resident noncitizens have formerly been known as "illegal" or "undocumented" immigrants or "aliens". Per 8 U.S.C. 1611(a) and (b)(1)(A) an unauthorized resident noncitizen is ineligible for Title XIX Medicaid benefits except for emergency Medicaid as defined at subparagraph (e) below. However, an unauthorized resident noncitizen who is pregnant is eligible for benefits under Title XXI separate Children's Health Insurance Program (CHIP) for services that benefit the unborn child, if the unborn child meets all eligibility requirements.

(2) **Authorized resident noncitizen, not qualified.** An authorized resident noncitizen is a foreign-born individual who is lawfully present in the United States (U.S.) and is lawfully

residing in the U.S., but who does not meet the definition of qualified noncitizen, per 8 U.S.C. 1611(a) and (b)(1)(A). The Oklahoma Medicaid program does not exercise the CHIPRA 214 option; therefore, an authorized resident noncitizen is ineligible for Title XIX or Title XXI Medicaid benefits except for emergency Medicaid as defined at subparagraph (e) below. However, an authorized resident noncitizen who is pregnant is eligible for benefits under Title XXI separate CHIP for services that benefit the unborn child, if the unborn child meets all eligibility requirements.

(3) **Qualified noncitizen.** A "qualified noncitizen" is an authorized resident noncitizen who, at the time of applying for Medicaid, has a "qualified noncitizen" immigration status as identified at 8 U.S.C. 1641, as may be amended from time to time. Any qualified noncitizen is eligible for full Title XIX Medicaid benefits after a five-year waiting period beginning on the date of the noncitizen's entry into the U.S. with an immigration status identified as "qualified noncitizen" if the noncitizen meets all other eligibility criteria at the end of the waiting period. During the waiting period, as per 8 U.S.C. 1613(a), any qualified noncitizen is eligible to receive emergency Medicaid as described in subparagraph (e) below if the noncitizen meets all other eligibility requirements, including but not limited to residency requirements.

(A) **Qualified noncitizen immigration statuses.**

Immigration statuses identified by federal law as "qualified noncitizen", as of November 2, 2021, include:

- (i) A noncitizen who is lawfully admitted for permanent residence under the Immigration and Nationality Act [INA], per 8 U.S.C. 1101 et seq.;
- (ii) A noncitizen who is granted asylum under INA section 208, per 8 U.S.C. 1158;
- (iii) A noncitizen who is admitted to the U.S. under INA section 207 refugee, per 8 U.S.C. 1157;
- (iv) A noncitizen who is paroled into the U.S. under INA section 212(d)(5), per 8 U.S.C. 1182(d)(5), for a period of at least one (1) year;
- (v) A noncitizen whose deportation is being withheld under INA section 243(h), per 8 U.S.C. 1253 (as in effect immediately before the effective date of section 307 of division C of Public Law 104B208) or section 241(b)(3) of such Act, per 8 U.S.C. 1231(b)(3) (as amended by section 305(a) of division C of Public Law 104B208);
- (vi) A noncitizen who is granted conditional entry before 1980 pursuant to INA section 203(a)(7), per 8 U.S.C. 1153(a)(7), as in effect prior to April 1, 1980;
- (vii) A noncitizen who is a Cuban and Haitian entrant (as defined in section 501(e) of the Refugee Education Assistance Act of 1980);

(viii) A noncitizen who, or whose parent or child, has been battered or subjected to extreme cruelty in the U.S. by a U.S. citizen or lawful permanent resident spouse or parent or by a member of the spouse's or parent's family residing in the same household, except during any period in which the individual responsible for such battery or cruelty resides in the same household or family eligibility unit as the individual subjected to such battery or cruelty and only when the alien meets all of the following requirements:

(I) The noncitizen, if not the individual subjected to battery or extreme cruelty, had no active participation in the battery or cruelty;

(II) The noncitizen is a credible victim; and

(III) The noncitizen is able to show a substantial connection between the need for benefits sought and the batter or extreme cruelty; and

(IV) The noncitizen has been approved or has a petition pending which sets forth a prima facie case for one of the following: status as a spouse or child of a U.S. citizen under INA 204(a)(1)(A); classification under INA 204(a)(1)(B)(ii) or (iii); suspension of deportation under INA 244(a)(3); status as a spouse or child of a U.S. citizen under INA 204(a)(1)(A); or classification under INA 204(a)(1)(B); or cancellation of removal under INA 240A(b)(2).

(ix) A noncitizen who is or has been a victim of a severe form of trafficking in persons and who has been granted nonimmigrant status under INA 101(a)(15)(T) or who has a pending application that sets forth a prima facie case for eligibility for such immigration status; or

(x) Beginning December 27, 2020, a noncitizen who lawfully resides in the state in accordance with the Compacts of Free Association between the Government of the United States and the Governments of the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau.

(B) Five-year wait exception for refugees and asylees.

(i) Excepted from the five-year waiting period per 8 U.S.C. 1612(b)(2)(A), the following qualified noncitizens are immediately eligible for a Medicaid determination upon the date:

(I) A noncitizen is admitted to the U.S. as a refugee under INA section 207 [INA 207

Refugee], per 8 U.S.C. 1157;

(II) A noncitizen is granted asylum under INA section 208, per 8 U.S.C. 1158;

(III) A noncitizen's deportation is withheld under INA section 243(h), per 8 U.S.C. 1253 (as in effect immediately before the effective date of section 307 of division C of Public Law 104B208) or section 241(b)(3) of such Act, per 8 U.S.C. 1231(b)(3) (as amended by section 305(a) of division C of Public Law 104B208);

(IV) A noncitizen is granted status as a Cuban and Haitian entrant (as defined in section 501(e) of the Refugee Education Assistance Act of 1980); or

(V) A noncitizen is admitted to the U.S. as an Amerasian immigrant under the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1988, section 584.

(ii) This exception to the five-year waiting period expires seven (7) years after the date of action indicated in the list at (c)(3)(B)(i) above. Upon expiration of the exception, the five-year waiting period must be calculated.

(C) Five-year wait exception for certain permanent resident noncitizens. The five-year waiting period does not apply and the noncitizen is immediately eligible for a Medicaid determination per 8 U.S.C. 1612(b)(2)(B), if:

(i) The noncitizen is lawfully admitted to the U.S. for permanent residence;

(ii) The noncitizen has either:

(I) worked forty (40) qualifying quarters of coverage as defined under the Act; or

(II) can be credited with such qualifying quarters as provided under 8 U.S.C. 1645; and

(iii) In the case of any such qualifying quarters creditable for any period beginning after December 31, 1996, the noncitizen did not receive any federal means-tested public benefit during any such period.

(D) Five-year wait exception for veteran and active-duty noncitizens. As per 8 U.S.C. 1612(b)(2)(C) and 1613, the five-year waiting period does not apply, and the noncitizen is immediately eligible for a Medicaid determination if the noncitizen is a qualified noncitizen who is lawfully residing in the state and is:

(i) A veteran (as defined at INA sections 101, 1101, or 1301, or as described at 38 U.S.C. section 107) with a discharge characterized as an honorable

discharge and not on account of noncitizenship and who fulfills the minimum active-duty service requirements of 38 U.S.C. section 5303A(d);

(ii) On active duty (other than active duty for training) in the Armed Forces of the United States; or

(iii) The spouse or unmarried dependent child of an individual described herein as a veteran or active-duty noncitizen; or

(iv) The unremarried surviving spouse of an individual described herein as a veteran or active-duty noncitizen who is deceased, if the marriage fulfills the requirements of 38 U.S.C. section 1304.

(E) Five-year wait exception for COFA migrants. Per 8 U.S.C. 1613(b)(3) and as of December 27, 2020, any noncitizen who lawfully resides in the state in accordance with the Compacts of Free Association between the Government of the United States and the Governments of the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau is, with regard to the Medicaid program, are not subject to the five-year waiting period unless and until the individual's status is adjusted to lawful permanent resident (LPR), at which time the five year waiting period must be calculated, unless the individual meets a separate exception to the five-year waiting period:

(i) If the individual entered the U.S. before December 27, 2020, and the date of adjustment to LPR status occurred before December 27, 2020, then the waiting period begins on the date of adjustment and ends after five (5) years;

(ii) If the individual entered the U.S. before December 27, 2020, and the date of adjustment to LPR status occurred after December 27, 2020, the waiting period expires on December 27, 2025; and

(iii) If the individual entered the U.S. after December 27, 2020, and the date of adjustment to LPR status occurred after December 27, 2020, the waiting period begins on the date of entry into the U.S. and ends after five (5) years.

(F) Five-year wait exception for qualified noncitizens receiving SSI. Per 8 U.S.C. 1612(b)(2)(F), a qualified noncitizen who is receiving benefits under the supplemental security income program (SSI) under Title XVI of the Act shall be eligible for medical assistance under a state plan under Title XIX of the Social Security Act, per 42 U.S.C. 1396 et seq), under the same terms and conditions that apply to other recipients of SSI benefits.

(4) Special categories of noncitizens and conferred benefits. For the following noncitizens, federal law has expressly authorized Title XIX Medicaid benefits as described below and at

law.

(A) **Certain American Indian / Alaskan Native (AI/AN) noncitizens.** The qualified noncitizen requirement and the five-year waiting period do not apply to any individual who is:

- (i) An American Indian born in Canada to whom section 289 of the Immigration and Nationality Act apply, per 8 U.S.C. 1359; or
- (ii) A member of a federally recognized Indian tribe as defined at 25 U.S.C. 450b(e).

(B) **Certain Iraqi nationals.**

(i) Public Law 110-181, Section 1244, while in force and as amended from time to time, created a new category of special immigrant for Iraqi nationals, including:

(I) Principal noncitizens who have provided relevant service to the U.S. government, while employed by or on behalf of the U.S. government in Iraq, for not less than 1 year beginning on or after March 20, 2003, and who have experienced or are experiencing an ongoing serious threat as a consequence of that employment;

(II) The spouse or surviving spouse of a principal noncitizen; and

(III) The child of a principal noncitizen.

(ii) Public Law 111-118, Section 8120, while in force and as amended from time to time, extended Iraqi special immigrant eligibility for medical assistance to the same extent as INA 207 Refugees are eligible for medical assistance [see subparagraph (c)(3)(B) above] as of December 19, 2009.

(iii) As of August 3, 2021, pursuant to the Office of Refugee Resettlement Policy Letter 21-07, while in force and as may be amended, Iraqi nationals granted special immigrant parole, noncitizens with applications pending for special immigrant status, are also eligible for medical assistance to the same extent as INA 207 Refugees are eligible for medical assistance [see subparagraph (c)(3)(B) above];

(C) **Certain Afghan nationals.**

(i) Public Law 111-8, Section 602, while in force and as amended from time to time, created a new category of special immigrant for Afghan nationals, including:

(I) Principal noncitizens who have provided relevant service to the U.S. government or the International Security Assistance Force, while employed by or on behalf of the U.S. government in Afghan, for not less than one

(1) year beginning on or after October 7, 2001, and who have experienced or are experiencing an ongoing serious threat as a consequence of that employment;

(II) The spouse or surviving spouse of a principal noncitizen; and

(III) The child of a principal noncitizen.

(ii) Public Law 111-118, Section 8120, while in force and as amended from time to time, amended Public Law 111-8, Section 602, to extend Afghan special immigrant eligibility for medical assistance to the same extent as INA 207 Refugees are eligible for medical assistance [see subparagraph (c)(3)(B) above] as of December 19, 2009;

(iii) As of August 3, 2021, pursuant to the Office of Refugee Resettlement Policy Letter 21-07, while in force and as may be amended, Afghan nationals granted special immigrant parole, noncitizens with applications pending for special immigrant status, are also eligible for medical assistance to the same extent as INA 207 Refugees are eligible for medical assistance [see subparagraph (c)(3)(B) above];

(iv) Pursuant to Public Law 117-43, Section 2502, while in force and as may be amended from time to time, "applicable individuals" have time-limited eligibility for medical assistance to the same extent as INA 207 Refugees are eligible for medical assistance [See subsection (c)(3)(B) above], until March 21, 2023, or the term of parole, whichever is later. In this subparagraph, the term "applicable individual" includes only:

(I) A citizen or national of Afghanistan or a person with no nationality who last habitually resided in Afghanistan, if the individual is paroled into the U.S. between July 31, 2021, and September 30, 2022;

(II) The spouse or child of an individual described at (c)(3)(C)(iv)(I) of this section, if the spouse or child is paroled into the U.S. after September 30, 2022; and

(III) The parent or legal guardian of an individual described at (c)(3)(C)(iv)(I) who is determined to be an unaccompanied child, if the parent or legal guardian is paroled into the U.S. after September 30, 2022.

(D) **Certain Ukrainian nationals.** Public Law 117-128, Section 401, while in force and as amended from time to time, created a new category of special immigrant for Ukraine nationals, including:

- (i) A citizen or national of Ukraine, or a person who last habitually resided in Ukraine, who was paroled into the United States between February 24, 2022 and September 30, 2023; or
- (ii) A citizen or national of Ukraine, or a person who last habitually resided in Ukraine, who was paroled into the United States after September 30, 2023, and is the spouse or child of an individual described in (D)(i)(I) above, or is the parent, legal guardian, or primary caregiver of an individual described in (D)(i)(I) above who is determined to be an unaccompanied child; and
- (iii) The individual's parole has not been terminated by the Secretary of Homeland Security.

(d) **Continuing conformance with federal law.** Notwithstanding any other provision of this section, any noncitizen population that federal law or authority, as amended from time to time, identifies as eligible for medical assistance under Title XIX is eligible for such benefits to the same extent, under the same conditions, and for the same period of time as indicated in the relevant federal law or official federal guidance documents, including any amendments to the law or guidance.

(e) **Emergency Medicaid.** Emergency Medicaid in this section means medical assistance provided to a noncitizen under Title XIX for care and services that are necessary for the treatment of an emergency medical condition, as defined by section 1903(v)(3) of the Act and including labor and delivery but not related to organ transplant procedure, of the noncitizen involved if the noncitizen otherwise meets eligibility requirements for medical assistance under the state plan, including but not limited to residency requirements.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 15 Ok Reg 557, eff 11-5-97 (emergency); Amended at 15 Ok Reg 1554, eff 5-11-98 ; Amended at 20 Ok Reg 2793, eff 5-26-03 (emergency); Amended at 21 Ok Reg 2235, eff 6-25-04 ; Amended at 24 Ok Reg 2116, eff 6-25-07 ; Amended at 25 Ok Reg 430, eff 1-1-08 (emergency); Amended at 25 Ok Reg 1227, eff 5-25-08 ; Amended at 26 Ok Reg 115, eff 10-1-08 (emergency); Amended at 26 Ok Reg 545, eff 2-1-09 (emergency); Amended at 26 Ok Reg 2128, eff 6-25-09 ; Amended at 26 Ok Reg 3029, eff 7-21-09 (emergency); Amended at 27 Ok Reg 630, eff 1-14-10 (emergency); Amended at 27 Ok Reg 1492, eff 6-11-10 ; Amended at 28 Ok Reg 269, eff 11-15-10 (emergency); Amended at 28 Ok Reg 1511, eff 6-25-11 ; Amended at 32 Ok Reg 1128, eff 8-27-15 ; Amended at 35 Ok Reg 1460, eff 9-14-18 ; Amended at 39 Ok Reg 436, eff 12-21-21 (emergency); Amended at 39 Ok Reg 1534, eff 9-12-22 ; Amended at 40 Ok Reg 659, eff 2-21-23 (emergency); Amended at 40 Ok Reg 2254, eff 9-11-23]

317:35-5-26. Residence requirements; residents of public institutions; homeless persons; and residents of IHS, BIA or Tribal controlled dormitories

(a) **Residence.** To be eligible for SoonerCare services, the applicant must be residing in the State of Oklahoma with intent to remain at the time the medical service is received. A durational residence requirement is not imposed.

- (1) Temporary absence from the State, with subsequent returns to the State, or intent to return when the purposes of the absence have been accomplished, does not interrupt continuity of Oklahoma residence.

(2) Oklahoma residence does not include transients or visitors passing through the state but does not preclude persons who do not have a fixed address if intent is established.

(3) Intent to remain or return is defined as a clear statement of plans to remain or return in addition to other evidence and/or corroborative statements of others.

(4) When a non-resident makes application for SoonerCare benefits, the local office provides services necessary to make available to the applicant any SoonerCare services for which he/she might be eligible from his/her state of residence. The local office contacts the state or county of the applicant's residence to explore possible eligibility for medical benefits from the state and to obtain information needed for the determination of medical eligibility for the services received while in Oklahoma.

(5) If a member's whereabouts are unknown, as indicated by the return of unforwardable agency mail, refer to OAC 317:35-5-67.

(b) Individuals residing in institutions (correctional facilities and institutions for mental disease). The SoonerCare program will only pay for services rendered to adults (21 through 64 years of age) who are inpatients in an institution for mental disease (IMD), juveniles in the custody of the Office of Juvenile Affairs who are inmates in a state-owned and operated facility, or inmates in a correctional facility, when these individuals are admitted as an inpatient to a hospital, nursing facility, juvenile psychiatric facility or an intermediate care facility for the mentally retarded and meet all other eligibility requirements.

(c) Homeless individuals. Individuals are not required to have a fixed address in order to be eligible for assistance. Individuals who lack a fixed or regular residence, who have temporary accommodations, i.e., supervised shelters, residence of other individuals, a hallway, bus station, car or other similar places, are considered as "homeless".

(d) Individuals residing in IHS, BIA or Tribal controlled dormitories. Individuals that reside in a facility which provides students boarding and lodging on a temporary residential basis for the purpose of attending a Bureau-operated or Indian-controlled contract or public school are considered Oklahoma residents for SoonerCare eligibility purposes.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 21 Ok Reg 2234, eff 6-25-04 ; Amended at 23 Ok Reg 277, eff 9-1-05 (emergency); Amended at 23 Ok Reg 1389, eff 5-25-06 ; Amended at 25 Ok Reg 436, eff 12-1-07 (emergency); Added at 25 Ok Reg 1227, eff 5-25-08 ; Amended at 36 Ok Reg 1112, eff 7-1-19 (emergency); Amended at 37 Ok Reg 1627, eff 9-14-20]

317:35-5-27. Social Security number

Federal regulations require that an individual must furnish, or show documentation of application for, a Social Security number at the time of application for Title XIX services. Documentation of application for a SSN number may include, but is not limited to, Form SSA-2853 or DHS Form Adm-101 (Social Security Number Enumeration Referral).

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 3533, eff 7-23-97 (emergency); Amended at 15 Ok Reg 1554, eff 5-

PART 5. COUNTABLE INCOME AND RESOURCES

317:35-5-40. Scope and applicability

The rules in this Part are used to determine financial eligibility once categorical relationship and other factors of eligibility have been determined.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95]

317:35-5-41. Determination of capital resources for individuals categorically related to aged, blind and disabled

(a) **General.** The term capital resources is a general term representing any form of real and/or personal property which has an available money value. All available capital resources, except those required to be disregarded by law or by policies of the Oklahoma Health Care Authority (OHCA) or Oklahoma Department of Human Services (DHS) are considered in determining need. DHS Appendix C-1, Schedule VIII establishes the allowable limit for nonexcludable resources. Available resources are those resources which are in hand or under the control of the individual.

(1) In defining need, OHCA and DHS recognize the importance of a member retaining a small amount of resources for emergencies or special need and has established a maximum resource standard a member or family may hold and be considered in need.

(2) Capital resources are evaluated on a monthly basis in determining eligibility for an applicant for medical services. An applicant is determined ineligible for any month resources exceed the resource standard at any time during that month. When a member has resources which exceed the resource standard, case closure action is taken for the next possible effective date.

(3) State law is specific on the mutual responsibility of spouses for each other. Therefore, if husband and wife are living together, a capital resource and/or income available to one spouse constitutes a resource and/or income to the other. When there is a break in the family relationship and the husband and wife are separated, but not divorced or legally separated, they constitute a possible resource to each other and this possible resource is explored to determine what, if any, resource can be made available. When a spouse is in a nursing facility, see Subchapters 9 and 19 of this Chapter.

(4) Only the resources of the child determined eligible for Tax Equity Fiscal Responsibility Act (TEFRA) are considered in determining eligibility.

(5) Household goods and personal effects are not considered capital resources. Household goods and personal effects are defined as follows:

- (A) Household goods are:
 - (i) Items of personal property, found in or near the home, that are used on a regular basis; and/or
 - (ii) Items needed by the householder for maintenance, use, and occupancy of the premises as a home.
- (B) Personal effects are:
 - (i) Items of personal property ordinarily worn or carried by the individual; and/or
 - (ii) Articles otherwise having an intimate relation to the individual.
- (C) Personal effects do not include items that were acquired or are held for their value or as an investment. Such items can include but are not limited to gems, jewelry that is not worn or held for family significance, or collectibles.

(6) Each time that need is determined, gross income and the equity of each capital resource are established. Equity equals current market value minus indebtedness. The member may change the form of capital resources from time to time without affecting eligibility so long as the equity is not decreased in doing so or increased in excess of the allowable maximum resource standard. In the event the equity is decreased as the result of a sale or transfer, the reduction in the equity is evaluated in relation to policy applicable to resources disposed of while receiving assistance.

(b) **Eligibility.** In determining eligibility based on resources, only those resources available for current use or those which the member can convert for current use (no legal impediment involved) are considered as countable resources. Examples of legal impediments include, but are not limited to, clearing an estate, probate, petition to sell, or appointment of legal guardian.

(1) Generally, a resource is considered unavailable if there is a legal impediment to overcome. However, the member must agree to pursue all reasonable steps to initiate legal action within thirty (30) days. While the legal action is in process, the resource is considered unavailable.

(2) If a determination is made and documented that the cost of making a resource available exceeds the gain, the member will not be required to pursue action to make it available.

(3) Determination of available and unavailable resources must be well documented in the case record.

(4) The major types of capital resources are listed in Sections Oklahoma Administrative Code (OAC) 317:35-5-41.1 through 317:35-5-41.7, as well as OAC 317:35-5-41.12. The list is not intended to be all inclusive and consideration must be given to all resources.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 796, eff 12-24-96 (emergency); Amended at 14 Ok Reg 1814, eff 5-27-97 ; Amended at 15 Ok Reg 564, eff 9-18-97 (emergency); Amended at 15 Ok Reg 1124, eff 1-6-98 (emergency); Amended at 15 Ok Reg 1559, eff 5-11-98 ; Amended at 15 Ok Reg 3695, eff 5-18-98

(emergency); Amended at 15 Ok Reg 4212, eff 8-5-98 (emergency); Amended at 16 Ok Reg 1438, eff 5-27-99 ; Amended at 17 Ok Reg 430, eff 11-2-99 (emergency); Amended at 17 Ok Reg 1212, eff 5-11-00 ; Amended at 18 Ok Reg 132, eff 10-7-00 (emergency); Amended at 18 Ok Reg 792, eff 1-23-01 through 7-14-01 (emergency)¹; Amended at 19 Ok Reg 136, eff 9-1-01 (emergency); Amended at 19 Ok Reg 2149, eff 6-27-02 ; Amended at 21 Ok Reg 2239, eff 6-25-04 ; Amended at 22 Ok Reg 1016, eff 2-1-05 (emergency); Amended at 22 Ok Reg 2494, eff 7-11-05 ; Amended at 24 Ok Reg 680, eff 2-1-07 (emergency); Amended at 24 Ok Reg 2122, eff 6-25-07 ; Amended at 25 Ok Reg 130, eff 8-1-07 (emergency); Amended at 25 Ok Reg 1257, eff 5-25-08 ; Amended at 36 Ok Reg 925, eff 9-1-19]

Editor's Note: ¹*This emergency action expired without being superseded by a permanent action. Upon the expiration of an emergency amendatory action, the last prior permanent text is reinstated. Therefore, on 7-15-01 (after the expiration of this emergency action), the text of 317:35-5-41 reverted back to the permanent text that became effective 5-11-00, as was last published in the 2000 OAC Supplement, and remained as such until amended again by emergency action on 9-1-01.*

317:35-5-41.1. Home/real property

(a) Home property is excluded from resources regardless of value unless the individual is applying for long-term care services [See Oklahoma Administrative Code (OAC) 317:35-5-41.8(a) (relating to eligibility for long-term care services)]. For purposes of the home property resource exclusion, a home is defined as any shelter in which the individual has an ownership interest and which is used by the individual as his/her principal place of residence. The home may be either real or personal property, fixed or mobile.

(1) Home property includes all property which is adjacent to the home. Land is considered adjacent even if separated by a boundary line, street, alley, highway, or waterway.

(2) Property has a value regardless of whether there is an actual offer to purchase. Verification of home/real property value is established by collateral contacts with specialized individuals knowledgeable in the type and location of property being considered. Mineral rights and wind rights associated with the home property are not valued separate from the surface.

(3) The home may be retained without affecting eligibility during periods when it is necessary to be absent for illness or other necessity. When it is determined that the member does not have a feasible plan for and cannot be expected to return to his/her home, the market value of the property is considered in relation to the resource. The member is responsible for taking all steps necessary to convert the resource for use in meeting current needs. If the member is making an effort to make the resource available, a reasonable period of time is given [not to exceed ninety (90) days] to convert the resource. He/she is advised in writing that the ninety-day (90-day) period begins with the determination that the property be considered in relation to the resource. The ninety-day (90-day) period is given only if efforts are in progress to make the resource available. Any extension beyond the initial ninety-day (90-day) period is justified only after interviewing the member, determining that a good faith effort to sell is still being made and failure to sell is due to circumstances

beyond the control of the member. A written notification is also provided to the member at any time an extension is allowed. Detailed documentation in the case record is required.

(4) If the member fails or is unwilling to take steps necessary to convert the resource for use in meeting current needs, continuing eligibility cannot be established and the member is advised as to the effective date of closure and of the right to receive assistance when the resources are within the maximum allowable resources provided other conditions of eligibility continue to be met.

(5) When a member sells his/her home with the intention of purchasing another home or when an insurance payment for damage to the home is received, a reasonable period of time is given to reinvest the money in another home. A reasonable period of time is considered to not exceed a ninety-day (90-day) period. Extensions beyond the ninety (90) days may be justified only after interviewing the member; and determining that a good faith effort is still being made; and that completion of the transaction is beyond his/her control. This must be documented in the case record.

(6) At the point a member decides not to reinvest the proceeds from the sale of his/her home in another home, the member's plan for use of the proceeds is evaluated in relation to rules on resources disposed of while receiving assistance.

(7) A home traded for another home of equal value does not affect the member's eligibility status. If the home is traded for a home of lesser value, the difference may be invested in improvement of the new home.

(8) Absences from home for up to ninety (90) days for trips or visits or six (6) months for medical care (other than nursing facilities) do not affect receipt of assistance or the home exclusion as long as the individual intends to return home. Such absences, if they extend beyond those limits, may indicate the home no longer serves as the principal place of residence.

(9) Mineral rights, associated with the home property, are considered along with the surface rights and are excluded as a resource.

(b) Real property other than home property shall be treated as follows:

(1) Mineral rights which are not associated with the home property are considered as a resource. Since evaluation and salability of mineral rights fluctuate, the establishment of the value of mineral rights are established based on the opinion of collateral sources. Actual offers of purchase are used when established as a legitimate offer through a collateral source. Mineral rights not associated with home property which are income producing are considered in the same way as income producing property. Refer to OAC 317:35-5-41.12(c)(3) for treatment of mineral rights as non-trade or non-business property.

(2) The market value of real estate other than home property owned by the member or legal dependent and encumbrances against such property are ascertained in determining the equity (including the cost to the member of a merchantable title to be

determined when the resource approaches the maximum). The market value of real estate other than the home owned by the applicant is established on the basis of oral or written information which the applicant has on hand and counsel with persons who have specialized knowledge about this kind of resource. Refer to OAC 317:35-5-41.12(c) for exclusion of real estate that produces income.

(3) For any individual (and spouse, if any) who is of Indian descent from a federally recognized Indian tribe, any interest in land which is held in trust by the United States for an individual Indian or tribe, or which is held by an individual Indian or tribe and which can only be sold, transferred, or otherwise disposed of with the approval of other individuals, his or her tribe, or an agency of the federal government, shall be excluded from resource determinations, in accordance with 20 Code of Federal Regulations (C.F.R.§ 416.1234.

(4) A life estate conveys upon an individual or individuals for his/her lifetime, certain rights in property. Its duration is measured by the lifetime of the tenant or of another person; or by the occurrence of some specific event, such as remarriage of the tenant. The owner of a life estate has the right of possession, the right to use the property, the right to obtain profits from the property and the right to sell his/her life estate interest. However, the contract establishing the life estate may restrain one or more rights of the individual. The individual does not have title to all interest in the property and does not have the right to sell the property other than the interest owned during his/her lifetime. He/she may not usually pass it on to heirs in the form of an inheritance.

(A) When a life estate in property is not used as the member's home, it is necessary to establish the value. A computer procedure is available to compute the value of a life estate by input of the current market value of the property and the age of the life estate owner.

(B) The value of a life estate on mortgaged property is based on equity rather than market value and the age of the individual.

(C) In the event the member does not accept as valid the value of the life estate as established through this method, the member must secure a written estimate by two (2) persons who are familiar with current values. If there is substantial unexplained divergence between these appraisals, the worker and the member will jointly arrange for the market value to be established by an appraisal made by a third (3rd) person who is familiar with current market values and who is acceptable to both the member and the worker.

(5) Real and/or personal property which produces income is excluded if it meets the following conditions established in OAC 317:35-5-41.12.

[Source: Added at 25 Ok Reg 130, eff 8-1-07 (emergency); Added at 25 Ok Reg 1257, eff 5-25-08 ; Amended at 33 Ok Reg 894, eff 9-1-16 ; Amended at 36 Ok Reg 925, eff 9-1-19 ; Amended at 37 Ok Reg 1629, eff 9-14-20]

317:35-5-41.10. Changes in capital resources

(a) **Capital resources of an applicant or member currently receiving assistance.** If the resource(s) of an applicant is in a form which is not available for immediate use, such as real estate, mineral rights, or one of many other forms, and the applicant is trying to make the resource available, the applicant may be certified and given a reasonable amount of time to make this available. If a member who is currently receiving medical assistance acquires resources which increase his/her available resources at an amount above the maximum resource standard, he/she is given a reasonable amount of time to make the resources available. A reasonable amount of time would normally not exceed 90 days. The member is notified in writing that a period of time not to exceed 90 days will be given to make the resource available. Any extension beyond the initial 90 day period is justified only after interviewing the member, determining that a good faith effort is still being made and that failure to make the resource available is due to circumstances beyond the control of the member.

(b) **Money borrowed on member's resources.** Money borrowed on any of the member's resources, except the home, merely changes his/her resource from one form to another. Money borrowed on the home is evaluated in relation to the maximum reserve standard.

(c) **Transfer of resources.** Rules on transfer or disposal of capital resources are not applicable unless the individual enters a nursing home or receives Home and Community Based Waiver Services, HCBWS/MR or ADvantage waiver services. [See OAC 317:35-9, OAC 317:35-17, and OAC 317:35-19]

[Source: Added at 25 Ok Reg 130, eff 8-1-07 (emergency); Added at 25 Ok Reg 1257, eff 5-25-08 ; Amended at 26 Ok Reg 2132, eff 6-25-09]

317:35-5-41.11. Maximum resources

Maximum resources is a term used to designate the largest amount which a member can have in one or more nonexempt resources, and still be considered to be in need. A member's resources may be held in any form or combination of forms. If the resources of the applicant or member exceed the maximums listed on OKDHS Appendix C-1, he/she is not eligible.

(1) For each minor blind or disabled child up to the age of 18 living with parent(s) whose needs are not included in a TANF grant, or receiving SSI and/or SSP, the resource limit is the same as the individual limit as shown on OKDHS Appendix C-1. If the parent's resources exceed the maximum amount, the excess is deemed available to the child (resources of an ineligible child are not deemed to an eligible child). If there is more than one eligible child, the amount is prorated.

(2) If the minor blind or disabled child:

(A) is residing in a nursing facility, or a medical facility if the confinement lasts or is expected to last for 30 days, the parent(s)' resources are not deemed to the child; or
(B) under age 19 is eligible for TEFRA, the parent's(s)' resources are not deemed to the child.

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

(4) When both parents are in the home and one parent is included in an aged, blind or disabled case and the spouse is included in an TANF case with the children, the resources of both parents are evaluated in relation to eligibility for SSI and therefore not considered on the AFDC case. All resources of the parents would be shown on the aged, blind or disabled case.

[Source: Added at 25 Ok Reg 130, eff 8-1-07 (emergency); Added at 25 Ok Reg 1257, eff 5-25-08]

317:35-5-41.12. Real or personal property essential to self-support

(a) This rule describes exclusions when real or personal property is essential to an individual's means of self-support.

(b) Categories of property essential to self-support.

(1) Property used in a trade or business; property used by an individual as an employee for work; or government permits that represent authority granted by a government agency to engage in an income-producing activity.

(A) Are excluded as a resource regardless of value or rate of return.

(B) Government permits includes any permit, license, or similar instrument issued by a federal, state, or local government agency.

(C) Personal property used by an employee for work includes farm machinery, tools, safety equipment, uniforms, etc.

(2) Nonbusiness real or personal property used to produce goods or services essential to basic daily living needs:

(A) Up to six-thousand dollars (\$6,000) of the equity value is excluded, regardless of rate of return.

(B) Any portion of the property's equity value in excess of six-thousand dollars (\$6,000) is a countable resource.

(C) Nonbusiness property used to produce goods or services includes, but is not limited to:

(i) Growing produce or livestock solely for personal consumption in the individual's household or performing activities essential to the production of food solely for home consumption.

(ii) Timber lots, wood splitters, and other tools used to produce firewood solely for use in the applicant's or recipient's home.

(3) Nonbusiness income-producing property.

(A) Up to six-thousand dollars (\$6,000) of the equity value is excluded as a resource if the property produces a net annual return equal to at least six percent (6%) of the excluded equity.

(B) Any portion of the property's equity value in excess of six-thousand dollars (\$6,000) is a countable resource.

(C) If the property produces less than a six percent (6%) return, the exclusion can only apply if the lower return is for reasons beyond the individual's control and there is a reasonable expectation that the property will again produce a six percent (6%) return. Otherwise, none of the equity value is excluded under this section.

(D) If the earnings decline was for reasons beyond the individual's control, up to twenty-four (24) months can be allowed for the property to resume producing a six percent (6%) return. The twenty-four (24) month period begins with the first day of the tax year following the one in which the return dropped to below six percent (6%).

(E) If the tax return shows that the activity has operated at a loss for the two (2) most recent years or longer, the property cannot be excluded unless the individual submits current receipts and records to show that it currently is producing a six percent (6%) return.

(F) If an individual owns more than one (1) piece of income-producing property, the six percent (6%) return requirement applies individually to each property and the six-thousand dollar (\$6,000) equity value limit applies to the total equity value of all the properties meeting the six percent (6%) return requirement.

(G) If all properties meet the six percent (6%) test but the total equity value exceeds six-thousand dollars (\$6,000), that portion of the total equity value in excess of six-thousand dollars (\$6,000) is a countable resource.

(c) For any of the exclusions to apply, the property must be in current use in the type of activity that qualifies it as essential.

(d) Property not in current use. If the property is not in current use, it must be for reasons beyond the individual's control and there must be a reasonable expectation that the use will resume within twelve (12) months of last use.

(1) Property not in current use can be excluded for twelve (12) months as essential for self-support if it has been in use and there is reasonable expectation that the use will resume. The individual must provide a signed statement of last date of use, reason the property is not in use, and when the individual expects to resume the self-support activity.

(2) If an individual alleges that self-support property is not in current use because of a disabling condition of the individual, the

individual must provide a signed statement of the nature of the condition, the date the individual ceased the self-support activity, and when the individual intends to resume activity to receive up to an additional twelve (12) months.

(3) If the individual does not intend to resume the self-support activity, the property is a countable resource in the month after the month of last use.

(4) If, after property has been excluded because an individual intends to resume self-support activity, the individual decides not to resume such activity, the exclusion ceases to apply as of the date of the change of intent. The property is a resource in the following month.

(e) Individual responsibilities. The individual shall:

(1) Provide a copy of the tax return for the tax year prior to application or renewal to be used to determine the net income earned for the individual from the income-producing property.

(2) Provide pertinent documents and a signed statement if the individual alleges owning a government license, permit, or other property that represents government authority to engage in an income-producing activity, and has value as a resource. The statement shall include:

(A) The type of license, permit, or other property;

(B) The name of the issuing agency, if appropriate;

(C) Whether the law requires such license, permit, or property for engaging in the income-producing activity at issue; and

(D) How the license, permit, or other property is being used; or

(E) Why it is not being used.

(3) Provide a signed statement if the individual alleges owning items used in his or her work as an employee. The statement shall include:

(A) The name, address, and telephone number of the employer;

(B) A general description of the items;

(C) A general description of the individual's duties; and

(D) Whether the items are currently being used.

[Source: Added at 36 Ok Reg 925, eff 9-1-19]

317:35-5-41.2. Miscellaneous Personal property

(a) **Cash savings and bank accounts.** Pursuant to Section 416.1208 of Title 20 of the Code of Federal Regulations (C.F.R.), funds held in a financial institution account (including savings, checking, and time deposits, also known as certificates of deposit) are an individual's resource if the individual has an ownership interest in the account and can use the funds for his or her support and maintenance. Verification of the member's countable income or resources held in bank accounts or at other financial institutions can be established through an Asset Verification System (AVS). Section 1671 of Title 56 of the Oklahoma

Statutes provides that financial records obtained for the purpose of establishing eligibility for assistance or services must be furnished without cost to the member or the Agency. If an individual is designated as sole owner by the account title, and can withdraw funds and use them for his or her support and maintenance, all of the funds, regardless of their source, are that individual's resource. For as long as these conditions are met, it is presumed that the individual owns one-hundred percent (100%) of the funds in the account. This presumption is non-rebuttable.

(1) If there is only one applicant or recipient account holder on a jointly held account, it is presumed that all of the funds in the account belong to that individual. If there is more than one (1) applicant or recipient account holder, it is presumed that all the funds in the account belong to those individuals in equal shares.

(2) If none of the account holders is an applicant or recipient, it is presumed that all of the funds in a jointly-held account belong to the deemor(s), in equal shares if there is more than one (1) deemor. A deemor is a person whose income and resources are required to be considered when determining eligibility and computing the SoonerCare benefit for an eligible individual.

(3) The presumption of ownership, as is established in Oklahoma Administrative Code (OAC) 317:35-5-41.2(a)(1) and (a)(2), above, may be rebutted, as follows, in accordance with 20 C.F.R. § 416.1208. Successful rebuttal may be retroactive as well as prospective.

(A) The individual must submit his/her statement, along with corroborating statements from other account holders, regarding who owns the funds in the joint account, why there is a joint account, who has made deposits to and withdrawals from the account, and how withdrawals have been spent;

(B) The individual must submit account records showing deposits, withdrawals, and interest (if any) in the months for which ownership of funds is at issue; and

(C) The individual must correct the account title to show that the individual is no longer a co-owner if the individual owns none of the funds; or, if the individual owns only a portion of the funds, separate the funds owned by the other account holder(s) from his/her own funds and correct the account title on the individual's own funds to show they are solely-owned by the individual.

(b) Life insurance policies. Life insurance owned by an individual (and spouse, if any) will be considered a resource to the extent of its cash surrender value. The cash surrender value is the amount which the insurer will pay upon cancellation of the policy before death of the insured or before maturity of the policy.

(1) If the total face value of all life insurance policies on any person does not exceed \$1,500, no part of the cash surrender value of such life insurance will be taken into account in determining the resources of the individual (and spouse, if any).

(2) In determining the face value of life insurance on the individual (and spouse, if any), term insurance and burial insurance, as defined in 20 C.F.R. § 416.1230, will not be taken into account.

(c) **Burial spaces.** The value of burial spaces for an individual, the individual's spouse or any member of the individual's immediate family will be excluded from resources.

(1) "Burial spaces" means burial plots, gravesites, crypts, mausoleums, urns, niches and other repositories which are customarily and traditionally used for the remains of deceased persons. Additionally, the term includes necessary and reasonable improvements or additions to or upon such burial spaces, including, but not limited to, vaults, headstones, markers, plaques, or burial containers and arrangements for opening and closing the gravesite for burial of the deceased.

(2) "Immediate family" means the individual's minor and adult children, including adopted children and step-children; and the individual's brothers, sisters, parents, adoptive parents, and the spouse of these individuals. Neither dependency nor living in the same household will be a factor in determining whether a person is an immediate family member.

(d) **Burial funds.** In accordance with 20 C.F.R. § 416.1231, up to \$1,500 each of funds specifically set aside for the burial expenses of the individual or the individual's spouse is excluded from resources. This exclusion applies only if the funds set aside for burial expenses are kept separate from all other resources not intended for burial of the individual (or spouse) and are clearly designated as set aside for the individual's (or spouses) burial expenses. This exclusion is in addition to the burial space exclusion. Each person's \$1,500 exclusion shall be reduced by:

- (1) The face value of insurance policies on the life of an individual owned by the individual or spouse (if any), if the cash surrender value of those policies has been excluded from resources; and
- (2) Amounts in an irrevocable trust (or other irrevocable arrangement) available to meet the burial expenses.

(e) **Irrevocable burial contract.** Oklahoma law provides that a purchaser (buyer) of a prepaid funeral contract may elect to make the contract irrevocable.

(1) The irrevocability cannot become effective until thirty (30) days after purchase.

(2) For an irrevocable contract to be valid, the election to make it irrevocable must be made by the purchaser (owner) or the purchaser's guardian or an individual with power of attorney for the purchaser (owner). In instances where the DHS Form 08MA084E, Management of Recipient's Funds, is on file in the nursing facility, the form serves as a power of attorney for the administrator to purchase and/or elect to make irrevocable the burial funds for the member.

(3) The assignment of an insurance policy used to fund an irrevocable contract must also be made irrevocable.

(4) The irrevocable contract shall not be considered a countable resource.

(f) **Medical insurance.** If a member is covered by insurance other than SoonerCare, then SoonerCare is the payer of last resort and should not be billed until all other payers have paid. If payment is made directly to the member, the member must reimburse OHCA up to the amount paid by SoonerCare. Any amount remaining after payment to OHCA is considered as an available resource.

[Source: Added at 25 Ok Reg 130, eff 8-1-07 (emergency); Added at 25 Ok Reg 1257, eff 5-25-08 ; Amended at 27 Ok Reg 112, eff 11-1-09 (emergency); Amended at 27 Ok Reg 967, eff 5-13-10 ; Amended at 32 Ok Reg 232, eff 1-1-15 (emergency); Amended at 32 Ok Reg 1132, eff 8-27-15 ; Amended at 36 Ok Reg 925, eff 9-1-19]

317:35-5-41.3. Automobiles, pickups, and trucks

In accordance with Section 416.1218 of Title 20 of the Code of Federal Regulations (C.F.R.), "automobile" includes cars, pickups, trucks, and other vehicles used to provide necessary transportation.

(1) **Exempt automobiles.** One automobile is totally excluded from counting as a resource, regardless of its value, if it is used for transportation of the individual or a member of the individual's household.

(2) **Other automobiles.** Any other automobiles are considered to be nonliquid resources. The equity in other automobiles is considered as a countable resource. The current market value, less encumbrances on the vehicle, is the equity, per 20 C.F.R. § 416.1201(c). Only encumbrances that can be verified are considered in computing equity.

(A) The market value of each year's make and model is established on the basis of the "Avg. Trade In" value as shown in the current publication of the National Automobile Dealers Association (NADA) on "Cars, Trucks, and Imports".

(B) If a vehicle's listing has been discontinued in the NADA book, the household's estimate of the value of the vehicle is accepted unless the worker has reason to believe the estimate is incorrect.

(C) The market value of a vehicle that is no longer operable is its verified salvage value.

(D) In the event the member and worker cannot agree on the value of the vehicle, the member secures written appraisal by two (2) persons who are familiar with current values. If there is substantial unexplained divergence between these appraisals or between the book value and one (1) or more of these appraisals, the worker and the member jointly arrange for the market value to be established by an appraisal made by a third (3rd) person who is familiar with current values and who is acceptable to both the member and the worker.

[Source: Added at 25 Ok Reg 130, eff 8-1-07 (emergency); Added at 25 Ok Reg 1257, eff 5-25-08 ; Amended at 32 Ok Reg 232, eff 1-1-15 (emergency); Amended at 32 Ok Reg 1132, eff 8-27-15 ; Amended at 36 Ok Reg 925, eff 9-1-19]

317:35-5-41.4. Stocks and bonds

(a) The member's equity in stocks and bonds (including U.S. Savings Bonds series A thru EE) is considered in relation to the maximum resource limit. The current market value less encumbrances is the equity. In general, determination of current market value can be obtained from daily newspaper quotations, brokerage houses, banks, etc.

(b) The current value of U.S. Savings bonds which have been held beyond the maturity date is the redemption value listed in the table on the back of the bond for the anniversary date most recently reached. If the bond has been held beyond maturity date, it has continued to draw interest. An acceptable determination of the value may be made by checking against a chart at the bank.

[Source: Added at 25 Ok Reg 130, eff 8-1-07 (emergency); Added at 25 Ok Reg 1257, eff 5-25-08]

317:35-5-41.5. Purchase of promissory notes, loans, or mortgages

(a) The amount which can be realized from promissory notes, loans, mortgages, and similar instruments, if offered for immediate sale, constitutes a countable resource. Promissory notes, loans, mortgages, and similar instruments have value regardless of whether there is an actual offer. Appraisals obtained from bankers, realtors, loan companies and others qualified to make such estimates are obtained in determining current market value. When a total resource approaches the maximum, it is desirable to get two or more estimates.

(b) Promissory Notes, loans, and mortgages (including contracts for deed) which are income producing are liquid countable resources.

(c) For an individual who has purchased a promissory note, loan, or mortgage on or after February 8, 2006, and is applying for long-term care services, see OAC 317:35-5-41.8(b).

[Source: Added at 25 Ok Reg 130, eff 8-1-07 (emergency); Added at 25 Ok Reg 1257, eff 5-25-08]

317:35-5-41.6. Trust accounts

Monies held in trust for an individual applying for or receiving SoonerCare must have the availability of the funds determined. Funds held in trust are considered available when they are under the direct control of the individual or his/her spouse, and disbursement is at their sole discretion. Funds may also be held in trust and under the control of someone other than the individual or his/her spouse, such as the courts, agencies, other individuals, or the Bureau of Indian Affairs.

(1) **Availability determinations.** The worker should be able to determine the availability of a trust using the definitions and explanations listed in (2) of this subsection. However, in some cases, the worker may wish to submit a trust to the Oklahoma Department of Human Services (OKDHS) State Office for determination of availability. In these instances, all pertinent data is submitted to Family Support Services Division, Attention: Health Related and Medical Services Section, for a decision.

(2) **Definition of terms.** The following words and terms, when used in this paragraph, have the following meaning, unless the

context clearly indicates otherwise:

(A) **Beneficiary.** Beneficiary means the person(s) who is to receive distributions of either income or principal, or on behalf of whom the trustee is to make payments.

(B) **Corpus/principal.** Corpus/principal means the body of the trust or the original asset used to establish the trust, such as a sum of money or real property.

(C) **Discretionary powers.** Discretionary powers means the grantor gives the trustee the power to make an independent determination whether to distribute income and/or principal to the beneficiary(ies) or to retain the income and add it to the principal of the trust.

(D) **Distributions.** Distributions means payments or allocations made from the trust from the principal or from the income produced by the principal (e.g., interest on a bank account).

(E) **Grantor (trustor/settlor).** Grantor (trustor/settlor) means the individual who establishes the trust by transferring certain assets.

(F) **Irrevocable trust.** Irrevocable trust means a trust in which the grantor has expressly not retained the right to terminate or revoke the trust and reclaim the trust principal and income.

(G) **Pour over or open trust.** Pour over or open trust means a trust which may be expanded from time to time by the addition to the trust principal (e.g., a trust established to receive the monthly payment of an annuity, a workers' compensation settlement, a disability benefit or other periodic receivable). The principal may accumulate or grow depending upon whether the trustee distributes the receivable or permits it to accumulate. Generally, the terms of the trust will determine the availability of the income in the month of receipt and the availability of the principal in subsequent months.

(H) **Primary beneficiary.** Primary beneficiary means the first person or class of persons to receive the benefits of the trust.

(I) **Revocable trust.** Revocable trust means a trust in which the grantor has retained the right to terminate or revoke the trust and reclaim the trust principal and income. Unless a trust is specifically made irrevocable, it is revocable. Even an irrevocable trust is revocable upon the written consent of all living persons with an interest in the trust.

(J) **Secondary beneficiary.** Secondary beneficiary means the person or class of persons who will receive the benefits of the trust after the primary beneficiary has died or is otherwise no longer entitled to benefits.

(K) **Testamentary trust.** Testamentary trust means a trust created by a will and effective upon the death of the individual making the will.

(L) **Trustee.** Trustee means an individual, individuals, a corporation, court, bank or combination thereof with responsibility for carrying out the terms of the trust.

(3) **Documents needed.** To determine the availability of a trust for an individual applying for or receiving SoonerCare, copies of the following documents are obtained:

(A) Trust document;

(B) When applicable, all relevant court documents including the Order establishing the trust, Settlement Agreement, Journal Entry, etc.; and

(C) Documentation reflecting prior disbursements (date, amount, purpose).

(4) **Trust accounts established on or before August 10, 1993.** The rules found in (A) - (C) of this paragraph apply to trust accounts established on or before August 10, 1993.

(A) **Support trust.** The purpose of a support trust is the provision of support or care of a beneficiary. A support trust will generally contain language such as "to provide for the care, support and maintenance of ...", "to provide as necessary for the support of ...", or "as my trustee may deem necessary for the support, maintenance, medical expenses, care, comfort and general welfare." Except as provided in (i)-(iii) of this subparagraph, the amount from a support trust deemed available to the beneficiary is the maximum amount of payments that may be permitted under the terms of the trust to be distributed to the beneficiary, assuming the full exercise of discretion by the trustee(s) for distribution of the maximum amount to the beneficiary. The beneficiary of a support trust, under which the distribution of payments to the beneficiary is determined by one or more trustees who are permitted to exercise discretion with respect to distributions, may show that the amounts deemed available are not actually available by:

(i) Commencing proceedings against the trustee(s) in a court of competent jurisdiction;

(ii) Diligently and in good faith asserting in the proceedings that the trustee(s) is required to provide support out of the trust; and

(iii) Showing that the court has made a determination, not reasonably subject to appeal, that the trustee must pay some amount less than the amount deemed available. If the beneficiary makes the showing, the amount deemed available from the trust is the amount determined by the court. Any action by a beneficiary or the beneficiary's representative, or by the trustee or the trustee's representative, in attempting a showing to make the Agency or the State of Oklahoma a party to the proceeding, or to show to the court that SoonerCare benefits may be

available if the court limits the amounts deemed available under the trust, precludes the showing of good faith required.

(B) **Medicaid Qualifying Trust (MQT).** A MQT is a trust, or similar legal device, established (other than by will) by an individual or an individual's spouse, under which the individual may be the beneficiary of all or part of the distributions from the trust and such distributions are determined by one or more trustees who are permitted to exercise any discretion with respect to distributions to the individual. A trust established by an individual or an individual's spouse includes trusts created or approved by a representative of the individual (parent, guardian or person holding power of attorney) or the court where the property placed in trust is intended to satisfy or settle a claim made by or on behalf of the individual or the individual's spouse. This includes trust accounts or similar devices established for a minor child pursuant to 12 Oklahoma Statutes 83. In addition, a trust established jointly by at least one of the individuals who can establish an MQT and another party or parties (who do not qualify as one of these individuals) is an MQT as long as it meets the other MQT criteria. The amount from an irrevocable MQT deemed available to the individual is the maximum amount of payments that may be permitted under the terms of the trust to be distributed to the individual assuming the full exercise of discretion by the trustee(s). The provisions regarding MQT apply even though an MQT is irrevocable or is established for purposes other than enabling an individual to qualify for SoonerCare, and, whether or not discretion is actually exercised.

(i) **Similar legal device.** MQT rules listed in this subsection also apply to "similar legal devices" or arrangements having all the characteristics of an MQT except that there is no actual trust document. An example is the member petitioning the court to irrevocably assign all or part of his/her income to another party (usually the spouse). The determination whether a given document or arrangement constitutes a "similar legal device" should be made by the OKDHS Office of General Counsel, Legal Unit.

(ii) **MQT resource treatment.** For revocable MQTs, the entire principal is an available resource to the member. Resources comprising the principal are subject to the individual resource exclusions (e.g., the home property exclusion) since the member can access those resource items without the intervention of the trustee. For irrevocable MQTs, the countable amount of the principal is the maximum amount the trustee can disburse to (or

for the benefit of) the member, using his/her full discretionary powers under the terms of the trust. If the trustee has unrestricted access to the principal and has discretionary power to disburse the entire principal to the member (or to use it for the member's benefit), the entire principal is an available resource to the member. Resources transferred to such a trust lose individual resource consideration (e.g., home property transferred to such a trust is no longer home property and the home property exclusions do not apply). The value of the property is included in the value of the principal. If the MQT permits a specified amount of trust income to be distributed periodically to the member (or to be used for his/her benefit), but those distributions are not made, the member's countable resources increase cumulatively by the undistributed amount.

(iii) **Income treatment.** Amounts of MQT income distributed to the member are countable income when distributed. Amounts of income distributed to third parties for the member's benefit are countable income when distributed.

(iv) **Transfer of resources.** If the MQT is irrevocable, a transfer of resources has occurred to the extent that the trustee's access to the principal (for purposes of distributing it to the member or using it for the member's benefit) is restricted (e.g., if the trust stipulates that the trustee cannot access the principal but must distribute the income produced by that principal to the member, the principal is not an available resource and has, therefore, been transferred).

(C) **Special needs trusts.** Some trusts may provide that trust benefits are intended only for a beneficiary's "special needs" and require the trustee to take into consideration the availability of public benefits and resources, including SoonerCare benefits. Some trusts may provide that the trust is not to be used to supplant or replace public benefits, including SoonerCare benefits. If a trust contains such terms and is not an MQT, the trust is not an available resource.

(5) **Trust accounts established after August 10, 1993.** The rules found in (A) - (C) of this paragraph apply to trust accounts established after August 10, 1993.

(A) For purposes of this subparagraph, the term "trust" includes any legal document or device that is similar to a trust. An individual is considered to have established a trust if assets of the individual were used to form all or part of the principal of the trust and if the trust was established other than by will and by any of the following

individuals:

- (i) the individual;
- (ii) the individual's spouse;
- (iii) a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse;
- or
- (iv) a person, including a court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

(B) Where trust principal includes assets of an individual described in this subparagraph and assets of any other person(s), the provisions of this subparagraph apply to the portion of the trust attributable to the assets of the individual. This subparagraph applies without regard to the purposes for which the trust is established, whether the trustees have or exercise any discretion under the trust, and restrictions on when or whether distributions may be made from the trust, or any restrictions on the use of the distribution from the trust.

(C) There are two types of trusts, revocable trusts and irrevocable trusts.

(i) In the case of a revocable trust, the principal is considered an available resource to the individual. Payments from the trust to or for the benefit of the individual are considered income of the individual. Other payments from the trust are considered assets disposed of by the individual for purposes of the transfer of assets rule and are subject to the sixty (60) months look back period.

(ii) In the case of an irrevocable trust, if there are any circumstances under which payments from the trust could be made to or for the benefit of the individual, the portion of the principal of the trust, or the income on the principal, from which payment to the individual could be made is considered available resources. Payments from the principal or income of the trust is considered income of the individual. Payments for any other purpose are considered a transfer of assets by the individual and are subject to the sixty (60) months look back period. Any portion of the trust from which, or any income on the principal from which no payment could under any circumstances be made to the individual is considered as of the date of establishment of the trust (or if later, the date on which payment to the individual was foreclosed) to be assets disposed by the individual for purposes of the asset transfer rules and are subject to the 60 months look back period.

(6) **Exempt trusts.** Paragraph (5) of this subsection does not apply to the following trusts:

(A) A trust containing the assets of a disabled individual under the age of sixty-five (65) which was established for the benefit of such individual by the individual, parent, grandparent, legal guardian of the individual or a court if the State receives all amounts remaining in the trust on the death of the individual up to an amount equal to the total medical assistance paid on behalf of the individual.

This type of trust requires:

- (i) The trust may only contain the assets of the disabled individual.
- (ii) The trust must be irrevocable and cannot be amended or dissolved without the written agreement of the OKDHS or the Oklahoma Health Care Authority (OHCA).
- (iii) Trust records must be open at all reasonable times to inspection by an authorized representative of the OHCA or OKDHS.
- (iv) The exception for the trust continues after the disabled individual reaches age sixty-five (65). However, any addition or augmentation after age sixty-five (65) involves assets that were not the assets of an individual under age sixty-five (65); therefore, those assets are not subject to the exemption.
- (v) Establishment of this type of trust does not constitute a transfer of assets for less than fair market value if the transfer is made into a trust established solely for the benefit of a disabled individual under the age of sixty-five (65).
- (vi) Payments from the trust are counted according to SSI rules. According to these rules, countable income is anything the individual receives in cash or in kind that can be used to meet the individual's needs for food and shelter. Accordingly, any payments made directly to the individual are counted as income to the individual because the payments could be used for food or shelter for the individual. This rule applies whether or not the payments are actually used for these purposes, as long as there is no legal impediment which would prevent the individual from using the payments in this way. In addition, any payments made by the trustee to a third party to purchase food or shelter for the individual can also count as income to the individual. For example, if the trustee makes a mortgage payment for the individual, that payment is a shelter expense and counts as income.
- (vii) A corporate trustee may charge a reasonable fee for services in accordance with its published

fee schedule.

(viii) The OKDHS Form 08MA018E, Supplemental Needs Trust, is an example of the trust. Workers may give the sample form to the member or his/her representative to use or for their attorney's use.

(ix) To terminate or dissolve a Supplemental Needs Trust, the worker sends a copy of the trust instrument and a memorandum to OKDHS Family Support Services Division, Attention: Health Related and Medical Services, explaining the reason for the requested termination or dissolution of the Supplemental Needs Trust, and giving the name and address of the trustee. The name and address of the financial institution and current balance are also required. Health Related and Medical Services (HRMS) notifies Oklahoma Health Care Authority/Third Party Liability (OHCA/TPL) to initiate the recovery process.

(B) A trust (known as the Medicaid Income Pension Trust) established for the benefit of an individual if:

(i) The individual is in need of long-term care and has countable income above the categorically needy standard for long-term care (OKDHS Appendix C-1 Schedule VIII.B) but less than the average cost of nursing home care per month (OKDHS Appendix C-1 Schedule VIII.B).

(ii) The trust is composed only of pension, social security, or other income of the individual along with accumulated income in the trust. Resources cannot be included in the trust.

(iii) All income is paid into the trust and the applicant is not eligible until the trust is established and the monthly income has been paid into the trust.

(iv) The trust must retain an amount equal to the member's gross monthly income less the current categorically needy standard of OKDHS Appendix C-1. The Trustee distributes the remainder.

(v) The income disbursed from the trust is considered as the monthly income to determine the cost of their care, and can be used in the computations for spousal diversion.

(vi) The trust must be irrevocable and cannot be amended or dissolved without the written agreement of the OHCA. Trust records must be open at all reasonable times to inspection by an authorized representative of the OHCA or OKDHS.

(vii) The State will receive all amounts remaining in the trust up to an amount equal to the total SoonerCare benefits paid on behalf of the individual subsequent to the date of establishment

of the trust.

(viii) Accumulated funds in the trust may only be used for medically necessary items not covered by SoonerCare, or other health programs or health insurance and a reasonable cost of administrating the trust. Reimbursements cannot be made for any medical items to be furnished by the nursing facility. Use of the accumulated funds in the trust for any other reason will be considered as a transfer of assets and would be subject to a penalty period.

(ix) The trustee may claim a fee of up to three percent (3%) of the funds added to the trust that month as compensation.

(x) An example trust is included on OKDHS Form 08MA011E. Workers may give this to the member or his/her representative to use or for their attorney's use as a guide for the Medicaid Income Pension Trust.

(xi) To terminate or dissolve a Medicaid Income Pension Trust, the worker sends a memorandum with a copy of the trust to OKDHS Family Support Services Division, Attention: HR&MS, explaining the reason and effective date for the requested termination or dissolution of the Medicaid Income Pension Trust, and giving the name and address of the trustee. The name and address of the financial institution, account number, and current balance are also required. HRMS notifies OHCA/TPL to initiate the recovery process.

(C) A trust containing the assets of a disabled individual when all of the following are met:

(i) The trust is established and managed by a non-profit association;

(ii) The trust must be made irrevocable;

(iii) The trust must be approved by the OKDHS and may not be amended without the permission of the OKDHS;

(iv) The disabled person has no ability to control the spending in the trust;

(v) A separate account is maintained for each beneficiary of the trust but for the purposes of investment and management of funds, the trust pools these accounts;

(vi) The separate account on behalf of the disabled person may not be liquidated without payment to OHCA for the medical expenses incurred by the members;

(vii) Accounts in the trust are established by the parent, grandparent, legal guardian of the individual, the individual, or by a court;

(viii) To the extent that amounts remaining in the beneficiary's account on the death of the beneficiary are not retained by the trust, the trust pays to the State from such remaining amounts an amount equal to the total medical assistance paid on behalf of the individual. A maximum of thirty percent (30%) of the amount remaining in the beneficiary's account at the time of the beneficiary's death may be retained by the trust.

(7) **Funds held in trust by Bureau of Indian Affairs.** Interests of individual Indians in trust or restricted lands are not considered in determining eligibility for assistance under the Social Security Act or any other federal or federally assisted program.

(8) **Disbursement of trust.** At any point that disbursement occurs, the amount disbursed is counted as a non-recurring lump sum payment in the month received. Some trusts generate income on a regular basis and the income is sent to the beneficiary. In those instances, the income is treated as unearned income in the month received.

[Source: Added at 25 Ok Reg 130, eff 8-1-07 (emergency); Added at 25 Ok Reg 1257, eff 5-25-08 ; Amended at 28 Ok Reg 1515, eff 6-25-11 ; Amended at 30 Ok Reg 273, eff 12-13-12 (emergency); Amended at 30 Ok Reg 1246, eff 7-1-13 ; Amended at 33 Ok Reg 894, eff 9-1-16 ; Amended at 35 Ok Reg 6, eff 8-10-17 (emergency); Amended at 35 Ok Reg 1467, eff 9-14-18 ; Amended at 38 Ok Reg 1600, eff 7-19-21 (emergency); Amended at 39 Ok Reg 1556, eff 9-12-22]

317:35-5-41.7. Retirement funds

The rules regarding the countable value, if any, of retirement funds are found in (1) - (2) of this subsection.

(1) Annuities.

(A) Annuities purchased prior to February 1, 2005. An annuity gives the right to receive fixed, periodic payments either for life or a term of years. The annuity instrument itself must be examined to determine the provisions and requirements of the annuity. For example, it is determined whether the individual can access the principal of the annuity; e.g., can it be cashed in. If so, the annuity is treated as a revocable trust (OAC 317:35-5-41.6(a)(5)(C)(i)). If the individual cannot access the principal, the annuity is treated as an irrevocable trust. In this instance, it must also be determined what part of the annuity can, under any circumstances, be paid to, or for the benefit of the individual. When making such a determination, the date of application is used or, if later, the date of institutionalization (for an institutionalized individual) or the date of creation of the annuity (for a non-institutionalized individual). Also, these dates are used in determining whether the transfer of asset provisions apply to a particular annuity. If the annuity provides for payments to be made to the individual, those payments would be considered income to the individual. Any portion

of the principal of the annuity that could be paid to or on behalf of the individual would be treated as a resource to the individual and portions of the annuity that cannot be paid to or for the benefit of the individual are treated as transfers of assets. Annuities may also be a transfer of assets for less than fair market value. The worker determines, in accordance with the OKDHS life expectancy tables, whether the member will receive fair market value from the annuity during his/her projected lifetime. Any funds used to purchase the annuity that will not be repaid to the member during his/her projected lifetime, are a transfer of assets and the appropriate penalty period is imposed.

(B) Annuities purchased after January 31, 2005.

(i) An annuity is presumed to be an available resource to the individual who will receive the payments because the annuity can be sold. The value of the annuity is the total of all remaining payments, discounted by the Applicable Federal Rate set by the IRS for the valuation of annuities for the month of application or review.

(ii) The applicant or member may rebut the presumption that the annuity can be sold by showing compelling evidence to the contrary, in which case the annuity is not considered available. The applicant or member may also rebut the presumed annuity value by showing compelling evidence that the actual value of the annuity is less than the presumed value.

(C) For an individual who has purchased an annuity on or after February 8, 2006, and is applying for long-term care services, see OAC 317:35-5-41.8(c).

(2) **Other retirement investment instruments.** This paragraph relates to individual retirement accounts (IRA), Keogh plans, profit sharing plans, and work related plans in which the employee and/or employer contribute to a retirement account.

(A) **Countability of asset.** In each case, the document governing the retirement instrument must be examined to determine the availability of the retirement benefit at the time of application. Retirement benefits are considered countable resources if the benefits are available to the applicant and/or spouse. Availability means that the applicant and/or spouse has an option to receive retirement benefits or is actually receiving benefits. For example, a retirement instrument may make a fund available at the time of termination of employment, at age 65, or at some other time. A retirement fund is not a countable resource if the applicant is currently working and must terminate employment in order to receive benefits. An individual may have the choice of withdrawing the monies from the retirement fund in a single payment

or periodic payments (i.e., monthly, quarterly, etc.). If the individual elects to receive a periodic payment, the payments are considered as income as provided in OAC 317:35-5-42(c)(3). If the monies are received as a lump sum, the rules at OAC 317:35-5-42(c)(3)(C)(i) apply.

(B) **Asset valuation.** Valuation of retirement benefits is the amount of money that an individual can currently withdraw from the fund or is actually receiving. Valuation does not include the amount of any penalty for early withdrawal. Taxes due on the monies received by the applicant are not deducted from the valuation.

(C) **Timing of valuation.** Retirement funds are a countable resource in the month that the funds are available to the applicant. For purposes of this subsection, the month that the funds are available means the month following the month of application for the funds. For example, the retirement instrument makes retirement funds available at age 65. The applicant turns 65 on January 1st. The applicant makes a request for the funds on February 1st and the monies are received on June 1st. The retirement fund would be considered as a countable resource in the month of March. The resource would not be counted in the month in which it is later received.

[Source: Added at 25 Ok Reg 130, eff 8-1-07 (emergency); Added at 25 Ok Reg 1257, eff 5-25-08]

317:35-5-41.8. Eligibility regarding long-term care services

(a) **Home Property.** In determining eligibility for long-term care services for applications filed on or after January 1, 2006, home property is excluded from resources unless the individual's equity interest in his or her home exceeds the amount at Oklahoma Department of Human Services (DHS) Appendix C-1, Schedule VIII(D)(2).

(1) Long-term care services include nursing facility (NF) services and other long-term care services. For purposes of this Section, other long-term care services include:

(A) A level of care in any institution equivalent to nursing facility services; and

(B) Home and community-based services furnished under a waiver.

(2) An individual whose equity interest exceeds the amount at DHS Appendix C-1, Schedule VIII(D)(2) is not eligible for long-term care services unless one of the following circumstances applies:

(A) The individual has a spouse who is lawfully residing in the individual's home;

(B) The individual has a child under the age of twenty-one (21) who is lawfully residing in the individual's home;

(C) The individual has a child of any age who is blind or permanently and totally disabled who is lawfully residing in the individual's home; or

(D) The denial would result in undue hardship. Undue hardship exists when denial of SoonerCare long-term care services based on an individual's home equity exceeding the amount at DHS Appendix C-1, Schedule VIII(D)(2) would deprive the individual of medical care such that the individual's health or life would be endangered; or of food, clothing, shelter, or other necessities of life.

(E) An individual may reduce their total equity interest in the home through the use of a reverse mortgage or home equity loan.

(3) Absence from home due to NF care does not affect the home exclusion as long as the individual intends to return home within twelve (12) months from the time he/she entered the facility. The DHS Form 08MA010E, Acknowledgment of Temporary Absence/Home Property Policy, is completed at the time of application for NF care when the applicant has home property. After an explanation of temporary absence, the member, guardian, or responsible person indicates whether there is or is not intent to return to the home and signs the form.

(A) If at the time of application the applicant states he/she does not have plans to return to the home, the home property is considered a countable resource. For members in nursing facilities, a lien may be filed in accordance with Oklahoma Administrative Code (OAC) 317:35-9-15 and OAC 317:35-19-4 on any real property owned by the member when it has been determined, after notice and opportunity for a hearing, that the member cannot reasonably be expected to be discharged and return home. However, a lien is not filed on the home property of the member while any of the persons described in OAC 317:35-9-15(b)(1) and OAC 317:35-19-4(b)(1) are lawfully residing in the home:

(B) If the individual intends to return home, he/she is advised that:

- (i) the twelve (12) months of home exemption begins effective with the date of entry into the NF regardless of when application is made for SoonerCare benefits, and
- (ii) after twelve (12) months of nursing care, it is assumed there is no reasonable expectation the member will be discharged from the facility and return home and a lien may be filed against real property owned by the member for the cost of medical services received.

(C) "Intent" in regard to absence from the home is defined as a clear statement of plans in addition to other evidence and/or corroborative statements of others.

(D) At the end of the twelve-month (12-month) period the home property becomes a countable resource unless medical evidence is provided to support the feasibility of the member to return to the home within a reasonable

period of time (ninety (90) days). This ninety-day (90-day) period is allowed only if sufficient medical evidence is presented with an actual date for return to the home.

(E) A member who leaves the NF must remain in the home at least three (3) months for the home exemption to apply if he/she has to re-enter the facility.

(F) However, if the spouse, minor child under twenty-one (21), or child who is blind or permanently disabled resides in the home during the individual's absence, the home continues to be exempt as a resource so long as the spouse, minor child, or child who is blind or permanently disabled lives there (regardless of whether the absence is temporary).

(G) Once a lien has been filed against the property of an NF resident, the property is no longer considered as a countable resource.

(b) Promissory notes, loans, or mortgages. The rules regarding the treatment of funds used to purchase a promissory note, loan, or mortgage on or after February 8, 2006, are found in (1) through (2) of this subsection.

(1) Funds used to purchase a promissory note, loan, or mortgage on or after February 8, 2006, are treated as assets transferred, and the value of such note, loan, or mortgage shall be the amount of the outstanding balance due on the note, loan, or mortgage as of the date of the individual's application for medical assistance unless the note, loan, or mortgage meets all of the conditions in paragraphs (A) through (C) of this paragraph.

(A) The note, loan, or mortgage has a repayment term that is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the United States Social Security Administration).

(B) The note, loan, or mortgage provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made.

(C) The note, loan, or mortgage prohibits the cancellation of the balance upon the death of the lender.

(2) Funds used to purchase a promissory note, loan, or mortgage for less than its fair market value are treated as assets transferred for less than fair market value regardless of whether:

(A) The note, loan, or mortgage was purchased before February 8, 2006; or

(B) The note, loan, or mortgage was purchased on or after February 8, 2006, and the conditions described in paragraph (1) of this subsection were met.

(c) Annuities. Treatment of annuities purchased on or after February 8, 2006.

(1) The purchase of an annuity shall be treated as the disposal of an asset for less than fair market value unless the Oklahoma Health Care Authority is named as the remainder beneficiary:

(A) In the first position for at least the total amount of medical assistance paid on behalf of the institutionalized

individual; or

(B) In the second position after the community spouse, child under twenty-one (21) years of age, or disabled child and is named in the first position if the spouse or a representative of the child disposes of any such remainder for less than fair market value.

(2) For purposes of determining financial eligibility for long-term care services under this chapter, the term "assets" shall include an annuity purchased by or on behalf of an annuitant who has applied for SoonerCare NF services or other long-term care services unless the annuity meets one (1) of the following conditions.

(A) The annuity is an annuity described in subsection (b) or (q) of Section 408 of the United States Internal Revenue Code of 1986; or

(B) The annuity is purchased with proceeds from:

(i) An account or trust described in subsection (a), (c), or (p) of Section 408 of the United States Internal Revenue Code of 1986;

(ii) A simplified employee pension as defined in Section 408(k) of the United States Internal Revenue Service Code of 1986; and/or

(iii) A Roth IRA described in Section 408A of the United States Internal Revenue Service Code of 1986; or

(C) The annuity:

(i) is irrevocable and nonassignable;

(ii) is actuarially sound as determined in accordance with actuarial publications of the Office of the Chief Actuary of the United States Social Security Administration; and

(iii) provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.

(d) **Life Estates.** This subsection pertains to the purchase of a life estate in another individual's home.

(1) The entire amount used to purchase a life estate in another individual's home on or after February 8, 2006, is treated as assets transferred for less than fair market value, unless the purchaser resides in the home for at least one (1) year after the date of the purchase.

(2) Funds used to purchase a life estate in another individual's home for less than its fair market value are treated as assets transferred for less than fair market value regardless of whether:

(A) The life estate was purchased before February 8, 2006; or

(B) The life estate was purchased on or after February 8, 2006, and the purchaser resided in the home for one (1) year after the date of purchase.

(e) **Oklahoma Long-Term Care Partnership (LTCP) Program.** This subsection pertains to individuals with Oklahoma Long-Term Care

Partnership policies. The Oklahoma Insurance Department approves long-term care insurance policies as Long-term Care Partnership Program policies. The face page of the policy document will indicate if the insurance qualifies as a Long-Term Care Partnership Program policy.

(1) Benefits from the LTCP policy must be exhausted before the individual can be eligible for long-term care under the SoonerCare program.

(2) Assets in an amount equal to the amount paid out under the LTCP policy can be protected for the insured individual once the LTCP policy benefits are exhausted. Protected assets are disregarded when determining eligibility for the SoonerCare program per OAC 317:35-5-41.9(b)(26). A record of the amount paid on behalf of the policy holder is available through the Oklahoma Health Care Authority or insurance company holding the LTCP policy.

(A) At the time of application for SoonerCare the individual must determine the asset(s) to be protected. The protected asset(s) cannot be changed. If the value of the protected asset(s) decreases, the individual does not have the option to select additional assets to bring the total up to the protected amount.

(B) If the protected asset(s) are income-producing, the income earned while on SoonerCare is counted in accordance with 317:35-5-42.

(C) The individual can choose to transfer the protected asset without incurring a transfer of assets penalty.

(D) When determining resource eligibility for a couple when one of them enters the nursing home or applies for a HCBS waiver, the LTCP protected asset(s) are disregarded in determining the total amount of the couple's resources.

[Source: Added at 25 Ok Reg 130, eff 8-1-07 (emergency); Added at 25 Ok Reg 1257, eff 5-25-08 ; Amended at 26 Ok Reg 2132, eff 6-25-09 ; Amended at 29 Ok Reg 1158, eff 6-25-12 ; Amended at 33 Ok Reg 55, eff 8-24-15 (emergency); Amended at 33 Ok Reg 900, eff 9-1-16 ; Amended at 36 Ok Reg 925, eff 9-1-19]

317:35-5-41.9. Exclusions from resources

(a) The following are excluded resources. In order for payments and benefits listed in paragraph (b) and (c) to be excluded from resources, such funds must be segregated and not commingled with other countable resources so that the excludable funds are identifiable.

(b) Resources excluded by the Social Security Act, in accordance with Section 416.1210 of Title 20 of the Code of Federal Regulations (C.F.R.), unless otherwise noted:

(1) The home that is the principal place of residence, as described at Oklahoma Administrative Code (OAC) 317:35-5-41.1;

(2) Household goods and personal effects, as described at OAC 317:35-5-41(a)(5);

(3) One automobile, as described at OAC 317:35-5-41.3;

(4) Property essential to self-support:

- (A) Property of a trade or business which is essential to the means of self-support, as described at OAC 317:35-5-41.12(c);
 - (B) Nonbusiness property used to produce goods or services essential to self-support, as described at OAC 317:35-5-41.12(c);
 - (C) Nonbusiness income producing property, as described at OAC 317:35-5-41.12(c);
- (5) Resources of a blind or disabled individual which are necessary to fulfill an approved plan for achieving self-support;
 - (6) Stock in regional or village corporations held by natives of Alaska during the twenty-year (20-year) period in which the stock is inalienable pursuant to the Alaska Native Claims Settlement Act;
 - (7) Life insurance policies, as described at OAC 317:35-5-41.2(b);
 - (8) Restricted allotted Indian lands;
 - (9) Disaster relief assistance provided under Federal law or by state or local government;
 - (10) Burial spaces, as described at OAC 317:35-5-41.2(c);
 - (11) Burial funds, as described at OAC 317:35-5-41.2(d);
 - (12) Irrevocable burial contracts as described at OAC 317:35-5-41.2(e);
 - (13) Supplemental Security Income (SSI) and Social Security retroactive payments for nine (9) months following the month of receipt;
 - (14) Housing assistance paid pursuant to:
 - (A) The United States Housing Act of 1937;
 - (B) The National Housing Act;
 - (C) Section 101 of the Housing and Urban Development Act of 1965;
 - (D) Title V of the Housing Act of 1949;
 - (E) Section 202(h) of the Housing Act of 1959;
 - (15) Refunds of Federal income taxes and advances made by an employer relating to an earned income tax credit for nine (9) months following the month of receipt;
 - (16) Payments received as compensation for expenses incurred or losses suffered as a result of a crime;
 - (17) Relocation assistance for nine (9) months beginning with the month following the month of receipt. The assistance must be provided by a State or local government that is comparable to assistance provided under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 that is subject to the treatment required by Section 216 of that Act;
 - (18) Money in a dedicated account for SSI-eligible individuals under age eighteen (18) that is required by 20 C.F.R. § 416.640(e);
 - (19) Gifts to children under age eighteen (18) with life-threatening conditions from an organization described at 26 United States Code (U.S.C.) § 501(c)(3) that is exempt from taxation under 26 U.S.C. § 501(a);

(20) Restitution of Social Security, SSI, or a Special Benefit for World War II Veterans made because of misuse by a representative payee, for nine (9) months following the month of receipt;

(21) Any portion of a grant, scholarship, fellowship, or gift used or set aside for paying tuition, fees, or other necessary educational expenses, for nine (9) months beginning the month after the month of receipt;

(22) Payment of a refundable child tax credit for nine (9) months following the month of receipt;

(23) Any annuity paid by a State to a person (or his or her spouse) based on the State's determination that the person is:

(A) A veteran (as defined in 38 U.S.C. § 101); and

(B) Blind, disabled, or aged;

(24) The principal and income of trusts complying with OAC 317:35-5-41.6(6). See also 42 U.S.C. § 1396p(d)(4);

(25) Workers' Compensation Medicare Set Aside Arrangements (WCMSAs) which allocate a portion of the workers' compensation settlement for future medical expenses; and/or

(26) For individuals with an Oklahoma Long-Term Care Partnership Program approved policy, resources equal to the amount of benefits paid on the insured's behalf by the long-term care insurer. Said disregard is made at the time of application for long-term care services provided by SoonerCare. The Oklahoma Insurance Department approves policies as Long-term Care Partnership Program policies.

(c) Resources excluded by federal laws other than the Social Security Act, in accordance with 20 C.F.R. § 416.1236, unless otherwise noted:

(1) An Achieving a Better Life Experience (ABLE) account is regulated by the Internal Revenue Service as a tax-advantaged account that protects resources from being counted toward the resource limit of public benefits programs (including Medicaid) if used according to the federal regulations. Funds and interest held in an ABLE account, pursuant to 26 U.S.C. § 529A:

(A) A contribution to an ABLE account by another individual is neither income nor a resource to the individual with the ABLE account. If the individual who made the contribution later requests Medicaid for long-term care services, the contribution shall be evaluated in accordance with OAC 317:35-5-41.8.

(B) A distribution from an ABLE account that is retained after the month of receipt is neither income nor a resource to the individual in any month when spent on a qualified disability expense (QDE).

(C) A QDE is any expense related to the blindness or disability of the individual and made for the benefit of the individual. QDE's include but are not limited to:

(i) Education;

(ii) Housing;

(iii) Transportation;

(iv) Employment training and support;

- (v) Assistive technology;
- (vi) Health;
- (vii) Prevention and wellness;
- (viii) Financial management and administrative services;
- (ix) Legal fees;
- (x) Expenses for ABLE account oversight and monitoring;
- (xi) Funeral and burial; and
- (xii) Basic living expenses.

(D) A distribution, or portion of a distribution, from an ABLE account that is retained after the month of receipt, and used for a non-QDE in the next or subsequent month, is a countable resource to the individual in the month in which the funds were spent. Any unspent portion of the distribution the individual continues to retain is not a countable resource.

(E) A distribution, or portion of a distribution, from an ABLE account that is received and used for a non-QDE in the same month, is considered unearned income to the individual in the month of receipt. Any unspent portion of the distribution the individual retains after the month of receipt is not a countable resource.

(F) The responsibility of an Oklahoma Medicaid administrator is to ask the ABLE account beneficiary or Authorized Legal Representative (ALR) if the account has been used only in accordance with ABLE regulations and, if so, to exclude the balance of the ABLE account from the determination of countable resources.

(G) The testimony of the ABLE account beneficiary or ALR is all that is required in the determination of appropriate use of the ABLE account.

(2) Payments made under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (84 Stat. 1902, 42 U.S.C. ' 4636);

(3) Payments made to Native Americans as listed in paragraphs (b) and (c) of section IV of the Appendix to Subpart K of Part 416 of C.F.R. Title 20;

(4) Indian judgment funds held in trust by the Secretary of the Interior or distributed per capita pursuant to a plan prepared by the Secretary of the Interior and not disapproved by a joint resolution of the Congress under Public Law 93-134, as amended by Public Law (Pub.L.) 97-458 (25 U.S.C. § 1407). Indian judgment funds include interest and investment income accrued while the funds are so held in trust. This exclusion extends to initial purchases made with Indian judgment funds, but will not apply to proceeds from sales or conversions of initial purchases or to subsequent purchases;

(5) Supplemental Nutrition Assistance Program benefits;

(6) The value of assistance to children under the National School Lunch Act (60 Stat. 230, 42 U.S.C. §§ 1751 et seq.) as amended by

Pub.L. 90-302 [82 Stat. 117, 42 U.S.C. § 1761 (h)(3)];

(7) The value of assistance to children under the Child Nutrition Act of 1966 [80 Stat. 889, 42 U.S.C. § 1780(b)];

(8) Any grant or loan to any undergraduate student for educational purposes made or insured under any program administered by the Commissioner of Education as provided by section 507 of the Higher Education Amendments of 1968, Pub.L. 90-575 (82 Stat. 1063);

(9) Incentive allowances received under Title I of the Comprehensive Employment and Training Act of 1973 [87 Stat. 849, 29 U.S.C. § 821(a)];

(10) Compensation provided to volunteers by the Corporation for National and Community Service (CNCS), unless determined by the CNCS to constitute the minimum wage in effect under the Fair Labor Standards Act of 1938 (29 U.S.C. §§ 201 et seq.) or applicable State law, pursuant to 42 U.S.C. § 5044(f)(1). Programs include:

- (A) AmeriCorps;
- (B) Special and demonstration volunteer programs;
- (C) University year for ACTION;
- (D) Retired senior volunteer program;
- (E) Foster grandparents program; and
- (F) Senior companion program;

(11) Distributions received by an individual Alaska Native or descendant of an Alaska Native from an Alaska Native Regional and Village Corporation pursuant to the Alaska Native Claims Settlement Act, as follows: cash, including cash dividends on stock received from a Native Corporation, is disregarded to the extent that it does not, in the aggregate, exceed two-thousand (\$2,000) per individual each year [the \$2,000 limit is applied separately each year, and cash distributions up to \$2,000 which an individual received in a prior year and retained into subsequent years will not be counted as resources in those years]; stock, including stock issued or distributed by a Native Corporation as a dividend or distribution on stock; a partnership interest; land or an interest in land, including land or an interest in land received from a Native Corporation as a dividend or distribution on stock; and an interest in a settlement trust. This exclusion is pursuant to the exclusion under section 15 of the Alaska Native Claims Settlement Act Amendments of 1987, Pub.L. 100-241 [43 U.S.C. § 1626(c)], effective February 3, 1988;

(12) Value of Federally donated foods distributed pursuant to section 32 of Pub.L. 74B320 or section 416 of the Agriculture Act of 1949 [7 C.F.R. § 250.6(e)(9) as authorized by 5 U.S.C. § 301];

(13) All funds held in trust by the Secretary of the Interior for an Indian tribe and distributed per capita to a member of that tribe under Pub.L. 98-64;

(14) Home energy assistance payments or allowances under the Low-Income Home Energy Assistance Act of 1981, as added by Title XXVI of the Omnibus Budget Reconciliation Act of 1981, Pub.L. 97-35 [42 U.S.C. § 8624(f)];

(15) Student financial assistance for attendance costs received from a program funded in whole or in part under Title IV of the Higher Education Act of 1965, as amended, or under Bureau of Indian Affairs (BIA) Student assistance programs if it is made available for tuition and fees normally assessed a student carrying the same academic workload, as determined by the institution, including costs for rental or purchase of any equipment, materials, or supplies required of all students in the same course of study; and an allowance for books, supplies, transportation, and miscellaneous personal expenses for a student attending the institution on at least a half-time basis, as determined by the institution, under section 14(27) of Pub.L. 100-50, the Higher Education Technical Amendments Act of 1987 (20 U.S.C. § 1087uu) or under BIA student assistance programs. This includes, but is not limited to:

- (A) Pell grants;
- (B) Student services incentives;
- (C) Academic achievement incentive scholarships;
- (D) Byrd scholars;
- (E) Federal supplemental education opportunity grants;
- (F) Federal educational loans (federal PLUS loans, Perkins loans, Stafford loans, Ford loans, etc.);
- (G) Upward Bound;
- (H) GEAR UP (Gaining Early Awareness and Readiness for Undergraduate Programs);
- (I) State educational assistance programs funded by the leveraging educational assistance programs; and
- (J) Work-study programs;

(16) Amounts paid as restitution to certain individuals of Japanese ancestry and Aleuts under the Civil Liberties Act of 1988 and the Aleutian and Pribilof Islands Restitution Act, sections 105(f) and 206(d) of Pub.L. 100-383 (50 U.S.C. app. 1989 b and c);

(17) Payments made on or after January 1, 1989, from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In Re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.) under Pub.L. 101-201 (103 Stat. 1795) and section 10405 of Pub.L. 101-239 (103 Stat. 2489);

(18) Payments made under section 6 of the Radiation Exposure Compensation Act, Pub.L. 101-426 (104 Stat. 925, 42 U.S.C. § 2210);

(19) Payments made to individuals because of their status as victims of Nazi persecution excluded pursuant to section 1(a) of the Victims of Nazi Persecution Act of 1994, Pub.L. 103-286 (108 Stat. 1450);

(20) Any matching funds and interest earned on matching funds from a demonstration project authorized by Pub.L. 105-285 that are retained in an Individual Development Account, pursuant to section 415 of Pub.L. 105-285 (112 Stat. 2771);

(21) Any earnings, Temporary Assistance for Needy Families matching funds, and accrued interest retained in an Individual Development Account, pursuant to section 103 of Pub.L. 104-193

[42 U.S.C. § 604(h)(4)];

(22) Payments made to individuals who were captured and interned by the Democratic Republic of Vietnam as a result of participation in certain military operations, pursuant to section 606 of Pub.L. 105-78 and section 657 of Pub.L. 104-201 (110 Stat. 2584);

(23) Payments made to certain Vietnam veteran's children with spina bifida, pursuant to section 421 of Pub.L. 104-204 [38 U.S.C. § 1805(d)];

(24) Payments made to the children of women Vietnam veterans who suffer from certain birth defects, pursuant to section 401 of Pub.L. 106-419, [38 U.S.C. § 1833(c)];

(25) Assistance provided for flood mitigation activities under section 1324 of the National Flood Insurance Act of 1968, pursuant to section 1 of Public Law 109-64 (119 Stat. 1997, 42 U.S.C. § 4031); and/or

(26) Payments made to individuals under the Energy Employees Occupational Illness Compensation Program Act of 2000, pursuant to section 1, app. [Div. C. Title XXXVI section 3646] of Public Law 106-398 (114 Stat. 1654A-510, 42 U.S.C. § 7385e).

[Source: Added at 25 Ok Reg 130, eff 8-1-07 (emergency); Added at 25 Ok Reg 674, eff 12-18-07 (emergency); Added at 25 Ok Reg 1227, eff 5-25-08 ; Amended at 26 Ok Reg 2132, eff 6-25-09 ; Amended at 26 Ok Reg 1768, eff 7-1-09 (emergency); Amended at 27 Ok Reg 969, eff 5-13-10 ; Amended at 28 Ok Reg 1515, eff 6-25-11 ; Amended at 36 Ok Reg 925, eff 9-1-19 ; Amended at 38 Ok Reg 1068, eff 9-1-21]

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

(a) **General.** The term income is defined as a gross gain or gross recurrent benefit that derives from labor, business, property, retirement and other benefits or sources that are available for use on a regular basis.

(1) If it appears the applicant or SoonerCare member is eligible for any type of income [excluding Supplemental Security Income (SSI)] or resources, Oklahoma Department of Human Services (OKDHS) staff must notify the individual in writing of his/her potential eligibility, per Section 416.210 of Title 20 of the Code of Federal Regulations (20 C.F.R. § 416.210).

(A) Potential income may include, but is not limited to:

- (i) Retirement, Survivors, Disability Insurance (RSDI) benefits;
- (ii) Benefits from the United States (U.S.) Department of Veterans Affairs (VA);
- (iii) Workers' compensation payments;
- (iv) Unemployment insurance benefits (UIB);
- (v) Annuities;
- (vi) Pensions or other retirement benefits; or
- (vii) Disability benefits.

(B) The notice must contain the information that failure to file for and take all appropriate steps to obtain the potential income within thirty (30) calendar days from the

date of the notice will result in an ineligibility determination of ineligibility.

(C) When the individual has a good cause reason for not filing for the potential income within the thirty (30) calendar day period or taking other necessary steps to obtain the income, he or she is not determined ineligible.

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

(3) When an eligible individual or child resides with an ineligible spouse or parent(s), a portion of the ineligible spouse's or parent's income is deemed as available income to the eligible individual, per Oklahoma Administrative Code (OAC) 317:35-5-42(k).

(4) If only one (1) spouse in a couple is eligible and the couple stops living together, only the income and resources that the ineligible spouse actually contributes to the eligible spouse are considered in determining the eligible spouse's eligibility, beginning with the month after the month they stop living together.

(5) Refer to OAC 317:35-9-68 to determine how to consider a community spouse's income eligibility for SoonerCare (Medicaid) when his or her spouse:

(A) Is institutionalized in a nursing facility or an intermediate care facility for the intellectually disabled;

(B) Is sixty-five (65) years or older and lives in a mental health hospital; or

(C) Receives ADvantage or Home and Community Based Waiver services.

(6) In certain circumstances, the amount of income determined to be available to an individual may be greater than the amount of income the individual actually receives for his or her own use.

This includes, but is not limited to:

(A) Court-ordered income deductions for child and/or spousal support even when the support is paid directly to the child's guardian or spouse by the individual's employer or benefit payer;

(B) Deductions due to a repayment of an overpayment, loan, or other debt, unless the amount being withheld to reduce a previous overpayment was included when determining the amount of unearned income for a previous month in the determination of medical assistance eligibility; or

(C) Garnishments or liens placed against earned or unearned income of the individual, regardless of the purpose for the garnishment or lien.

(7) The individual's statement regarding the source and amount of available income must be verified at application, renewal, and when changes occur by:

(A) Award letters, warrants, or other documents provided by the individual;

(B) Automated data exchange with other agencies such as Beneficiary and Earnings Data Exchange System (BENDEX); Supplemental Security Income (SSI)/State Data Exchange System (SDX), or UIB;

(C) The Asset Verification System (AVS) when income is held in bank accounts or other financial institutions;

(D) Public records; or

(E) Collateral contacts such as employers, agencies, businesses, or community action groups.

(8) The individual is responsible for reporting and verifying income changes within ten (10) calendar days of the change occurring.

(b) **Sources of income considered.** The individual is responsible for reporting information regarding all sources of available income. All monies or payments that are available for current living expenses, unless specifically disregarded per (c) of this Section are considered in determining monthly gross income. Some of the more common income sources to be considered in determining eligibility are included in (1) through (8) of this subsection:

(1) **Annuities, pensions, retirement, disability, and other payments.** In accordance with 20 C.F.R. §416.1123, benefits and payments are considered for the month they are received, unless they include retroactive payments. Retroactive payments are considered as lump sum payments per (b)(5) of this Section.

(A) Payments include, but are not limited to:

(i) RSDI and SSI benefits;

(ii) Veteran's benefits;

(iii) Railroad retirement annuities;

(iv) Pensions, retirement, or disability benefits from government or private sources;

(v) Workers' compensation; and

(vi) UIB.

(B) Determination of RSDI benefits to be considered; disregarding cost-of-living adjustments (COLAs) for former State Supplemental Payment recipients, who are reapplying for medical benefits under the Pickle Amendment, are computed, per OKDHS Appendix C-2-A, COLA Increase Computation Formulas.

(C) The U.S. Department of Veterans Affairs allows their recipients to request reimbursement for medical expenses not covered by SoonerCare. When a recipient is eligible for a readjustment payment, it is paid in a lump sum for the entire past year. When received, this reimbursement is disregarded as income or a resource for the month received. Any amount retained in the month following receipt is considered as a resource.

(D) Government financial assistance in the form of Veterans Affairs (VA) Aid and Attendance or Champus payments are considered as:

(i) A third-party resource whether paid to the individual or the facility when the individual

resides in a nursing facility. These payments do not affect income eligibility or the vendor payment of the member; or

(ii) Excluded income when paid for an attendant in the individual's home.

(E) SSI benefits may be continued for up to three (3) months for a recipient who enters a public medical or psychiatric institution, a SoonerCare approved hospital, extended care facility, intermediate care facility for individuals with an intellectual disability, or nursing facility. To be eligible for the continuation of benefits, the SSI recipient must have a physician's certification that the institutionalization is not expected to exceed three (3) months and there must be a need to maintain and provide expenses for the home. These continued payments are intended for the use of the recipient and do not affect the vendor payment.

(F) A veteran or his or her surviving spouse who receives a VA pension may have the pension reduced to ninety dollars (\$90) per month if the veteran does not have dependents, is SoonerCare (Medicaid) eligible, and resides in a nursing facility that is approved under SoonerCare, per Section 8003 of Public Law (P.L.) 101-508. The VA pension for a veteran or his or her surviving spouse who meets these conditions is reduced the month following the month of admission to a SoonerCare (Medicaid) approved nursing facility.

(i) The reduced VA pension is not used to compute the vendor payment or spenddown. The nursing facility resident is entitled to receive the ninety-dollars (\$90) reduced VA pension and the regular nursing facility maintenance standard, per OKDHS Appendix C-1, Maximum Income, Resource, and Payment Standards, Schedule VIII.B.2, Maximum Income, Resource, and Payment Standards.

(ii) The vendor payment or spenddown is computed using other income minus the monthly nursing facility maintenance standard and any applicable medical deductions.

(2) Child support and alimony payments. Child support and alimony payments are counted as unearned income whether in cash or in-kind. Per (f)(11) of this Section, one-third (1/3) of child support payments received on behalf of the disabled minor child is excluded.

(3) Dividends, interest, and certain royalties. Dividends, interest, and certain royalties are counted as unearned income. Dividends and interest are returns on capital investments, such as stocks, bonds, or savings accounts. Royalties are compensation paid to the owner for the use of property or natural resources. Royalties are considered earned income when received as part of the individual's trade or business or in conjunction with a work

publication.

(4) Income from capital resources and rental property.

Income from capital resources may be received from the use of real or personal property, such as land, housing, machinery, leasing of minerals, a life estate, homestead rights, or interest.

(A) Rental income may be treated as self-employment income when the individual participates in the management of the trade or business or invests his/her own labor in producing the income. When the individual does not participate in the management of the trade or business or does not invest his/her own labor in producing the income, it is considered as unearned income.

(i) The individual's federal income tax return or business records verify when the rental income is considered as self-employment income. When the individual's federal tax return or business records do not verify the rental income is from self-employment, the income is considered unearned income.

(ii) Expenses necessary for the production or collection of the rental income are deducted when paid, not when they are incurred. Examples of deductible expenses include interest on debt, state and local taxes on real or personal property and on motor fuel, general sales taxes, and expenses on managing or maintaining the property. Depreciation or depletion of property is not considered a deductible expense.

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

(B) If the individual receives royalty income monthly but in irregular amounts or less often than monthly, the income is averaged over the previous six (6) month period to determine the countable monthly income.

(i) At any time a dramatic increase or decrease in royalty income occurs, the previous two (2) months of royalty income is averaged to compute the countable monthly income.

(ii) When the difference between the gross and net royalty income is due to a production or severance tax, the net income is used to determine income eligibility as this tax is considered the cost of producing the income.

(5) Lump sum payments. Any income received in a lump sum, with the exception of an SSI or RSDI lump sum, covering a period of more than one (1) month, whether received on a recurring or nonrecurring basis, is considered as income in the month it is received. Any amount retained on the first day of the month following receipt of the lump sum is considered as a resource.

(A) A lump sum payment may be considered as earned or unearned income, depending on the source of the lump sum payment. Lump sum payments may include, but are not limited to:

- (i) Wages or wage bonuses;
- (ii) Retroactive RSDI, VA, or workers' compensation payments;
- (iii) Bonus lease payments;
- (iv) Annual rentals from land or minerals;
- (v) Life insurance death benefits;
- (vi) Lottery or gambling winnings;
- (vii) Personal injury awards or settlements; or
- (viii) Inheritances.

(B) RSDI and SSI retroactive payments do not count as income in the month of receipt. Any unspent portion retained on the first day of the month following receipt of the lump sum is excluded from resources for nine (9) calendar months, per 20 C.F.R. § 416.1233. However, unspent money from a retroactive payment must be identifiable from other resources for this exclusion to apply. The money may be commingled with other funds, but if this is done in such a fashion that the retroactive amount can no longer be separately identified, that amount is counted toward the resource limit.

(C) Lump sum payments used to establish dedicated bank accounts by representative payees in order to receive and maintain retroactive SSI benefits for children with disabilities or blindness who are under eighteen (18) years of age are excluded as income or a resource. The interest income generated from dedicated bank accounts is also excluded.

(D) A life insurance death benefit received by the individual for another person is considered as income in the month received except for amounts paid for the person's last illness and burial expenses. Money retained in the month following receipt of the benefit is counted as a resource to the extent that it is available.

(E) Changing a resource from one form to another, such as converting personal property to cash, is not considered a lump sum payment, all other things being equal.

(6) **Non-negotiable notes and mortgages.** Installment payments received on a note or mortgage are considered as monthly unearned income.

(7) **Income from the Workforce Innovation and Opportunity Act (WIOA).** Unearned income received by an adult, such as a need-based payment, cash assistance, compensation in lieu of wages, or allowances from a program funded by WIOA is considered as any other unearned income.

(8) **In-kind support and maintenance.** In-kind support and maintenance is food or shelter given to the individual or that the individual receives because someone else pays for it. Shelter

includes room, rent, mortgage payments, real property taxes, heating fuel, gas, electricity, water, sewerage, and garbage collection services. The value of this support may be counted as income using the one-third (1/3) reduction rule, per 20 C.F.R. §§ 416.1131 through 416.1133 or the presumed value rule, per 20 C.F.R. §§ 416.1140 through 416.1145.

(A) **One-third (1/3) reduction rule.** The one-third (1/3) reduction rule applies when the individual or the individual and his/her spouse lives in the household of a person who provides him/her with both food and shelter for at least a full calendar month. Per 20 C.F.R. § 416.1131, instead of determining the actual value of in-kind support and maintenance, one-third (1/3) of the SSI federal benefit rate, per OKDHS Appendix C-1, Schedule VIII.C is counted as income.

(i) The one-third (1/3) reduction rule applies in full or not at all. When the individual lives in another person's household and the one-third (1/3) reduction rule applies, no income exclusions are applied to the reduction amount.

(ii) When the one-third (1/3) reduction rule applies and the individual receives other support and maintenance, the other support and maintenance is not counted.

(iii) The one-third (1/3) reduction rule does not apply when the individual or the individual and his/her spouse:

(I) Lives in another person's household but does not receive both food and shelter from that person;

(II) Lives in his/her own household; or

(III) Lives in a non-medical institution such as a public or private non-profit educational or vocational institution, or a private non-profit retirement home.

(B) **Another person's household.** The individual is considered to be living in another person's household if the person is not considered to be living in his/her own home per (C) of this subsection, the person who supplies the support and maintenance lives in the same household, and is not:

(i) The individual's spouse;

(ii) A minor child; or

(iii) An ineligible person whose income may be deemed to the individual per OAC 317:35-5-42(k).

(C) **Living in own household.** The individual or the individual and his/her spouse are considered to be living their own household when:

(i) The individual, the individual and his/her spouse, or a person whose income is deemed to the individual, live in a home in which one of them has

an ownership interest or life estate in the home;
(ii) The individual, the individual and his/her spouse, or a person whose income is deemed to the individual is liable for any part of the rent charges;
(iii) The individual pays at least a pro rata share of the household and operating expenses;
(iv) The individual lives in a non-institutional care setting. The individual is considered to be living in a non-institutional care situation when:

(I) He/she is placed by a public or private agency under a specific program such as foster or family care;

(II) The placing agency is responsible for the individual's care;

(III) He/she lives in a private household that is licensed or approved by the placing agency to provide care; and

(IV) The individual, a public agency, or someone else pays for his/her care; or

(v) All members of the household receive public maintenance payments such as:

(I) Supplemental Security Income (SSI);

(II) State Supplemental Payment (SSP);

(III) Temporary Assistance for Needy Families (TANF);

(IV) Refugee cash assistance;

(V) Assistance provided under the Disaster Relief and Emergency Assistance Act;

(VI) Bureau of Indian Affairs (BIA) general assistance programs;

(VII) State or local government assistance programs based on need; or

(VIII) VA payments based on need.

(D) **Presumed value rule.** The presumed value rule applies when the individual receives in-kind support and maintenance and the one-third (1/3) reduction rule does not apply. The maximum presumed value is one-third (1/3) of the SSI Federal Benefit Rate (FBR), per OKDHS Appendix C-1, Schedule VIII.C plus the twenty dollars (\$20) general income exclusion.

(i) The presumed value rule allows the individual to show that the amount of in-kind support and maintenance is not equal to the maximum presumed value. When the individual does not question the maximum presumed value, one-third (1/3) of the SSI FBR, per OKDHS Appendix C-1, Schedule VIII.C plus the twenty dollars (\$20) general income exclusion is counted as unearned income.

(I) When the individual disputes the amount counted for in-kind support and

maintenance, he/she may verify that the current market value of the food or shelter he/she receives or the actual amount someone else pays for the individual's food and shelter is lower than the maximum presumed value.

(II) When the individual verifies that the food or shelter received is lower the maximum presumed value, the lower amount is used as the presumed value and counted as unearned income.

(III) When the individual verifies the actual value of the food or shelter he she receives and it is higher than the maximum presumed value amount, the actual amount is counted as unearned income.

(ii) In-kind support and maintenance received by an individual is excluded if:

(I) It is identified as excluded per (e) or (f) of this Section,

(II) It is received from another member of a public assistance household; or

(iii) The individual receives SSI and the SSA does not reduce the individual's SSI benefit because of in-kind support and maintenance.

(iv) When the individual or the individual and his or her spouse live in a household in which all members receive a public maintenance payment per (b)(8)(C)(v) of this subsection, in-kind support and maintenance is not counted unless the individual receives food and shelter from someone outside of the household.

(9) **Earned income.** Earned income may include:

(A) **Wages.** Wages include the gross income earned for work performed as an employee before deductions, such as taxes, bonds, pensions, union dues, credit union payments, or cafeteria plans are subtracted.

(i) Wages paid in cash may include salaries, commissions, tips, piece-rate payments, longevity payments, bonuses, severance pay, and any other special payments received due to employment.

(ii) Wages paid to uniformed service members include basic pay, some types of special pay, and some allowances. Allowances paid for on-base housing or privatized military housing are considered unearned income in the form of in-kind support and maintenance. Allowances paid for private housing are considered wages.

(iii) Wages paid in-kind may include the value of food, clothing, shelter, or other items provided in lieu of or in conjunction with wages. The cash

value of in-kind benefits must be verified by the employer. Medical insurance secured through the employer, whether purchased or as a benefit, is not considered a countable in-kind benefit. Exception: In-kind pay received by a domestic or agricultural worker is considered unearned income.

(iv) Work study received by an individual who is attending school is considered as earned income with appropriate earned income exclusions, per (g) of this Section applied.

(v) Payments received for services performed in a sheltered workshop or work activities center are counted as earned income. Payments for each calendar quarter are averaged to determine monthly income.

(vi) Income received as wages from a program funded by WIOA is counted as any other earned income.

(vii) Earnings received from the Senior Community Service Employment Program under Title V of the Older Americans Act of 1965 as amended and employment positions allocated at the discretion of Governor of Oklahoma are counted as earned income.

(B) **Self-employment income.** Self-employment income is the gross income earned from a trade or business. Self-employment income also includes in-kind benefits for a work activity or service for which the self-employed person ordinarily receives payment in his/her business enterprise, such as an exchange of business or labor, the individual's share of profit or loss in any partnership to which he/she belongs, and money received for the sale of whole blood or plasma. Income eligibility is based on the individual's net self-employment income after subtracting business expenses. Refer to (i)(4) of this Section for self-employment income determination procedures.

(c) **What is not income.** Items that are not considered income per 20 C.F.R. § 416.1103 because the individual cannot use them as food or shelter or to obtain food or shelter include, but are not limited to:

(1) Medical care and services, including medical insurance premiums paid directly by anyone on the individual's behalf:

(2) Social services, as follows:

(A) Assistance provided in cash or in-kind under any federal, state, or local government program to provide social services such as vocational rehabilitation or VA aid and attendance services;

(B) In-kind assistance provided under a non-governmental program for social services. This does not include food or shelter;

(C) Cash provided by a non-governmental social services program, except for cash to cover food or shelter, when

the cash:

- (i) Is a repayment for program-approved services for which the individual already paid; or
 - (ii) Is a payment restricted to the future purchase of a program-approved service.
- (3) Receipts from the sale, exchange, or replacement of a resource, including cash or an in-kind item provided to replace or repair a resource that was lost, damaged, or stolen;
- (4) Any amount refunded on income taxes already paid by the individual;
- (5) Payments made to the individual under a credit life or credit disability insurance policy;
- (6) Money the individual borrows or receives as repayment of a loan. When the individual borrow money, regardless of use, it is not considered income if a bona fide debt or obligation to pay can be established. Interest the individual receives on money he/she loans someone else is considered income. Criteria to establish a loan as bona fide includes:
- (A) An acknowledgment of the obligation to repay or evidence that the loan was from an individual or financial institution in the loan business. If the loan agreement is not written, OKDHS Form 08AD103E, Loan Verification, should be completed by the borrower attesting that the loan is bona fide and signed by the lender verifying the date and amount of loan. When copies of written agreements or OKDHS Form 08AD103E are not available, documentation must show that the loan is bona fide and how the debt amount and date of receipt was verified.
 - (B) The borrower's acknowledgment of obligation to repay, with or without interest, and the lender's verification of the loan are required to indicate that the loan is bona fide when the loan is from a person(s) not in the loan business.
- (7) Bills paid for the individual by someone else directly to the provider unless it is considered payment for food or shelter;
- (8) Replacement of income that is lost, destroyed, or stolen, such as receiving a replacement paycheck because the original payment was stolen;
- (9) Weatherization assistance; or
- (10) Receipt of certain non-cash items that would be excluded as a non-liquid resource.

(d) **Income exclusions.** Certain types and amounts of income are excluded in determining the individual's eligibility for SoonerCare. When applying exclusions:

- (1) Unearned income exclusions are applied before applying earned income exclusions;
- (2) Income excluded by other federal laws per (e) of this Section are excluded first and then unearned income excluded by the Social Security Act per (f) of this Section;
- (3) Earned income exclusions are then applied in the order listed per (h) of this Section;
- (4) Income must never reduce income below zero (0);

- (5) Unused portions of a monthly exclusion must not be carried over for use in a subsequent month;
- (6) Other than the twenty dollars (\$20) general income exclusion, unused unearned income exclusions are not applied to earned income; and
- (7) Unused earned income exclusions are never applied to unearned income.

(e) **Income excluded by other federal laws.** Unearned income excluded by federal laws other than the Social Security Act, per the Appendix to Subpart K of Part 416, includes:

- (1) Federal food and nutrition programs, including:
 - (A) The value of Supplemental Nutrition Assistance Program (SNAP) food benefits;
 - (B) U.S. Department of Agriculture food commodities distributed by a private or governmental program;
 - (C) The value of supplemental food assistance received under the Child Nutrition Act or the special food service program for children under the National School Lunch Act;
 - (D) Women, infants, and children program (WIC); and
 - (E) Nutrition programs for older Americans;
- (2) Housing and utility programs including:
 - (A) Energy assistance provided through the Low-Income Home Energy Program that includes the Energy Crisis Assistance Program;
 - (B) Housing assistance provided under the:
 - (i) U.S. Housing Act of 1937;
 - (ii) National Housing Act;
 - (iii) Governmental rental or housing subsidies received in-kind or in cash by governmental agencies, such as the Department of Housing and Urban Development (HUD) for rent, mortgage payments, or utilities;
 - (iv) Title V of the Housing Act of 1949; or
 - (v) Any payment received under Section 216 of P. L. 91-646, the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970;
- (3) Student financial assistance that includes:
 - (A) Grants or loans to undergraduate students made or insured under programs administered by the Secretary of Education under Section 507 of the Higher Education Amendments of 1968 (P. L. 90-575);
 - (B) Wages, allowances, or reimbursements for transportation and attendant care costs, unless excepted on a case-by-case basis, when received by an eligible individual with disabilities employed in a project under Title VI of the Rehabilitation Act of 1973 as added by 29 U.S.C. § 795(b)(c); and
 - (C) Student financial assistance received for attendance costs from a program funded in whole or in part under Title IV of the Higher Education Act of 1965, as amended,

or under BIA student assistance programs when it is made available for tuition and fees normally assessed to a student carrying the same academic workload, as determined by the institution. This includes costs for rental or purchase of any equipment, materials, or supplies required of all students in the same course of study and an allowance for books, supplies, transportation, and miscellaneous personal expenses for a student attending the institution on at least a half-time basis, as determined by the institution, under Section 14(27) of P. L. 100-50, the Higher Education Technical Amendments Act of 1987 (20 U.S.C. § 1087uu);

(4) Native American payments excluded without regard to a specific tribe or group includes:

(A) Indian judgment funds that are held in trust by the Secretary of the Interior or distributed per capita pursuant to a plan prepared by the Secretary of the Interior and not disapproved by a joint resolution of the Congress under P. L. 93-134 as amended by Section 4 of P. L. 97-458 (25 U.S.C. § 1408). Indian judgment funds include interest and investment income accrued while such funds are so held in trust. This exclusion extends to initial purchases made with Indian judgment funds but does not apply to sales or conversions of initial purchases or to subsequent purchases. This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household;

(B) All funds held in trust by the Secretary of the Interior for an Indian tribe and distributed per capita to a member of that tribe under P.L. 98-64 (25 U.S.C. § 117b). Funds held by Alaska Native Regional and Village Corporations (ANRVC) are not held in trust by the Secretary of the Interior and therefore ANRVC dividend distributions are not excluded from countable income under this exclusion. This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household;

(C) Cash distributions and dividends received by an individual Alaska Native or descendant under the Alaska Native Claims Settlement Act Amendments of 1987, P.L. 100-241, (43 U.S.C. § 1626(c)) to the extent that it does not, in the aggregate, exceed two-thousand dollars (\$2,000) per individual each year. This exclusion does not apply in deeming income from sponsors to aliens;

(D) Up to two-thousand dollars (\$2,000) per year received by Indians that is derived from individual interests in trust or restricted lands under P.L. 103-66, (25 U.S.C. § 1408), as amended;

(5) Payments made to members of specific Indian tribes and groups. Refer to 20 C.F.R § 416 Subpart K Appendix, Section IV.B for the complete list. Payments to tribes in Oklahoma on this list include:

(A) Judgement funds distributed per capita to, or held in trust for, members of the Sac and Fox Indian Nation, and the availability of such funds under Section 6 of P. L. 94-189. This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household;

(B) Any judgement funds distributed per capita or made available for programs for members of the Delaware Tribe of Indians and the Absentee Delaware Tribe of Western Oklahoma under Section 8 of P. L. 96-318;

(C) Any distribution of judgement funds to members of the Wyandotte Nation of Oklahoma under Section 6 of P. L. 97-371;

(D) Distributions of judgement funds to members of the Shawnee Tribe of Indians (Absentee Shawnee Tribe of Oklahoma, the Eastern Shawnee Tribe of Oklahoma, and the Cherokee Band of Shawnee descendants) under Section 7 of P. L. 97-372;

(E) Judgement funds distributed per capita or made available for programs for members of the Miami Tribe of Oklahoma and the Miami Indians of Indiana under Section 7 of P. L. 97-376;

(F) Judgement funds distributed per capita or made available for any tribal program for members of the Wyandotte Nation of Oklahoma and the Absentee Wyandottes under Section 106 of P. L. 98-602; and

(G) Judgement funds distributed per capita, or held in trust, or made available for programs, for members of the Seminole Nation of Oklahoma, the Seminole Tribe of Florida, the Miccosukee Tribe of Indians of Florida, and the independent Seminole Indians of Florida under Section 8 of P. L. 101-277. This exclusion applies to income of sponsors of aliens only when the alien lives in the sponsor's household;

(6) Receipts from lands held in trust and:

(A) Distributed to members of certain Indian tribes under Section 6 of P.L. 94-114, (25 U.S.C. § 459e);

(B) Awarded to the Pueblo of Santa Ana and distributed to members of that tribe under Section 6 of P.L. 95-498; and

(C) Awarded to the Pueblo of Zia in New Mexico and distributed to members of that tribe under Section 6 of P.L. 95-499;

(7) Compensation provided to volunteers by the Corporation for National and Community Service (CNCS), unless determined by the CNCS to constitute the federal or state minimum wage.

Programs included under CNCS include:

(A) AmeriCorps programs;

(B) The Retired Senior Volunteer Program;

(C) The Foster Grandparent Program; and

(D) The Senior Companion Program;

(8) Benefits from State and Community Programs on Aging, per Title III of the Older Americans Act of 1965, as amended by P.L.

- 114-144, Older Americans Act Reauthorization Act of 2016. Income received from the Senior Community Service Employment Program under Title V of the Older Americans Act as well as employment positions allocated at the discretion of Governor of Oklahoma is counted as earned income;
- (9) Payments made as restitution under the Civil Liberties Act of 1988 to certain individuals of Japanese ancestry who were detained in internment camps during World War II;
- (10) Payments made on or after January 1, 1989, from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In Re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.) under P. L. 101-201 and Section 10405 of P.L. 101-239;
- (11) Payments made under Section 6 of the Radiation Exposure Compensation Act, P.L. 101-426 for injuries or deaths resulting from the exposure to radiation from nuclear testing and uranium mining;
- (12) The value of any childcare provided or arranged under the Child Care and Development Block Grant Act, as amended by Section 8(b) of P.L. 102-586.
- (13) Payments made to individuals because of their status as victims of Nazi persecution per P.L. 103-286;
- (14) Matching funds and any interest earned on these funds that are deposited into individual development accounts (IDAs), as a demonstration project or TANF-funded, per 42 U.S.C. § 604;
- (15) Payments made to individuals who were captured and interned by the Democratic Republic of Vietnam as a result of participation in certain military operations, per P.L. 105-78;
- (16) Payments made to certain Vietnam or Korea veterans' children with spina bifida, per P.L. 104-204 (38 U.S.C. § 1805(a)) or PL 108-183;
- (17) Payments made to the children of women Vietnam veterans who suffer from certain birth defects, per P.L. 106-419 (38 U.S.C. § 1833(c));
- (18) Payments of the refundable child tax credit made under Section 24 of the Internal Revenue Code of 1986;
- (19) Assistance provided for flood mitigation activities, per Section 1 of P.L. 109-64 (42 U.S.C. § 4031);
- (20) Payments made to individuals under the Energy Employees Occupational Illness Compensation Program Act of 2000, per Section 1 of P.L. 106-398 (42 U.S.C. § 7385e); and
- (21) The Oklahoma Achieving a Better Life Experience (ABLE) Program, in accordance with OAC 317:35-5-41.9(c)(1) and 26 U.S.C. § 529A. Money deposited into or withdrawn from a qualified ABLE Program account or a qualified ABLE Program account set up in any other state, is excluded as income or a resource when the individual:
- (A) Provides documents to verify the account meets exemption criteria;
 - (B) Verifies money deposited in the account does not exceed the annual federal gift tax exclusion amount per 26

U.S.C. § 2503(b). Any money deposited in the account in the calendar year that is in excess of the annual federal gift tax exclusion amount is considered as countable income in the amount deposited; and

(C) Verifies withdrawals from the account were used to pay qualified disability expenses (QDE). Money withdrawn for reasons other than to pay QDE is considered as income for the month of withdrawal.

(22) Any other income exempted by new or revised federal statutes that are in effect before the Subpart K Appendix is updated.

(f) Unearned income excluded by the Social Security Act. Unearned income excluded by the Social Security Act, per 20 C.F.R. § 416.1124 includes:

(1) Any public agency's refund of taxes on real property or food;
(2) Need-based assistance that is wholly funded by a State or one of its political subdivisions. For purposes of this rule, an Indian tribe is considered a political subdivision of a State. Assistance is based on need when it is provided under a program that uses the individual's income as an eligibility factor. State need-based assistance programs include the SSP program, but not federal/state programs such as TANF;

(3) Any portion of a grant, scholarship, fellowship, or gift used or set aside for paying tuition, fees, or other necessary educational expenses. This does not include any portion set aside or actually used for food or shelter;

(4) Food raised by the individual and/or his or her spouse, if it is consumed by the individual or the individual's household;

(5) Assistance received under the Disaster Relief and Emergency Assistance Act and assistance provided under any federal statute because of a presidentially-declared disaster;

(6) The first sixty dollars (\$60) of unearned income received in a calendar quarter that is received infrequently or irregularly.

Income is considered:

(A) To be infrequent when the individual receives it only once during a calendar quarter from a single source and did not receive that type of income in the month preceding or following the month the income was received; and

(B) Irregular when the individual cannot reasonably expect to receive it;

(7) Alaska longevity bonus payments;

(8) Payments for providing foster care to an ineligible child placed in the individual's home by a public or private nonprofit child placement or childcare agency;

(9) Any interest earned on excluded burial funds and any appreciation in the value of an excluded burial arrangement that are left to accumulate and become a part of the separate burial fund;

(10) Certain support and maintenance assistance as described in 20 C.F.R. § 416.1157 that is certified in writing by the appropriate state agency to be both based on need and:

- (A) Provided in-kind by a private nonprofit agency; or
- (B) Provided in cash or in-kind by a:
 - (i) Supplier of home heating oil or gas;
 - (ii) Rate-of-return entity providing home energy; or
 - (iii) A municipal utility providing home energy;
- (11) One-third (1/3) of child support payments received on behalf of the minor child with disabilities;
- (12) The first twenty dollars (\$20) of any unearned income received in a month other than income in the form of in-kind support and maintenance received in the household of another per (b)(8) of this Section and need-based income. Need-based income is a benefit that uses financial need as a factor to determine eligibility. The twenty dollars (\$20) exclusion does not apply to a needs-based benefit that is totally or partially funded by the federal government or by a nongovernmental agency. However, assistance which is based on need and funded wholly by a State or one of its political subdivisions, such as SSP, is excluded totally from income. When the individual has less than twenty dollars (\$20) of unearned income in a month, the rest of the twenty dollars (\$20) exclusion may be deducted from the individual's countable earned income;
- (13) Any unearned income received and used to fulfill an approved plan to achieve self-support (PASS) for an individual with disabilities or blindness. The Social Security Administration (SSA) approves the plan, the amount of income excluded, and the period of time approved;
- (14) Federal housing assistance provided under:
 - (A) The U.S. Housing Act of 1937;
 - (B) The National Housing Act;
 - (C) Section 101 of the Housing and Urban Development Act of 1965;
 - (D) Title V of the Housing Act of 1949; or
 - (E) Section 202(h) of the Housing Act of 1959;
- (15) Any interest accrued on and left to accumulate as part of the value of an excluded burial space purchase agreement. This exclusion from income applies to interest accrued on or after April 1, 1990;
- (16) The value of any commercial transportation ticket among the fifty states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands, that is received as a gift and is not converted to cash;
- (17) Payments received by an individual from a fund established by a state to aid crime victims;
- (18) Relocation assistance provided by a state or local government that is comparable to assistance provided under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 that is subject to the treatment required by Section 216 of that Act;
- (19) Special pay received from one of the uniformed services, per 37 U.S.C. § 310;

(20) Interest or other earnings on a dedicated account established for an eligible individual under eighteen (18) years of age when past due benefit payments must or may be paid into such an account, per 20 C.F.R. § 416.1247;

(21) Gifts to children under eighteen (18) years of age with life-threatening conditions from an organization described in Section 501(c)(3) of the Internal Revenue Code of 1986, provided that:

(A) In-kind gifts not converted to cash; or

(B) Cash gifts do not exceed two-thousand dollars (\$2,000) within a calendar year;

(22) Interest and dividend income from a countable resource or from a resource excluded under a federal statute other than Section 1613(a) of the Social Security Act;

(23) AmeriCorps State and National and AmeriCorps National Civilian Community Corps cash or in-kind payments made to participants or on their behalf, such as food, shelter, and clothing allowances;

(24) Any annuity paid by a state to an individual, or his or her spouse, based on the State's determination that the individual is a veteran and is blind, disabled, or aged; and

(25) The first two-thousand dollars (\$2,000) per calendar year received as compensation for participation in clinical trials that meet the criteria, per Section 1612(b)(26) of the Social Security Act.

(g) **Earned income exclusions.** Per 20 C.F.R. § 416.1112, earned income exclusions are applied after the unearned income exclusions, and in the order listed per (1) through (11) of this subsection. Earned income exclusions must not exceed the amount earned and include:

(1) Earned income tax credit and child tax credit payments;

(2) The first thirty dollars (\$30) of infrequent or irregular earned income received in a calendar quarter;

(3) The student earned income exclusion (SEIE) up to the SEIE monthly limit, per OKDHS Appendix C-1, Schedule VIII.E is applied to the earned income of a student who:

(A) Is blind or disabled;

(B) Is under twenty-two (22) years of age; and

(C) Attends a college, university, or a course of vocational or technical training designed to prepare students for gainful employment.

(4) Any portion of the twenty (\$20) month general income exclusion that was not excluded from unearned income in the same month;

(5) The first five-hundred dollars (\$500) of the monthly earnings of an individual who is blind, per Section 15 of Title 7 of the Oklahoma Statutes;

(6) Sixty-five dollars (\$65) of earned income in a month. This exclusion is applied once per couple;

(7) The earned income individuals with disabilities who are not blind used to pay impairment-related work expenses, per 20 C.F.R. § 404.1576, including, but not limited to:

(A) Attendant care services;

- (B) Assistance with personal functions;
- (C) Payments for medical devices;
- (D) Payments for prosthetic devices;
- (E) Payments for work-related equipment;
- (F) Payments for drugs and medical services used to control the impairment; and
- (G) Payments for transportation costs.

(8) One-half (1/2) of any remaining earned income in a month;

(9) Actual work expenses paid by individuals who are blind and under age sixty-five (65) or who receive SSI as a blind person the month before reaching the age of sixty-five (65), such as transportation expenses to and from work and job performance or improvement expenses;

(10) Earned income received and used to fulfill an approved plan to achieve self-support (PASS) for individuals who are blind or disabled and under sixty-five (65) years of age or who are blind and disabled and received SSI as a blind or disabled person for the month before reaching sixty-five (65) years of age. The SSA approves the plan, the amount of income excluded, and the period of time approved; and

(11) Payments made to participants in AmeriCorps State and National and AmeriCorps National Civilian Community Corps (NCCC). These payments may be made in cash or in-kind and may be made directly to the AmeriCorps participant or on the AmeriCorps participant's behalf. These payments include, but are not limited to: living allowance payments, stipends, educational awards, and payments in lieu of educational awards.

(h) Unused exclusions. Unused:

- (1) Earned or unearned exclusions are never reduced below zero (0);
- (2) Portions of a monthly exclusion cannot be carried over for use in a subsequent month;
- (3) Earned income exclusions are never applied to unearned income; and/or
- (4) Unearned income exclusions are not applied to earned income except for any remaining portion of the twenty dollars (\$20) general income exclusion.

(i) Monthly income determination. The total gross amount of earned and unearned income available to the eligible individual and eligible or ineligible spouse is determined before subtracting applicable unearned and earned income exclusions per (d) through (g) of this Section. In calculating monthly income, cents are included in the computation until the monthly amount of each income source is established. Once the monthly amount of each income source is established, cents are rounded to the nearest dollar, one (1) to forty-nine (49) cents is rounded down, and fifty (50) to ninety-nine (99) cents is rounded up.

(1) **Averaging income.** When the individual indicates that he/she receives income monthly, but on an irregular basis, the most recent two (2) months of income are averaged to determine income eligibility.

(A) Income that is received less often than monthly or in amounts that vary significantly over the course of a year may be averaged over a longer period of time. For instance, royalty income must be averaged over a six (6) month period.

(B) Less than two (2) months of income may be used when the income started less than two (2) months ago or previous income amounts are not representative of future income. For instance, the individual may have started a new job less than two (2) months ago or may have received a one-time bonus or overtime pay that is not expected to recur.

(2) **Converting income to a monthly amount.** Income received more often than monthly is converted to monthly amounts as indicated in (A) through (E) of this subsection:

(A) **Daily.** Income received on a daily basis is converted to a weekly amount. When there is consistency in days worked each week and regular pay dates, the income is multiplied by 4.3. When there is no consistency, refer to (3) of this subsection for irregular income processing.

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

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

(D) **Biweekly.** Income received every two (2) weeks is multiplied by 2.15.

(E) **Irregular income.** Income received monthly but at irregular intervals is not converted by 4.3, 2, or 2.15 when there is no consistency in the work offered or when pay is received. Instead, the income received over the last two (2) months is added together and divided by two (2) to arrive at a monthly average.

(3) **Infrequent or irregular income.** Infrequent or irregular income is considered countable income in the month it is received unless excluded per (C) of this paragraph.

(A) Income is considered to be infrequent if the individual receives it only once during a calendar quarter from a single source and the individual did not receive that type of income in the month preceding or following the month the income was received.

(B) Income is considered to be irregular if the individual cannot reasonably expect to receive it.

(C) When the individual receives infrequent or irregular income, exclude the first:

(i) Thirty dollars (\$30) per calendar quarter of earned income; and

(ii) Sixty dollars (\$60) per calendar quarter of unearned income.

(4) **Self-employment income determination.** Self-employment income is determined per (A) through (E) of this paragraph:

(A) When filed, the federal income tax form for the most recent year is used to calculate the individual's self-

employment income and business expenses for the certification period. The net earnings shown on the income tax form after business expenses are subtracted is divided by twelve (12) months to determine the individual's monthly countable self-employment income.

(B) When the individual did not file a federal tax form for the most recent year, the individual's business records showing monthly income and expenses are used to determine the individual's self-employment income. When the business was in operation for the entire year, the individual's net income after subtracting business expenses is divided by twelve (12) months to determine the individual's monthly countable self-employment income.

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

(D) If the household's business has operated for less than a year, the income from that business is averaged over the period of time the business has operated to establish the monthly income amount.

(E) After the net countable self-employment income is determined, the earned income exclusions per (g) of this section are then applied to establish countable earned income.

(5) **SSI recipients.** If a member is determined to be categorically needy and is also an SSI recipient, any change in countable income does not affect SoonerCare receipt and the State Supplemental Payment (SSP) payment amount as long as the changed income amount does not cause SSI ineligibility.

(A) Income considered by SSI in the retrospective cycle is not counted until SSI makes the change, so the income is not counted twice. If the SSI change is not made timely by SSA, the income is counted as if it had been timely.

(B) If the receipt of the income causes SSI ineligibility, the income is considered immediately with proper action taken to reduce or close the SoonerCare and SSP benefit. Any SSI overpayment caused by SSA not making timely changes will result in recovery by SSI in the future. When the OKDHS worker becomes aware of income changes that affect the individual's SSI eligibility or payment amount, he/she shares the information with the SSA office.

(j) **Computation of income.** After determining the individual's and his/her spouse's monthly income.

(1) **General income exclusion.** The general income exclusion of twenty dollars (\$20) per month is subtracted from the combined unearned income of the eligible individual and eligible or

ineligible spouse, unless the only unearned income is SSP. If any portion of the general income exclusion is not subtracted from unearned income, it is subtracted from earned income.

(2) **Earned income deduction.** When the individual has earned income, after deducting the twenty dollars (\$20) exclusion, the sixty-five (\$65) and one-half of the remaining combined earned income is then deducted.

(3) **Deeming computation procedures.** Refer to OAC 340:35-5-42(k) for deeming computation procedures from an ineligible spouse, ineligible parent, sponsor of an alien or an essential person to the eligible individual or child.

(k) **General income deeming procedures.** The term deeming is used to identify the process for considering another individual's income to be available to the applicant or SoonerCare member, described in this Section as the eligible individual or child. Per Section 416.1160 of Title 20 of the Code of Federal Regulations (20 C.F.R. § 416.1160), there are four (4) categories of individuals whose income may be deemed when determining eligibility: an ineligible spouse, ineligible parent, the sponsor of an alien, or an essential individual. The first step in deeming is determining how much income the applicable individual(s) has. When deeming rules apply, it does not matter if the other individual's income is actually available to the eligible individual or child.

(1) **Ineligible spouse.** An ineligible spouse is a spouse who lives in the same household with the eligible individual and is not eligible for Supplemental Security Income (SSI). For spouse-to-spouse deeming to apply, the eligible individual must be eligible based on his or her own income.

(2) **Ineligible parent.** An ineligible parent is a natural or adoptive parent or stepparent who lives with an eligible child under eighteen (18) years of age and is not eligible for SSI. A stepparent's income is not deemed if the eligible child's natural or adoptive parent dies or permanently leaves the home, per 20 C.F.R. § 416.1165.

(3) **Sponsor of an alien.** A sponsor is an individual, not an organization or an employer, who signs an affidavit agreeing to support the alien as a condition for the alien's admission for permanent residence in the U.S. A portion of the sponsor's income is deemed to the alien for three (3) years even when the sponsor and alien do not live together unless (A) if this paragraph applies.

(A) Deeming rules regarding sponsored aliens do not apply when the alien:

- (i) Is a refugee admitted to the U.S., per Section 203(a)(7), 207(c)(1) or Section 212(d)(5) the Immigration and Nationality Act;
- (ii) Was granted asylum by the Attorney General of the U. S.; or
- (iii) Becomes blind or disabled, per 20 C.F.R § 416.901 after admission to the U. S. When this occurs, the sponsor's income is no longer deemed beginning with the month in which you're the disability or blindness begins.

(B) If the sponsor is the alien's ineligible spouse or ineligible parent(s), the spouse-to-spouse or parent-to-child deeming calculations apply.

(C) If a sponsored alien has a sponsor and an ineligible spouse or ineligible parent(s) who is not his/her sponsor, both sponsor-to-alien and spouse-to-spouse or parent-to-child deeming calculations apply.

(4) **Household definition.** A household for deeming purposes may include the eligible individual or child, an eligible or ineligible spouse, and any children of the couple or of either member of the couple. A household for an eligible child includes the eligible child's parent(s), and any other children of the parent(s).

(A) A child is considered a member of the household from birth for deeming purposes unless the parent(s) completed paperwork to give the child up for adoption or the child was placed in the temporary custody of a public children's services agency. Exception: A premature infant born at thirty-seven (37) weeks or less whose birth weight is less than two (2) pounds ten (10) ounces is considered disabled by the SSA even if no other medical impairment exists.

When this occurs, the parent(s)' income is not deemed to the child until the month after the month the child leaves the hospital and begins living with his/her parent(s).

(B) An eligible individual or an ineligible spouse or ineligible parent who is temporarily absent from the home per (5) of this subsection, is considered to be a member of the household for deeming purposes per 20 C.F.R. § 416.1167.

(5) **Temporary absence for deeming purposes.** During a temporary absence, per 20 C.F.R. § 416.1167, the absent individual is considered a household member for deeming purposes when an:

(A) Eligible individual or child, ineligible spouse, ineligible parent, or an ineligible child leaves the household but intends to and does return in the same month or the next month;

(B) Eligible individual or child enters a medical treatment facility for up to two (2) or three (3) full months;

(C) Eligible child is away at school but comes home on some weekends or lengthy holidays and is subject to his/her parent's control; or

(D) Ineligible spouse or parent is absent from the household due solely to a duty assignment as a member of the Armed Forces on active duty.

(l) **Income exclusions for an ineligible spouse or ineligible parent.** Income excluded for an ineligible spouse or parent per 20 C.F.R. § 416.1161 include:

(1) Income excluded by federal laws other than the Social Security Act, per the Appendix to Subpart K of Part 416 and Oklahoma Administrative Code (OAC) 317:35-5-42(e);

- (2) Any public income-maintenance payments the ineligible spouse or parent receives and any income that was counted or excluded in figuring the amount of that payment. Per 20 C.F.R. § 416.1142, these payments include SSI, State Supplemental Payment (SSP), TANF, refugee cash assistance, disaster relief and emergency assistance, general assistance provided by the Bureau of Indian Affairs, and U.S. Department of Veterans Affairs, State or local government assistance programs based on need;
- (3) Any of the ineligible spouse's or parent's income that is used by a public income-maintenance program to determine that program's benefits to someone else;
- (4) Income used to comply with the terms of court-ordered support, or support payments enforced under Title IV-D of the Social Security Act;
- (5) Income the ineligible spouse or ineligible parent was paid under a federal, state, or local government program to provide the eligible spouse or child with chore, attendant, or homemaker services, such as payments under Title XX of the Social Security Act;
- (6) Any portion of a grant, scholarship, fellowship, or gift used or set aside to pay tuition, fees or other necessary educational expenses;
- (7) Money received for providing foster care to an ineligible child;
- (8) The value of Supplemental Nutrition Assistance Program food benefits and the value of Department of Agriculture donated foods;
- (9) Food raised by the spouse or parent and consumed by members of the household in which you live;
- (10) Tax refunds on income, real property, or food purchased by the family;
- (11) Income used to fulfill an approved plan for achieving self-support, per 20 C.F.R. §§ 416.1180 through 416.1182 and OAC 317:35-5-42(f)(13) and (g)(10);
- (12) The value of in-kind support and maintenance as described in OAC 317:35-5-42(b)(8);
- (13) Alaska longevity bonus payments;
- (14) Disaster assistance, per 20 C.F.R. §§ 416.1150 and 416.1151;
- (15) Income received infrequently or irregularly, per 20 C.F.R. §§ 416.1112(c)(1) and 416.1124(c)(6) and OAC 317:35-5-42(f)(6) and (g)(2);
- (16) Work expenses if the ineligible spouse or parent is blind such as transportation expenses to and from work and job performance or improvement expenses;
- (17) Certain support and maintenance assistance, per 20 C.F.R. § 416.1157(c) and OAC 317:35-5-42(e)(10);
- (18) Housing assistance, per 20 C.F.R. § 416.1124(c)(14);
- (19) The value of a commercial transportation ticket, per 20 C.F.R. § 416.1124(c)(16). However, if such a ticket is converted to cash, the cash is income in the month your spouse or parent receives the cash;

- (20) Refunds of federal income taxes and advances made by an employer relating to an earned income tax credit, per 20 C.F.R. § 416.1112(c);
- (21) Payments from a fund established by a State to aid victims of crime, per 20 C.F.R. § 416.1124(c)(17));
- (22) Relocation assistance, per 20 C.F.R. § 416.1124(c)(18);
- (23) Special pay received from one of the uniformed services pursuant to Section 310 of Title 37 of the United States Code;
- (24) Impairment-related work expenses, per 20 C.F.R. §404.1576 and OAC 317:35-5-42(g)(7), incurred and paid by an ineligible spouse or parent, if the ineligible spouse or parent receives disability benefits under Title II of the Social Security Act;
- (25) Interest earned on excluded burial funds and appreciation in the value of excluded burial arrangements which are left to accumulate and become part of separate burial funds, and interest accrued on and left to accumulate as part of the value of agreements representing the purchase of excluded burial spaces per 20 C.F.R. § 416.1124(c)(9) and (15));
- (26) Interest and dividend income from a countable resource or from a resource excluded under a Federal statute other than Section 1613(a) of the Social Security Act;
- (27) Earned income of a student, per 20 C.F.R. § 416.1112(c)(3) and OAC 317:35-5-42(g)(3); and
- (28) Any additional increment in pay, other than any increase in basic pay, received while serving as a member of the uniformed services, if the ineligible spouse or parent:

- (A) Received the pay as a result of deployment to or service in a combat zone; and

- (B) Was not receiving the additional pay immediately prior to deployment to or service in a combat zone.

(m) **Deeming from an ineligible spouse.** When the eligible individual lives with an ineligible spouse who has income, the deeming steps in (1) through (5) of this paragraph are used to calculate the amount of income to deem to the eligible individual.

- (1) The ineligible's spouse's total gross unearned and earned income is determined and appropriate exclusions per (l) of this Section are applied.

- (2) An ineligible child allocation is then subtracted for each ineligible child in the home, per OKDHS Appendix C-1, Maximum Income, Resource, and Payment Standards, Schedule VIII.C.

- (A) The ineligible child allocation is subtracted from the ineligible spouse's unearned income before subtracting any remaining allocation from his/her earned income.

- (B) An ineligible child allocation is not allowed for a child who receives a public income-maintenance payment, per 20 C.F.R. § 416.1142 and as listed per (l)(2) of this Section.

- (C) When the ineligible child has countable income, the child's income is subtracted from the ineligible child allocation before subtracting the remaining allocation from the ineligible spouse's income.

(3) When the ineligible spouse sponsors an alien(s), the allocation for the alien(s) that is deemed from the ineligible spouse's income is subtracted from the ineligible spouse's unearned income before subtracting any remaining allocation from his/her earned income.

(A) The allocation for each sponsored alien is the difference between the SSI FBR for an eligible couple minus the FBR for an eligible individual, per OKDHS Appendix C-1, Schedule VIII.C.

(B) Each alien's allocation is reduced by the amount of the alien's own income, per (m) of this Section.

(4) When, after subtracting the ineligible child allocation and, if appropriate, the sponsored alien allocation, the ineligible spouse's income is less than or equal to the difference between the SSI FBR for an eligible couple and the SSI FBR for an eligible individual, per OKDHS Appendix C-1, Schedule VIII.C, no income is deemed from the ineligible spouse.

(A) In this instance, only the eligible individual's own countable income minus exclusions per (l) of this Section is considered.

(B) When the eligible individual's countable income is less than or equal to the SSI FBR for an individual, per OKDHS Appendix C-1, Schedule VIII.C, he/she is financially eligible for SoonerCare (Medicaid). When the eligible individual's countable income is over the SSI FBR standard, the individual's eligibility for Qualified Medicare Beneficiary Plus (QMBP) must still be evaluated.

(5) When, after subtracting the appropriate allocations, the ineligible spouse's income is greater than the difference between the SSI FBR for an eligible couple and the SSI FBR for an eligible individual, per OKDHS Appendix C-1, Schedule VIII.C, the spouses are treated as an eligible couple by:

(A) Combining the remainder of the ineligible spouse's unearned income with the eligible individual's unearned income and the remainder of the ineligible spouse's earned income with the eligible individual's earned income;

(B) Applying appropriate income exclusions, per OAC 317:35-5-42(e), (f), and (g) from the eligible spouse's income, including the twenty dollars (\$20) general exclusion from the couple's unearned income and sixty-five dollars (\$65) plus one-half (1/2) of the remaining earned income from the couple's earned income; and

(C) Subtracting the couple's countable income from the SSI FBR for an eligible couple, per OKDHS Appendix C-1, Schedule VIII.C. When the income is less than or equal to the SSI FBR for an eligible couple, the eligible individual is financially eligible for SoonerCare (Medicaid). When the eligible individual's countable income is over the SSI FBR standard, the individual's eligibility for Qualified Medicare Beneficiary Plus (QMBP) must still be evaluated.

(n) **Deeming from ineligible parent(s).** When a child with disabilities or blindness lives with ineligible parent(s), the deeming steps in (1) through (6) of this paragraph are used to calculate the amount of income to deem to the eligible child, up through the month in which the child reaches age eighteen (18).

(1) The gross unearned and earned income of each ineligible parent living in the home is determined and appropriate exclusions are applied, per (l) of this Section.

(2) An ineligible child allocation is subtracted for each ineligible child in the home, per OKDHS Appendix C-1, Schedule VIII.C. Exception: An ineligible child allocation is not allowed for a child who receives public income-maintenance payments, per 20 C.F.R. § 416.1142 and as listed per (l)(2) of this Section.

(A) The ineligible child allocation is first subtracted from the ineligible parent(s)' combined unearned income before subtracting any remaining allocation from their earned income.

(B) When the ineligible child has countable income, the child's income is subtracted from the ineligible child allocation before applying the allocation.

(3) When the ineligible parent sponsors an alien(s), the allocation for the alien(s) that is deemed from the ineligible parent's income per (p) of this Section is subtracted from the ineligible parent(s)' income.

(4) An allocation is then subtracted for the ineligible parent(s) unless the parent receives public income-maintained payments. The allocation is calculated by:

(A) Subtracting the twenty dollars (\$20) general exclusion from the combined unearned income of the ineligible parent(s). If there is less than twenty dollars (\$20) of unearned income, subtract the twenty dollars (\$20) remaining exclusion from their combined earned income;

(B) Subtracting sixty-five dollars (\$65) and one-half of the remainder of their earned income; and

(C) Totaling the ineligible parent(s)' remaining earned and unearned income and depending on the number of parents in the home, subtracting the SSI FBR for an individual or a couple, per OKDHS Appendix C-1, Schedule VIII.C.

(5) The parent(s)' remaining income is then deemed to the eligible child. When there is more than one (1) eligible child in the home, the parent(s)' remaining income is divided by the number of eligible children in the home.

(6) The deemed income is added to the eligible child's own countable unearned income. When the eligible child's deemed and own unearned and earned income, minus appropriate exclusions, per OAC 317:35-5-42(e),(f), and (g), is less than or equal to the SSI FBR for an individual, per OKDHS Appendix C-1, Schedule VIII.C, the child is financially eligible for SoonerCare (Medicaid).

(A) When a child with intellectual disabilities is ineligible for SoonerCare due to the deeming process, he/she may be approved for SoonerCare under the Home and

Community Based Services Waiver (HCBS) Program, per OAC 317:35-9-5.

(B) When a child is eligible for Tax Equity & Fiscal Responsibility Act (TEFRA), the income of child's parent(s) is not deemed to him/her.

(C) The parent(s)' income is not deemed to a premature infant born at thirty-seven (37) weeks or less whose birth weight is less than twelve hundred (1200) grams or approximately two (2) pounds ten (10) ounces until the child leaves the hospital and begins living with his/her parent(s).

(o) Deeming when the household includes an ineligible spouse, an eligible spouse, and an eligible and ineligible child. When the household includes an ineligible spouse, an eligible spouse, one or more eligible children, and one or more ineligible children, the ineligible spouse's income is first deemed to the eligible spouse and the remainder to the eligible child(ren) using the deeming steps in (1) through (6) of this subsection.

(1) The gross unearned and earned income of the ineligible spouse is determined and appropriate exclusions are applied, per (l) of this Section.

(2) An ineligible child allocation is subtracted for each ineligible child in the home, per OKDHS Appendix C-1, Schedule VIII.C. Exception: An ineligible child allocation is not allowed for a child who receives public income-maintenance payments, per 20 C.F.R. § 416.1142 and as listed per (l)(2) of this Section.

(3) If the ineligible spouse's remaining income is less than or equal to the current SSI FBR for a couple minus the current SSI FBR for an individual, no income is deemed to the eligible spouse or eligible child(ren).

(A) Compare the eligible spouse's and each eligible child's own countable income, after applying appropriate exclusions, per OAC 317:35-5-42(e),(f), and (g) to the current SSI FBR for an individual, per OKDHS Appendix C-1, Schedule VIII.C.

(B) When the eligible spouse's and/or each eligible child's own income is less than or equal to the current SSI FBR for an individual, they are financially eligible for SoonerCare.

(4) If the ineligible spouse's remaining income after subtracting the ineligible child allocation(s) is greater than the current SSI FBR for a couple minus the current SSI FBR for an individual:

(A) Combine the ineligible spouse's post-allocation unearned and earned income and the eligible spouse's unearned and earned income, after applying the appropriate exclusions, per OAC 317:35-5-42(e),(f), and (g);

(B) Subtract the twenty dollars (\$20) general exclusion from the couple's combined unearned income. If there is less than twenty dollars (\$20) of unearned income, then subtract the remainder of the exclusion from the couple's

combined earned income; and

(C) Subtract sixty-five dollars (\$65) plus one-half of the remainder from the couple's combined earned income.

(5) If the couple's countable income is less than or equal to the current SSI FBR for a couple, per OKDHS Appendix C-1, Schedule VIII.C, the eligible spouse is financially eligible for SoonerCare and no income is deemed to the eligible child(ren). If the couple's countable income is greater than the current SSI FBR for a couple, the eligible spouse is not financially eligible for SoonerCare.

(6) When the eligible spouse is not financially eligible for SoonerCare, the amount of the couple's income in excess of the SSI FBR for a couple is divided by the number of eligible children in the household. The resulting amount is deemed to each eligible child.

(A) Any income deemed to an eligible child is added to the eligible child's own unearned income.

(B) The eligible child's unearned and earned income are combined after applying appropriate exclusions, per OAC 317:35-5-42(e),(f), and (g).

(C) If each eligible child's resulting countable income is less than or equal to the current SSI FBR for an individual, per OKDHS Appendix C-1, Schedule VIII.C, the eligible child is financially eligible for SoonerCare.

(p) Deeming from a sponsor to an alien. Sponsor-to-alien deeming applies regardless of whether the sponsor and the sponsored alien live in the same household or whether the sponsor actually provides any support to the sponsored alien unless (a)(3)(A) applies.

(1) The income of the sponsor and the sponsor's spouse, if applicable, is first determined and applicable exclusions applied, per OAC 317:35-5-42(e).

(2) The appropriate allocation for the sponsor, the sponsor's spouse, and any children of the sponsor is then subtracted. An ineligible dependent's income is not subtracted from the sponsor's child(ren)'s allocation.

(A) The allocation amount for the sponsor is the current SSI FBR for an individual, per OKDHS Appendix C-1, Schedule VIII.C.

(B) The allocation for each sponsor's spouse and child(ren) of each sponsor is one-half of the current SSI FBR for an individual, per OKDHS Appendix C-1, Schedule VIII.C.

(3) The remaining income amount is deemed to the sponsored alien as unearned income. If the sponsor sponsors multiple aliens, the deemed amount is applied in full to each sponsored alien.

(4) The sponsored alien's unearned and earned income is combined and applicable exclusions applied, per OAC 317:35-5-42(e),(f), and (g). When the alien's countable income and deemed income is less than or equal to the current SSI FBR for an individual, per OKDHS Appendix C-1, Schedule VIII.C, the alien is financially eligible for SoonerCare.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 13 Ok Reg 911, eff 8-1-95 (emergency); Amended at 13 Ok Reg 2537, eff 6-27-96 ; Amended at 15 Ok Reg 564, eff 9-18-97 (emergency); Amended at 15 Ok Reg 712, eff 12-15-97 (emergency); Amended at 15 Ok Reg 1124, eff 1-6-98 (emergency); Amended at 15 Ok Reg 1559, eff 5-11-98 ; Amended at 15 Ok Reg 3708, eff 1-1-99 (emergency); Amended at 16 Ok Reg 708, eff 1-1-99 (emergency); Amended at 16 Ok Reg 1438, eff 5-27-99 ; Amended at 19 Ok Reg 136, eff 9-1-01 (emergency); Amended at 19 Ok Reg 2149, eff 6-27-02 ; Amended at 21 Ok Reg 2234, eff 6-25-04 ; Amended at 22 Ok Reg 2494, eff 7-11-05 ; Amended at 25 Ok Reg 674, eff 12-18-07 (emergency); Amended at 25 Ok Reg 698, eff 2-1-08 through 7-14-08 (emergency)¹; Amended at 25 Ok Reg 2704, eff 7-25-08 ; Amended at 26 Ok Reg 1768, eff 7-1-09 (emergency); Amended at 27 Ok Reg 114, eff 10-2-09 (emergency); Amended at 27 Ok Reg 1498, eff 6-11-10 ; Amended at 28 Ok Reg 1515, eff 6-25-11 ; Amended at 29 Ok Reg 478, eff 5-11-12 ; Amended at 32 Ok Reg 232, eff 1-1-15 (emergency); Amended at 32 Ok Reg 1132, eff 8-27-15 ; Amended at 35 Ok Reg 527, eff 2-27-18 (emergency); Amended at 35 Ok Reg 1472, eff 9-14-18 ; Amended at 36 Ok Reg 939, eff 9-1-19 ; Amended at 37 Ok Reg 1629, eff 9-14-20 ; Amended at 39 Ok Reg 1560, eff 9-12-22]

Editor's Note: ¹*This emergency action expired on 7-14-08 before being superseded by a permanent action. Upon expiration of an emergency amendatory action, the last effective permanent text is reinstated. Therefore, on 7-15-08 (after the 7-14-08 expiration of the emergency action), the text of 317:35-5-42 reverted back to the permanent text that became effective 7-11-05, as was last published in the 2006 Edition of the OAC, and remained as such until amended by permanent action on 7-25-08.*

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

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

(1) Insurance.

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

(B) **Government benefits.** Individuals requesting SoonerCare who are also eligible for Civilian Health and

Medical Programs for Uniformed Services (CHAMPUS), must disclose that the coverage is available. They are considered a third party liability source.

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

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

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

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

(4) **Medicare eligibility.** If it appears the applicant may be eligible for Medicare but does not have a Medicare card or other verification, the information is cleared with the Social Security Office and the findings entered with the date of the verification in the record. If the applicant did not enroll for Part A or Part B at the time he/she became eligible for Medicare and is now subject to pay an escalated premium for Medicare enrollment, he/she is required to do so. Payment can be made for services within the scope of SoonerCare.

(5) **Absent parent.**

(A) Applicants are required to cooperate with the Oklahoma Department of Human Services Oklahoma Child Support Services (OCSS) in the assignment of child/spousal support rights. The families involved are those with a minor child(ren) in the home. The child(ren) must be related to the children's, the blind, or the disabled groups and have a parent(s) absent from the home. Any

support collected on behalf of these families will be paid to them as if they were receiving non-public assistance child support services, with one exception. The exception is regarding child support collected for foster care child(ren) in OKDHS temporary custody. This support is paid to OKDHS Children and Family Services Division (CFSD). The child support income continues to be counted in determining SoonerCare eligibility if it is counted under the financial eligibility methodology used for the group for which eligibility is being determined. The rules in OAC 317:35-10 are used, with the following exceptions:

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

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

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

(B) Cash medical support may be ordered to be paid to the OHCA by the non-custodial parent if there is no access to health insurance at a reasonable cost or if the health insurance is determined not accessible to the child according to OCSS Rules. Reasonable is deemed to be 5% or less of the non-custodial parent's gross income. The administration and collection of cash medical support will be determined by OKDHS OCSS and will be based on the income guidelines and rules that are applicable at the time. However, at no time will the non-custodial parent be required to pay more than 5% of his/her gross income for cash medical support unless payment in excess of 5% is ordered by the Court. The disbursement and hierarchy of payments will be determined pursuant to OKDHS/OCSS guidelines.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 26 Ok Reg 2137, eff 6-25-09 ; Amended at 27 Ok Reg 1481, eff 6-11-10 ; Amended at 27 Ok Reg 2767, eff 7-20-10 (emergency); Added at 28 Ok Reg 1532, eff 6-25-11 ; Amended at 29 Ok Reg 1153, eff 6-25-12 ; Amended at 30 Ok Reg 1209, eff 7-1-13 ; Amended at 31 Ok Reg 73, eff 9-24-13 (emergency); Amended at 31 Ok Reg 1720, eff 9-12-14]

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

The Omnibus Budget Reconciliation Act of 1987 requires the Oklahoma Department of Human Services (OKDHS) to provide Child Support Services to certain families receiving SoonerCare benefits through the Oklahoma Child Support Services Division (OCSS). The families are required to cooperate in assignment of medical support rights except as specified in Oklahoma Administrative Code (OAC) 317:35-5-7(b) In accordance with Section 433.152 of Title 42 of the Code of Federal Regulations, the Oklahoma Health Care Authority (OHCA) may not refer a case for medical support enforcement when the Medicaid referral is based solely upon health care services provided through an Indian Health Program [as defined at 25 United States Code § 1603(12)], including through the Purchased/Referred Care program, to a child who is eligible for health care services from the Indian Health Services. These families will not be required to cooperate with the OCSS in the assignment of child/spousal support rights. The families involved are those with a minor child(ren) in the home. The child(ren) must be related to the children's, the blind or the disabled groups and have a parent(s) absent from the home. Any support collected on behalf of these families will be paid to them as if they were receiving non-public assistance child support services, with one exception. The exception is regarding child support collected for foster care child(ren) in OKDHS temporary custody. This support is paid to OKDHS Children and Family Services Division (CFSD). The rules in OAC 317:10 are used, with the following exceptions:

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

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

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

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 19 Ok Reg 136, eff 9-1-01 (emergency); Amended at 19 Ok Reg 2149, eff 6-27-02 ; Amended at 27 Ok Reg 1481, eff 6-11-10 ; Amended at 30 Ok Reg 1209, eff 7-1-13 ; Amended at 31 Ok Reg 73, eff 9-24-13 (emergency); Amended at 31 Ok Reg 1720, eff 9-12-14 ; Amended at 38 Ok Reg 428, eff 12-18-20 (emergency); Amended at 38 Ok Reg 1071, eff 9-1-21]

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

(a) **Prior to October 1, 2013.** Income is determined in accordance with OAC 317:35-10 for individuals categorically related to AFDC. Unless questionable, the income of categorically needy individuals who are categorically related to AFDC does not require verification. Individuals categorically related to AFDC are excluded from the AFDC resource test.

Certain AFDC rules are specific to money payment cases and are not applicable when only SoonerCare services are requested. Exceptions to the AFDC rules are:

- (1) the deeming of the parent(s)' income to the minor parent;
- (2) the deeming of the sponsor's income to the sponsored alien;
- (3) the deeming of stepparent income to the stepchildren. The income of the stepparent who is not included for SoonerCare in a family case is not deemed according to the stepparent liability. Only the amount of the stepparent's contribution to the individual is considered as income. The amount of contribution is determined according to OAC 317:35-10-26(a)(8), Person acting in the role of a spouse;
- (4) the AFDC lump sum income rule. For purposes of SoonerCare eligibility, a period of ineligibility is not computed;
- (5) mandatory inclusion of minor blood-related siblings or minor dependent children. For SoonerCare purposes, the family has the option to exclude minor blood-related siblings and/or minor dependent children;
- (6) the disregard of one half of the earned income;
- (7) dependent care expense. For SoonerCare only, dependent care expenses may be deducted for an in-home provider who, though not approved, would have qualified had the qualification process been followed;
- (8) AFDC trust rule. The availability of trusts for all SoonerCare only cases is determined according to OAC 317:35-5-41.6;
- (9) AFDC Striker rules. Striker status has no bearing on SoonerCare eligibility;
- (10) ET&E Sanction rule. The ET&E status has no bearing on SoonerCare eligibility. However, a new SoonerCare application is required.

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

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 16 Ok Reg 170, eff 11-1-98 (emergency); Amended at 16 Ok Reg 708, eff 1-1-99 (emergency); Amended at 16 Ok Reg 1438, eff 5-27-99 ; Amended at 17 Ok Reg 721, eff 1-10-00 (emergency); Amended at 17 Ok Reg 1212, eff 5-11-00 ; Amended at 21 Ok Reg 2234, eff 6-25-04 ; Amended at 25 Ok Reg 130, eff 8-1-07 (emergency); Amended at 25 Ok Reg 1257, eff 5-25-08 ; Amended at 26 Ok Reg 118, eff 10-1-08 (emergency); Amended at 26 Ok Reg 1074, eff 5-11-09 ; Amended at 30 Ok Reg 1209, eff 7-1-13 ; Amended at 31 Ok Reg 73, eff 9-24-13 (emergency); Amended at 31 Ok Reg 1720, eff 9-12-14]

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

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

services are excluded from a resource test.

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

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 16 Ok Reg 170, eff 11-1-98 (emergency); Amended at 16 Ok Reg 1438, eff 5-27-99 ; Amended at 20 Ok Reg 2775, eff 7-1-03 (emergency); Amended at 21 Ok Reg 2234, eff 6-25-04 ; Amended at 25 Ok Reg 130, eff 8-1-07 (emergency); Amended at 25 Ok Reg 1257, eff 5-25-08 ; Amended at 26 Ok Reg 118, eff 10-1-08 (emergency); Amended at 26 Ok Reg 1074, eff 5-11-09 ; Amended at 30 Ok Reg 1209, eff 7-1-13 ; Amended at 31 Ok Reg 73, eff 9-24-13 (emergency); Amended at 31 Ok Reg 1720, eff 9-12-14]

317:35-5-47. Determination of income and resources for categorical relationship to Disability for TB infected individuals

Countable income and resources for an individual categorically related because of a diagnosis of TB are determined in accordance with rules for individuals determined aged, blind, or disabled. (See OAC 317:35-5-41 through 317:35-5-41.11 and 317:35-5-42.)

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 25 Ok Reg 130, eff 8-1-07 (emergency); Amended at 25 Ok Reg 1257, eff 5-25-08]

317:35-5-48. Determination of income and resources for categorical relationship to expansion adults

Income is determined in accordance with the Modified Adjusted Gross Income (MAGI) methodology for individuals related to expansion adults. See Subchapter 6 of this Chapter for MAGI rules.

[Source: Added at 38 Ok Reg 799, eff 7-1-21 (emergency); Added at 39 Ok Reg 1544, eff 9-12-22]

317:35-5-49. Determination of income and resources for categorical relationship to Tax Equity and Fiscal Responsibility Act (TEFRA)

Countable income and resources for a child categorically related to disability for TEFRA are determined in accordance with rules for individuals determined aged, blind, or disabled (see Oklahoma Administrative Code 317:35-5-41 through 317:35-5-41.11, 317:35-5-42, and 317:35-7-36). The family is required to declare their household income so that the Oklahoma Health Care Authority may determine if the child qualifies for the TEFRA program or is otherwise SoonerCare eligible.

[Source: Added at 22 Ok Reg 2494, eff 7-11-05 ; Amended at 25 Ok Reg 130, eff 8-1-07 (emergency); Amended at 25 Ok Reg 1257, eff 5-25-08 ; Amended at 36 Ok Reg 921, eff 9-1-19]

PART 7. APPLICATION AND ELIGIBILITY DETERMINATION PROCEDURES

317:35-5-60. Application for SoonerCare; forms

(a) **Application.** An application for medical services consists of the SoonerCare application. The application form is signed by the individual, parent, spouse, guardian or someone else acting on the individual's behalf. An individual does not have to have received a medical service nor expect to receive one to be certified for SoonerCare. The application form is available as an online application, as a paper form, and is available to be completed by telephone with the assistance of the agency.

(1) An application may be made in a variety of locations, for example, a physician's office, a hospital or other medical facility or in the county OKDHS office. An application may be made online by individuals who are pregnant or have children or are applying for family planning services only. A face-to-face interview is not required. Only SoonerCare applications for women who are pregnant, and families with children and for family planning services are mailed to the OHCA Eligibility Unit. Applications for other medical services may be mailed or faxed to the local county OKDHS office. If faxed, it is not necessary to send the original application. When an individual indicates a need for health benefits, the physician or facility may forward an application or 08MA005E to the OKDHS county office of the patient's residence for processing. The physician or facility may forward an application or OKDHS form 08MA005E for individuals who are pregnant or have children or are applying for family planning services only to the OHCA Eligibility Unit for processing. If the applicant is unable to sign the application, someone acting on his/her behalf may sign the application. An application for SoonerCare may also be submitted through the Health Insurance Exchange.

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

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

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

(5) If the applicant also wishes to apply for a State Supplemental Payment, either the applicant or his/her guardian must sign the Medical Assistance Application form.

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

[Source: Added at 30 Ok Reg 1209, eff 7-1-13 ; Amended at 38 Ok Reg 799, eff 7-1-21 (emergency); Amended at 39 Ok Reg 1544, eff 9-12-22]

317:35-5-61. [RESERVED]

[Source: Added at 30 Ok Reg 1209, eff 7-1-13]

317:35-5-62. [RESERVED]

[Source: Reserved at 30 Ok Reg 1209, eff 7-1-13]

317:35-5-63. Agency responsible for determination of eligibility

(a) **Determination of eligibility by Oklahoma Health Care Authority (OHCA).** OHCA is responsible for determining eligibility for the following eligibility groups:

- (1) Children;
- (2) Newborns deemed eligible;
- (3) Pregnant women;
- (4) Pregnancy-related services under Title XXI;
- (5) Parents and caretaker relatives;
- (6) Former foster care children;
- (7) Breast and Cervical Cancer (BCC) treatment program;
- (8) SoonerPlan family planning program;
- (9) Programs of All-Inclusive Care for the Elderly (PACE); and
- (10) Expansion adults.

(b) **Determination of eligibility by OKDHS.** OKDHS is responsible for determining eligibility for the following eligibility groups:

- (1) TANF recipients;
- (2) Recipients of adoption assistance or kinship guardianship assistance;
- (3) State custody;
- (4) Refugee medical assistance;
- (5) Aged;
- (6) Blind;
- (7) Disabled;
- (8) Tuberculosis;
- (9) Qualified Medicare Beneficiary Plus (QMBP);
- (10) Qualified Disabled Working Individual (QDWI);

- (11) Specified Low-Income Medicare Beneficiary (SLMB);
- (12) Qualifying Individual (QI-1);
- (13) Long-term care services; and
- (14) Alien emergency services.

(c) **Determination of eligibility for programs offered through the Health Insurance Exchange.** OHCA assesses applicants who are found to be ineligible for SoonerCare for potential eligibility for affordable insurance programs offered through the Health Insurance Exchange. OHCA does not determine eligibility or ineligibility for those programs. OHCA facilitates the determination for those affordable insurance programs by forwarding applicants' electronic applications to the Health Insurance Exchange.

[Source: Added at 30 Ok Reg 1209, eff 7-1-13 ; Amended at 35 Ok Reg 1464, eff 9-14-18 ; Amended at 37 Ok Reg 1650, eff 9-14-20 ; Amended at 38 Ok Reg 799, eff 7-1-21 (emergency); Amended at 39 Ok Reg 1544, eff 9-12-22]

317:35-5-64. Cooperation in determination of eligibility

- (a) If an applicant does not cooperate in determination of eligibility and/or the agency does not have sufficient information to determine or redetermine eligibility, the application is denied or benefits are terminated for that reason. The agency responsible for determining eligibility provides the applicant with notice of outstanding requirements that must be met before eligibility can be determined.
- (b) If an applicant or member cannot be located to assist in determination or redetermination of eligibility, the application is denied or benefits are terminated. Notice is sent to the applicant or member's last known address.

[Source: Added at 30 Ok Reg 1209, eff 7-1-13]

317:35-5-65. Notification of eligibility

When eligibility for SoonerCare is established, the appropriate notice is computer generated to the applicant. When the computer file is updated for changes, notices are generated only if there is a change in the eligibility of any household member.

[Source: Amended and renumbered from 317:35-6-62 at 35 Ok Reg 1477, eff 9-14-18]

317:35-5-66. Electronic Notices

- (a) The agency allows SoonerCare members the choice to receive SoonerCare notices and information through electronic formats.
 - (1) SoonerCare members who elect to receive electronic notices will have this election confirmed by regular mail.
 - (2) SoonerCare members will be able to change this election by regular mail, telephone, or through the SoonerCare application.
- (b) The agency will ensure all notices it generates will be posted to the member's individual account within one business day.
 - (1) The agency will send an email or other electronic communication alerting SoonerCare members that a notice has been posted to their member account.

(2) The agency will not include the member's confidential information in the email or electronic communication alert.

(3) The agency will send a notice by mail within three business days of a failed email or electronic alert that was undeliverable to the member.

(4) At the member's request, all notices that are posted to the member's account may also be provided through mail.

(c) Electronic notices that are posted to the member's account which require the member to take certain action, submit additional documentation, or contain eligibility, appeal, or SoonerCare benefits information are considered the same as if the notice was sent by mail to the member.

[Source: Amended and renumbered from 317:35-6-62.1 at 35 Ok Reg 1477, eff 9-14-18]

317:35-5-67. Returned mail

If the member's whereabouts are unknown, as indicated by the return of unforwardable agency mail directed to the member, and the Oklahoma Health Care Authority has made reasonable attempts to verify the member's current address, the member's eligibility will be discontinued. Notice thereof will be sent to the member by mail and by electronic notice. If the member's whereabouts become known within the eligibility period, eligibility shall be reinstated in accordance with Section 431.231(d) of Title 42 of the Code of Federal Regulations. If the member's whereabouts become known after the eligibility period, a new application will be required.

[Source: Added at 36 Ok Reg 1112, eff 7-1-19 (emergency); Added at 37 Ok Reg 1627, eff 9-14-20]

SUBCHAPTER 6. SOONERCARE FOR PREGNANT WOMEN AND FAMILIES WITH CHILDREN

PART 1. GENERAL

317:35-6-1. Scope and applicability

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

- (1) Children;
- (2) Pregnant women;
- (3) Pregnancy-related services under Title XXI;
- (4) Parents and caretaker relatives;
- (5) SoonerPlan family planning program;
- (6) Independent foster care adolescents;
- (7) Individuals under age twenty-one (21) in public psychiatric facilities;
- (8) Tuberculosis;

- (9) Former foster care children;
- (10) Children with non-IV-E adoption assistance;
- (11) Individuals in adoptions subsidized in full or part by a public agency; and
- (12) Expansion adults.

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

(c) MAGI rules took effect on October 1, 2013.

[Source: Added at 16 Ok Reg 708, eff 1-1-99 (emergency); Added at 16 Ok Reg 1438, eff 5-27-99 ; Amended at 30 Ok Reg 1209, eff 7-1-13 ; Amended at 31 Ok Reg 73, eff 9-24-13 (emergency); Amended at 31 Ok Reg 1720, eff 9-12-14 ; Amended at 35 Ok Reg 1464, eff 9-14-18 ; Amended at 38 Ok Reg 799, eff 7-1-21 (emergency); Amended at 39 Ok Reg 1544, eff 9-12-22]

PART 3. APPLICATION PROCEDURES

317:35-6-15. SoonerCare application for pregnant women, families with children, and expansion adults; forms

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

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

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

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

(4) If OKDHS form 08MA005E is received and a SoonerCare application cannot be completed, receipt of OKDHS form 08MA005E constitutes an application which must be registered

and subsequently denied. The applicant and provider are notified by computer-generated notice.

(5) A hospital providing services may file an electronic Notification of Date of Service (NODOS) form with OHCA up to five (5) days from the date services are rendered. The hospital, applicant, or someone acting on the applicant's behalf has fifteen (15) days from the date the NODOS form was received by OHCA to submit a completed SoonerCare application. Filing a NODOS does not guarantee coverage and if a completed application is not submitted within fifteen (15) days, the NODOS is void.

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

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

[Source: Added at 16 Ok Reg 708, eff 1-1-99 (emergency); Added at 16 Ok Reg 1438, eff 5-27-99 ; Amended at 25 Ok Reg 437, eff 11-1-07 (emergency); Amended at 25 Ok Reg 1227, eff 5-25-08 ; Amended at 27 Ok Reg 711, eff 2-4-10 (emergency); Amended at 27 Ok Reg 1471, eff 6-11-10 ; Amended at 29 Ok Reg 1160, eff 6-25-12 ; Amended at 30 Ok Reg 1209, eff 7-1-13 ; Amended at 31 Ok Reg 73, eff 9-24-13 (emergency); Amended at 31 Ok Reg 1720, eff 9-12-14 ; Amended at 38 Ok Reg 799, eff 7-1-21 (emergency); Amended at 39 Ok Reg 1544, eff 9-12-22]

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

317:35-6-35. General eligibility consideration

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

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

Part 1 of this Subchapter for a list of the MAGI groups).

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

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

[Source: Added at 16 Ok Reg 708, eff 1-1-99 (emergency); Added at 16 Ok Reg 1438, eff 5-27-99 ; Amended at 30 Ok Reg 1209, eff 7-1-13 ; Amended at 31 Ok Reg 73, eff 9-24-13 (emergency); Amended at 31 Ok Reg 1720, eff 9-12-14]

317:35-6-36. Financial eligibility of individuals categorically related to aid to families with dependent children (AFDC), pregnancy-related services or expansion adults

(a) When determining financial eligibility for an individual related to AFDC, pregnancy-related services or expansion adults, the income of the following persons (if living together or if living apart as long as there has been no break in the family relationship) are considered. These persons include the:

- (1) Individual;
- (2) Spouse of the individual;
- (3) Biological or adoptive parent(s) of the individual who is a minor dependent child. For health benefits only, income of the stepparent of the minor dependent child is determined according to OAC 317:35-5-45;
- (4) Minor dependent children of the individual if the children are being included in the case for health benefits. If the individual is nineteen (19) years or older and not pregnant, at least one (1) minor dependent child must be living in the home and included in the case for the individual to be related to AFDC;
- (5) Blood related siblings, of the individual who is a minor child, if they are included in the case for health benefits; or
- (6) Caretaker relative and spouse (if any) and minor dependent children when the caretaker relative is to be included for coverage.

(b) The MAGI methodology is used to determine eligibility for MAGI eligibility groups. See OAC 317:35-6-39 through 317:35-6-54.

(c) Individuals who are determined to be part of a MAGI household cannot be excluded from the household; likewise, income of individuals determined to be part of a MAGI household cannot be excluded unless the exclusion is expressly required under MAGI rules.

[Source: Added at 16 Ok Reg 708, eff 1-1-99 (emergency); Added at 16 Ok Reg 1438, eff 5-27-99 ; Amended at 19 Ok Reg 136, eff 9-1-01 (emergency); Amended at 19 Ok Reg 2149, eff 6-27-02 ; Amended at 20 Ok Reg 2775, eff 7-1-03 (emergency); Amended at 21 Ok Reg 2234, eff 6-25-04 ; Amended at 30 Ok Reg 1209, eff 7-1-13 ; Amended at 31 Ok Reg 73, eff 9-24-13 (emergency); Amended at 31 Ok Reg 1720, eff 9-12-14 ; Amended at 38 Ok Reg 799, eff 7-1-21 (emergency); Amended at 39 Ok Reg 1544, eff 9-12-22]

317:35-6-37. Financial eligibility of categorically needy individuals related to aid to families with dependent children (AFDC),

pregnancy-related services, parent/caretaker relatives, families with children, and expansion adults

Individuals whose income is less than the SoonerCare income guidelines for the applicable eligibility group are financially eligible for SoonerCare.

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

(2) **Categorically related to the children and parent/caretaker relative groups.**

(A) **Parent/caretaker relative group.** For the individual in the parent/caretaker relative group to be considered categorically needy, the SoonerCare income guidelines must be used.

(i) Individuals age nineteen (19) years or older, other than pregnant women, are determined categorically needy if countable income is equal to or less than the categorically needy standard, according to the family size.

(ii) All individuals under nineteen (19) years of age are determined categorically needy if countable income is equal to or less than the categorically needy standard, according to the size of the family.

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

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

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

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

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

(3) **Expansion adults.** Individuals who meet financial eligibility criteria for expansion adults are established and defined by 42 C.F.R. § 435.119 and by the Oklahoma Medicaid State Plan.

[Source: Added at 16 Ok Reg 708, eff 1-1-99 (emergency); Added at 16 Ok Reg 1438, eff 5-27-99 ; Amended at 19 Ok Reg 136, eff 9-1-01 (emergency); Amended at 19 Ok Reg 2149, eff 6-27-02 ; Amended at 30 Ok Reg 1209, eff 7-1-13 ; Amended at 31 Ok Reg 73, eff 9-24-13 (emergency); Amended at 31 Ok Reg 1720, eff 9-12-14 ; Amended at 33 Ok Reg 903, eff 9-1-16 ; Amended at 38 Ok Reg 799, eff 7-1-21 (emergency); Amended at 39 Ok Reg 1544, eff 9-12-22]

317:35-6-38. Hospital presumptive eligibility (HPE)

(a) **General.** HPE is a limited period of SoonerCare eligibility for individuals who are categorically related to certain Modified Adjusted Gross Income (MAGI) eligibility groups listed in OAC 317:35-6-38(a)(1)(A)(i) through (vi) and are also determined by a qualified hospital [see OAC 317:35-6-38(a)(2)(A) through (L) for the conditions of a qualified hospital], on the basis of preliminary information provided by the applicant on a completed HPE application, to be eligible for SoonerCare services. The rules in this Section apply only to those individuals applying for, or qualified hospitals determining eligibility under, the HPE program.

(1) **Individuals eligible to participate in the HPE program.**

To be eligible to participate in the HPE program, an individual must be categorically related to a MAGI eligibility group (see OAC 317:35-5-2 for categorical relationship criteria) and also meet the income standard and non-medical eligibility specified in this Section.

(A) **MAGI eligibility groups.** The following MAGI eligibility groups are eligible to have a presumptive eligibility (PE) determination made by a qualified hospital participating in the HPE program:

- (i) Children;
- (ii) Pregnant women;
- (iii) Parent/caretaker relatives;
- (iv) Expansion adults;
- (v) Former foster care children;
- (vi) Breast and Cervical Cancer (BCC) treatment program; and
- (vii) SoonerPlan family planning program.

(B) **Income standard.** The income that is counted in determining PE for an individual is that individual's household income. The income limit for the MAGI eligibility groups covered under the HPE program is the same as defined in OAC 317:35-6-39(b)(8) and is listed on the HPE application. The calculation of countable household income for an individual covered under the HPE program is the same as OAC 317:35-6-39, except that, in determining the individual's household composition, only the MAGI household composition non-filer rules listed under OAC 317:35-6-43 apply for all individuals applying for the HPE program regardless of whether or not the individual is a tax filer, plans on filing taxes, or is a tax dependent.

(C) **Non-medical eligibility requirements.** Individuals covered under the HPE program must also meet the non-medical eligibility requirements described in OAC 317:35-

5-25.

(D) **Pregnant women covered under the HPE program.** Coverage for pregnant women who are covered under the HPE program is limited to ambulatory prenatal care only, and the number of PE periods that may be authorized for pregnant women is one (1) per pregnancy. Pregnant women who may be covered for the benefit of the unborn child(ren) under Title XXI are not eligible for the HPE program.

(E) **Other individuals covered under the HPE program.** Coverage for other individuals listed under OAC 317:35-6-38(a)(1)(A)(i) through (vi) who are covered under the HPE program, except for pregnant women, is the same as covered under the State Plan. The number of PE periods that may be authorized is one (1) period every three hundred sixty-five (365) days beginning on the date the individual is enrolled in HPE.

(2) **Qualified hospital.** The decision that a hospital is qualified to make PE determinations is made by the Oklahoma Health Care Authority. In order to participate in the HPE program and make PE determinations, a qualified hospital must:

(A) Meet all the conditions of an eligible provider under OAC 317:30-5-40;

(B) Elect to participate in the HPE program by:

(i) Completing and submitting a HPE Statement of Intent and Memorandum of Understanding to the OHCA and agreeing to all the terms and conditions of the HPE program;

(ii) Amending its current contract with the OHCA to include participation in the HPE program;

(C) Assign and designate a hospital employee to serve as the HPE program administrator and point of contact;

(D) Assign and designate hospital employees to make PE determinations. The term "authorized hospital employee(s) (AHE)" means all individuals making PE determinations on behalf of a hospital participating in the HPE program. The AHE must meet the following conditions:

(i) Be an employee of the hospital (i.e. the AHE may not be a third party contractor);

(ii) Attend, complete, and pass the HPE program training course provided and assessed by the OHCA;

(iii) The AHE certificate of HPE course completion must be kept in the worker's file at the hospital and must be made available to the OHCA upon request;

(iv) Follow state and federal privacy and security requirements regarding patient confidentiality;

(v) Agree to abide by all the rules and guidelines of the HPE program established by the OHCA under this Section.

(E) Notify the OHCA of any changes in the AHE's employment status or in the designation of that individual as the hospital's AHE;

(F) Abide by the rules and regulations of the Uniform Electronic Transaction Act as outlined in OAC 317:30-3-4.1;

(G) Keep internal records of all individuals for whom a PE determination was made and make those records available to the OHCA upon request;

(H) Agree to submit all completed HPE applications and PE determinations to the OHCA within five (5) days of the PE determination;

(I) Notify the applicant in writing, or in cases where the HPE application was made on behalf of a child, notify the child's parent or caretaker of the PE determination outcome and provide and explain to eligible members the "HPE Program Policy and Enrollment" form;

(J) Assist HPE applicants with the completion of a full SoonerCare application within fifteen (15) days of the HPE application submission to the OHCA;

(K) Agree to adhere to the processes and procedures established by the OHCA regarding the operation and oversight of the HPE program; and

(L) Cooperate with the OHCA regarding audit and quality control reviews on PE determinations the hospital makes. The agency may terminate the HPE agreement with the hospital if the hospital does not meet the standards and quality requirements set by the OHCA.

(3) **Limited hospital PE determinations.** The agency limits the PE determinations that a hospital may make to only those eligibility groups described in OAC 317:35-6-38(a)(1)(A) using the MAGI methodology rules established for the HPE program. Additionally, PE determinations made for individuals categorically related to the Breast and Cervical Cancer (BCC) treatment program are limited to qualified hospitals that are also qualified entities through the National Breast and Cervical Cancer Early Detection Program (NBCCEDP).

(b) **General provisions of the HPE program.** The agency provides SoonerCare coverage to eligible individuals covered during a period of PE.

(1) **PE period.** The PE period begins on the date a qualified hospital determines an individual to be eligible under the HPE program. A qualified hospital has five (5) days to notify the agency of its PE determination. The PE period ends with the earlier of:

(A) The day the agency receives the SoonerCare application form as described in OAC 317:35-5-60 and an eligibility determination is made by the agency; or

(B) If a SoonerCare application is not received, the last day of the month following the month in which the PE determination was made.

(2) **Agency approval of PE.** When the OHCA receives a timely and completed HPE application, a case number and, if needed, SoonerCare member ID is assigned to the member by the agency. Qualified hospitals will be able to review member enrollment and eligibility, once those members have been entered into the system by the OHCA, for claims billing and member eligibility verification.

(3) **Incomplete HPE applications.** Upon receiving a HPE application, the OHCA reviews it for completeness and correctness. The HPE application is considered incomplete if it is not filled out in its entirety (e.g., the applicant's first or last name is not provided on the application) or if the application is not filed timely with the OHCA. When the HPE application is determined to be incomplete, the HPE application is returned to the AHE or the HPE program administrator at the qualified hospital to correct the application errors or amend the HPE application. To maintain the original PE certification period, the qualified hospital must return the completed or corrected HPE application to the agency within five (5) working days.

(4) **Applicant appeal.** The HPE applicant cannot appeal the PE determination made by a qualified hospital or the expiration date of the PE period.

(5) **Applicant ineligibility.** Applicants ineligible for the HPE program are individuals who do not meet the HPE criteria, individuals who have previously been enrolled in the HPE program within the last three hundred sixty-five (365) days, and individuals currently enrolled in SoonerCare. Individuals currently enrolled in SoonerPlan family planning are not eligible for HPE family planning services, but may be eligible for other programs under HPE. When the OHCA receives a HPE application from a qualified hospital for an ineligible applicant [e.g., the applicant has been previously enrolled in the HPE program within the last three hundred sixty-five (365) days], the OHCA will disenroll the individual from the HPE program immediately and notify the hospital of the error. The hospital will be responsible for following up with that individual to notify them of their disenrollment from the HPE program. If the applicant is not currently enrolled into SoonerCare, the applicant may submit a full SoonerCare application and receive a full eligibility determination by the OHCA. HPE services provided to ineligible applicants, other than persons currently enrolled into SoonerCare or SoonerPlan family planning program, may not be eligible for reimbursement by the OHCA.

[Source: Added at 16 Ok Reg 708, eff 1-1-99 (emergency); Added at 16 Ok Reg 1438, eff 5-27-99 ; Amended at 19 Ok Reg 136, eff 9-1-01 (emergency); Amended at 19 Ok Reg 2149, eff 6-27-02 ; Amended at 27 Ok Reg 711, eff 2-4-10 (emergency); Amended at 27 Ok Reg 1471, eff 6-11-10 ; Revoked at 30 Ok Reg 1209, eff 7-1-13 ; Added at 32 Ok Reg 1139, eff 8-27-15 ; Amended at 38 Ok Reg 799, eff 7-1-21 (emergency); Amended at 39 Ok Reg 446, eff 12-21-21 (emergency); Amended at 39 Ok Reg 1575, eff 9-12-22]

317:35-6-39. General calculation of countable income for MAGI eligibility groups

(a) The income that is counted in determining eligibility for an individual is that individual's household income.

(b) In order to calculate the countable household income for an individual:

- (1) Determine who is in the individual's household (see OAC 317:35-6-40 to 317:35-6-43);
- (2) Identify all sources of income for all household members;
- (3) Determine whether each source of income is considered for SoonerCare eligibility or is excluded (see Part 6, Countable Income, of this Subchapter);
- (4) Determine the gross monthly amount of each source of countable income (see Part 6, Countable Income, of this subchapter);
- (5) Determine whether each household member's income counts toward the household (see 317:35-6-44);
- (6) Sum the gross monthly amounts of all countable sources of income of all household members whose income is counted;
- (7) Subtract allowable adjustments to income (see OAC 317:35-6-52); and
- (8) Compare the result to the income limit for the individual's eligibility group (see SoonerCare Income Guidelines). If the result is equal to or less than the dollar amount of the income limit, the individual is financially eligible.
- (9) When calculating the percentage of the Federal Poverty Level (FPL) that corresponds to the individual's monthly countable income, subtract 5% from the FPL percentage reached to determine the countable FPL level for the individual. This countable percentage of FPL is compared to the FPL limit for the individual's eligibility group in order to determine whether the individual is financially eligible. This 5% deduction from FPL has already been accounted for in the dollar amounts of the income limits given in the SoonerCare Income Guidelines.

(c) If an individual's household income using this methodology is over the income limit for SoonerCare eligibility and that individual's household income using the MAGI household and income-counting methodology used by the Federally Facilitated Exchange (FFE) is less than 100% of FPL, the FFE's MAGI rules, as promulgated by the Internal Revenue Service, are used to determine SoonerCare eligibility in place of the rules in this Chapter. The FFE rules including, but not limited to, those in the following areas may need to be followed in place of the SoonerCare rules in this Chapter:

- (1) Rules on household composition;
- (2) Rules on countable sources of income; and
- (3) Rules on the budget period used to calculate income, i.e. annual income (FFE) versus current monthly income (SoonerCare).

317:35-6-40. MAGI household composition; taxpayers and tax dependents

(a) The rules used to determine MAGI household composition depend on tax relationships.

(b) Whether an individual is a taxpayer or a tax dependent at the time of application is determined by whether the applicant expects to file taxes or expects to be claimed as a tax dependent by another taxpayer for the current tax year in which the determination of eligibility for SoonerCare is made.

[Source: Added at 30 Ok Reg 1209, eff 7-1-13]

317:35-6-41. MAGI household composition; tax filers

(a) **Scope.** This section applies to individuals who expect to file taxes themselves or who expect to be claimed by another taxpayer as a tax dependent for the taxable year in which the eligibility determination is being made.

(b) **Taxpayers.** The household of an individual who expects to be a taxpayer consists of him or herself and all of the tax dependents he or she expects to claim.

(c) **Tax dependents.** If an individual expects to be both a taxpayer and a tax dependent, the individual is considered a tax dependent. Unless an exception listed in OAC 317:35-6-42 applies, the household of an individual who expects to be claimed as a tax dependent consists of the taxpayer claiming him or her and all other dependents expected to be claimed by that taxpayer.

(d) **Spouses.** Spouses who live together are always counted in each other's households, regardless of whether or how they expect to file taxes, and regardless of whether one or both of them expect to be claimed as a tax dependent by another taxpayer.

(e) **Unborn children.** If any member of the household is pregnant, the number of children she expects to deliver is counted in the household size of all households of which she is a member.

(f) **No option to exclude.** Individuals may not choose to exclude any person counted as a household member under this rule from the household.

[Source: Added at 30 Ok Reg 1209, eff 7-1-13]

317:35-6-42. MAGI household composition; exceptions to tax filer rules

(a) The tax filer household composition rules in OAC 317:35-6-41 do not apply to the following individuals:

- (1) Individuals who expect to be claimed as a tax dependent by a taxpayer who is not their spouse or biological, adoptive, or step parent, regardless of the individual's age;
- (2) Individuals under the age of 19 who are living with two parents, whose parents do not expect to file a joint return, and who expect to be claimed as a dependent by one of their parents;

or

(3) Individuals under the age of 19 who expect to be claimed as a tax dependent by a non-custodial parent.

(b) The non-filer household composition rules in OAC 317:35-6-43 apply to individuals who are claimed as tax dependents but are described in one of the exceptions to the tax filer rules in (a).

(c) If an individual's declaration that another person is a tax dependent is not reasonably compatible with other information available to OHCA, the non-filer household composition rules are used to determine whether the person will be included in the household of the taxpayer.

[Source: Added at 30 Ok Reg 1209, eff 7-1-13]

317:35-6-43. MAGI household composition; non-filers

(a) The household composition defined in this section applies to individuals who do not expect to file taxes and do not expect to be claimed as a tax dependent by another taxpayer for the taxable year during which eligibility is being determined. This section also applies to individuals described in an exception to the tax filer household in OAC 317:35-6-42.

(b) The non-filer household consists of the individual, and if applicable and if living with the individual:

(1) the individual's spouse;

(2) the individual's natural, adopted and step children under the age of 19;

(3) if the individual is under the age of 19, the individual's natural, adoptive and step parents; and

(4) if the individual is under the age of 19, the individual's natural, adoptive and step siblings who are also under the age of 19.

(c) If any member of the household is pregnant, the number of children she expects to deliver is counted in the household size of all households of which she is a member.

(d) Individuals may not choose to exclude any person counted as a household member under this rule from the household.

[Source: Added at 30 Ok Reg 1209, eff 7-1-13]

317:35-6-44. Determination of whether a household member's income is counted

(a) Unless a household member falls into an exception listed in this Section, his or her income counts for him or herself and for all members of all households of which the individual is a member.

(b) The income of the following individuals is not included in household income of the household to which the exception applies:

(1) Individuals included in a household of which their biological, adoptive or step parent(s) is/are also member(s), who are not expected to be required to file a tax return for the tax year during which eligibility is being determined (regardless of whether the individual later does in fact file a tax return, and regardless of the

individual's age); and

(2) Individuals claimed as tax dependents by someone other than their spouse or biological, adoptive or step parent who are not expected to be required to file a tax return for the tax year during which eligibility is being determined (regardless of whether the individual does in fact file a tax return, and regardless of the individual's age).

(c) If an individual's income is excluded from the household of a parent or of the taxpayer claiming him or her as a dependent because one of the exceptions in paragraph (b) of this section applies, the individual's income is still included in other households of which the individual is also a member, provided no exceptions listed in this section apply to those households.

(d) See 317:35-10-38 for rules regarding temporary absence from the home.

[Source: Added at 30 Ok Reg 1209, eff 7-1-13]

317:35-6-45. Eligibility for inmates

(a) The Oklahoma Health Care Authority (OHCA) shall receive applications from and make eligibility determinations for individuals residing in correctional institutions, including juvenile facilities. However, the SoonerCare program will only pay for services rendered to individuals residing in a correctional institution as specified in Oklahoma Administrative Code (OAC) 317:35-5-26.

(b) In accordance with federal law, including, but not limited to, 42 United States Code (U.S.C.) § 1396a(a)(84), individuals residing in correctional institutions who are under the age of twenty-one (21) or who meet the former foster care child requirements found at OAC 317:35-5-2, shall have their eligibility suspended for the duration of the incarceration period, except for periods of time that inpatient services are provided as specified in OAC 317:35-5-26.

(c) The effective date of the suspension is the calendar day following the date on which an individual described in (b) of this section becomes incarcerated.

(d) A redetermination of eligibility for an individual described in (b) of this section shall be conducted prior to release to determine if the individual continues to meet the eligibility requirements for SoonerCare. A new application will not be required to redetermine eligibility.

(e) Suspended eligibility shall be restored to the release date after a redetermination of eligibility, when:

(1) The Oklahoma Department of Human Services (OKDHS), using the release date supplied by the Oklahoma Office of Juvenile Affairs (OJA) or the Oklahoma Department of Corrections (DOC), removes the suspension;

(2) The individual reports his or her release to the Oklahoma Health Care Authority (OHCA) within ten (10) calendar days of the release date; or

(3) The individual reports his or her release to OHCA more than ten (10) calendar days from the release date, and there is good

cause for the delay in reporting.

[Source: Added at 37 Ok Reg 528, eff 1-6-20 (emergency); Added at 37 Ok Reg 1651, eff 9-14-20]

PART 6. COUNTABLE INCOME FOR MAGI

317:35-6-50. Countable sources of income

Unless an exception listed in OAC 317:35-6-51 applies, all income included in Modified Adjusted Gross Income in Section 36B of the Internal Revenue Code is included in the MAGI calculation for SoonerCare eligibility.

[Source: Added at 30 Ok Reg 1209, eff 7-1-13]

317:35-6-51. Exceptions to Internal Revenue Code rules

(a) The following sources of income are excluded from household income for SoonerCare eligibility under Modified Adjusted Gross Income (MAGI), regardless of whether they are included in MAGI in Section 36B of the Internal Revenue Code:

(1) Scholarships, awards, or fellowship grants used for education purposes and not for living expenses; and

(2) The following types of American Indian / Alaska Native income:

(A) Distributions from any property held in trust, subject to Federal restrictions, located within the most recent boundaries of a prior Federal reservation, or otherwise under the supervision of the Secretary of the Interior;

(B) Distributions and payments from rents, leases, rights of way, royalties, usage rights, or natural resource extraction and harvest from:

(i) Rights of ownership or possession in any lands described in Paragraph (a)(2)(A) of this section; or

(ii) Federally protected rights regarding off-reservation hunting, fishing, gathering, or usage of natural resources;

(C) Distributions resulting from real property ownership interests related to natural resources and improvements:

(i) Located on or near a reservation or within the most recent boundaries of a prior Federal reservation; or

(ii) Resulting from the exercise of federally-protected rights relating to such real property ownership interests;

(D) Payments resulting from ownership interests in or usage rights to items that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable Tribal Law or custom;

- (E) Student financial assistance provided under the Bureau of Indian Affairs education programs; and
- (F) Distributions from Alaska Native Corporations and Settlement Trusts.

(b) Amounts received as a lump sum are counted as income only in the month received (see also Oklahoma Administrative Code (OAC) 317:35-10-26), with the exception of certain lottery or gambling winnings as specified in OAC 317:35-6-55. If a lump sum amount is received from an income source that is not counted in MAGI according to section 36B(d)(2) (B) of the Internal Revenue Code or the exceptions listed in this section, the amount is not counted.

[Source: Added at 30 Ok Reg 1209, eff 7-1-13 ; Amended at 37 Ok Reg 763, eff 5-14-20 (emergency); Amended at 38 Ok Reg 1072, eff 9-1-21]

317:35-6-52. Adjustments to income

Amounts subtracted from gross income to calculate MAGI for a household are defined in Section 36B of the Internal Revenue Code. No other deductions are applicable, except the subtraction of 5 percent from the percentage of FPL as provided in OAC 317:35-6-39.

[Source: Added at 30 Ok Reg 1209, eff 7-1-13]

317:35-6-53. Determination of current monthly income

(a) **Use of current monthly income.** Current monthly income is used in determinations of financial eligibility at application, when a member reports a change in circumstances, and at renewal. See 317:35-6-39 for potential exceptions.

(b) **Calculation of monthly income.** For computation of monthly income, see OAC 317:35-10-26(e).

(c) **Anticipated income.** Income which can reasonably be anticipated to be received is considered to be available for the month its receipt is anticipated.

(d) **Expected changes in income.** Reasonably predictable future increases or decreases in income, such as for contract or seasonal employees, are prorated over the year the income is expected to support the household. The predicted annual amount of the income is divided by 12 to reach the monthly amount.

(e) **Lump sum income.** Whether a particular lump sum is counted in household income depends first on whether the source of the lump sum is a countable source of income according to OAC 317:35-6-50 and OAC 317:35-6-51. See also OAC 317:35-10-26 for detailed rules regarding lump sum income.

[Source: Added at 30 Ok Reg 1209, eff 7-1-13]

317:35-6-54. Determination of current monthly amount of adjustments to income

(a) Expenses or losses that qualify as deductions for MAGI according to OAC 317:35-6-52 are totaled to reach an annual amount. The annual

amount is then divided by 12 and subtracted from gross monthly income to calculate the household's current monthly MAGI.

(b) Whether a deduction is allowed when it has already been paid or when it has only been incurred is determined in accordance with Section 36B of the Internal Revenue Code.

[Source: Added at 30 Ok Reg 1209, eff 7-1-13]

317:35-6-55. Treatment of qualified lottery or qualified gambling winnings

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

(1) **"Qualified lottery winnings"** means winnings from a sweepstakes, lottery, or pool described in paragraph three (3) of Section 4402 of the Internal Revenue Code of 1986 or a lottery operated by a multistate or multijurisdictional lottery association paid out in a single payout and not in installments over a period of time.

(2) **"Qualified gambling winnings"** means monetary winnings from gambling, as defined by Section (§) 1955(b)(4) of Title 18 of the United States Code (U.S.C.).

(3) **"Undue hardship"** means circumstances resulting from a loss or denial of SoonerCare eligibility that would deprive an individual of medical care, such that the individual's health or life would be endangered, or that would deprive the individual or his or her financially dependent family members of food, clothing, shelter, or other necessities of life.

(b) **Income determinations.** In accordance with 42 U.S.C. § 1396a(e) (14)(K), qualified lottery and gambling winnings shall be considered as income in determining the financial eligibility of individuals whose eligibility is determined based on the application of Modified Adjusted Gross Income (MAGI), as follows:

(1) Winnings less than \$80,000 are counted in the month received;

(2) Winnings greater than or equal to \$80,000, but less than \$90,000, are counted as income over two (2) months, with an equal amount counted in each month;

(3) Winnings greater than or equal to \$90,000, but less than \$100,000, are counted as income over three (3) months, with an equal amount counted in each month;

(4) Winnings greater than or equal to \$100,000 are counted as income over three (3) months, with one (1) additional month for every increment of \$10,000 in winnings received over \$100,000, with an equal amount counted in each month; and

(5) The maximum period of time over which winnings may be counted is one hundred and twenty (120) months, which would apply to winnings greater than or equal to \$1,260,000.

(c) **Treatment of household members.** Qualified lottery and gambling winnings shall be counted as household income for all household

members in the month of receipt; however, the requirement to count qualified lottery and gambling winnings in household income over multiple months applies only to the individual receiving the winnings.

(d) **Undue hardship.** An individual who loses or is denied eligibility due to qualified lottery or gambling winnings may timely file a member appeal, in accordance with Oklahoma Administrative Code 317:2-1-2. If, as part of that appeal, the individual proves by a preponderance of the evidence that loss or denial of eligibility would result in undue hardship, eligibility shall be restored or approved, provided all other conditions of eligibility have been met.

(e) **Notice.** SoonerCare members or applicants who are determined financially ineligible due to the counting of lottery or gambling winnings will receive a notice of the date on which the lottery or gambling winnings will no longer be counted for eligibility purposes. The notice will also inform the member or applicant of the undue hardship exemption and of their opportunity to enroll in a Qualified Health Plan on the Federally Facilitated Exchange.

[Source: Added at 37 Ok Reg 763, eff 5-14-20 (emergency); Added at 38 Ok Reg 1072, eff 9-1-21]

PART 7. CERTIFICATION, REDETERMINATION AND NOTIFICATION

317:35-6-60. Certification for SoonerCare for pregnant women and families with children

(a) General rules of certification.

(1) An individual determined eligible for SoonerCare may be certified for a prospective period of coverage on or after the date of certification.

(2) In accordance with 42 Code of Federal Regulations (C.F.R.) § 435.915 and Oklahoma Administrative Code (OAC) 317:35-6-60.2, an individual may also be determined eligible and certified for a retroactive period of coverage during the three (3) month period directly prior to the date of application. This only applies if the individual received covered medical services at any time during that period and would have been eligible for SoonerCare at the time he or she received the services, regardless of whether the individual is alive when application for Medicaid is made. An individual may be eligible for the retroactive period even though ineligible for the prospective period.

(3) The individual who is categorically needy and related to pregnancy-related services retains eligibility for the period covering prenatal, delivery, and postpartum periods without regard to eligibility for other household members in the case. Eligibility during the postpartum period does not apply to women receiving pregnancy-related coverage under Title XXI.

(b) Certification as a TANF (cash assistance) recipient. A categorically needy individual who is determined eligible for TANF is certified effective the first day of the month of TANF eligibility.

(c) Certification of non-cash assistance individuals related to the children and parent and caretaker relative groups. The certification period for the individual related to the children or parent and caretaker relative groups is twelve (12) months. The certification period can be less than twelve (12) months if the individual:

- (1) Is certified as eligible in a money payment case during the twelve-month (12-month) period;
- (2) Is certified for long-term care during the twelve-month (12-month) period;
- (3) Becomes ineligible for SoonerCare after the initial month; or
- (4) Becomes financially ineligible.

(A) If an income change after certification causes the case to exceed the income standard, the case is closed.

(B) Individuals, however, who are determined pregnant and financially eligible continue to be eligible for pregnancy-related services through the prenatal, delivery and postpartum period, regardless of income changes. A pregnant individual included in a TANF case which closes continues to be eligible for pregnancy-related services through the postpartum period.

(d) Certification of individuals related to pregnancy-related services. The certification period for the individual related to pregnancy-related services will cover the prenatal, delivery and postpartum periods. The postpartum period is defined as the twelve (12) months following the month the pregnancy ends. Financial eligibility is based on the income received in the first month of the certification period. No consideration is given to changes in income after certification.

(e) Certification of newborn child deemed eligible.

(1) Every newborn child is deemed eligible on the date of birth for SoonerCare when the child is born to a woman who is eligible for and enrolled in pregnancy-related services as categorically needy. The newborn child is deemed eligible through the last day of the month the newborn child attains the age of one (1) year. The newborn child's eligibility is not dependent on the mother's continued eligibility. The mother's coverage may expire at the end of the postpartum period; however, the newborn child is deemed eligible until age one (1). The newborn child's eligibility is based on the original eligibility determination of the mother for pregnancy-related services, and consideration is not given to any income or resource changes that occur during the deemed eligibility period.

(2) The newborn child is deemed eligible for SoonerCare as long as he/she continues to live in Oklahoma. In accordance with 42 C.F.R. § 435.117, no other conditions of eligibility are applicable, including social security number enumeration, child support referral, and citizenship and identity verification. However, it is recommended that social security number enumeration be completed as soon as possible after the newborn child's birth. It is also recommended that a child support referral be completed, if needed, as soon as possible and sent to the Oklahoma Child Support Services (OCSS) division at DHS. The referral enables

child support services to be initiated.

(3) When a categorically needy newborn child is deemed eligible for SoonerCare, he/she remains eligible through the end of the month that the newborn child reaches age one (1). If the child's eligibility is moved from the case where initial eligibility was established, it is required that the newborn receive the full deeming period. The certification period is shortened only in the event the child:

(A) Loses Oklahoma residence; or

(B) Expires.

(4) A newborn child cannot be deemed eligible when the mother's only coverage was presumptive eligibility, and continued eligibility was not established.

[Source: Added at 16 Ok Reg 708, eff 1-1-99 (emergency); Added at 16 Ok Reg 1438, eff 5-27-99 ; Amended at 20 Ok Reg 646, eff 2-1-03 (emergency); Amended at 20 Ok Reg 1943, eff 6-26-03 ; Amended at 20 Ok Reg 2775, eff 7-1-03 (emergency); Amended at 21 Ok Reg 2234, eff 6-25-04 ; Amended at 23 Ok Reg 268, eff 9-1-05 (emergency); Amended at 23 Ok Reg 1378, eff 5-25-06 ; Amended at 27 Ok Reg 630, eff 1-14-10 (emergency); Amended at 27 Ok Reg 711, eff 2-4-10 (emergency); Amended at 27 Ok Reg 1492, eff 6-11-10 ; Amended at 30 Ok Reg 1209, eff 7-1-13 ; Amended at 37 Ok Reg 767, eff 5-14-20 (emergency); Amended at 38 Ok Reg 1074, eff 9-1-21 ; Amended at 40 Ok Reg 657, eff 2-21-23 (emergency); Amended at 40 Ok Reg 2252, eff 9-11-23 ; Amended at 41 Ok Reg, Number 14, effective 3-8-24 (emergency)]

317:35-6-60.1. Changes in circumstances

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

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

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

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

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

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

(B) If the information received has an effect on the eligibility of a member of the household, the agency will

request more information from the member, including, but not limited to, an explanation of the discrepancy or verification documenting the correct information regarding the factor of eligibility affected by the information received from a third party.

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

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

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

[Source: Added at 30 Ok Reg 1209, eff 7-1-13 ; Amended at 31 Ok Reg 73, eff 9-24-13 (emergency); Amended at 31 Ok Reg 1720, eff 9-12-14 ; Amended at 41 Ok Reg, Number 14, effective 3-8-24 (emergency)]

317:35-6-60.2. Retroactive eligibility

(a) Retroactive eligibility, as outlined in this section, shall be available to pregnant women and/or members under the age of nineteen (19). For retroactive eligibility rules related to other SoonerCare population groups, refer to Oklahoma Administrative Code (OAC) 317:35-7-60(b).

(b) In addition to the period of eligibility specified in Oklahoma Administrative Code (OAC) 317:35-6-60, an applicant, or individuals within the applicant's household, shall be eligible for SoonerCare benefits up to three (3) months prior to the date of application if all of the following requirements are met:

(1) The individual for whom retroactive coverage is being requested would have been eligible for SoonerCare coverage if an application for SoonerCare had been made during the retroactive month.

(A) The individual does not have to be eligible for the month of application to be found eligible for one (1) of the three (3) retroactive months.

(B) The eligibility factors (e.g. income, residency, household composition, etc.) are evaluated separately for each retroactive month for which retroactive eligibility is being requested.

(2) The applicant completes the retroactive eligibility application form and provides, within six (6) months of the date the services were provided, documentation for verification purposes as requested by SoonerCare.

(3) The individual applying for retroactive coverage states that the individual for whom retroactive coverage is being requested received reimbursable SoonerCare services which were provided by a SoonerCare-contracted provider during the retroactive month.

- (4) An applicant cannot be approved for retroactive coverage for a month in which his or her application was previously denied.
- (c) Per 42 Code of Federal Regulations (CFR) § 435.915(b), if an applicant is determined to be eligible for retroactive coverage at any time during the requested retroactive month, then coverage will begin on the first (1st) day of the month and be effective for the entire month.
- (d) If the applicant is applying for SoonerCare benefits due to pregnancy, then the applicant must have been pregnant during the requested retroactive month.
- (e) Regardless of retroactive eligibility being granted, the requirement for the claim to be filed timely, per OAC 317:30-3-11, is still in effect.
- (f) Retroactive coverage for SoonerCare health services received during a retroactive month will be secondary to any third-party which has primary responsibility for payment. If the individual eligible for retroactive coverage has already paid for the health services, the provider may refund the payment and bill SoonerCare in accordance with the timely filing requirements in OAC 317:30-3-11.
- (g) Retroactive coverage for SoonerCare reimbursable health services that require prior authorization shall not be denied solely because of a failure to secure prior authorization. Medical necessity, however, must be established before reimbursement can be made.
- (h) Denials of requests for retroactive eligibility may be appealed in accordance with OAC 317:2-1-2(d)(1)(F).

[Source: Added at 37 Ok Reg 767, eff 5-14-20 (emergency); Added at 38 Ok Reg 1074, eff 9-1-21]

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

- (a) A periodic redetermination of eligibility for SoonerCare is required for all members. The redetermination is made prior to the end of the initial certification period and each 12 months thereafter. A deemed newborn is eligible through the last day of the month the newborn child attains the age of one year, without regard to eligibility of other household members in the case.
- (b) Effective January 1, 2014, when the agency has sufficient information available electronically to redetermine eligibility, eligibility will be redetermined on that basis and a notice will be sent to the household explaining the action taken by the agency. The member is responsible for notifying the agency if any information used to redetermine eligibility is incorrect. If the agency does not have sufficient information to redetermine eligibility, the agency will send notice to that effect, and the member is responsible for providing the necessary information to redetermine eligibility.
- (c) A member's case is closed if he/she does not return the form(s) and any verification necessary for redetermination timely. If the member submits the form(s) and verification necessary for redetermination within 90 days after closure of the case, benefits are reopened effective the date of the closure, provided the member is eligible and benefits were closed because the redetermination process was not completed.

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

[Source: Added at 16 Ok Reg 708, eff 1-1-99 (emergency); Added at 16 Ok Reg 1438, eff 5-27-99 ; Amended at 21 Ok Reg 2234, eff 6-25-04 ; Amended at 23 Ok Reg 268, eff 9-1-05 (emergency); Amended at 23 Ok Reg 621, eff 12-1-05 (emergency); Amended at 23 Ok Reg 1378, eff 5-25-06 ; Amended at 27 Ok Reg 630, eff 1-14-10 (emergency); Amended at 27 Ok Reg 1492, eff 6-11-10 ; Amended at 30 Ok Reg 1209, eff 7-1-13 ; Amended at 31 Ok Reg 73, eff 9-24-13 (emergency); Amended at 31 Ok Reg 1720, eff 9-12-14 ; Amended at 41 Ok Reg, Number 14, effective 3-8-24 (emergency)]

317:35-6-62. Notification of eligibility [AMENDED AND RENUMBERED TO 317:35-5-65]

[Source: Added at 16 Ok Reg 708, eff 1-1-99 (emergency); Added at 16 Ok Reg 1438, eff 5-27-99 ; Amended at 27 Ok Reg 711, eff 2-4-10 (emergency); Amended at 27 Ok Reg 1471, eff 6-11-10 ; Amended and renumbered to 317:35-5-65 at 35 Ok Reg 1477, eff 9-14-18]

317:35-6-62.1. Electronic Notices [AMENDED AND RENUMBERED TO 317:35-5-66]

[Source: Amended at 32 Ok Reg 1142, eff 8-27-15 ; Amended and renumbered to 317:35-5-66 at 35 Ok Reg 1477, eff 9-14-18]

317:35-6-63. Denials

If the denial of SoonerCare is for the entire household, the appropriate notice is computer generated to the applicant. If an individual(s) is being denied but other family members are eligible, the denied individual(s) is provided with a notice.

[Source: Added at 16 Ok Reg 708, eff 1-1-99 (emergency); Added at 16 Ok Reg 1438, eff 5-27-99 ; Amended at 20 Ok Reg 2775, eff 7-1-03 (emergency); Amended at 21 Ok Reg 2234, eff 6-25-04 ; Amended at 27 Ok Reg 711, eff 2-4-10 (emergency); Amended at 27 Ok Reg 1471, eff 6-11-10]

317:35-6-64. Closures

SoonerCare cases are closed at any time during the certification period that the case becomes ineligible. A computer-generated notice is sent to the head of the household.

[Source: Added at 16 Ok Reg 708, eff 1-1-99 (emergency); Added at 16 Ok Reg 1438, eff 5-27-99 ; Amended at 27 Ok Reg 711, eff 2-4-10 (emergency); Amended at 27 Ok Reg 1471, eff 6-11-10]

317:35-6-64.1. Transitional Medical Assistance (TMA)

(a) Conditions for TMA.

(1) **Transitional Medical Assistance.** Health benefits are continued when the benefit group loses eligibility due to new or increased earnings of the parent(s)/caretaker relative or the receipt of spousal support. The health benefit coverage is of the same amount, duration, and scope as if the benefit group continued receiving SoonerCare. Eligibility for TMA begins with the effective date of case closure or the effective date of closure had the income been reported timely. An individual is included for TMA only if that individual was eligible for SoonerCare and included in the benefit group at the time of the closure. To be

eligible for TMA the benefit group must meet all of the requirements listed in (A) - (C) of this paragraph.

(A) At least one member of the benefit group was included in at least three of the six months immediately preceding the month of ineligibility.

(B) The health benefit cannot have been received fraudulently in any of the six months immediately preceding the month of ineligibility.

(C) The benefit group must have included a dependent child who met the age and relationship requirements for SoonerCare and whose needs were included in the benefit group at the time of closure, unless the only eligible child is a Supplemental Security Income (SSI) recipient.

(2) **Closure due to spousal support.** Health benefits are continued if the case closure is due to the receipt of new or increased payments for spousal support in the form of alimony. The needs of the parent(s) or caretaker relative must be included in the benefit group at the time of closure. The health benefits are continued for four months.

(3) **Closure due to new or increased earnings of parent(s) or caretaker relative.** Health benefits are continued if the closure is due to the new or increased earnings of the parent(s) or caretaker relative. The needs of the parent(s) or caretaker relative must be included in the benefit group at the time of closure. The parent(s) or caretaker relative is required to cooperate with OKDHS Oklahoma Child Support Services during the period of time the family is receiving TMA.

(4) **Eligibility period.** Health benefits may be continued for a period up to 12 months if the reason for closure is new or increased earnings of the parent(s) or caretaker relative. This period is divided into two six-month periods with eligibility requirements and procedures for each period.

(A) **Initial six-month period.**

(i) The benefit group is eligible for an initial six-month period of TMA without regard to income or resources if:

(I) an eligible child remains in the home;

(II) the parent(s) or caretaker relative remains the same; and

(III) the benefit group remains in the state.

(ii) An individual benefit group family member remains eligible for the initial six-month period of TMA unless the individual:

(I) moves out of the state,

(II) dies,

(III) becomes an inmate of a public institution,

(IV) leaves the household,

(V) does not cooperate, without good cause, with the OKDHS Oklahoma Child Support Services or third party liability

requirements.

(B) Additional Six-month period.

(i) Health benefits are continued for the additional six-month period if:

- (I) an eligible child remains in the home;
- (II) the parent(s) or caretaker relative remains the same;
- (III) the benefit group remains in the state;
- (IV) the benefit group was eligible for and received TMA for each month of the initial six-month period;
- (V) the benefit group has complied with reporting requirements in subsection (g) of this Section;
- (VI) the benefit group has average monthly earned income (less child care costs that are necessary for the employment of the parent or caretaker relative) that does not exceed the 185% of the Federal Poverty Level (see SoonerCare Income Guidelines); and
- (VII) the parent(s) or caretaker relative had earnings in each month of the required three-month reporting period described in (g)(2) of this Section, unless the lack of earnings was due to an involuntary loss of employment, illness, or other good cause.

(ii) An individual benefit group family member remains eligible for the additional six-month period unless the individual meets any of the items listed in (4)(A)(ii) of this paragraph.

(b) Income and resource eligibility.

(1) The unearned income and resources of the benefit group are disregarded in determining eligibility for TMA. There is no earned income test for the initial six-month period.

(2) Health benefits are continued for the additional six-month period if the benefit group's countable earnings less child care costs that are necessary for the employment of the parent(s) or caretaker relative are below 185% of the Federal Poverty Level (see the standards on the OHCA website or the OKDHS Form 08AX001E, Schedule I.A) and the benefit group meets the requirements listed in (a)(4)(B).

(A) The earnings of all benefit group members are used in determining the earned income test. The only exception is that earnings of full time students included in the benefit group are disregarded.

(B) Income is determined by averaging the benefit group's gross monthly earnings (except full time student earnings) for the required three-month reporting period.

(C) A deduction from the benefit group's earned income is allowed for the cost of approved child care necessary for

the employment of the parent(S) or caretaker relative. The child care deduction is averaged for the same three-month reporting period. There is no maximum amount for this deduction.

(D) All individuals whose earnings are considered are included in the benefit group. The family size remains the same during both reporting periods.

(c) **Eligible child.** When the SoonerCare benefit is closed and TMA begins, the benefit group must include an eligible child whose needs were included in the SoonerCare benefit at the time of closure, unless the only eligible child is a SSI recipient. After the TMA begins, the benefit group must continue to include an eligible child. Age is the only requirement an eligible child must meet.

(d) **Additional members.** After the TMA begins, family members who move into the home cannot be added to the TMA coverage. This includes siblings and a natural or adoptive parent(s) or caretaker relative. If the additional member is in need of health benefits, an application for services under the SoonerCare program is completed. If a benefit group member included in TMA leaves the home and then returns, that member may be added back to TMA coverage if all conditions of eligibility are met.

(e) **Third party liability.** The benefit group's eligibility for TMA is not affected by a third party liability. However, the benefit group is responsible for reporting all insurance coverage and any changes in the coverage. The worker must explain the necessity for applying benefits from private insurance to the cost of medical care.

(f) **Notification.**

(1) **Notices.** Notices are sent to the benefit group, both at the onset of and throughout the TMA period. These notices, which are sent at specific times, inform the benefit group of its rights and responsibilities. When SoonerCare is closed and the benefit group is eligible for TMA, the computer generated closure notice includes notification of the continuation of health benefits. Another computer generated notice is sent at the same time to advise the benefit group of the reporting requirements and under what circumstances the health benefits may be discontinued. Each notice listed in (A)-(C) of this paragraph includes specific information about what the benefit group must report. The notices serve as the required advance notification in the event benefits are discontinued as a result of the information furnished in response to these notices.

(A) **Notice #1.** Notice #1 is issued in the third month of the initial TMA period. This notice advises the benefit group of the additional six-month period of TMA, the eligibility conditions, reporting requirements, and appeal rights.

(B) **Notice #2.** Notice #2 is issued in the sixth month of the TMA period, but only if the benefit group is eligible for the additional six-month period. This notice advises the benefit group of the eligibility conditions, reporting requirements, and appeal rights.

(C) **Notice #3.** Notice #3 is issued in the ninth month of the TMA period, or the third month of the additional six-month period. This notice advises the benefit group of the eligibility conditions, the reporting requirements, appeal rights, and the expiration of TMA coverage.

(2) **Notices not received.** In some instances the benefit group does not receive all of the notices listed in (1) of this subsection. The notices and report forms are not issued retroactively.

(g) **Reporting.** The benefit group is required to periodically report specific information. The information may be reported by telephone or by letter.

(1) The benefit group must report:

- (A) gross earned income of the entire benefit group for the appropriate three-month period;
- (B) child care expenses, for the appropriate three-month period, necessary for the continued employment of the parent(s) or caretaker relative;
- (C) changes in members of the benefit group;
- (D) residency; and
- (E) third party liability.

(2) The reporting requirement time frames are explained in this subparagraph.

(A) The information requested in the third month must be received by the 21st day of the fourth month and is used to determine the benefit group's eligibility for the additional six-month period. While this report is due in the fourth month, negative action cannot be taken during the initial period for failure to report. If the benefit group fails to submit the requested information, benefits are automatically suspended effective the seventh month. If action to reinstate is not taken by deadline of the suspension month, the computer automatically closes the case effective the next month.

(B) The information requested in the sixth month must be furnished by the 21st day of the seventh month. The decision to continue benefits into the eighth month is determined by the information reported.

(C) The information requested in the ninth month must be furnished by the 21st day of the tenth month. The decision to continue health benefits into the 11th month is determined by the information reported. When the information is not reported timely, the TMA is automatically suspended by the computer for the appropriate effective date. If the benefit group subsequently reports the necessary information, the worker determines eligibility. If all eligibility factors are met during and after the suspension period, the health benefits are reinstated. The effective date of the reinstatement is the same as the effective date of the suspension so the benefit group has continuous medical coverage.

(h) **Termination of TMA.** The TMA coverage is discontinued any time the benefit group fails to meet the eligibility requirements as shown in this Section. If it becomes necessary to discontinue the TMA coverage for the benefit group or any member of the benefit group, the individual(s) must be advised that he or she may be eligible for health benefits under the SoonerCare program and how to obtain these benefits.

(i) **Receipt of health benefits after TMA ends.** To ensure continued medical coverage a computer generated recertification form is mailed to the benefit group during the third month of TMA for benefits closed due to the receipt of child or spousal support or the 11th month of TMA for benefits closed due to increased earnings. The benefit group must return the form prior to the termination of the TMA benefits. When determined eligible, health benefits continue as SoonerCare, not TMA. If the benefit group fails to return the recertification form, TMA benefits are terminated.

[Source: Added at 22 Ok Reg 105, eff 5-1-04 (emergency); Added at 22 Ok Reg 2522, eff 7-11-05 ; Amended at 27 Ok Reg 711, eff 2-4-10 (emergency); Amended at 27 Ok Reg 1471, eff 6-11-10 ; Amended at 33 Ok Reg 903, eff 9-1-16]

317:35-6-65. Transfer of case records between counties

Case records on Health Benefits applications, active cases or closed cases are transferred in accordance with OAC 340:65.

[Source: Added at 16 Ok Reg 708, eff 1-1-99 (emergency); Added at 16 Ok Reg 1438, eff 5-27-99]

SUBCHAPTER 7. MEDICAL SERVICES

PART 1. GENERAL

317:35-7-1. Scope and applicability

The rules in this Subchapter apply when determining eligibility for medical services for children who are reported by OKDHS as being in custody and individuals categorically related to: Aged, Blind and Disabled (ABD); Tuberculosis; SoonerPlan family planning program; Qualified Medicare Beneficiary Plus (QMBP); Qualified Disabled Working Individual (QDWI); Specified Low-Income Medicare Beneficiary (SLMB); Qualifying Individual (QI-1); and TEFRA.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 16 Ok Reg 708, eff 1-1-99 (emergency); Amended at 16 Ok Reg 1438, eff 5-27-99 ; Amended at 20 Ok Reg 2775, eff 7-1-03 (emergency); Amended at 21 Ok Reg 2234, eff 6-25-04 ; Amended at 38 Ok Reg 799, eff 7-1-21 (emergency); Amended at 39 Ok Reg 1544, eff 9-12-22]

PART 3. APPLICATION PROCEDURES

317:35-7-15. Application for Medical Services; forms [REVOKED]

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 16 Ok Reg 708, eff 1-1-97 (emergency); Amended at 16 Ok Reg 1438, eff 5-27-99 ; Amended at 18 Ok Reg 114, eff 11-1-00 (emergency); Amended at 18 Ok Reg 1139, eff 5-11-01 ; Amended at 25 Ok Reg 437, eff 11-1-07 (emergency); Amended at 25 Ok Reg 1227, eff 5-25-08 ; Amended at 27 Ok Reg 711, eff 2-4-10 (emergency); Amended at 27 Ok Reg 1471, eff 6-11-10 ; Amended at 29 Ok Reg 1160, eff 6-25-12 ; Revoked at 30 Ok Reg 1209, eff 7-1-13]

317:35-7-16. Special application procedures for children in OKDHS custody

The rules in this section apply when determining eligibility for health benefits for children who are reported by OKDHS as being in custody.

- (1) When a child placed in custody as reported by OKDHS remains in the parent's home and there is not an active medical case:
 - (A) The OKDHS child welfare specialist advises the family that an application for medical services may be made at the local OKDHS office.
 - (B) The OKDHS Family Support Services (FSS) worker is responsible for processing the SC-1, SoonerCare Health Benefits application or FSS-1, Comprehensive Application and Review, whichever is appropriate.
- (2) When a child placed in custody as reported by OKDHS has an active case and a change in placement is made to a home or facility outside the parent's home:
 - (A) The OKDHS child welfare specialist completes Form CWS-KIDS-4, Eligibility Determination, and forwards it to the OKDHS custody specialist advising of this change, including the date the child was placed outside the home. This referral is made within five working days of the placement.
 - (B) The OKDHS custody specialist makes the appropriate change to remove the child from the family case and opens a child only case the next effective date.
- (3) When a child in custody as reported by OKDHS is placed outside the home and there is not an active case, the OKDHS child welfare specialist is responsible for completing and forwarding the CWS-KIDS-4, Eligibility Determination, to the OKDHS custody specialist. The CWS-KIDS-4 must be sent within five working days of removal from the home. The date of application is the date the child is placed in custody. The OKDHS custody specialist is responsible for processing the application.
- (4) When a child in custody as reported by OKDHS placed outside the home is later returned to the home but remains in custody:
 - (A) The OKDHS child welfare specialist forwards Form K-13 to the OKDHS custody specialist advising of the change in placement. The OKDHS child welfare specialist advises the family that a Medicaid application may be made at the local OKDHS office for medical benefits to continue, if the

family meets eligibility criteria.

(B) The OKDHS custody specialist is responsible for sending a SC-1 to the family so the child's Medicaid eligibility can be redetermined. If the family does not return the completed SC-1, the OKDHS custody specialist closes the child's Medicaid case.

(5) When a child in custody as reported by OKDHS and living in an out of home placement attains age 18, he/she may still be eligible for medical benefits until the age of 21 under the Foster Care Independence Act if his/her income is below the standard on OKDHS Appendix C-1, Schedule 1.A. The individual must complete a new application and have eligibility redetermined in accordance with OAC 317:35-6.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 23 Ok Reg 275, eff 9-1-05 (emergency); Amended at 23 Ok Reg 1387, eff 5-25-06 ; Amended at 41 Ok Reg, Number 14, effective 3-8-24 (emergency)]

317:35-7-17. Special application procedures for children in emergency shelters [REVOKED]

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 6, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Revoked at 23 Ok Reg 275, eff 9-1-05 (emergency); Revoked at 23 Ok Reg 1387, eff 5-25-06]

317:35-7-18. Special application procedures for a child in Children's Hospital of Oklahoma (CHO) [REVOKED]

[Source: Added at 12 Ok Reg 753, eff 7-14-95 through 1-6-96 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Revoked at 16 Ok Reg 708, eff 1-1-99 (emergency); Revoked at 16 Ok Reg 1438, eff 5-27-99]

317:35-7-19. Special application procedures for categorically needy pregnant women and young children [REVOKED]

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Revoked at 14 Ok Reg 56, eff 4-30-96 (emergency); Revoked at 14 Ok Reg 1802, eff 5-27-97]

PART 5. DETERMINATION OF ELIGIBILITY FOR MEDICAL SERVICES

317:35-7-35. General eligibility consideration; categorically related family members [REVOKED]

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 16 Ok Reg 708, eff 1-1-99 (emergency); Amended at 16 Ok Reg 1438, eff 5-27-99 ; Revoked at 30 Ok Reg 1209, eff 7-1-13]

317:35-7-36. Financial eligibility of individuals categorically related to ABD

In determining financial eligibility for Medical Services for an individual related to ABD, the income and resources of the individual and spouse (if any) are considered. However, consideration is not given to the income and resources of a spouse included in a TANF case. Income of an ineligible spouse may be deemed to the minor dependent child as explained in OAC 317:35-7-38(1)(D). The income and resources of a minor dependent child are not considered in determining financial eligibility for the individual related to ABD. The minor dependent child is defined as any biological or adopted child under 18 years of age and residing in the home.

(1) If an individual and spouse cease to live together because of institutionalization or any other reason, income and resources are considered available to each other through the month in which they are separated. Mutual consideration ceases with the month after the month in which the separation occurs. Any amounts which are actually contributed to the eligible individual after the mutual consideration has ended are considered.

(2) If the individual related to Aid to the Blind or Aid to the Disabled is a minor child living in the home of parent(s) or spouse of a parent, the parent'(s) or spouses' income and resources are deemed to the child.

(A) Income is not deemed if the parent or spouse is included in a TANF case or determined categorically needy for Medicaid benefits only. A minor is defined as a child under 18 years and residing in the home. At the point that the minor child no longer resides in the home of the parent(s) or spouse of the parent, the deeming of income and resources ceases with the month after the month of separation. No longer residing in the home includes not only residing in the home of another, but also confinement in a medical facility if the confinement lasts, or is expected to last, 30 days. Any amounts which are actually contributed to the minor child after deeming ends are considered.

(B) For TEFRA children, the income and resources of the parent(s) are not considered.

(3) Premature infants (i.e., 37 weeks or less) whose birth weight is less than 1200 grams (approximately 2 pounds 10 ounces) will be considered disabled by SSA even if no other medical impairment(s) exist. In this event, the parent's income and resources are not deemed to the child until the month following the month in which the child leaves the hospital and begins living with his/her parents. While an infant born below this birth weight is considered disabled under SSI disability provisions, SSI cash payments are only effective the month the parent or legal guardian files an SSI application. If the SSI effective date does not go back to the month of birth, it will not be necessary to request a decision from the Level of Care Evaluation Unit at OHCA in order to consider the infant disabled effective the date of birth.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 (emergency); Added at 12 Ok Reg 1929, eff 5-22-95 (emergency); Added at 14 Ok Reg 56, eff 4-30-96 (emergency); Added at 13 Ok Reg 2537, eff 6-27-96 ; Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 16 Ok Reg 708, eff 1-1-99 (emergency); Amended at 16 Ok Reg 1438, eff 5-27-99 ; Amended at 19 Ok Reg 136, eff 9-1-01 (emergency); Amended at 19 Ok Reg 2149, eff 6-27-02 ; Amended at 22 Ok Reg 2494, eff 7-11-05]

317:35-7-37. Financial eligibility of individuals categorically related to AFDC, or pregnancy-related services [REVOKED]

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 13 Ok Reg 911, eff 8-1-95 (emergency); Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 13 Ok Reg 2537, eff 6-27-96 ; Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 16 Ok Reg 708, eff 1-1-99 (emergency); Amended at 16 Ok Reg 1438, eff 5-27-99 ; Amended at 19 Ok Reg 136, eff 9-1-01 (emergency); Amended at 19 Ok Reg 2149, eff 6-27-02 ; Amended at 20 Ok Reg 2775, eff 7-1-03 (emergency); Amended at 21 Ok Reg 2234, eff 6-25-04 ; Amended at 22 Ok Reg 1012, eff 4-1-05 (emergency); Amended at 22 Ok Reg 2518, eff 7-11-05 ; Amended at 29 Ok Reg 1149, eff 6-25-12 ; Revoked at 30 Ok Reg 1209, eff 7-1-13]

317:35-7-38. Financial eligibility of categorically needy individuals related to ABD

(a) **Income and resources below State Supplemental Payment (SSP) standard.** Individuals whose income and resources meet SSP requirements on OKDHS Appendix C-1, Schedules VIII. A. and D., are considered categorically needy.

(1) **Categorical Relationship.** For an individual categorically related to ABD to be categorically needy at the SSP standard, the countable income must be less than the standards on OKDHS Appendix C-1, Schedule VIII. A. and the equity in capital resources cannot exceed the maximum allowable resources on OKDHS Appendix C-1, Schedule VIII. D. for the following groups:

(A) An eligible individual. An eligible individual is a single individual who is aged, blind or disabled and has total countable income less than the "Categorically Needy Standard for an Eligible Individual";

(B) An eligible individual and essential spouse. An essential spouse is defined as having been continuously included in the case since prior to 1974. The total countable income of both must be less than the "Categorically Needy Standard for Eligible Individual with Essential or Ineligible Spouse";

(C) An eligible individual and ineligible spouse. An ineligible spouse does not meet the definition of aged, blind or disabled nor the requirement as "essential". The total countable income of the eligible individual must be less than the "Categorically Needy Standard for Eligible Individual", and the total countable income of both must be less than the "Categorically Needy Standard for Eligible Individual with Essential or Ineligible Spouse";

(D) An eligible individual with a spouse ineligible for ABD and dependent children.

(i) If the spouse and dependent children are included in a TANF diversion payment or ongoing TANF benefits, their income is not deemed to the

ABD eligible individual.

(ii) If the spouse's needs are not included in the TANF case for the children, the portion of the spouse's income that is considered in determining the grant for the children is not considered in the SSP case;

(E) An eligible couple. An eligible couple means a husband and wife who are both either aged, blind or disabled and have total countable income less than the "Categorically Needy Standard for Eligible Couple".

(2) **Verification.** Verification of receipt of SSI establishes financial eligibility with these exceptions:

(A) Countable income including SSI cannot be equal to or exceed the appropriate Categorically Needy Standards on OKDHS Appendix C-1, Schedule VIII. A.

(B) The individual must meet the OHCA's requirements on irrevocable burial funds.

(3) **Related to ABD.** Individuals who meet the definition of categorically needy with income below the SSP standard and categorically related to ABD are:

(A) Individuals in an active ABD case.

(B) Individuals categorically related to ABD whose countable income and resources are within current SSP standards for eligibility but who do not choose to receive financial assistance.

(C) Individuals in ABD cases who are eligible for Medicaid due to the disregard of Social Security cost of living increases (COLA) under the Pickle Amendment. An individual is eligible under the Pickle Amendment if the following conditions are met:

(i) is currently receiving OASDI;

(ii) has been eligible for and simultaneously received both OASDI and SSP for at least one month since April, 1977;

(iii) lost eligibility for SSP since April, 1977; and

(iv) would be eligible for SSP if OASDI COLA increases received since the closure of SSP case were deducted from countable income.

(D) Spouses "grandfathered in" as essential persons to ABD recipients when the ABD case load was converted to SSI on January 1, 1974, so long as they continue as an essential person to an eligible ABD recipient converted to SSI (even though there is a change in category within ABD).

(E) Individuals in ABD cases who continue to be eligible for Medicaid because the Social Security Administration has determined that they still qualify as "disabled" (by classifying as 1619(b) of the Social Security Act) even though they become employed and lose eligibility for SSI benefits due to the earned income. To retain Medicaid eligibility, the individual must have received Medicaid for

the month prior to the determination by SSA. Income and resources excluded by SSA are also disregarded by OKDHS for these individuals. The county is responsible for the periodic redetermination of eligibility. The individual who meets all other factors of eligibility without consideration of income, resources or disability remains eligible until the SSI status changes.

(F) Individuals in blind or disabled cases who have become ineligible for SSP because of becoming entitled to or receiving an increase in OASDI (Title II)

Widow's/Widower's benefits. They may continue to qualify for Medicaid as categorically needy until age 65 or upon entitlement to Medicare Part A benefits if they also meet the following criteria:

- (i) Are at least 60 but not yet 65;
- (ii) Are not entitled to Medicare;
- (iii) Received SSI prior to age 60; and
- (iv) Meet all other factors of eligibility.

(G) Individuals in blind or disabled cases who become ineligible for SSP due to entitlement of OASDI (Title II) Disabled Widow's/Widower's and Disabled Surviving Divorced Spouse's benefits. This group's eligibility as categorically needy terminates at age 65 or upon entitlement to Medicare Part A benefits. Each month the individual received SSI/SSP will count toward meeting the 24-month Medicare waiting period. This may greatly reduce or even eliminate the normal waiting period of Medicare. Care must be taken to determine if and when these individuals become eligible for Medicare Part A benefits. This group's Medicaid eligibility may continue if they also meet the following criteria:

- (i) Received SSP for the month prior to the month they began receiving the OASDI benefits;
- (ii) Not entitled to Medicare Part A; and
- (iii) Meet all other factors of Medicaid eligibility.

(H) A, B or D recipients (who are at least 18 years of age) who have become ineligible for an SSP due to the receipt of or increase in OASDI child's benefits [Disabled Adult Child (DAC)] which are based on their own disability.

(I) A, B or D recipients who lost their SSP eligibility due to a reduction in the maximum SSP payment. (OKDHS Appendix C-1, Schedule VIII.) These individuals remain eligible for Medicaid benefits.

(4) **SSP eligible.** If a categorically needy applicant for Medicaid is also eligible for a State Supplemental Payment, the certification includes both Medicaid and the state payment.

(5) **Potentially Qualified Medicare Beneficiary Plus eligible.** The individual determined as categorically needy is also potentially eligible as a Qualified Medicare Beneficiary Plus (QMBP) (refer to subsection (b) of this Section). A determination is done to decide if income and resources are within standards on

OKDHS Appendix C-1, Schedule VI., in which the income standards are based on 100% of the Federal Poverty Level. If the individual exercises the option of choosing QMBP coverage only, he/she is not certified to receive the State Supplemental Payment.

(b) Income and resources at or above the SSP standard. Individuals whose income and resources are at or above the SSP standard but less than the standards on OKDHS Appendix C-1, Schedule VI. are considered categorically needy.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 15 Ok Reg 544, eff 12-1-97 (emergency); Amended at 15 Ok Reg 1554, eff 5-11-98 ; Amended at 16 Ok Reg 170, eff 11-1-98 (emergency); Amended at 16 Ok Reg 708, eff 1-1-99 (emergency); Amended at 16 Ok Reg 1438, eff 5-27-99 ; Amended at 17 Ok Reg 721, eff 1-10-00 (emergency); Amended at 17 Ok Reg 1212, eff 5-11-00 ; Amended at 18 Ok Reg 114, eff 11-1-00 (emergency); Amended at 18 Ok Reg 1139, eff 5-11-01 ; Amended at 21 Ok Reg 2525, eff 7-11-05]

317:35-7-39. Financial eligibility of medically needy individuals [REVOKED]

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 15 Ok Reg 544, eff 12-1-97 (emergency); Amended at 15 Ok Reg 1554, eff 5-11-98 ; Amended at 16 Ok Reg 708, eff 1-1-99 (emergency); Amended at 16 Ok Reg 1438, eff 5-27-99 ; Amended at 18 Ok Reg 114, eff 11-1-00 (emergency); Amended at 18 Ok Reg 1139, eff 5-11-01 ; Revoked at 20 Ok Reg 2775, eff 7-1-03 (emergency); Revoked at 21 Ok Reg 2234, eff 6-25-04]

317:35-7-40. Eligibility as Qualified Medicare Beneficiary Plus

An individual determined to be categorically related to aged, blind or disabled is eligible for Medical Services as a Qualified Medicare Beneficiary Plus (QMBP) if he/she meets the conditions of eligibility shown in paragraphs (1)-(3) of this subsection. For persons age 65 and older in mental health hospitals, refer to Oklahoma Administrative Code 317:35-9-7.

(1) The individual's income and resources do not exceed the standard as shown on OKDHS Appendix C-1, Schedule VI, of which the income standard is based on 100 percent (100%) of the Federal Poverty Level. For an individual whose spouse is not eligible for Medicare, total countable income of the eligible individual must be equal to or less than the QMBP standards for an individual, and the income of both must be equal to or less than the QMBP standards for a couple. For a couple who are both eligible for Medicare, total countable income must be equal to or less than the QMBP standards for a couple.

(2) Countable income and resources are determined using the same rules followed in determining eligibility for individuals categorically related to Aged, Blind or Disabled, except that a \$20 general income disregard is applied to either earned or unearned income, but not both. For couples, only one \$20 general income disregard is given.

(3) The individual meets all other eligibility conditions for SoonerCare.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 15 Ok Reg 3679, eff 5-18-98 (emergency); Amended at 16 Ok Reg 708, eff 1-1-99 (emergency); Amended at 16 Ok Reg 1438, eff 5-27-99 ; Amended at 18 Ok Reg 114, eff 11-1-00 (emergency); Amended at 18 Ok Reg 1139, eff 5-11-01 ; Amended at 35 Ok Reg 27, eff 11-1-17 (emergency); Amended at 35 Ok Reg 1479, eff 9-14-18 ; Amended at 37 Ok Reg 1629, eff 9-14-20]

317:35-7-41. Eligibility as Qualified Disabled and Working Individual

(a) An individual determined to be categorically related to Aid to the Blind or Disabled is eligible for Medicaid as a Qualified Disabled and Working Individual (QDWI) if the following eligibility conditions are met.

(1) Social Security disability benefits were terminated solely due to excess earnings.

(2) Countable income and resources do not exceed the standards as shown on DHS Appendix C-1, Schedule V, in which the income standards are based on 200% of the Federal Poverty Level.

(3) Medicaid eligibility cannot be established under QMB or categorically needy programs.

(4) Individual is enrolled in Medicare Part A.

(b) Individuals applying for QDWI must also meet the general eligibility requirements for social security number, residence, citizenship, and assignment of rights. Refer to OAC 317:35-5-25 regarding citizenship/alien status and identity verification requirements.

(c) Countable income and resources are determined using the same rules followed in determining eligibility for individuals categorically related to Aid to the Aged, Blind or Disabled, with the following exception: The \$20 general income disregard is applied to either earned or unearned income, but not both.

(d) Coverage for a Qualified Disabled and Working Individual is restricted to payment of the Medicare Part A premiums. Medical cards are not issued.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 16 Ok Reg 708, eff 1-1-99 (emergency); Amended at 16 Ok Reg 1438, eff 5-27-99 ; Amended at 20 Ok Reg 2775, eff 7-1-03 (emergency); Amended at 21 Ok Reg 2234, eff 6-25-04 ; Amended at 24 Ok Reg 2116, eff 6-25-07]

317:35-7-42. Presumptive eligibility for pregnant women [REVOKED]

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Revoked at 16 Ok Reg 708, eff 1-1-99 (emergency); Revoked at 16 Ok Reg 1438, eff 5-27-99]

317:35-7-43. Eligibility as Specified Low-Income Medicare Beneficiaries

An individual determined to be categorically related as aged, blind or disabled is eligible as a Specified Low-Income Medicare Beneficiary (SLMB) if he/she meets the conditions of eligibility in paragraphs (1) and (2) of this Section. For persons age 65 and older in mental health hospitals, refer to OAC 317:35-9-7.

(1) The individual is enrolled for Medicare hospital insurance benefits under Part A, which includes an individual entitled to hospital insurance benefits by reason of voluntary enrollment in the premium-paying Part A program.

(2) The individual's income and resources do not exceed the standard as shown on DHS Appendix C-1, Schedule VII, of which the income standard is based on 120% of the Federal Poverty Level. State Supplemental Payments are not considered when determining the countable income. For an individual whose spouse is not eligible for Medicare, total countable income of the eligible individual must be equal to or less than the SLMB standards for an individual and the income of both must be equal to or less than the SLMB standards for a couple. For a couple who are both eligible for Medicare, total countable income must be equal to or less than the SLMB standards for a couple. Countable income and resources are determined using the same rules followed in determining eligibility for individuals categorically related to Aid to the Aged, Blind or Disabled, except that a \$20 general income disregard is also applied to either earned or unearned income, but not both. For couples, only one \$20 general income disregard is given.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 15 Ok Reg 3679, eff 5-18-98 (emergency); Amended at 16 Ok Reg 708, eff 1-1-99 (emergency); Amended at 16 Ok Reg 1438, eff 5-27-99]

317:35-7-44. Eligibility for TB related services

(a) An individual determined to be categorically related to disability because of TB is eligible for limited Medicaid benefits if he/she meets the conditions of eligibility shown in paragraphs (1)-(4) of this subsection.

(1) Must have verification of active TB infection from a medical practitioner;

(2) Countable income (earned and unearned) must be less than the categorically needy standards shown on DHS Appendix C-1, Schedule XIII. The income standard is based on the break-even point which is described in the Social Security Procedure/Operations Manual (POMS-SI 00810.350).

(3) Equity in capital resources cannot exceed the maximum allowable resources on DHS Appendix C-1, Schedule XIII. which is the allowable SSI resource standard for an individual.

(4) The individual meets all other eligibility conditions for Medicaid.

(b) Coverage is restricted to payment of TB related services with unlimited TB related drugs. Separate eligibility determinations are made for regular Medicaid and TB related services.

(c) Medical identification cards will be issued to all individuals determined eligible for TB related services.

(d) In cases where both members of a married couple or more than one member of a family are TB infected, each applicant shall be considered as a single individual and be subject to independent income and resource

standards.

(e) In cases where only one spouse is eligible or applies for TB related services, deeming can be done from the ineligible spouse's income in accordance with OAC 317:35-5-42(d)(6).

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 13 Ok Reg 731, eff 12-1-95 (emergency); Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 13 Ok Reg 2537, eff 6-27-96 ; Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 16 Ok Reg 708, eff 1-1-99 (emergency); Amended at 16 Ok Reg 1438, eff 5-27-99]

317:35-7-45. Eligibility for catastrophic illness [REVOKED]

[Source: Added at 14 Ok Reg 56, eff 4-30-96 (emergency); Added at 14 Ok Reg 538, eff 12-24-96 (emergency); Added at 14 Ok Reg 1814, eff 5-27-97 ; Amended at 16 Ok Reg 708, eff 1-1-99 (emergency); Amended at 16 Ok Reg 1438, eff 5-27-99 ; Revoked at 20 Ok Reg 2775, eff 7-1-03 (emergency); Revoked at 21 Ok Reg 2234, eff 6-25-04]

317:35-7-46. Eligibility as Qualifying Individuals

An individual determined to be categorically related as aged, blind or disabled is eligible as a Qualifying Individual (QI) if he/she meets the conditions of eligibility in paragraphs (1), (2), and (3) of this Section.

(1) The individual is enrolled for Medicare hospital insurance benefits under Part A, which includes an individual entitled to hospital insurance benefits by reason of voluntary enrollment in the premium-paying Part A program.

(2) The individual's income and resources do not exceed the standard as shown on DHS Appendix C-1, Schedule VII.A for QI-1. The maximum income standard for the QI-1 program is an amount greater than 120% but less than 135% of the Federal Poverty Level. For an individual whose spouse is not eligible for Medicare, total countable income of the eligible individual must be equal to or less than the QI standards for an individual and the income of both must be equal to or less than the QI standards for a couple. For a couple who are both eligible for Medicare, total countable income must be equal to or less than the QI standards for a couple. Countable income and resources are determined using the same rules followed in determining eligibility for individuals categorically related to Aid to the Aged, Blind or Disabled, with the following exceptions:

(A) Payments from Champus for medical care or from VA for Aid and Attendance are not considered in determining income eligibility.

(B) A \$20 general income disregard is also applied to either earned or unearned income, but not both. For couples, only one \$20 general income disregard is given.

(3) A Qualifying Individual cannot be otherwise eligible for Medicaid. Therefore, unlike QMB and SLMB individuals who may be determined eligible for Medicaid benefits in addition to their QMB/SLMB benefits, a QI recipient cannot be receiving or eligible for any other type of Medicaid benefit.

[Source: Added at 15 Ok Reg 3679, eff 5-18-98 (emergency); Added at 16 Ok Reg 60, eff 9-11-98 (emergency); Amended at 16 Ok Reg 1438, eff 5-27-99 ; Amended at 21 Ok Reg 2234, eff 6-25-04]

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

(a) Non-pregnant women and men ages 19 and above are eligible to receive family planning services if they meet all of the conditions of eligibility in paragraphs (1), (2), (3), and (4) of this Subsection. This is regardless of pregnancy or paternity history and includes women who gain eligibility for SoonerCare family planning services due to a pregnancy, but whose eligibility ends 60 days postpartum.

(1) MAGI financial eligibility rules are used to determine eligibility for SoonerPlan.

(2) MAGI household composition rules are used to determine eligibility for SoonerPlan.

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

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

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

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

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

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

[Source: Added at 22 Ok Reg 1012, eff 4-1-05 (emergency); Added at 22 Ok Reg 2518, eff 7-11-05 ; Amended at 24 Ok Reg 693, eff 2-1-07 (emergency); Amended at 24 Ok Reg 2134, eff 6-25-07 ; Amended at 25 Ok Reg 128, eff 10-1-07 (emergency); Amended at 25 Ok Reg 1227, eff 5-25-08 ; Amended at 29 Ok Reg 1149, eff 6-25-12 ; Amended at 30 Ok Reg 1209, eff 7-1-13 ; Amended at 31 Ok Reg 73, eff 9-24-13 (emergency); Amended at 31 Ok Reg 1720, eff 9-12-14 ; Amended at 33 Ok Reg 903, eff 9-1-16 ; Amended at 35 Ok Reg 1481, eff 9-14-18]

PART 7. CERTIFICATION, REDETERMINATION AND NOTIFICATION

317:35-7-60. Certification for SoonerCare

(a) **General.** The rules in this Section apply to the following categories of eligibles:

- (1) Categorically needy SoonerCare members who are categorically related to Aged, Blind, and Disabled (ABD);
- (2) Categorically needy SoonerCare members who are categorically related to ABD, and are eligible for one of the following:

- (A) Qualified Medicare Beneficiary Plus (QMBP);
- (B) Qualified Disabled and Working Individual (QDWI);
- (C) Specified Low-Income Medicare Beneficiary (SLMB);
- (D) Tuberculosis (TB) related services;
- (E) Qualifying Individual (QI); or
- (F) Tax Equity and Fiscal Responsibility Act (TEFRA).

(b) Certification of individuals categorically needy and categorically related to ABD. The certification period for the categorically needy individual who is categorically related to ABD can be up to twelve (12) months from the date of certification. The individual must meet all factors of eligibility for each month of the certification period. The certification can be for a retroactive period of coverage, during the three (3) months directly before the month of application, if the individual received covered medical services at any time during those three (3) months and would have been eligible for SoonerCare at the time he or she received the services. The cash payment portion of the State Supplemental Payment (SSP) may not be paid for any period prior to the month of application.

- (1) The certification period is twelve (12) months unless the individual:

- (A) Is certified as eligible in a money payment case during the twelve (12) month period;
- (B) Is certified for long-term care during the twelve (12) month period;
- (C) Becomes ineligible for medical assistance after the initial month;
- (D) Becomes ineligible as categorically needy; or
- (E) Is deceased.

- (2) If any of the situations listed in subparagraph (1) of this paragraph occur after the initial month, the case is closed by the worker.

- (A) If income and/or resources change after certification causing the case to exceed the categorically needy maximums, the case is closed.
- (B) A pregnant individual included in an ABD case which closes continues to be eligible for pregnancy related services through the postpartum period.

(c) Certification of individuals categorically related to ABD and eligible as QMBP. The SoonerCare benefit may be certified on the first day of the third month prior to the month of application or later. If the individual receives Medicare and is eligible for SSP, the effective date of certification for the Medicare Part B premium buy-in is the month of certification for SSP. If the individual receives Medicare and is not eligible for SSP, the effective date of certification for the Medicare Part B premium buy-in is the first day of the month following the month in which the eligibility determination is made (regardless of when application was

made).

(1) An individual determined eligible for QMBP benefits is assigned a certification period of twelve (12) months. At any time during the certification period that the individual becomes ineligible, the case is closed using regular negative action procedures.

(2) At the end of the certification period a redetermination of QMBP eligibility is required, using the same forms and procedures as for ABD categorically needy individuals.

(d) Certification of individuals categorically related to ABD and eligible as QDWI. The Social Security Administration (SSA) is responsible for referrals of individuals potentially eligible for QDWI. Eligibility factors verified by the SSA are Medicare Part A eligibility and discontinuation of disability benefits due to excessive earnings. When the OKDHS State office receives referrals from the SSA, the county will be notified and is responsible for obtaining an application and establishing other factors of eligibility. If an individual contacts the county office stating he/she has been advised by SSA that he/she is a potential QDWI, the county takes a SoonerCare application. The effective date of certification for QDWI benefits is based on the date of application and the date all eligibility criteria, including enrollment for Medicare Part A, are met. For example, if an individual applies for benefits in October and is already enrolled in Medicare Part A, eligibility can be effective October 1 [or up to three (3) months prior to October 1, if all eligibility criteria are met during the three (3) month period]. However, if in the example, the individual's enrollment for Part A is not effective until November 1, eligibility cannot be effective until that date. Eligibility can never be effective prior to July 1, 1990, the effective date of this provision. These cases will be certified for a period of twelve (12) months. At the end of the twelve (12) month period, eligibility redetermination is required. If the individual becomes ineligible at any time during the certification period, the case is closed.

(e) Certification of individuals categorically related to ABD and eligible as SLMB. The effective date of certification of SLMB benefits may begin on the first day of the third month prior to the month of application or later. A certification can never be earlier than the date of entitlement of Medicare Part A. An individual determined eligible for SLMB benefits is assigned a certification period of twelve (12) months. At any time during the certification period the individual becomes ineligible, the case is closed using standard negative action procedures. At the end of the certification period a redetermination of SLMB eligibility is required. A redetermination of SLMB eligibility must also be done at the same time a dually eligible individual has a redetermination of eligibility for other SoonerCare benefits such as long-term care.

(f) Certification of individuals categorically related to disability and eligible for TB related services.

(1) An individual determined eligible for TB related services may be certified the first day of the third month prior to the month of application or later, but no earlier than the first day of the month the TB infection is diagnosed.

(2) A certification period of twelve (12) months will be assigned. At any time during the certification period that the individual becomes ineligible, the case is closed using the regular negative action procedures.

(3) At the end of the certification period a new application will be required if additional treatment is needed.

(g) Certification of individuals categorically related to ABD and eligible as QI. The effective date of certification for the QI-1 may begin on the first day of the third month prior to the month of application or later. A certification can never be earlier than the date of entitlement of Medicare Part A. An individual determined eligible for QI benefits is assigned a certification period of twelve (12) months. At any time during the certification period the individual becomes ineligible, the case is closed using standard negative action procedures. At the end of the certification period, a redetermination of QI eligibility is required.

(1) Since the State's allotment to pay Medicare premiums for this group of individuals is limited, the State must limit the number of QIs so that the amount of assistance provided during the year does not exceed the State's allotment for that year.

(2) Persons selected to receive assistance are entitled to receive assistance with their Medicare premiums for the remainder of the federal fiscal year, but not beyond, as long as they continue to qualify. The fact that an individual is selected to receive assistance at any time during the year does not entitle the individual to continued assistance for any succeeding year.

(h) Certification of individuals related to Aid to the Disabled for TEFRA. The certification period for individuals categorically related to the Disabled for TEFRA is twelve (12) months.

[Source: Amended at 16 Ok Reg 60, eff 9-11-98 (emergency); Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 15 Ok Reg 3679, eff 5-18-98 (emergency); Amended at 16 Ok Reg 60, eff 9-11-98 ; Amended at 16 Ok Reg 708, eff 1-1-99 (emergency); Amended at 16 Ok Reg 1438, eff 5-27-99 ; Amended at 18 Ok Reg 114, eff 11-1-00 (emergency); Amended at 18 Ok Reg 1139, eff 5-11-01 ; Amended at 20 Ok Reg 646, eff 2-1-03 (emergency); Amended at 20 Ok Reg 1943, eff 6-26-03 ; Amended at 20 Ok Reg 2775, eff 7-1-03 (emergency); Amended at 21 Ok Reg 2234, eff 6-25-04 ; Amended at 22 Ok Reg 1012, eff 4-1-05 (emergency); Amended at 22 Ok Reg 2518, eff 7-11-05 ; Amended at 29 Ok Reg 1149, eff 6-25-12 ; Amended at 38 Ok Reg 799, eff 7-1-21 (emergency); Amended at 39 Ok Reg 1544, eff 9-12-22]

317:35-7-60.1. Certification for the SoonerPlan Family Planning Program

The effective date of certification for the SoonerPlan Family Planning Program is the date of application or later. The period of certification may not be for a retroactive period. An individual determined eligible for the SoonerPlan Family Planning Program is assigned a certification period of 12 months. At any time during the certification period the individual becomes ineligible, the case is closed using standard negative action procedures. At the end of the certification period, a redetermination of eligibility is required.

[Source: Added at 22 Ok Reg 1012, eff 4-1-05 (emergency); Added at 22 Ok Reg 2518, eff 7-11-05 ; Amended at 27 Ok Reg 711, eff 2-4-10 (emergency); Amended at 27 Ok Reg 1471, eff 6-11-10 ; Amended at 29 Ok Reg 1149, eff 6-25-12 ; Amended at 30 Ok Reg 1209, eff 7-1-13]

317:35-7-61. Redetermination of eligibility for persons receiving ABD or TANF

A periodic redetermination of eligibility for Medical Services is required every twelve months on all categorically needy cases which also receive a money payment, QMBP, SLMB, QI-1, QDWI, or TEFRA.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 16 Ok Reg 708, eff 1-1-99 (emergency); Amended at 16 Ok Reg 1438, eff 5-27-99 ; Amended at 18 Ok Reg 114, eff 11-1-00 (emergency); Amended at 18 Ok Reg 1139, eff 5-11-01 ; Amended at 22 Ok Reg 2494, eff 7-11-05]

317:35-7-61.1. Special redetermination procedures for Tax Equity and Fiscal Responsibility Act (TEFRA)

In addition to redetermining the level of care annually, the OHCA also conducts an annual cost effectiveness review for all active TEFRA children. If OHCA determines the child does not meet any level of care, is no longer disabled, or the estimated cost of care in the home is greater than the estimated cost of care in an institution, at the appropriate level of care, the case is closed.

[Source: Added at 22 Ok Reg 2494, eff 7-11-05 ; Amended at 32 Ok Reg 1118, eff 8-27-15 ; Amended at 36 Ok Reg 921, eff 9-1-19 ; Amended at 41 Ok Reg, Number 12, effective 1-30-24 (emergency)]

317:35-7-62. Special redetermination procedures for children in custody or subsidized adoptions

A periodic redetermination of eligibility for Medical Services is required every twelve months for children in custody or subsidized adoptions as reported by DHS.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 20 Ok Reg 2797, eff 5-26-03 (emergency); Amended at 21 Ok Reg 2235, eff 6-25-04]

317:35-7-63. Notification of eligibility [REVOKED]

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 27 Ok Reg 711, eff 2-4-10 (emergency); Amended at 27 Ok Reg 1471, eff 6-11-10 ; Revoked at 30 Ok Reg 1209, eff 7-1-13]

317:35-7-64. Denials [REVOKED]

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 20 Ok Reg 2775, eff 7-1-03 (emergency); Amended at 21 Ok Reg 2234, eff 6-25-04 ; Amended at 27 Ok Reg 711, eff 2-4-10 (emergency); Amended at 27 Ok Reg 1471, eff 6-11-10 ; Revoked at 30 Ok Reg 1209, eff 7-1-13]

317:35-7-65. Closures [REVOKED]

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 27 Ok Reg 711, eff 2-4-10 (emergency); Amended at 27 Ok Reg 1471, eff 6-11-10 ; Revoked at 30 Ok Reg 1209, eff 7-1-13]

**317:35-7-66. Transfer of case records between counties
[REVOKED]**

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Revoked at 30 Ok Reg 1209, eff 7-1-13]

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

PART 1. SERVICES

**317:35-9-1. Overview of long-term medical care services;
relationship to QMB, SLMB, and other Medicaid services
eligibility, and spenddown calculation**

(a) **Long Term Medical Care Services.** Long-term medical care for the categorically needy includes care in a nursing facility (refer to OAC 317:35-19), public and private intermediate care facility for the mentally retarded (refer to this subchapter), persons age 65 years or older in mental health hospitals (refer to this subchapter), Home and Community Based Waiver Services for the Intellectually Disabled (refer to this subchapter), and Home and Community Based Waiver Services for frail elderly and a targeted group of adults with physical disabilities age 21 and over who have not been determined to have a developmental disability, an intellectual disability or a related condition (refer to OAC 317:35-17). Personal Care provides services in the own home for categorically needy individuals (refer to OAC 317:35-15). Any time an individual is certified as eligible for Medicaid coverage of long-term care, the individual is also eligible for other Medicaid services. Another application or additional spenddown computation is not required. Spenddown is applied to the first long-term care claim filed. Any time an aged, blind or disabled individual is determined eligible for long-term care, a separate determination must be made to see if eligibility conditions as a Qualified Medicare Beneficiary (QMB) or Specified Low-Income Medicare Beneficiary (SLMB) are met. Another application for QMB or SLMB benefits is not required. Any spenddown computed for long-term care is not applicable to QMB or SLMB coverage.

(b) **Medicaid recovery.** The State of Oklahoma operates a Medicaid Recovery program to recover for services identified in OAC 317:35-9-15. Recovery can be accomplished in two ways: liens against real property or claims made against estates.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 17 Ok Reg 2410, eff 6-26-00 ; Amended at 20 Ok Reg 2775, eff 7-1-03 (emergency); Amended at 21 Ok Reg 2234, eff 6-25-04 ; Amended at 29 Ok Reg 1162, eff 6-25-12]

317:35-9-2. Services in a Nursing Facility (NF) [REVOKED]

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Revoked at 17 Ok Reg 2410, eff 6-26-00]

317:35-9-3. ADvantage program services [REVOKED]

[Source: Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Revoked at 17 Ok Reg 2410, eff 6-26-00]

317:35-9-4. Services in Intermediate Care Facility for Individuals with Intellectual Disabilities (public and private)

(a) Services in a private Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) may be provided to members requiring health or habilitative services above the level of room and board.

Services are provided to members who meet level of care and eligibility requirements per OAC 317:30-5-122 and 317:35-9-45.

(b) Services in a public ICF/IID may be provided to members who require health or habilitative services above the level of room and board.

Services are provided to members who meet level of care requirements per OAC 317:30-5-122.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 17 Ok Reg 2410, eff 6-26-00 ; Amended at 28 Ok Reg 1534, eff 6-25-11 ; Amended at 34 Ok Reg 721, eff 9-1-17]

317:35-9-5. Home and Community - Based Services (HCBS) Waivers for persons with intellectual disabilities or certain persons with related conditions

(a) Home and Community Based Services (HCBS) Waivers for persons with intellectual disabilities or certain persons with related conditions are operated by the Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD) per OAC 317:40-1-1. Oklahoma's Medicaid agency, the Oklahoma Health Care Authority (OHCA), provides oversight of Waiver operation. HCBS Waivers allow the OHCA to offer certain home and community based services to categorically needy members who, without such services, would be eligible for care in an Intermediate Care Facility for persons with Mental Retardation (ICF/MR).

(b) Members receiving HCBS Waiver services per OAC 317:40-1-1 are subject to HCBS Waiver service conditions (1)-(11) of this subsection. The rules in this subsection shall not be construed as a limitation of the rights of class members set forth in the Second Amended Permanent Injunction in *Homeward Bound vs. The Hissom Memorial Center*.

(1) HCBS Waiver services are subject to annual appropriations by the Oklahoma Legislature.

(2) DDSD must limit the utilization of the HCBS Waiver services based on:

(A) the federally-approved member capacity for the individual HCBS Waivers; and

- (B) the cost effectiveness of the individual HCBS Waivers as determined according to federal requirements; and
- (3) DDS must limit enrollment when utilization of services under the HCBS Waiver programs is projected to exceed the spending authority.
- (4) Members receiving Waiver services must have full access to State plan services for which they are eligible including Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services when children participate in a Waiver.
- (5) A member's room and board expenses may not be paid through a Waiver. Room and board expenses must be met from member resources or through other sources.
- (6) A member must require at least one Waiver service per month or monthly case management monitoring in order to function in the community.
- (7) Waiver services required by a member must be documented in advance of service delivery in a written plan of care.
- (8) Members exercise freedom of choice by choosing Waiver services instead of institutional services.
- (9) Members have the right to freely select from among any willing and qualified provider of Waiver services.
- (10) The average costs of providing Waiver and non-Waiver SoonerCare services must be no more costly than the average costs of furnishing institutional (and other SoonerCare state plan) services to persons who require the same level of care.
- (11) Members approved for services provided in a specific Waiver must be afforded access to all necessary services offered in the specific Waiver if the member requires the service.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 17 Ok Reg 2410, eff 6-26-00 ; Amended at 26 Ok Reg 2139, eff 6-25-09 ; Amended at 28 Ok Reg 1534, eff 6-25-11 ; Amended at 29 Ok Reg 1162, eff 6-25-12]

317:35-9-5.1. Home and Community Based Waiver Services for individuals with mental retardation and related conditions [REVOKED]

[Source: Added at 14 Ok Reg 56, eff 4-30-96 (emergency); Added at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 17 Ok Reg 2410, eff 6-26-00 ; Revoked at 28 Ok Reg 1534, eff 6-25-11]

317:35-9-6. Non-Technical Medical Care in own home [REVOKED]

[Source: Added at 12 Ok Reg 753, eff 1-6-95 (emergency); Added at 12 Ok Reg 1935, eff 5-22-95 (emergency); Added at 13 Ok Reg 2537, eff 6-27-96 ; Revoked at 17 Ok Reg 2410, eff 6-26-00]

317:35-9-7. Services for persons age 65 or older in mental health hospitals

Services for persons age 65 years or older in mental health hospitals are mental health services provided in an inpatient hospital setting to eligible categorically needy individuals whose condition cannot adequately be treated on an outpatient basis. These individuals are not

eligible for the Qualified Medicare Beneficiary program (QMB) or the Specified Low-Income Medicare Beneficiary program (SLMB).

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95]

PART 2. MEDICAID RECOVERY PROGRAM

317:35-9-15. Medicaid recovery

(a) **General overview.** The Omnibus Budget Reconciliation Act of 1993 mandates the State to seek recovery against the estate of certain Title XIX members who received medical care on or after July 1, 1994, and who were 55 years of age or older when the care was received. The payment of Title XIX by the Oklahoma Health Care Authority (OHCA) on behalf of a member who is an inpatient of a nursing facility, intermediate care facility for the mentally retarded or other medical institution creates a debt to the OHCA subject to recovery by legal action either in the form of a lien filed against the real property of the member and/or a claim made against the estate of the member. Only Title XIX received on or after July 1, 1994, will be subject to provisions of this Part. Recovery for payments made under Title XIX for nursing care is limited by several factors, including the family composition at the time the lien is imposed and/or at the time of the member's death and by the creation of undue hardship at the time the lien is imposed or the claim is made against the estate. [See OAC 317:35-5-41.8(a)(3)(H) for consideration of home property as a countable resource.] State Supplemental Payments are not considered when determining the countable income. The types of medical care for which recovery can be sought include:

- (1) nursing facility services;
- (2) home and community based services;
- (3) related hospital services;
- (4) prescription drug services;
- (5) physician services; and
- (6) transportation services.

(b) **Recovery through lien.** The Oklahoma Health Care Authority (OHCA) may file and enforce a lien, after notice and opportunity for a hearing, against the real property of a member who is an inpatient in a nursing facility, ICF/MR or other medical institution in certain instances.

(1) **Exceptions to filing a lien.**

(A) A lien may not be filed on the home property if the member's family includes:

- (i) a surviving spouse residing in the home;
- (ii) a child or children age 20 or less lawfully residing in the home ;
- (iii) a disabled child or children of any age lawfully residing in the home; or
- (iv) a brother or sister of the member who has an equity interest in the home and has been residing in the home for at least one year immediately prior

to the member's admission to the nursing facility and who has continued to live there on a continuous basis since that time.

(B) If an individual covered under an Oklahoma Long-term Care Partnership Program approved policy received benefits for which assets or resources were disregarded as provided for in OAC 317:35-5-41.9, the Oklahoma Health Care Authority will not seek recovery from the individual for the amount of assets or resources disregarded.

(2) **Reasonable expectation to return home.** A lien may be filed only after it has been determined, after notice and opportunity for a hearing, that the member cannot reasonably be expected to be discharged and return to the home. To return home means the member leaves the nursing facility and resides in the home on which the lien has been placed for a period of at least 90 days without being re-admitted as an inpatient to a facility providing nursing care. Hospitalizations of short duration that do not include convalescent care are not counted in the 90 day period. Upon certification for Title XIX for nursing care, OKDHS provides written notice to the member that a one-year period of inpatient care constitutes a determination by the OKDHS that there is no reasonable expectation that the member will be discharged and return home for a period of at least 90 days. The member or the member's representative is asked to declare intent to return home by signing the OKDHS Form 08MA024E, Acknowledgment of Intent to Return Home/Medicaid Recovery Program. Intent is defined here as a clear statement of plans in addition to other evidence and/or corroborative statements of others. Should the intent be to return home, the member must be informed that a one-year period of care at a nursing facility or facilities constitutes a determination that the member cannot reasonably be expected to be discharged and return home. When this determination has been made, the member receives a notice and opportunity for hearing. This notification occurs prior to filing of a lien. At the end of the 12-month period, a lien may be filed against the member's real property unless medical evidence is provided to support the feasibility of his/her returning to the home within a reasonable period of time (90 days). This 90-day period is allowed only if sufficient medical evidence is presented with an actual date for the return to the home.

(3) **Undue hardship waiver.** When enforcing a lien or a recovery from an estate [see (c) of this Section] would create an undue hardship, a waiver may be granted. Undue hardship exists when enforcing the lien would deprive the individual of medical care such that the individual's health or life would be endangered. Undue hardship exists when application of the rule would deprive the individual or family members who are financially dependent on him/her for food, clothing, shelter, or other necessities of life. Undue hardship does not exist, however, when the individual or his/her family is merely inconvenienced or when their lifestyle is

restricted because of the lien or estate recovery being enforced. Decisions on undue hardship waivers are made at OKDHS State Office, Family Support Services Division, Health Related and Medical Services Section. Upon applying for an undue hardship waiver, an individual will receive written notice, in a timely process, whether an undue hardship waiver will be granted. If an undue hardship waiver is not granted, the individual will receive written notice of the process under which an adverse determination can be appealed. The OHCA Legal Division staff will receive notification on all undue hardship waiver decisions.

(4) **Filing the lien.** After it has been determined that the member cannot reasonably be expected to be discharged from the nursing facility and return home and the member has been given notice of an intent to file a lien against the real property and an opportunity for a hearing on the matter, a lien is filed by the Oklahoma Health Care Authority, Third Party Liability Unit, for record against the legal description of the real property in the office of the county clerk of the county in which the property is located. A copy of the lien is sent by OHCA to the member or his/her representative. The lien must contain the following information:

- (A) the name and mailing address of the member, spouse, legal guardian, authorized representative, or individual acting on behalf of the member;
- (B) the amount of Title XIX paid at the time of the filing of the lien and a statement that the lien amount will continue to increase by any amounts paid thereafter for Title XIX on the member's behalf;
- (C) the date the member began receiving compensated inpatient care at a nursing facility or nursing facilities, intermediate care facility for the mentally retarded or other medical institution;
- (D) the legal description of the real property against which the lien will be recorded; and
- (E) the address of the Oklahoma Health Care Authority.

(5) **Enforcing the lien.** The lien filed by OHCA for Title XIX correctly received may be enforced before or after the death of the member. But it may be enforced only:

- (A) after the death of the surviving spouse of the member or until such time as the surviving spouse abandons the homestead to reside elsewhere;
- (B) when there is no child of the member, natural or adopted, who is 20 years of age or less residing in the home;
- (C) when there is no adult child of the member, natural or adopted, who is blind or disabled, as defined in OAC 317:35-1-2, residing in the home;
- (D) when no brother or sister of the member is lawfully residing in the home, who has resided there for at least one year immediately before the date of the member's admission to the nursing facility, and has resided there on

a continuous basis since that time; and

(E) when no son or daughter of the member is lawfully residing in the home who has resided there for at least two years immediately before the date of the member's admission to the nursing facility, and establishes to the satisfaction of the OKDHS that he or she provided care to the member which permitted the member to reside at home rather than in an institution and has resided there on continuous basis since that time.

(6) **Dissolving the lien.** The lien remains on the property even after transfer of title by conveyance, sale, succession, inheritance or will unless one of the following events occur:

(A) The lien is satisfied. The member or member's representative may discharge the lien at any time by paying the amount of lien to the OHCA. Should the payment of the debt secured by the lien be made to the county office, the payment is forwarded to OHCA/Third Party Liability, so that the lien can be released within 50 days. After that time, the member or the member's representative may request in writing that it be done. This request must describe the lien and the property with reasonable certainty. By statute, a fine may be levied against the lien holder if it is not released in a timely manner.

(B) The member leaves the nursing facility and resides in a property to which the lien is attached, for a period of more than 90 days without being re-admitted to a facility providing nursing care, even though there may have been no reasonable expectation that this would occur. If the member is re-admitted to a nursing facility during this period, and does return to his/her home after being released, another 90 days must be completed before the lien can be dissolved.

(7) **Capital resources.** Rules on the determination of capital resources for individuals related to the aged, blind, or disabled (See OAC 317:35-5-41 through 317:35-5-41.7) apply to the proceeds received for the property in excess of the amount of the lien after the lien is satisfied.

(c) **Recovery from estates.**

(1) If the member was age 55 or older when the nursing care was received, adjustment or recovery may be made only after the death of the individual's spouse, if any, and at a time when there are no surviving children age 20 or less and no surviving disabled children of any age living in the home. Oklahoma Statutes contain stringent time frames concerning when and how claims against an estate in probate are filed and paid. Therefore, timely updating of computer input forms indicating the death of the member is crucial to insure the OHCA's ability to file timely against the estate.

(2) The estate consists of all real and personal property and other assets included in member's estate as defined by Title 58 of the

Oklahoma Statutes. Although county staff ordinarily will not be responsible for inventorying or assessing the estate, assets and property that are not considered in determining eligibility should be documented in the case record.

(3) After updating of computer input form indicating member's death, a computer generated report is sent to OHCA/Third Party Liability (TPL). This report will serve as notification to OHCA/TPL to initiate estate recovery.

(4) Undue hardship waivers may be granted for estate recovery as provided in (b)(3) of the Section.

(5) If an individual covered under an Oklahoma Long-Term Care Partnership Program approved policy received benefits for which assets or resources were disregarded as provided for in OAC 317:35-5-41.9, the Oklahoma Health Care Authority will not seek recovery from the individual's estate for the amount of assets or resources disregarded.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 13 Ok Reg 1521, eff 3-27-96 (emergency); Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 15 Ok Reg 564, eff 9-18-97 (emergency); Amended at 15 Ok Reg 1554, eff 5-11-98 ; Amended at 24 Ok Reg 2135, eff 6-25-07 ; Amended at 25 Ok Reg 130, eff 8-1-07 (emergency); Amended at 25 Ok Reg 674, eff 12-18-07 (emergency); Amended at 25 Ok Reg 1227, eff 5-25-08 ; Amended at 27 Ok Reg 1680, eff 5-14-10 (emergency); Amended at 28 Ok Reg 1537, eff 6-25-11]

PART 3. APPLICATION PROCEDURES

317:35-9-25. Application for ICF/MR, HCBW/ID, and persons aged 65 or over in mental health hospitals.

(a) **Application procedures for long-term medical care.** An application for these types of services consists of the Medical Assistance Application. The Medical Assistance Application is signed by the patient, parent, spouse, guardian or someone else acting on the patient's behalf.

(1) All conditions of eligibility must be verified and documented in the case record. When current information already available in the local office establishes eligibility, such information may be used by recording source and date of information. If the applicant also wishes to apply for a State Supplemental Payment, either the applicant or his/her guardian must sign the application form.

(2) At the request of an individual in an ICF/MR or receiving Home and Community Based Waiver Services for the Intellectually Disabled or the community spouse, if application for Medicaid is not being made, an assessment of the resources available to each spouse is made by use of DHS Form MA-11, Assessment of Assets. Documentation of resources must be provided by the individual and/or spouse. This assessment reflects all countable resources of the couple (owned individually or as a couple) and establishes the spousal share to be protected when subsequent determination of Medicaid eligibility is made. A copy of Form MA-11 is provided to each spouse for planning in regard to future eligibility. A copy is retained in the county office in case

of subsequent application.

(3) If assessment by Form MA-11 was not done at the time of entry into the ICF/MR or HCBW/ID services, assessment by use of Form MA-11 must be done at the time of application for Medicaid. The spousal share of resources is determined in either instance for the month of entry into the ICF/MR or HCBW/ID services. If the individual applies for Medicaid at the time of entry into the ICF/MR or HCBW/ID services, Form MA-11 is not appropriate. However, the spousal share must be determined using the resource information provided on the Medicaid application form and computed using DHS Form MA-12, Title XIX Worksheet.

(b) Date of application. When application is made in the county office the date of application is the date the applicant or someone acting on his/her behalf signs the application form. When the application is initiated outside the county office, the date of application is the date the application is stamped into the county office. When a request for Medicaid is first made by an oral request, and the application form is signed later, the date of the oral request is entered in "red" above the date the form is signed. The date of the oral request is the date of application.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 17 Ok Reg 2410, eff 6-26-00 ; Amended at 29 Ok Reg 1162, eff 6-25-12]

317:35-9-26. Application procedures for private ICF/MR

Individuals may apply for private ICF/MR at the OKDHS human services center (HSC) of their choice. A written application is not required for an individual who has an active SoonerCare case. The OKDHS Notification Regarding Patient in a Nursing Facility, Intermediate Care Facility for the Mentally Retarded or Hospice form 08MA083E, when received in the HSC, also constitutes an application request and is handled the same as an oral request. The local HSC will send the ICF/MR OKDHS form 08MA038E within three working days of receipt of OKDHS forms 08MA083E and 08MA084E, Management of Recipient's Funds, indicating actions that are needed or have been taken regarding the member.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 17 Ok Reg 2410, eff 6-26-00 ; Amended at 26 Ok Reg 408, eff 1-1-09 (emergency); Amended at 26 Ok Reg 2139, eff 6-25-09]

317:35-9-27. Application procedures for public ICF/MR

When an individual is admitted to a public ICF/MR, an application for payment of long-term care in the facility is made at the time of admission. A designated worker from the county office in the county where the facility is located assists in this part of the admission process. The superintendent of the facility may sign the application on behalf of the individual if the responsible parent or guardian is not available. A case record is set up, in the county where the facility is located, for each applicant of the public ICF/MR. If the individual leaves the facility, the

county case is transferred, if necessary, to the county of residence.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 7-27-97 ; Amended at 17 Ok Reg 2410, eff 6-26-00]

317:35-9-28. Application procedures for services provided by Developmental Disability Services Division (DDSD)

(a) **Application.** The county office is responsible for taking a new application for Medicaid if an active case is not already in existence. The worker must determine if the individual would be financially eligible for Medicaid benefits as categorically needy according to DHS Appendix C-1, Schedule VIII. B.

(1) When DHS/DDSD resources are sufficient for initiation of HCBW services, the DDSD case manager notifies the DHS county office of the request by DHS form K-13. The application date is the date Form K-13 is received in the county office.

(2) When a request for HCBW originates in the county office, the DHS social worker refers the applicant to the DHS/DDSD Area Office for completion of DHS form DDS-1, Application for Developmental Disabilities Services.

(3) The DHS/DDSD case manager determines whether or not a categorical relationship decision is necessary.

(b) **Existing Medicaid case.** A new application is not required on existing cases when referral is from a public ICF/MR or nursing facility for an individual returning to the community. The DDSD case manager verifies receipt of Medicaid benefits and notifies the county social worker of the medical eligibility determination (M-S-52) for HCBW/MR by the use of the DHS form K-13 requesting the computer system be updated with the client's new mailing and finding address and the appropriate waiver code. A case number is assigned if necessary, retaining the application date, certification date and redetermination of eligibility date from the existing case with the institutional case number.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 17 Ok Reg 2410, eff 6-26-00]

317:35-9-29. Application procedures for persons age 65 or older in mental health hospitals

Under contracts between the OHCA and mental health hospitals, Medicaid applications for payment of care on behalf of individuals 65 years of age or older may be completed by the mental health hospital staff on behalf of these persons.

(1) An application for payment of care is made only on those patients age 65 years of age or older who are not eligible for (or who have exhausted) benefits under Title XVIII, Part A (Medicare, Part A), for the type of medical services for which they are now requesting payment under Medicaid. The completed application forms are forwarded to the local DHS office. A statement that the patient is not eligible under Medicare for the type of care for

which payment is being requested must be attached.

(2) When there is a spouse who is not a patient in the mental health hospital or there is a guardian, the spouse or guardian's name and address is shown on the application form in addition to the patient's name in order that notifications are sent to the responsible person.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 17 Ok Reg 2410, eff 6-26-00]

317:35-9-30. Special application procedures for children in DHS custody [REVOKED]

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Revoked at 17 Ok Reg 2410, eff 6-26-00]

PART 5. DETERMINATION OF MEDICAL ELIGIBILITY FOR ICF/IID, HCBW/IID, AND INDIVIDUALS AGE 65 OR OLDER IN MENTAL HEALTH HOSPITALS

317:35-9-45. Determination of medical eligibility for care in a private Intermediate Care Facility for Individuals with Intellectual Disabilities(ICF/IID)

(a) **Pre-approval of medical eligibility.** Pre-approval of medical eligibility for private ICF/IID care is based on level of care requirements per OAC 317:30-5-122. Pre-approval is not necessary for individuals with a severe or profound intellectual disability. Pre-approval is made by Oklahoma Health Care Authority (OHCA) Level of Care Evaluation Unit (LOCEU) analysts.

(b) **Application for ICF/IID services.** Within 30 calendar days after services begin, the facility must submit:

(1) The original of the ICF/IID Level of Care Assessment form (LTC-300) to LOCEU. Required attachments include:

(A) Current (within 90 days of requested approval date) medical information signed by a physician.

(B) A current (within 12 months of requested approval date) psychological evaluation by a licensed Psychologist or State staff supervised by a licensed Psychologist. The evaluation must include intelligence testing that yields a full-scale intelligence quotient, a full-scale functional or adaptive assessment, as well as the age of onset.

(C) A copy of the pertinent section of the Individual Plan or other appropriate documentation relative to the ICF/IID admission and the need for ICF/IID level of care.

(D) A statement that the member is not an imminent threat of harm to self or others (i.e., suicidal or homicidal).

(2) If pre-approval was determined by LOCEU and the above information is received, medical approval will be entered on an

electronic medical case list known as MEDATS. Pre-approval is not needed for individuals with a severe or profound intellectual disability.

(c) **Categorical relationship.** Categorical relationship must be established for determination of eligibility for long-term medical care. If categorical relationship has not already been established, the proper forms and medical information are submitted to LOCEU. (Refer to OAC 317:35-5-4). In such instances LOCEU will render a decision on categorical relationship using the same definition as used by the SSA. A follow-up is required by the OKDHS social worker with the SSA to be sure that their disability decision agrees with the decision of LOCEU.

(d) **Medical eligibility for ICF/IID services.**

(1) Individuals must require active treatment per 42 CFR 483.440.

(2) Individuals must have a diagnosis of an intellectual disability or a related condition based on level of care requirements per OAC 317:30-5-122 and results of a current comprehensive psychological evaluation by a licensed Psychologist or State staff supervised by a licensed Psychologist.

(A) Per the Diagnostic and Statistical Manual of Mental Disorders, intellectual disability is a condition characterized by a significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and originating before 18 years of age.

(B) Per 42 CFR 435.1010, persons with related conditions means individuals who have a severe, chronic disability that meets the following conditions:

- (i) It is attributable to cerebral palsy or epilepsy.
- (ii) It is attributable to any other condition, other than mental illness, found to be closely related to intellectual disability because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with intellectual disability and requires treatment or services similar to those required for these persons.
- (iii) It is manifested before the person reaches age 22.
- (iv) It is likely to continue indefinitely.
- (v) It results in substantial functional limitations in three or more areas of major life activity per OAC 317:30-5-122.

(C) Conditions closely related to intellectual disability include, but are not limited to the following:

- (i) autism or autistic disorder, childhood disintegrative disorder, Rett syndrome and pervasive developmental disorder, not otherwise specified (only if "typical autism");
- (ii) severe brain injury (acquired brain injury, traumatic brain injury, stroke, anoxia, meningitis);

- (iii) fetal alcohol syndrome;
- (iv) chromosomal disorders (Down syndrome, fragile x syndrome, Prader-Willi syndrome);and
- (v) other genetic disorders (Williams syndrome, spina bifida, phenylketonuria).

(D) The following diagnoses do not qualify as conditions related to intellectual disability. Nevertheless, a person with any of these conditions is not disqualified if there is a simultaneous occurrence of a qualifying condition:

- (i) learning disability;
- (ii) behavior or conduct disorders;
- (iii) substance abuse;
- (iv) hearing impairment or vision impairment;
- (v) mental illness that includes psychotic disorders, adjustment disorders, reactive attachment disorders, impulse control disorders, and paraphilias;
- (vi) borderline intellectual functioning, developmental disability that does not result in an intellectual impairment, developmental delay or "at risk" designations;
- (vii) physical problems (such as multiple sclerosis, muscular dystrophy, spinal cord injuries and amputations);
- (viii) medical health problems (such as cancer, acquired immune deficiency syndrome and terminal illnesses);
- (ix) milder autism spectrum disorders (such as Asperger's disorder and pervasive developmental disorder not otherwise specified if not "atypical autism");
- (x) neurological problems not associated with intellectual deficits (such as Tourette's syndrome, fetal alcohol effects and non-verbal learning disability);or
- (xi) mild traumatic brain injury (such as minimal brain injury and post-concussion syndrome).

[Source: Added at 12 Ok Reg 753, eff 1-6-95 (emergency); Added at 12 Ok Reg 1035, eff 5-22-95 (emergency); Added at 14 Ok Reg 56, eff 4-30-96 (emergency); Added at 13 Ok Reg 2537, eff 6-27-96 ; Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 17 Ok Reg 2410, eff 6-26-00 ; Amended at 24 Ok Reg 2866, eff 6-1-07 (emergency); Amended at 25 Ok Reg 1227, eff 5-25-08 ; Amended at 28 Ok Reg 1534, eff 6-25-11 ; Amended at 29 Ok Reg 1162, eff 6-25-12 ; Amended at 34 Ok Reg 721, eff 9-1-17]

317:35-9-45.1. Determination of medical eligibility for Non-Technical Medical Care [REVOKED]

[Source: Added at 12 Ok Reg 1935, eff 5-22-95 (emergency); Added at 14 Ok Reg 56, eff 4-30-96 (emergency); Added at 13 Ok Reg 2537, eff 6-27-96 ; Amended at 14 Ok Reg 1802, eff 5-27-97 ; Revoked at 17 Ok Reg 2410, eff 6-26-00]

317:35-9-46. Determination of continued medical eligibility for care in NF and private ICF/MR [REVOKED]

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Revoked at 17 Ok Reg 2410, eff 6-26-00]

317:35-9-47. Determination of continued medical eligibility for NTMC [REVOKED]

[Source: Added at 12 Ok Reg 753, eff 1-6-95 (emergency); Added at 12 Ok Reg 1935, eff 5-22-95 (emergency); Added at 14 Ok Reg 56, eff 4-30-96 (emergency); Added at 13 Ok Reg 2537, eff 6-27-96 ; Amended at 14 Ok Reg 1802, eff 5-27-97 ; Revoked at 17 Ok Reg 2410, eff 6-26-00]

317:35-9-48. Determination of medical eligibility for care in public ICF/MR

(a) DHS, Developmental Disability Services Division (DDSD) evaluation reports provide case material for referral to the LOCEU for

determination of the need for ICF/MR level of care/medical eligibility.

(b) The following procedure is used in handling referrals from a public ICF/MR for determination of eligibility for public assistance and/or long-term care in the community or private ICF/MR. The superintendent of the public ICF/MR refers to DHS DDSD those persons who in the judgement of the facility staff can adequately be cared for in the community. The referral includes (in addition to the social and financial information) current medical information on the Report of Physician's Examination form; the Long Term Care Assessment form; psychological information and, if applicable, Form SMR-103-A, Itemized Statement of Charges for Care and Treatment.

(1) The DDSD upon receiving the referral from the facility forwards the information to the Level of Care Evaluation Unit (LOCEU) to determine the medical eligibility for long-term care in the community. LOCEU enters the medical determination on MEDATS.

(2) In instances where referral is from a public ICF/MR for an individual returning to the home and/or Community Based Waiver Services, the DDSD case manager forwards to the worker the medical eligibility determination for HCBW/MR services along with the latest application and redetermination forms used to determine eligibility for long-term care. A new application will not be required. A case number is assigned retaining the application date, certification date and redetermination of eligibility date.

(3) The superintendent of the facility makes a referral to the county where the guardian or responsible relative resides. If there is no guardian or parent, the superintendent of the facility makes the referral to the county where the public ICF/MR is located. The county is responsible for taking the application, determining eligibility, certifying the case and for locating an ICF/MR for the applicant in the appropriate county (this may be within the county or in another county in the State). The date of application on these referrals from the public ICF/MR is the date

the superintendent made the referral.

(4) If a facility is located in another county, the complete active case is transferred in the usual manner to the county in which the ICF/MR is located. The transferring county is responsible for notifying the superintendent of the public ICF/MR when an active case is transferred to another county.

(5) When an individual is discharged from a public ICF/MR to return home and/or Community Based Waiver Services, the MRP or MRE case is updated with a discharge date, placed in closed status and retained in the county where the facility is located.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 17 Ok Reg 2410, eff 6-26-00]

317:35-9-48.1. Determining ICF/IID institutional level of care for TEFRA children

In order to determine ICF/IID level of care for TEFRA children:

(1) The child must be age 18 years or younger and expected to meet the following criteria for at least 30 days.

(A) Applicants under age three must:

- (i) have a diagnosis of a developmental disability; and
- (ii) have been evaluated by the SoonerStart Early Intervention Program or other appropriate healthcare provider, and found to have severe dysfunctional deficiencies with findings of at least two standard deviations in at least two total domain areas.

(B) Applicants age three years and older must:

- (i) have a diagnosis of intellectual disability or a developmental disability; and
- (ii) have received a psychological evaluation by a licensed psychologist or school psychologist certified by the Oklahoma Department of Education (ODE) within the last 12 months. The evaluation must include intelligence testing that yields a full-scale intelligence quotient, and a full-scale functional or adaptive assessment that yields a composite functional age. Eligibility for TEFRA ICF/IID level of institutional care requires an IQ of 70 or less, or a full-scale functional assessment indicating a functional age composite that does not exceed fifty percent of the child's chronological age. In no case shall eligibility be granted for a functional age greater than eight years.

(2) Psychological evaluations are required for children who are approved for TEFRA under ICF/IID level of care. Children under evaluation, including both intelligence testing and adaptive/functional assessment, by a licensed psychologist or school psychologist certified by the ODE, at age three, age six,

and, if medically necessary, thereafter to ascertain continued eligibility for TEFRA under the ICF/IID level of institutional care. The psychological evaluation must be completed and submitted to the LOCEU no later than 90 days following the child's third and sixth birthday, and, if medically necessary, thereafter.

[Source: Added at 25 Ok Reg 1257, eff 5-25-08 ; Amended at 29 Ok Reg 1162, eff 6-25-12 ; Amended at 32 Ok Reg 1118, eff 8-27-15 ; Amended at 34 Ok Reg 725, eff 9-1-17 ; Amended at 41 Ok Reg, Number 12, effective 1-30-24 (emergency)]

317:35-9-49. Determination of medical eligibility for Home and Community Based Waiver Services for the Intellectually Disabled

Determinations of medical eligibility for Home and Community Based Waiver Services for the Intellectually Disabled (HCBW/ID) is made through referral to the DHS DDS case manager.

(1) **Referral.** If the county receives an application, Form K-13 is forwarded to the DDS case manager, who is responsible for securing a HCBW/ID medical determination and a disability decision, if needed.

(2) **Initial request.** If the initial request is through DDS, Form K-13 is forwarded to the county for completing the application process.

(3) **Plan of care packet.** The DDS case manager submits the necessary information to LOCEU for medical determination and a disability decision if needed.

(4) **County notification.** LOCEU notifies the county and DDS case manager of determination by updating the MEDATS file.

(5) **Procedures for an individual returning home.** If referral is from a public ICF/MR for an individual returning to the home, the DDS case manager forwards to the worker the medical eligibility determination for HCBW/ID along with the latest application form and redetermination of eligibility form used to determine eligibility for institutional care. A new application will not be required. A case number will be assigned retaining the application date, certification date and redetermination of eligibility date.

(6) **Determination of continued eligibility for HCBW/ID.** The case manager is responsible for assuring that the individual's needs are re-evaluated and that recertification is established annually. Determination of continued medical eligibility is not necessary unless there is a significant change in the client's condition. The DDS cases manager will notify LOCEU if this is the case.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 17 Ok Reg 2410, eff 6-26-00 ; Amended at 29 Ok Reg 1162, eff 6-25-12]

317:35-9-50. Determination of medical eligibility for persons age 65 or older in mental health hospitals

Medical eligibility is determined based on residence in a mental health hospital due to the need for care and treatment provided under the direction of a physician in an institution for mental diseases. Visits are made to the mental health hospital by OHCA staff. Patients' charts are reviewed to determine if continued institutional care is appropriate and the medical records are maintained in accordance with federal regulations. A worksheet is completed on each case showing the findings of the reviews. The worksheets are maintained in the OHCA.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95]

317:35-9-51. Change in level of long-term medical care [REVOKED]

[Source: Added at 12 Ok Reg 753, eff 1-6-95 (emergency); Added at 12 Ok Reg 1935, eff 5-22-95 (emergency); Added at 14 Ok Reg 56, eff 4-30-96 (emergency); Added at 13 Ok Reg 2537, eff 6-27-96 ; Amended at 14 Ok Reg 1802, eff 5-27-97 ; Revoked at 17 Ok Reg 2410, eff 6-26-00]

317:35-9-52. Determination of medical eligibility for the ADvantage waiver [REVOKED]

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Revoked at 14 Ok Reg 56, eff 4-30-96 (emergency); Revoked at 14 Ok Reg 1802, eff 5-27-97]

PART 7. DETERMINATION OF FINANCIAL ELIGIBILITY

317:35-9-65. General financial eligibility requirements for ICF/MR, HCBW/MR, and individuals age 65 or older in mental health hospitals

Financial eligibility for these types of long-term medical care is determined using the rules on income and resources according to OAC 317:35-7-36.

- (1) Income, resources and expenses are evaluated on a monthly basis for all individuals requesting payment for long-term medical care.
- (2) To be eligible for long-term care in an ICF/MR (private and public), HCBW/MR services and for persons 65 years or older in mental health hospitals, the individual must be determined categorically needy.
- (3) If the individual's gross income exceeds the categorically needy standard as shown on OKDHS Form 08AX001E, Schedule VIII. B. 1., refer to OAC 317:35-5-41.6(a)(6)(B) for rules on establishing a Medicaid Income Pension Trust.
- (4) When eligibility for long-term care has been determined, the vendor payment amount, if applicable, is determined based on type of care, community spouse, etc. Individuals determined eligible for HCBW/MR services will not have a vendor payment.
- (5) The vendor payment is applied to the first claim(s) received on behalf of the individual.

(6) For an individual eligible for long-term care in an ICF/MR (private and public) or for an individual 65 years or older in a mental health hospital, the vendor payment is not prorated over the month. As SoonerCare is the payer of last resort, the full amount of the vendor payment must first be applied to the facility's charges before SoonerCare reimbursement begins.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 17 Ok Reg 2410, eff 6-26-00 ; Amended at 19 Ok Reg 76, eff 9-20-01 (emergency); Amended at 19 Ok Reg 1071, eff 5-13-02 ; Amended at 25 Ok Reg 130, eff 8-1-07 (emergency); Amended at 25 Ok Reg 1257, eff 5-25-08 ; Amended at 26 Ok Reg 2132, eff 6-25-09]

317:35-9-66. Determining financial eligibility for ADvantage waiver [REVOKED]

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Revoked at 14 Ok Reg 56, eff 4-30-96 (emergency); Revoked at 14 Ok Reg 1802, eff 5-27-97]

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

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

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

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

(A) The categorically needy standard on OKDHS Appendix C-1, Schedule VI, is applicable for individuals related to ABD. If the individual is in an ICF/MR and has received services for 30 days or longer, the categorically needy standard in OKDHS Appendix C-1, Schedule VIII. B., is used. If the individual leaves the facility prior to the 30 days, or does not require services past the 30 days, the categorically needy standard on OKDHS Appendix C-1, Schedule VI, is used. The rules on determination of income

and resources are applicable only when an individual has entered an ICF/MR and is likely to remain under care for 30 consecutive days. The 30-day requirement is considered to have been met even if it is interrupted by a hospital stay or the individual is deceased before the 30-day period ends [Refer to OAC 317:35-9-68 (a)(3)(B)(x)]. An individual who is a patient in an extended care facility may have SSI continued for a three month period if he/she meets conditions described in Subchapter 5 of this Chapter. The continuation of the payments is intended for use of the member and does not affect the vendor payment. If the institutional stay exceeds the three month period, SSI will make the appropriate change.

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

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

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

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

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

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

(I) the spouse;

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

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

to the nursing facility; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(D) The penalty period consists of a period of ineligibility (whole number of months dropping any leftover portion) determined by dividing the total uncompensated value of the asset by the average monthly cost to a private patient in a nursing facility in Oklahoma. There is no limit to the length of the penalty period for these transfers.

Uncompensated value is defined as the difference between the fair market value at the time of transfer less encumbrances and the amount received for the resource.

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

- (i) by the individual or such individual's spouse;
- (ii) by a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or such individual's spouse;
- or
- (iii) by any person, including any court or administrative body acting at the direction or upon the request of the individual or such individual's spouse.

(F) A penalty would not apply if:

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

- (I) the spouse;
- (II) the individual's child under age 21 or who is blind or totally disabled as determined by Social Security;
- (III) a sibling who has equity interest in the home and resided in the home for at least one year prior to the institutionalization of the individual; or
- (IV) the individual's son or daughter who resided in the home and provided care for

at least two years immediately prior to the individual's institutionalization;

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

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

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

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

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

(vii) the denial would result in undue hardship.

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

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

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

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

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

services for a period of asset ineligibility.

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

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

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

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

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

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

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

(ii) the date on which the individual is:

(I) eligible for medical assistance; and

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

(D) The penalty period:

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

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

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

(E) The penalty period consists of a period of ineligibility determined by dividing the total uncompensated value of the asset by the average monthly cost to a private patient in a nursing facility in Oklahoma shown on OKDHS

Appendix C-1. In this calculation, the penalty must include a partial month disqualification based upon the relationship between that fractional amount and the average monthly cost to a private patient in a nursing facility in Oklahoma. There is no limit to the length of the penalty period for these transfers. Uncompensated value is defined as the difference between the fair market value at the time of transfer less encumbrances and the amount received for the resource.

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

- (i) by the individual or such individual's spouse;
- (ii) by a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or such individual's spouse;
- or
- (iii) by any person, including any court or administrative body acting at the direction or upon the request of the individual or such individual's spouse.

(G) Special Situations.

(i) Separate Maintenance or Divorce.

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

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

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

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

(ii) Inheritance from a spouse.

(I) Oklahoma law provides that a surviving spouse is entitled to a minimum portion of a

deceased spouse's probate estate. The amount depends on several factors.

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

(H) A penalty would not apply if:

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

(I) the spouse; or

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

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

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

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

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

(iv) the asset was transferred to the individual's child who is blind or totally disabled as determined

by Social Security. The transfer may be to a trust established for the benefit of the individual's child.
(v) the asset was transferred to or from the spouse (either community or institutionalized) or to another person for the sole benefit of the spouse if the assets are not subsequently transferred to still another person for less than fair market value.

"Sole benefit" means that the amount transferred will be used for the benefit of the spouse (either community or institutionalized) during his or her expected life.

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

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

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

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

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

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

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

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

(L) The restoration or commensurate return will not entitle the member to benefits for the period of time that the

asset remained transferred. An applicant cannot be certified for nursing care services or HCBW for a period of asset ineligibility.

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

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

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

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

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

[Source: Added at 12 Ok Reg 753, eff 1-6-95 (emergency); Added at 12 Ok Reg 1929, eff 5-22-95 (emergency); Added at 14 Ok Reg 56, eff 4-30-96 (emergency); Added at 13 Ok Reg 2537, eff 6-27-96 ; Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 15 Ok Reg 564, eff 9-18-97 (emergency); Amended at 15 Ok Reg 1554, eff 5-11-98 ; Amended at 17 Ok Reg 2410, eff 6-26-00 ; Amended at 19 Ok Reg 136, eff 9-1-01 (emergency); Amended at 19 Ok Reg 2149, eff 6-27-02 ; Amended at 24 Ok Reg 2135, eff 6-25-07 ; Amended at 25 Ok Reg 674, eff 12-18-07 (emergency); Amended at 25 Ok Reg 1227, eff 5-25-08 ; Amended at 30 Ok Reg 1209, eff 7-1-13 ; Amended at 31 Ok Reg 73, eff 9-24-13 (emergency); Amended at 31 Ok Reg 1720, eff 9-12-14 ; Amended at 35 Ok Reg 1481, eff 9-14-18]

317:35-9-68. Determining financial eligibility for care in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (public and private), for HCBW/IID services, and for persons age sixty-five (65) or older in mental health hospitals

(a) **Determining financial eligibility for care in an ICF/IID.** Financial eligibility and spenddown for individuals in an ICF/IID is determined according to whether or not a spouse remains in the home.

(1) **Individual without a spouse.** For an individual without a spouse, the following rules are used to determine financial eligibility for ICF/IID care.

(A) **Income eligibility.** To determine the income of the individual without a spouse, the rules in (i) - (iii) of this subparagraph apply.

(i) If payment of income is made to the individual and another person(s), the income is considered in proportion to the individual's interest.

(ii) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

(iii) After determination of income, the gross income of the individual cannot exceed the categorically needy standard in Oklahoma Department of Human Services (OKDHS) Form 08AX001E (Appendix C-1), Schedule VIII. B. 1., to be eligible for ICF/IID services. If the individual's gross income exceeds this standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC 317:35-5-41.6(a)(6) (B)].

(B) **Resource eligibility.** In order for an individual without a spouse to be eligible for ICF/IID services, his/her countable resources cannot exceed the maximum resource standard listed in OKDHS Form 08AX001E (Appendix C-1), Schedule VIII. D.

(C) **Vendor payment.** When eligibility for ICF/IID services has been determined, the vendor payment is computed. For an individual eligible for long-term care in an ICF/IID, the individual's share of the vendor payment is not prorated over the month. As SoonerCare is the payer of last resort, the full amount of the member's share of the vendor payment must first be applied to the facility's charges before SoonerCare reimbursement begins. See (b) of this Section for calculation of the vendor payment after financial eligibility has been determined.

(D) **First month.** For the first month of care, the following procedures apply when determining the vendor payment:

(i) When an individual enters the facility on the first day of the month, all countable income is considered with the facility maintenance standard allowed.

(ii) When an individual enters the facility after the first day of the month, all countable income is considered with the own home standard allowed in computation of the vendor payment. Only the remaining income actually available is used to compute the vendor payment.

(E) **Equity in capital resources.** If the equity in capital resources is in excess of the standards, certification is delayed up to thirty (30) days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been

exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources, along with excess income to be considered against the vendor payment, are in excess of one (1) month's vendor payment, the application is denied.

(2) Individual with a spouse who is institutionalized in a NF or ICF/IID, or who receives ADvantage or HCBW/IID services, or is sixty-five (65) or over and in a mental health hospital. For an individual with a spouse who is institutionalized in a NF or ICF/IID, or who receives ADvantage or HCBW/IID services, or is sixty-five (65) or over and in a mental health hospital, resources are determined for each individual as the amount owned by each individual plus one-half of the jointly owned resources of the couple. Once this separation of assets is made, a resource of either spouse is not considered available to the other during institutionalization.

(A) Income eligibility. To determine income for an individual whose spouse is institutionalized in a NF or ICF/IID, or who receives ADvantage or HCBW/IID services, or is sixty-five (65) or over and in a mental health hospital, income determination is made individually. The income of either spouse is not considered as available to the other during institutionalization for determination of financial eligibility. See (b) of this Section for post-eligibility calculation of the vendor payment and the community spouse income allowance, if applicable. The rules in (i) - (v) of this subparagraph apply in this situation.

(i) If payment of income is made solely to one (1) or the other, the income is considered available only to that individual.

(ii) If payment of income is made to both, one-half is considered for each individual.

(iii) If payment of income is made to either one (1) or both and another person(s), the income is considered in proportion to either spouse's interest (if payment is to that spouse) or one-half of the joint interest if no interest is specified.

(iv) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

(v) After determination of income, the gross income of the individual cannot exceed the categorically needy standard in OKDHS Form 08AX001E (Appendix C-1), Schedule VIII. B. 1., to be eligible for ICF/IID care. If the individual's gross income exceeds this standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [Oklahoma Administrative Code (OAC) 317:35-5-41.6(a)(6)(B)].

(B) **Resource eligibility.** In order for an individual with a spouse who is institutionalized in a NF or ICF/IID, receives ADvantage or HCBW/IID services, or is sixty-five (65) or older and in a mental health hospital to be eligible for ICF/IID services, his/her countable resources cannot exceed the maximum resource standard for an individual listed in OKDHS Form 08AX001E (Appendix C-1), Schedule VIII. D.

(C) **Vendor payment.** When eligibility for ICF/IID services has been determined, the vendor payment is computed. For an individual eligible for long-term care in an ICF/IID, the individual's share of the vendor payment is not prorated over the month. As SoonerCare is the payer of last resort, the full amount of the member's share of the vendor payment must first be applied to the facility's charges before SoonerCare reimbursement begins. See (b) of this Section for calculation of the vendor payment after financial eligibility has been determined.

(D) **First month.** For the first month of care, the following procedures apply when determining the vendor payment:

(i) When an individual enters the facility on the first day of the month, all countable income is considered with the facility maintenance standard allowed.

(ii) When an individual enters the facility after the first day of the month, all countable income is considered with the own home standard allowed in computation of the vendor payment. Only the remaining income actually available is used to compute the vendor payment.

(E) **Equity in capital resources.** If the equity in capital resources is in excess of the standards, certification is delayed up to thirty (30) days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources, along with excess income to be considered against the vendor payment, are in excess of one (1) month's vendor payment, the application is denied.

(3) **Individual with a spouse remaining in the home who does not receive ADvantage or HCBW/IID services.** When an individual and spouse are separated due to the individual entering an ICF/IID, income and resources are determined separately. However, the income and resources of the community spouse must be included on the application form. At redetermination of eligibility, the community spouse's income must be included in the review process. During any month that the individual is in the ICF/IID, income of the community spouse is not considered available to that individual. The following rules are used to

determine the income and resources of each:

(A) **Income eligibility.** To determine the income of both spouses, the rules in this subparagraph apply:

(i) If payment of income is made solely to one (1) or the other, the income is considered available only to that individual.

(ii) If payment of income is made to both, one-half is considered for each individual.

(iii) If payment of income is made to either one (1) or both and another person(s), the income is considered in proportion to either the spouse's interest (if payment is to that spouse) or one-half of the joint interest if no interest is specified.

(iv) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

(v) If the individual's gross income exceeds the categorically needy standard as shown on OKDHS Form 08AX001E (Appendix C-1), Schedule VIII. B. 1., refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC 317:35-5-41.6(a)(6)(B)].

(B) **Resource eligibility.** To determine resource eligibility, it is necessary to determine the amount of resources for both spouses for the month of the individual's entry into the nursing facility. Of the resources available to the couple (both individual and joint ownership) an amount will be protected for the community spouse which will not be considered available to the spouse in the ICF/IID.

OKDHS Form 08MA011E, Assessment of Assets, is used for the assessment prior to application for SoonerCare. The amount determined as the spousal share is used for all subsequent applications for SoonerCare, regardless of changes in the couple's resources. The protected spousal share cannot be changed for any reason. When application for SoonerCare is made at the same time the individual enters the ICF/IID, OKDHS Form 08MA012E, Title XIX Worksheet, is used in lieu of OKDHS Form 08MA011E.

(i) The first step in the assessment process is to establish the total amount of resources for the couple during the first month of the entry of the spouse into the ICF/IID.

(ii) The community spouse's share is equal to one-half of the total resources of the couple not to exceed the maximum amount of resource value that can be protected for the community spouse, as shown on OKDHS Appendix C-1, Section XI.

(iii) The minimum resource standard for the community spouse is found on OKDHS Appendix C-1, Schedule XI. When the community spouse's share is less than the minimum standard, an

amount may be deemed from the other spouse's share to ensure the minimum resource standard for the community spouse. If the community spouse's share equals or exceeds the minimum resource standard, deeming cannot be done.

(iv) If deeming is necessary to meet the minimum resource standard for the community spouse, the amount that is deemed must be legally transferred to the community spouse within one (1) year of the effective date of certification for SoonerCare. At the first redetermination of eligibility, the worker must document that the resources have been transferred. After the first year of SoonerCare eligibility, resources of the community spouse will not be available to the other spouse and resources cannot be deemed to the community spouse.

(v) After the month in which the institutionalized spouse and community spouse have met the resource standards and the institutionalized spouse is determined eligible for benefits, no resources of the community spouse, regardless of value, will be considered available to the institutionalized spouse. If the resources of the community spouse grow to exceed the original deemed amount, the State cannot require the community spouse to apply any of these excess resources toward the cost of the care of the institutionalized spouse.

(vi) When determining eligibility for SoonerCare, the community spouse's share of resources is protected and the remainder considered available to the spouse in the ICF/IID.

(vii) The resources determined for the individual in the ICF/IID cannot exceed the maximum resource standard for an individual as shown in OKDHS Form 08AX001E (Appendix C-1), Schedule VIII. D.

(viii) Once the dollar value of the community spouse's share of resources is established for the month of the other spouse's entry into an ICF/IID, that amount is used when determining resource eligibility for a subsequent SoonerCare application for ICF/IID.

(ix) Once a determination of eligibility for SoonerCare is made, either spouse is entitled to a fair hearing. Any such hearing regarding the determination of the community spouse's resource allowance is held within thirty (30) days of the date of the request for the hearing. Either spouse is entitled to a fair hearing if dissatisfied with a determination of:

(I) The community spouse's monthly income allowance;

- (II) The amount of monthly income otherwise available to the community spouse;
- (III) Determination of the spousal share of resource;
- (IV) The attribution of resources (amount deemed); or
- (V) The determination of the community spouse's resource allowance.

(x) The rules on determination of income and resources are applicable only when an individual has entered an ICF/IID and is likely to remain under care for thirty (30) consecutive days. The thirty-day requirement is considered to have been met even if it is interrupted by a hospital stay or the individual is deceased before the thirty-day period ends.

(xi) The rules on resources included in this Section apply only to those cases in which an individual begins a continuous period of care in an ICF/IID on or after September 30, 1989.

(xii) If the individual was admitted prior to September 30, 1989, there is not a protected amount for the community spouse. Resources are separated according to spousal ownership with one-half of jointly owned resources counted for each. In this instance, each spouse's resources are considered separately and the resources of the community spouse does not affect the eligibility of the spouse in the ICF/IID.

(C) **Vendor payment.** After the institutionalized spouse has been determined eligible for long-term care, the vendor payment is computed. For an individual eligible for long-term care in an ICF/IID, the individual's share of the vendor payment is not prorated over the month. As SoonerCare is the payer of last resort, the full amount of the member's share of the vendor payment must first be applied to the facility's charges before SoonerCare reimbursement begins. See (b) of this Section for calculation of the vendor payment after financial eligibility has been determined.

(D) **Excess resources.** If the equity in capital resources is in excess of the standards but less than the amount of one (1) month's vendor payment, certification is delayed up to thirty (30) days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources, along with excess income to be considered against the vendor payment, are in excess of

the vendor payment, the application is denied.

(b) **Determination of the vendor payment for ICF/IID.** Calculation of the vendor payment after financial eligibility for care in an ICF/IID has been established is determined according to whether or not a spouse remains in the home. For the purpose of calculating the community spouse income allowance, spouses receiving ADvantage or HCBW/IID services are considered community spouses. The formula for determining the vendor payment for individuals without a spouse or other dependents is in accordance with OAC 317:35-19-21(b).

(c) **Determining financial eligibility for HCBW/IID.** For individuals determined eligible for HCBW/IID services, there is no vendor payment. Financial eligibility for HCBW/IID services for a single individual is determined the same as for ICF/IID services as outlined in paragraph (a) (1) of this Section with the exception of the vendor payment. Financial eligibility for HCBW/IID services for an individual with a spouse who is institutionalized in a NF or ICF/IID, or who receives ADvantage or HCBW/IID services, or is sixty-five (65) or over and in a mental health hospital is determined the same as for ICF/IID services as outlined in paragraph (a)(2) of this Section with the exception of the vendor payment. Financial eligibility for HCBW/IID services for an individual with a spouse in the home who does not receive ADvantage or HCBW/IID services is determined the same as for an individual with a community spouse according to paragraph (a)(3) of this Section. If the individual is a minor child who can be determined categorically needy and SSP eligible by considering the parent(s)' income and resources in the deeming process, the case is handled in the usual manner. If the child is not eligible for SSP only because of the deeming of parent(s)' income/resources, financial eligibility for HCBW/IID services is determined using only the child's income/resources and exempting the parent(s)' income and resources from the deeming process.

(d) **Determining financial eligibility for persons age sixty-five (65) years or older in mental health hospitals.** The eligibility determination for an individual age sixty-five (65) or older in a mental health hospital as categorically needy is the same as for any other person who is institutionalized. (Refer to subsection (a) in this Section.) The same procedure for determining excess income to be applied to the vendor payment as described in this Section is applicable.

[Source: Added at 12 Ok Reg 753, eff 7-14-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 13 Ok Reg 1211, eff 9-8-95 (emergency); Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 13 Ok Reg 2537, eff 6-27-96 ; Amended at 14 Ok Reg 546, eff 12-24-96 (emergency); Amended at 14 Ok Reg 1814, eff 5-27-97 ; Amended at 17 Ok Reg 2410, eff 6-26-00 ; Amended at 19 Ok Reg 76, eff 9-20-01 (emergency); Amended at 19 Ok Reg 1071, eff 5-13-02 ; Amended at 25 Ok Reg 130, eff 8-1-07 (emergency); Amended at 25 Ok Reg 1257, eff 5-25-08 ; Amended at 30 Ok Reg 1251, eff 7-1-13 ; Amended at 37 Ok Reg 1652, eff 9-14-20]

PART 9. CERTIFICATION, REDETERMINATION AND NOTIFICATION

317:35-9-75. Certification for long-term medical care through ICF/IID, HCBW/IID services and to persons age 65 and older in a

mental health hospital

(a) **Application date.** If the applicant is found eligible for SoonerCare, certification may be made retroactive for any service provided on or after the first day of the third month prior to the month of application and for future months. The first month of the certification period must be the first month that medical service was provided and the recipient was determined eligible.

(b) **Certification period for long-term medical care.** A certification period of twelve (12) months is assigned for an individual who is approved for long-term care.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 17 Ok Reg 2410, eff 6-26-00 ; Amended at 23 Ok Reg 268, eff 9-1-05 (emergency); Amended at 23 Ok Reg 1378, eff 5-25-06 ; Amended at 30 Ok Reg 1209, eff 7-1-13 ; Amended at 35 Ok Reg 27, eff 11-1-17 (emergency); Amended at 35 Ok Reg 1479, eff 9-14-18]

317:35-9-76. Redetermination of financial eligibility for long-term medical care

A redetermination of financial eligibility must be completed prior to the end of the certification period. A notice is generated only if there is a change which affects the client's financial responsibility.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 21 Ok Reg 2234, eff 6-25-04]

317:35-9-77. Case transfer between categories

If it becomes necessary to transfer a Medicaid long-term care case from one category to another because of change of age, income, or marital status, a new application is not required. If someone other than the client or guardian signed the original application form and the transfer is to a money payment case, an application with the client's signature is required. The new case is certified retaining the original certification date and redetermination date, using the appropriate code for transfer from the old category and the appropriate effective date which coincides with the closure of the previous case category. Recipients and appropriate medical providers are notified of the new case number and category by computer generated notice.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 17 Ok Reg 2410, eff 6-26-00]

317:35-9-78. Case changes

Any time there are changes which affect the long-term care case, computer generated notices are issued, if appropriate, based on the action taken.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97]

PART 11. PAYMENT, BILLING, AND OTHER ADMINISTRATIVE PROCEDURES

317:35-9-95. Payment to ICF/IID (public and private)

The Oklahoma Health Care Authority may execute agreements to provide care only with facilities which are properly licensed by the state licensing agency. The agreement is initiated by application from the facility and expires on a specified date, or with termination of the facility license, or shall be automatically terminated on notice to OHCA that the facility is not in compliance with Medicaid (or other federal long-term care) requirements.

(1) In the event that a facility changes ownership, the agreement with the previous owner may be extended to the new owner, pending certification of the new owner to provide care to individuals during the change of ownership. In the event that the new owner is not showing good faith in pursuit of certification, the OHCA will begin planning for alternate placement of Medicaid patients. The county office is immediately notified of any relevant change in facility status.

(2) Payment for long-term care is made only for those individuals who have been approved by the DHS for such care. The amount of payment is based on the actual time the individual received care (including therapeutic/hospital leave) from a nursing facility during any given month. Payment for nursing care cannot be made for any period during which the care has been temporarily interrupted for reasons other than therapeutic leave. Therapeutic leave is any planned leave other than hospitalization that is for the benefit of the patient. Therapeutic leave must be clearly documented in the patient's plan of care before payment for a reserved bed can be made by the OHCA. Hospital leave is planned or unplanned leave when the patient is admitted to a licensed hospital.

(3) A nursing facility may receive payment for up to 7 days per calendar year for each eligible individual in order to reserve a bed when the patient is on therapeutic leave.

(4) The ICF/IID may receive payment for a maximum of 60 days of therapeutic leave per calendar year for each recipient to reserve a bed. No more than 14 consecutive days of therapeutic leave may be claimed per absence. Recipients approved for ICF/IID on or after July 1 of the year will only be eligible for 30 days of therapeutic leave during the remainder of that year.

(5) The Statement of Compensable Therapeutic Leave Only form is used by the facility to record use of therapeutic leave. This form is to be made available by the local office to the nursing facility upon request.

(6) No payment shall be made for hospital leave.

(emergency); Amended at 13 Ok Reg 1677, eff 5-27-96 ; Amended at 17 Ok Reg 2410, eff 6-26-00 ; Amended at 33 Ok Reg 907, eff 9-1-16]

317:35-9-96. Non-Technical Medical Care providers; billing, training, and program administration [REVOKED]

[Source: Added at 12 Ok Reg 753, eff 1-6-95 (emergency); Added at 12 Ok Reg 1935, eff 5-22-95 (emergency); Added at 13 Ok Reg 2537, eff 6-27-96 ; Revoked at 17 Ok Reg 2410, eff 6-26-00]

317:35-9-97. Payment for Home and Community Based Waiver services for the Intellectually Disabled (HCBW/ID)

Payment is made to HCBW/ID providers who have been certified as eligible to provide such services by the DHS Developmental Disabilities Services Division (DDSD). Certification is made after the provider has completed required training or meets the State licensing requirements for that medical discipline. Each provider must enter into a contract to provide HCBW/ID services. Payment is made on a procedure-based reimbursement methodology for each service. All services must be preauthorized before payment can be made.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-2-97 ; Amended at 29 Ok Reg 1162, eff 6-25-12]

317:35-9-98. Payment to mental health hospitals

Payment is made to mental health hospitals who have contracts with the Oklahoma Health Care Authority to provide inpatient mental health services. Mental health hospitals must be certified by Medicare before they are eligible to enter into a contract with the OHCA.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95]

317:35-9-99. Billing procedures for ICF/MR, HCBW/MR services and services for individuals 65 older in a mental health hospital

Billing procedures for these services are contained in the OHCA Provider Manuals with procedures developed for each type of medical provider. Questions regarding billing procedures which cannot be resolved through a study of these manuals should be referred to the OHCA.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 9-27-95 ; Amended at 17 Ok Reg 2410, eff 6-26-00]

317:35-9-100. Management of client's funds while receiving care in NF, ICF/MR (public and private) or for persons age 65 or older in mental health hospitals

When an individual has been approved for long-term care in a facility, the administrator of the facility where he/she is receiving care completes the Management of Recipient's Funds form, and when applicable, the form is signed according to instructions on the form.

(1) If the recipient requests the administrator to hold the recipient's funds, the administrator of the facility completes the Management of Recipient's Funds form to acknowledge receipt of money and other items of value. As long as the recipient remains in the facility, the administrator is responsible for completing this form each time funds or other items of value, other than monthly income, are received. The form also serves to acknowledge the agreement to an accounting of funds expended in behalf of the recipient and as a source document for posting credits and debits to Form ABCDM-99, Ledger Sheet for Recipient's Account.

(2) The administrator of the facility prepares Form ABCDM-99 for each recipient for whom he/she is holding funds or other items of value. He/she is obligated to keep an accurate accounting of all receipts and expenditures and the amount of money on hand at all times. Form ABCDM-99 is to be available for inspection at all times.

(3) As a part of each redetermination of eligibility for a recipient for whom the administrator is holding funds or other items, the worker secures from the administrator a current Accounting Recipient's Personal Funds and Property form. This form is also prepared by the administrator of the facility when the recipient dies or leaves the facility for some other reason and is routed to the county office within five days from the last day the recipient was in residence.

(4) If the facility operator does not handle the recipient's funds, the worker is responsible for determining who does handle the funds, the amount of the funds and for recording this in the case narrative.

(5) If there is indication that, prior to the next regular determination of eligibility, the amount of the recipient's resources is likely to increase or decrease, he worker is responsible for taking the necessary action to assure continued eligibility on the part of the recipient.

(6) A copy of the Management of Recipient's Funds form must be on file in the local office for each recipient for whom Title XIX funds are being used for payment of care.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95]

317:35-9-101. 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 ICF/MR (public and private) under Medicaid. In Oklahoma, the State Department of Health is the agency responsible for surveying ICF/MRs to obtain information for use by the Federal Government in determining whether these facilities meet the standards required for participation as Title XVIII (Medicare) and Medicaid providers.

(1) Following its survey of each facility, the State Department of Health sends a copy of pertinent materials, showing its findings, to the OHCA, Contract Services/Service Contract Operations, who forwards pertinent materials to the DHS county office in the county where such facility is located.

(2) Each county office is responsible for permitting anyone, who requests permission to do so, to inspect and/or copy such findings, if this is done within the county office. Such request to see these materials may be specifically related to one provider or may be a request to see the available survey materials on all providers. The requests need not be made in writing and the person making the request need sign no document in order to obtain access to the materials. No one can be given permission to take any of these materials from the county office.

(3) These materials are to be filed in an administrative file. Only the material requested by the individual is made available to him/her. The county administrator is responsible for devising a plan for assuring that all such survey material made available to an individual is returned by him/her before he/she leaves the office.

(4) When a new survey report is received on a facility, the former survey report on that facility is to be destroyed. A permanent file of survey reports is maintained in the OHCA.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 17 Ok Reg 2410, eff 6-26-00]

317:35-9-102. Referral for social services

In many situations, social services are needed by adults who are receiving medical services through Medicaid. The LTC nurse may make referrals for social services to the worker in the local office by use of DHS Form K-13, Information/Referral Social Services. In addition to these referrals, a request for social services may be initiated by a client or by another individual acting upon behalf of a client.

(1) The worker is responsible for providing the indicated services or for referral to the appropriate resource outside the DHS if the services are not available within the DHS.

(2) Among the services provided by the worker are:

(A) Services which will enable individuals to attain and/or maintain as good physical and mental health as possible;

(B) Services to assist patients who are receiving care outside their own homes in planning for and returning to their own homes or to other alternate care;

(C) Services to encourage the development and maintenance of family and community interest and ties;

(D) Services to promote maximum independence in the management of their own affairs;

(E) Protective services, including evaluation of need for and arranging for guardianship; and

(F) Appropriate family planning services which include assisting the family in acquiring means to responsible

parenthood. Services are offered in making the necessary referral and follow-up.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 17 Ok Reg 2410, eff 6-26-00]

317:35-9-103. Special procedures for release of adults in mental health hospitals to long-term care facilities

(a) **Procedures.** Adult patients in state mental health hospitals being considered for release to long-term care facilities due to their physical conditions may be predetermined eligible for Medicaid.

(b) **Responsibility of mental hospitals.** The mental health hospital social and reimbursement staff works with the Social Security Administration to secure the approval for Supplemental Security Income (SSI) for individuals not currently eligible who may qualify for SSI. They will also assist the patient with the application for Medicaid medical services. By forwarding the completed Medical Assistance Application form and the Capital Resources Information form to the county office, the determination of financial eligibility by the DHS county worker can proceed at the same time that SSA is determining SSI eligibility. If the individual has other income (Social Security, VA, etc.) and does not qualify for SSI, the mental health hospital social and reimbursement staff evaluates the known resources. If the resources do not exceed the maximum as shown on the DHS Appendix C-1, Schedule VIII. D., individuals may be referred for a decision of eligibility for care in an intermediate care facility for the mentally retarded and, if necessary, categorical relationship. If the individual appears to meet the requirements as set out in this Subchapter, the mental health hospital social and reimbursement staff will submit a copy of the admitting history and physical progress notes, psychiatric examination and a physician's recommendation for a specific level of care, based on the individual's physical condition, to the Department of Mental Health and Substance Abuse Services, Central Office, Long-Term Care Division for review. If release to a long-term care facility appears appropriate, the medical information is submitted to LOCEU at the same time that the application forms are submitted to the county.

(c) **Responsibility of LOCEU.** The LOCEU reviews the hospital records, the social summary, the physician's recommendation for level of care as well as categorical relationship, if necessary. A Level II PASRR assessment is initiated by LOCEU at this point, if indicated. The MEDATS file is updated advising the DHS county office of LOCEU's decision.

(d) **Responsibility of the DHS county office.** The county office (in the county where the hospital is located) has the responsibility for the case number assignment, placing the case in application status and the subsequent determination of financial eligibility. The case is not certified until the patient enters an approved long-term care facility.

(1) Once the patient is determined financially and medically eligible a letter (including the assigned case number) is sent to the Department of Mental Health and Substance Abuse Services, Central Office, Long-Term Care Division.

(2) If the patient is determined to be ineligible, the denial is teleprocessed and a computer generated notice sent to the client or responsible person.

(e) **Release from mental health hospital to a long-term care facility.** After the hospital receives the letter from the county office with anticipated approval for Medicaid, the arrangements for release to the long-term care facility will proceed. The hospital will supply the long-term care facility with appropriate medical and social information and a copy of the DHS letter concerning the financial and medical eligibility.

(1) The long-term care facility, upon acceptance of the patient, forwards DHS form ABCDM-83, Notification Regarding Patient in a Nursing Facility, Intermediate Care Facility for the Mentally Retarded or Hospice (with the assigned case number) to the DHS county office where the long-term care facility is located.

(2) If the long-term care facility is in a different county than the hospital, the county of the facility requests the transfer of the case record. The certification is teleprocessed prior to the transfer of the case record.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 17 Ok Reg 2410, eff 6-26-00]

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

PART 1. GENERAL PROVISIONS

317:35-10-1. [RESERVED]

[Source: Reserved at 14 Ok Reg 2134, eff 4-2-97 (emergency); Reserved at 15 Ok Reg 1554, eff 5-11-98]

317:35-10-2. [RESERVED]

[Source: Reserved at 14 Ok Reg 2134, eff 4-2-97 (emergency); Reserved at 15 Ok Reg 1554, eff 5-11-98]

PART 3. RESOURCES

317:35-10-10. Capital resources

Capital resources are disregarded for individuals related to the children, parent and caretaker relative, former foster care children, SoonerPlan family planning program, expansion adults, or pregnancy eligibility groups, including pregnancies covered under Title XXI. Countable income generated from any resource is considered in accordance with Part 6 of Subchapter 6 of this Chapter.

[Source: Added at 14 Ok Reg 2134, eff 4-2-97 (emergency); Added at 15 Ok Reg 544, eff 12-1-97 (emergency); Added at 15 Ok Reg 1554, eff 5-11-98 ; Amended at 21 Ok Reg 2234, eff 6-25-04 ; Amended at 30 Ok Reg 1209, eff 7-1-13 ; Amended at 31 Ok Reg 73, eff 9-24-13 (emergency); Amended at 31 Ok

Reg 1720, eff 9-12-14 ; Amended at 35 Ok Reg 1481, eff 9-14-18 ; Amended at 38 Ok Reg 799, eff 7-1-21 (emergency); Amended at 39 Ok Reg 1544, eff 9-12-22]

317:35-10-11. Home property [TERMINATED]

[Source: Added at 14 Ok Reg 2134, eff 4-2-97 (emergency); Terminated at 15 Ok Reg 544, eff 12-1-97 (emergency)]

317:35-10-12. Real property other than home property [TERMINATED]

[Source: Added at 14 Ok Reg 2134, eff 4-2-97 (emergency); Terminated at 15 Ok Reg 544, eff 12-1-97 (emergency)]

317:35-10-13. Personal property [TERMINATED]

[Source: Added at 14 Ok Reg 2134, eff 4-2-97 (emergency); Terminated at 15 Ok Reg 544, eff 12-1-97 (emergency)]

317:35-10-14. Trust accounts [TERMINATED]

[Source: Added at 14 Ok Reg 2134, eff 4-2-97 (emergency); Terminated at 15 Ok Reg 544, eff 12-1-97 (emergency)]

317:35-10-15. Transfer or disposal of capital resources [TERMINATED]

[Source: Added at 14 Ok Reg 2134, eff 4-2-97 (emergency); Terminated at 15 Ok Reg 544, eff 12-1-97 (emergency)]

317:35-10-16. Resources acquired while receiving assistance [TERMINATED]

[Source: Added at 14 Ok Reg 2134, eff 4-2-97 (emergency); Terminated at 15 Ok Reg 544, eff 12-1-97 (emergency)]

317:35-10-17. Family relations as a resource [TERMINATED]

[Source: Added at 14 Ok Reg 2134, eff 4-2-97 (emergency); Terminated at 15 Ok Reg 544, eff 12-1-97 (emergency)]

317:35-10-18. Maximum reserve [TERMINATED]

[Source: Added at 14 Ok Reg 2134, eff 4-2-97 (emergency); Terminated at 15 Ok Reg 544, eff 12-1-97 (emergency)]

PART 5. INCOME

317:35-10-25. Income defined

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

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

[Source: Added at 14 Ok Reg 2134, eff 4-2-97 (emergency); Added at 15 Ok Reg 1554, eff 5-11-98 ; Amended at 30 Ok Reg 1209, eff 7-1-13 ; Amended at 31 Ok Reg 73, eff 9-24-13 (emergency); Amended at 31 Ok Reg 1720, eff 9-12-14]

317:35-10-26. Income

(a) General provisions regarding income.

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

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

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

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

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

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

Consideration is not given to an SSI recipient's income in computing eligibility for the AFDC or Pregnancy related unit. The Modified Adjusted Gross Income (MAGI) methodology rules determine whose income is considered in a particular household for MAGI eligibility groups as defined in Oklahoma Administrative Code (OAC) 317:35-6-1.

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

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

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

(4) Monies received in a lump sum from any source are considered income in the month received, with the exception of certain lottery or gambling winnings as specified in OAC 317:35-6-55. Changing a resource from one form to another, such as converting personal property to cash, is not considered a lump sum payment. Exception: lump sum payments used to establish dedicated bank accounts by representative payees in order to receive and maintain retroactive SSI benefits for disabled/blind children under age eighteen (18) are excluded as income. The interest income generated from dedicated bank accounts is also excluded.

(A) Whether a source of income is countable for MAGI eligibility groups is determined in accordance with Part 6 of Subchapter 6 of this Chapter.

(B) Whether a source of income is countable is determined in accordance with Part 6 of Subchapter 6 of this Chapter.

(C) When a lump sum is received by a stepparent not included in the household size, only the stepparent's contribution is considered in accordance with the stepparent's liability policy. Income received by a stepparent is considered in accordance with MAGI

household and income counting rules.

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

(E) Recurring lump sum income received from any source for a period covering more than one (1) month, that is received in a lump sum recurrently (such as annual rentals from surface or minerals, Windfall Profits tax refund, etc.) is prorated over a period of time it is intended to cover, beginning with the month of receipt of a lump sum payment.

(F) Net income from oil and gas production (gross minus production taxes withheld), received in varying amounts on a regular or irregular basis for the past six (6) months, will be averaged and considered as income for the next six (6) months. In instances where an applicant or a member receives new income from oil and gas production and verification for the past six (6) months is not available, the worker accepts the available verification and averages over the period of time intended to cover. Net income may be verified by seeing the individual's production check stub, or by contacting the oil and gas company. Whether a source of income is countable is determined in accordance with Part 6 of Subchapter 6 of this Chapter.

(5) Income that is based on the number of hours worked, as opposed to income based on regular monthly wages, must be computed as irregular income. The income received irregularly or in varying amounts will be averaged using the past two (2) months to establish the amount to be anticipated and considered for prospective budgeting.

(6) MAGI household rules are used to determine whether a caretaker relative or stepparent is included in a household.

(A) MAGI household and income counting rules are used to determine whether a caretaker relative and his/her spouse or a stepparent are included in the household and whether their income is considered for the children.

(B) MAGI household and income counting rules are used to determine whose income is considered and whether that income is counted. If an individual is eligible in the parent or caretaker relative group, his/her spouse, if living with him/her, is also related to the parent or caretaker relative group.

(7) A stepparent, if living with the parent or caretaker relative, can also be related to the parent or caretaker relative group, regardless of whether the parent is incapacitated or not in the home.

(8) MAGI household and income counting rules are used to determine whose income is considered and whether that income is counted.

(b) **Earned income.** The term "earned income" refers to monies earned by an individual through the receipt of wages, salary, commission or profit from activities in which the individual is engaged as self-employed or as an employee. Whether income is countable for MAGI eligibility groups is determined using MAGI income counting rules in Part 6 of Subchapter 6 of this Chapter.

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

(2) **Earned income from wages, salary or commission.** Countable income for MAGI eligibility groups is determined in accordance with MAGI income counting rules in Part 6 of Subchapter 6 of this Chapter.

(3) **Earned income from work and training programs.** Countable income for MAGI eligibility groups is determined in accordance with MAGI income counting rules in Part 6 of Subchapter 6 of this Chapter.

(4) **No individual earned income exemptions.** No earned income exemptions are subtracted to determine countable income for MAGI eligibility groups. The only deduction applied to determine net countable income under the MAGI methodology is the deduction of five percent (5%) of the Federal Poverty Level (FPL) for the individual's household size as defined in OAC 317:35-6-39.

(5) **Formula for determining the individual's net earned income for MAGI eligibility groups.** To determine net income, see MAGI rules in OAC 317:35-6-39.

(c) **Unearned income.** Countable earned and unearned income for MAGI eligibility groups is determined in accordance with MAGI income counting rules in Part 6 of Subchapter 6 of this Chapter.

(d) **Income disregards.** For MAGI eligibility groups, whether a source of income is disregarded is determined in accordance with MAGI income counting rules in Part 6 of Subchapter 6 of this Chapter.

(e) **Computing monthly income.** In computing monthly income, cents will be rounded down at each step. Income which is received monthly but in irregular amounts is averaged using two (2) month's income, if possible, to determine income eligibility. Less than two (2) month's income may be used when circumstances (e.g., new employment, unpaid sick leave, etc.) would indicate that previous income amounts would not be appropriate to use in determining future income amounts. Income received more often than monthly is converted to monthly amounts as follows:

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

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

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

(4) **Biweekly.** Income received every two (2) weeks is multiplied by 2.15.

[Source: Added at 14 Ok Reg 2134, eff 4-2-97 (emergency); Added at 15 Ok Reg 1554, eff 5-11-98 ; Amended at 16 Ok Reg 708, eff 1-1-99 (emergency); Amended at 16 Ok Reg 1438, eff 5-27-99 ; Amended at 20 Ok Reg 2775, eff 7-1-03 (emergency); Amended at 21 Ok Reg 2234, eff 6-25-04 ; Amended at 24 Ok Reg 694, eff 2-1-07 (emergency); Amended at 24 Ok Reg 2153, eff 6-25-07 ; Amended at 26 Ok Reg 1768, eff 7-1-09 (emergency); Amended at 27 Ok Reg 114, eff 10-2-09 (emergency); Amended at 27 Ok Reg 1481, eff 6-11-10 ; Amended at 28 Ok Reg 266, eff 11-15-10 (emergency); Amended at 28 Ok Reg 1515, eff 6-25-11 ; Amended at 30 Ok Reg 1209, eff 7-1-13 ; Amended at 31 Ok Reg 73, eff 9-24-13 (emergency); Amended at 31 Ok Reg 1720, eff 9-12-14 ; Amended at 35 Ok Reg 1481, eff 9-14-18 ; Added at 38 Ok Reg 799, eff 7-1-21 (emergency); Added at 39 Ok Reg 1544, eff 9-12-22 ; Amended at 39 Ok Reg 1544, eff 9-12-22]

317:35-10-27. Gross income maximum [REVOKED]

[Source: Added at 14 Ok Reg 2134, eff 4-2-97 (emergency); Added at 15 Ok Reg 1554, eff 5-11-98 ; Revoked at 16 Ok Reg 708, eff 1-1-99 (emergency); Revoked at 16 Ok Reg 1438, eff 5-27-99]

317:35-10-28. Lump sum payments [REVOKED]

[Source: Added at 14 Ok Reg 2134, eff 4-2-97 (emergency); Added at 15 Ok Reg 1124, eff 1-6-98 (emergency); Added at 15 Ok Reg 1559, eff 5-11-98 ; Amended at 17 Ok Reg 721, eff 1-10-99 (emergency); Amended at 17 Ok Reg 1212, eff 5-11-00 ; Revoked at 21 Ok Reg 2234, eff 6-25-04]

317:35-10-29. Irregular income [REVOKED]

[Source: Added at 14 Ok Reg 2134, eff 4-2-97 (emergency); Added at 15 Ok Reg 1554, eff 5-11-98 ; Amended at 16 Ok Reg 708, eff 1-1-99 (emergency); Amended at 16 Ok Reg 1438, eff 5-27-99 ; Amended at 20 Ok Reg 2775, eff 7-1-03 (emergency); Revoked at 21 Ok Reg 2234, eff 6-25-04]

317:35-10-30. Consideration of income of a relative-payee other than a natural or adoptive parent [REVOKED]

[Source: Added at 14 Ok Reg 2134, eff 4-2-97 (emergency); Added at 15 Ok Reg 1554, eff 5-11-98 ; Amended at 16 Ok Reg 708, eff 1-1-99 (emergency); Amended at 16 Ok Reg 1438, eff 5-27-99 ; Revoked at 21 Ok Reg 2234, eff 6-25-04]

317:35-10-31. Earned income [REVOKED]

[Source: Added at 14 Ok Reg 2134, eff 4-2-97 (emergency); Added at 15 Ok Reg 1554, eff 5-11-98 ; Amended at 16 Ok Reg 708, eff 1-1-99 (emergency); Amended at 16 Ok Reg 1438, eff 5-27-99 ; Amended at 20 Ok Reg 2775, eff 7-1-03 (emergency); Revoked at 21 Ok Reg 2234, eff 6-25-04]

317:35-10-32. Determination of earned income [REVOKED]

[Source: Added at 14 Ok Reg 2134, eff 4-2-97 (emergency); Added at 15 Ok Reg 1554, eff 5-11-98 ; Amended at 16 Ok Reg 708, eff 1-1-99 (emergency); Amended at 16 Ok Reg 1438, eff 5-27-99 ; Revoked at 21 Ok Reg 2234, eff 6-25-04]

317:35-10-33. Individual Earned income exemptions [REVOKED]

[Source: Added at 14 Ok Reg 2408, eff 4-2-97 (emergency); Added at 15 Ok Reg 1554, eff 5-11-98 ; Amended at 16 Ok Reg 708, eff 1-1-99 (emergency); Amended at 16 Ok Reg 1438, eff 5-27-99 ; Revoked at 21 Ok Reg 2234, eff 6-25-04]

317:35-10-34. Conditions under which exemptions are not allowed [REVOKED]

[Source: Added at 14 Ok Reg 2134, eff 4-2-97 (emergency); Added at 15 Ok Reg 1554, eff 5-11-98 ; Revoked at 16 Ok Reg 708, eff 1-1-99 (emergency); Revoked at 16 Ok Reg 1438, eff 5-27-99]

317:35-10-35. Formula for determining the individual's net earned income [REVOKED]

[Source: Added at 14 Ok Reg 2134, eff 4-2-97 (emergency); Added at 15 Ok Reg 1554, eff 5-11-98 ; Amended at 16 Ok Reg 708, eff 1-1-99 (emergency); Amended at 16 Ok Reg 1438, eff 5-27-99 ; Revoked at 21 Ok Reg 2234, eff 6-25-04]

317:35-10-36. Income other than earned income [REVOKED]

[Source: Added at 14 Ok Reg 2134, eff 4-2-97 (emergency); Added at 15 Ok Reg 1554, eff 5-11-98 ; Amended at 16 Ok Reg 708, eff 1-1-99 (emergency); Amended at 16 Ok Reg 1438, eff 5-27-99 ; Revoked at 21 Ok Reg 2234, eff 6-25-04]

317:35-10-37. Income disregards [REVOKED]

[Source: Added at 14 Ok Reg 2134, eff 4-2-97 (emergency); Added at 15 Ok Reg 1554, eff 5-11-98 ; Amended at 16 Ok Reg 708, eff 1-1-99 (emergency); Amended at 16 Ok Reg 1438, eff 5-27-99 ; Revoked at 21 Ok Reg 2234, eff 6-25-04]

317:35-10-38. Temporary absence from the home.

An individual who is temporarily absent from the home for the purpose of receiving training or education for employment, certain medical services, etc., may be considered part of the benefit group.

- (1) Individuals temporarily absent from the home, receiving training or education for employment are considered part of the benefit group during the period of time the training or educational activities are taking place.
- (2) Children temporarily absent from the home to attend boarding school are considered part of the benefit group during the school term.
- (3) Individuals temporarily absent from the home because of entrance into a private facility for counseling, rehabilitation, behavioral problems or special training, etc., are considered part of the benefit group. If care is projected for a period exceeding 90 days, the absence is not considered temporary. At any time an absence is determined as not temporary or no longer temporary, the needs of the individual cannot be included in the benefit group.
- (4) Individuals temporarily absent from the home for medical services, other than institutionalization for treatment of mental illness, intellectual disability, or tuberculosis, are considered part of the benefit group for up to six months. Six-month extensions may be allowed when the worker's verification indicates the individual may return to the home within the next six months.

[Source: Added at 21 Ok Reg 2525, eff 7-11-05 ; Amended at 29 Ok Reg 1162, eff 6-25-12]

PART 7. BUDGETING AND ASSISTANCE PAYMENTS

317:35-10-55. Structure of the assistance unit [REVOKED]

[Source: Added at 14 Ok Reg 2134, eff 4-2-97 (emergency); Added at 15 Ok Reg 1554, eff 5-11-98 ; Revoked at 21 Ok Reg 2234, eff 6-25-04]

317:35-10-56. Special considerations in budgeting [REVOKED]

[Source: Added at 14 Ok Reg 2408, eff 4-2-98 (emergency); Added at 15 Ok Reg 1554, eff 5-11-98 ; Revoked at 21 Ok Reg 2234, eff 6-25-04]

317:35-10-57. Income determination procedures [REVOKED]

[Source: Added at 14 Ok Reg 2134, eff 4-2-97 (emergency); Added at 15 Ok Reg 1554, eff 5-11-98 ; Revoked at 21 Ok Reg 2234, eff 6-25-04]

317:35-10-58. Budgeting [REVOKED]

[Source: Added at 14 Ok Reg 2134, eff 4-2-97 (emergency); Added at 15 Ok Reg 1554, eff 5-11-98 ; Revoked at 21 Ok Reg 2234, eff 6-25-04]

PART 9. CONDITIONS OF ELIGIBILITY-AGE AND RESIDENCE

317:35-10-65. Age [REVOKED]

[Source: Added at 14 Ok Reg 2134, eff 4-2-97 (emergency); Added at 15 Ok Reg 1554, eff 5-11-98 ; Revoked at 21 Ok Reg 2234, eff 6-25-04]

317:35-10-66. Residence [REVOKED]

[Source: Added at 14 Ok Reg 2134, eff 4-2-97 (emergency); Added at 15 Ok Reg 1554, eff 5-26-98 ; Revoked at 21 Ok Reg 2234, eff 6-25-04]

317:35-10-67. Homeless individuals [REVOKED]

[Source: Added at 14 Ok Reg 2134, eff 4-2-97 (emergency); Added at 15 Ok Reg 1554, eff 5-11-98 ; Revoked at 21 Ok Reg 2234, eff 6-25-04]

317:35-10-68. Institutional residence [REVOKED]

[Source: Added at 14 Ok Reg 2134, eff 4-2-97 (emergency); Added at 15 Ok Reg 1554, eff 5-11-98 ; Revoked at 21 Ok Reg 2234, eff 6-25-04]

PART 11. CONDITIONS OF ELIGIBILITY- RELATIONSHIP OF PAYEE TO CHILD

317:35-10-75. Relationship of payee to child [REVOKED]

[Source: Added at 14 Ok Reg 2134, eff 4-2-97 (emergency); Added at 15 Ok Reg 1554, eff 5-11-98 ; Revoked at 21 Ok Reg 2234, eff 6-25-04]

317:35-10-76. Definition of "living with a relative" [REVOKED]

[Source: Added at 14 Ok Reg 2134, eff 4-2-97 (emergency); Added at 15 Ok Reg 1554, eff 5-11-98 ; Revoked at 21 Ok Reg 2234, eff 6-25-04]

317:35-10-77. Verification of relationship [REVOKED]

[Source: Added at 14 Ok Reg 2134, eff 4-2-97 (emergency); Added at 15 Ok Reg 1554, eff 5-11-98 ; Revoked at 21 Ok Reg 2234, eff 6-25-04]

PART 13. CONDITIONS OF ELIGIBILITY-DEPRIVATION OF PARENTAL SUPPORT OR CARE BY A NATURAL OR ADOPTIVE PARENT

317:35-10-85. Deprivation of parental support or care by a natural or adoptive parent [REVOKED]

[Source: Added at 14 Ok Reg 2134, eff 4-2-97 (emergency); Added at 15 Ok Reg 1554, eff 5-11-98 ; Revoked at 21 Ok Reg 2234, eff 6-25-04]

317:35-10-86. Procedures for determining continued absence [REVOKED]

[Source: Added at 14 Ok Reg 2134, eff 4-2-97 (emergency); Added at 15 Ok Reg 1554, eff 5-11-98 ; Revoked at 21 Ok Reg 2234, eff 6-25-04]

317:35-10-87. Requirement for assignment of support rights and cooperation [REVOKED]

[Source: Added at 14 Ok Reg 2134, eff 4-2-97 (emergency); Added at 15 Ok Reg 1554, eff 5-11-98 ; Revoked at 21 Ok Reg 2234, eff 6-25-04]

317:35-10-88. Good cause [REVOKED]

[Source: Added at 14 Ok Reg 2134, eff 4-2-97 (emergency); Added at 15 Ok Reg 1554, eff 5-11-98 ; Revoked at 21 Ok Reg 2234, eff 6-25-04]

317:35-10-89. DHS responsibilities in relation to support payments [REVOKED]

[Source: Added at 14 Ok Reg 2134, eff 4-2-97 (emergency); Added at 15 Ok Reg 1554, eff 5-11-98 ; Revoked at 21 Ok Reg 2234, eff 6-25-04]

317:35-10-90. Physical or mental incapacity of natural or adoptive parent [REVOKED]

[Source: Added at 14 Ok Reg 2134, eff 4-2-97 (emergency); Added at 15 Ok Reg 1554, eff 5-11-98 ; Revoked at 21 Ok Reg 2234, eff 6-25-04]

317:35-10-91. Transportation and subsistence necessary to determine incapacity [REVOKED]

[Source: Added at 14 Ok Reg 2134, eff 4-2-97 (emergency); Added at 15 Ok Reg 1554, eff 5-11-98 ; Amended at 18 Ok Reg 2587, eff 6-25-01 ; Revoked at 21 Ok Reg 2234, eff 6-25-04]

317:35-10-92. Determination of incapacity at specified times other than at time of application [REVOKED]

[Source: Added at 14 Ok Reg 2134, eff 4-2-97 (emergency); Added at 15 Ok Reg 1554, eff 5-11-98 ; Revoked at 21 Ok Reg 2234, eff 6-25-04]

317:35-10-93. Need for physical restoration and/or training [REVOKED]

[Source: Added at 14 Ok Reg 2134, eff 4-2-97 (emergency); Added at 15 Ok Reg 1554, eff 5-11-98 ; Revoked at 18 Ok Reg 2587, eff 6-25-01]

317:35-10-94. Notification of denial or closure [REVOKED]

[Source: Added at 14 Ok Reg 2134, eff 4-2-97 (emergency); Added at 15 Ok Reg 1554, eff 5-11-98 ; Revoked at 21 Ok Reg 2234, eff 6-25-04]

317:35-10-95. Unemployed parent [REVOKED]

[Source: Added at 14 Ok Reg 2134, eff 4-2-97 (emergency); Added at 15 Ok Reg 1554, eff 5-11-98 ; Revoked at 21 Ok Reg 2234, eff 6-25-04]

PART 15. CONDITIONS OF ELIGIBILITY-SCHOOL ATTENDANCE

317:35-10-100. School attendance [REVOKED]

[Source: Added at 14 Ok Reg 2134, eff 4-2-97 (emergency); Added at 15 Ok Reg 1554, eff 5-11-98 ; Revoked at 17 Ok Reg 2410, eff 6-26-00]

PART 17. CONDITIONS OF ELIGIBILITY - ALIENAGE

317:35-10-105. Requirements [TERMINATED]

[Source: Added at 4 Ok Reg 2134, eff 4-2-97 (emergency); Terminated at 15 Ok Reg 557, eff 11-5-97 (emergency)]

317:35-10-106. Citizenship [TERMINATED]

[Source: Added at 14 Ok Reg 2134, eff 4-2-97 (emergency); Terminated at 15 Ok Reg 557, eff 11-5-97 (emergency)]

317:35-10-107. Alienage [TERMINATED]

[Source: Added at 14 Ok Reg 2134, eff 4-2-97 (emergency); Terminated at 15 Ok Reg 557, eff 11-5-97 (emergency)]

317:35-10-108. Immigrants [TERMINATED]

[Source: Added at 14 Ok Reg 2134, eff 4-2-97 (emergency); Terminated at 15 Ok Reg 557, eff 11-5-97 (emergency)]

317:35-10-109. Permanent residence under color of law (PRUCOL) [TERMINATED]

[Source: Added at 14 Ok Reg 2134, eff 4-2-97 (emergency); Terminated at 15 Ok Reg 557, eff 11-5-97 (emergency)]

317:35-10-110. Parolees [TERMINATED]

[Source: Added at 14 Ok Reg 2134, eff 4-2-97 (emergency); Terminated at 15 Ok Reg 557, eff 11-5-97 (emergency)]

317:35-10-111. Refugees [TERMINATED]

[Source: Added at 14 Ok Reg 2134, eff 4-2-97 (emergency); Terminated at 15 Ok Reg 557, eff 11-5-97 (emergency)]

317:35-10-112. Conditioned entries of aliens made available by the Attorney General of the United States for emergent reasons deemed strictly in the public interest [TERMINATED]

[Source: Added at 14 Ok Reg 2134, eff 4-2-97 (emergency); Terminated at 15 Ok Reg 557, eff 11-5-97 (emergency)]

317:35-10-113. Special provisions relating to Kickapoo Indians [TERMINATED]

[Source: Added at 14 Ok Reg 2134, eff 4-2-97 (emergency); Terminated at 15 Ok Reg 557, eff 11-5-97 (emergency)]

SUBCHAPTER 11. PROJECTS

317:35-11-1. Grants and local projects

(a) **Program development grants/contracts.** Periodically, as funds are available and based upon the programmatic needs of the Oklahoma Health Care Authority, OHCA announces a Request for Proposals (RFP) to offer grants/contracts for limited demonstrations of, or technical assistance in Medicaid programming.

(1) The design and development of the RFP's specifications will optimally meet the following cost containment and programmatic goals:

- (A) Medicaid cost containment.
- (B) Maximum services for dollars expended.
- (C) Maximum quality for dollars expended.
- (D) Minimize administrative costs.

(2) Proposals for limited demonstrations projects or models may generally be constrained by one or more of the following factors; recipient category type, specific facility type, specific Medicaid treatment protocols, geographic area, or by service delivery methodology, as determined appropriate to best accomplish the objectives and interest of the OHCA. Limited demonstration grants will allow the OHCA to study the feasibility of alternative medical programming for the purposes of state-wide implementation. Notification of the OHCA's intention to request proposals will be announced in the "Oklahoma Register" and/or local newspapers and/or through invitations to bid. Notification will occur at least one month prior to the due date for proposals.

(b) **Selection process.** Each RFP will be evaluated by an RFP selection panel. The panel will consist of OHCA personnel, and when appropriate other DHS personnel, and/or OHCA consultants. Proposals will be scored by panel members. Objective scoring criteria to evaluate the merit of the RFP will be developed prior to the receipt of proposals. Scoring criteria will be weighted based upon those factors deemed essential for successful demonstration and evaluation of the RFP objective's. Where appropriate, part of the evaluation may include a site visit on all proposals scoring 80% or more. Organization, knowledge, and advanced planning, will be evaluated prior to OHCA recommendations for award of contracts.

(c) **Monitoring of grants/contracts awards.** Grants will be monitored by OHCA staff through one or more of the following methods; monthly claims, periodic site visits, audits, performance reports, and/or time tables for deliverables as specified in the grant.

(d) **Renewal of grants/contracts.** Grants/Contracts will be awarded on a 12 month basis, and must be renewed annually thereafter subject to availability of funding and a OHCA approved project budget. Grantees must submit the required application materials to the OHCA by a due date to be determined annually. Renewals will be awarded only when a grantee has met the previous year's contractual obligations as determined by monitoring throughout the year and the annual performance evaluation submitted to the OHCA Contracts Unit. Renewal contracts will not change the RFP scope other than those changes necessitated due to the availability of funds, or OHCA approved

modifications required to accomplish the objectives of the original agreement.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95]

317:35-11-2. Poison control services [REVOKED]

[Source: Added at 13 Ok Reg 49, eff 6-21-95 (emergency); Added at 13 Ok Reg 2537, eff 6-27-96 ; Revoked at 19 Ok Reg 136, eff 9-1-01 (emergency); Revoked at 19 Ok Reg 2149, eff 6-27-02]

SUBCHAPTER 13. MEMBER RIGHTS AND RESPONSIBILITIES

317:35-13-1. Civil rights

A person shall not be denied Title XIX or Title XXI benefits or be subjected to discrimination on grounds of race, color, national origin, sex, age or handicap.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 30 Ok Reg 1209, eff 7-1-13]

317:35-13-2. Courteous and prompt action

(a) **Courteous treatment.** It is the responsibility of the staff members of the Agency to be courteous and equitable in their dealings with all persons applying for and receiving medical services through the Medical Assistance program.

(b) **Prompt action.** Eligibility determination for Title XIX benefits is to be completed within 60 days of the date of application for persons related to the disabled group, and within 45 days of the date of application for individuals related to all other eligibility groups.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 30 Ok Reg 1209, eff 7-1-13]

317:35-13-3. Choice of providers

Any person requesting help with payment for medical services has free choice of providers who are willing to accept payment from the OHCA and are eligible to receive such payment.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95]

317:35-13-4. Release of medical information

When a SoonerCare member or an authorized representative of a member, applies for services, explicit consent is given for the OHCA to release information to applicable state or federal agencies, medical providers, or an OHCA designee when the information is needed to provide, monitor or approve medical services or obtain payment of those services. Additionally, a physician may release medical information to the

member or an authorized representative of the member upon written request. The physician, in such instance, would be governed by the physician-patient relationship.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 27 Ok Reg 307, eff 11-3-09 (emergency); Amended at 27 Ok Reg 971, eff 5-13-10]

317:35-13-5. Overpayments

(a) **Overpayments due to client error or county error.** When it appears a medical payment has been made in error because the individual failed to provide correct information or the county failed to obtain complete or correct information, the county worker prepares a written summary of facts relating to such payment and submits it to the DHS State Office, Attention Family Support Services Division (FSSD). FSSD will follow up appropriately in cooperation with the staff in the OHCA.

(b) **Overpayment due to State Office error, provider error or fiscal agent processing error.** When it is determined that an incorrect payment has been made due to OHCA error, provider error or fiscal agent processing error, the procedures for correcting the payment errors are:

- (1) When the OHCA determines an overpayment has been made, automatic offset recoupment procedures are processed through the claims processing contractor. This process is followed when the overpayment is discovered by the OHCA or the fiscal agent.
- (2) When the local office receives information a medical provider has been overpaid, a memo is sent to the OHCA, giving the source of the information and a summary of the situation. The overpayment is recovered by the automatic recoupment process through the fiscal agent.
- (3) When the medical provider discovers they have been overpaid, the provider has two options. The provider may voluntarily repay the amount to the OHCA. OHCA will process a correction through its claims processing system. If the provider does not voluntarily refund the amount, but notifies the OHCA, OHCA will initiate a recoupment request.

(c) **Restitution owed to the Agency.** Title XIX benefits are not denied any person because of a debt of restitution owed in any program.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95]

317:35-13-6. Fraud

Federal and State laws make it unlawful for persons to make any false statement or misrepresent facts to receive benefits or payments under the Medicaid Program. The worker, employed by the Department of Human Services, is responsible for ensuring each individual who applies for Medicaid is advised of the responsibilities to provide correct information and to report changes in circumstances which may affect his/her eligibility for Medicaid benefits. As each new provider or supplier

of medical services is approved, a letter is mailed to him/her from the OHCA advising of the penalties for misrepresentation of fact on claims for Medicaid benefits. When a local office obtains information indicating possible fraud or abuse by a provider, supplier of medical services, or a recipient, a memorandum explaining the circumstances is forwarded to the OHCA Legal Division. This office has the responsibility for any required action on this type of complaint and appropriate referral of the complaint.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 20 Ok Reg 2797, eff 5-26-03 (emergency); Amended at 21 Ok Reg 1324, eff 5-27-04]

317:35-13-7. Program Abuse and Administrative Sanctions

(a) **Definitions.** The following words and terms, when used in this Section, shall have the following meaning, unless the context clearly indicates otherwise.

- (1) "Abuse" means member actions that defraud the Oklahoma Health Care Authority (OHCA), cause unnecessary medical expenses to the program or over-utilize services provided by the OHCA. It shall also mean causing unnecessary or excessive claims to be submitted to the OHCA.
- (2) "Conviction" or "Convicted" means a judgment of conviction has been entered by a Federal, State or local court, regardless of whether an appeal from that judgment is pending.
- (3) "Exclusion" means not being able to be certified for Medicaid benefits under the State Plan or Waivered services in Oklahoma.
- (4) "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.
- (5) "Knowingly" means that a person, with respect to information:
 - (A) has actual knowledge of the information;
 - (B) acts in deliberate ignorance of the truth or falsity of the information; or
 - (C) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.
- (6) "Medical Services Providers" means:
 - (A) "Practitioner" means a physician or other individual licensed under State law to practice his or her profession or a physician who meets all requirements for employment by the Federal Government as a physician and is employed by the Federal Government in an IHS facility or affiliated with a 638 Tribal facility.
 - (B) "Supplier" means an individual or entity, other than a provider or practitioner, who furnishes health care services under Medicaid or other medical services programs administered by the OHCA.
 - (C) "Provider" means:

(i) a hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, or a hospice that has in effect an agreement to participate in Medicaid, or any other medical services program administered by the OHCA, or

(ii) a clinic, a rehabilitation agency, or a public health agency that has a similar agreement.

(D) "Laboratories" means any laboratory or place equipped for experimental study in science or for testing or analysis which has an agreement with the OHCA to receive Medicaid monies.

(E) "Pharmacy" means any pharmacy or place where medicines are compounded or dispensed or any pharmacist who has an agreement with OHCA to receive Medicaid monies for the dispensing of drugs.

(F) "Any other provider" means any provider who has an agreement with OHCA to deliver health services, medicines, or medical services for the receipt of Medicaid monies.

(7) "OIG" means the Office of Inspector General of the Department of Health and Human Services.

(8) "Member" means a beneficiary, patient or person served by the OHCA.

(9) "Sanctions" means any administrative decision by OHCA to suspend or exclude a member from the ability to be certified for medical assistance. A sanction may include a decision to use the remedy provided in OAC 317:30-3-14(b) or to require payment by the member of the service.

(10) "Suspension" means an administrative action to suspend temporarily the certification of a case for medical assistance.

(11) "Willfully" means proceeding from a conscious motion of the will; voluntary, intending the result which comes to pass; intentional.

(b) Basis for sanctions.

(1) The OHCA may sanction a member who has or has had a certified medical assistance case with OHCA for the following reasons:

(A) Knowingly or willfully made, or causing to be made, any false statement or misrepresentation of material fact to get a case certified or causing services to be rendered to the member;

(B) Caused or ordered services under Medicaid that are substantially in excess of the member's needs or that fail to meet professionally recognized standards for health care;

(C) Submitted or caused to be submitted to the Medicaid program, bills or requests for payment containing charges or costs that are substantially in excess of customary charges or costs; or

(D) Threatened harm to medical providers or state officials.

(2) The agency may base its determination that services are excessive or unnecessary based upon reports, including sanction reports, from any of the following sources:

- (A) The PRO for the area served by the provider or the PRO contracted by OHCA;
- (B) State or local law enforcement agencies and licensing or certification authorities;
- (C) Peer review committees of fiscal agents or contractors;
- (D) State or local professional societies;
- (E) Surveillance and Utilization Review Section Reports done by OHCA;
- (F) Medicaid Fraud Control Unit;
- (G) Other sources, including internal investigations, deemed appropriate by the Medicaid agency or the OIG.

(3) OHCA must suspend from the Medicaid program any member who has been suspended from participation in Medicare or Medicaid due to a conviction of a program related crime. This suspension must be at a minimum, the same period as the Medicare suspension.

(c) Procedures for imposing sanctions.

(1) Notice of proposed administrative sanction.

(A) If the OHCA proposes to sanction, it will send the member a written notice stating:

- (i) the reasons for the proposed sanction;
- (ii) the date upon which the sanction will be effective;
- (iii) the result of the sanction should it be imposed; and
- (iv) a statement that the member has a right to an evidentiary hearing prior to the imposition of the sanction.

(B) A copy of this section of the rules will be attached to the letter of proposed action.

(2) Notice of sanction.

(A) After an evidentiary hearing is conducted under OAC 317:2-1-2, the Agency will make a final administrative decision regarding the decision to sanction.

(B) Based upon its final decision, the Agency shall send a notice to the member that provides:

- (i) the reasons for the decision;
- (ii) the effective date of the sanction;
- (iii) the effect of the sanction on the party's participation in the Medicaid program;
- (iv) the member's right to request a reconsideration of the Agency's final decision;
- (v) the earliest date in which the Agency will accept a request for reinstatement;
- (vi) the requirements and procedures for reinstatement; and

(vii) instructions on how to ask for reconsideration.

(d) **Effect of sanction.** OHCA will advise its eligibility agent of the closure or suspension of the case and when the member can be recertified. The sanctions are as follows:

(1) For the first violation in which the agency finds a member has abused SoonerCare benefits or SoonerCare waiver benefits, the member's eligibility may be suspended for a period of up to 6 months.

(2) For the second violation in which the agency finds a member has abused SoonerCare benefits or SoonerCare waiver benefits, the member's eligibility may be suspended for a period of up to 12 months.

(3) For the third violation in which the agency finds a member has abused SoonerCare benefits or SoonerCare waiver benefits, the member's eligibility may be suspended indefinitely.

(4) All members' sanctions, including the length of the penalty period, are subject to administrative due process as described in this section.

(e) **Criteria for reinstatement.**

(1) Upon the request for reinstatement made by the member, OHCA may consider the following factors to reinstate the member;

(A) The number and nature of the program violations and other related offenses.

(B) The nature and extent of any adverse impact the violations have had on providers or other members;

(C) The amount of any damages;

(D) Any mitigating circumstances;

(E) Other facts bearing on the nature and seriousness of the program violations and related offenses;

(F) Convictions in a federal, state, or local court of other offenses related to participation in the Medicare or Medicaid program which were not considered during the development of the exclusion; and

(G) Whether the state or local licensing authorities have taken any adverse action against the party for offenses related to participation in the Medicare or Medicaid program which were not considered during the development of the exclusion.

(2) Regardless of the applicability of one or many of the factors in paragraph (1) of this subsection, reinstatement shall not be granted unless it is reasonably certain that the violation(s) that led to the exclusion will not be repeated.

[Source: Added at 20 Ok Reg 2797, eff 5-26-03 (emergency); Added at 21 Ok Reg 1324, eff 5-27-04 ; Amended at 29 Ok Reg 1169, eff 6-25-12]

SUBCHAPTER 15. STATE PLAN PERSONAL CARE SERVICES

317:35-15-1. Overview of long-term medical care services; relationship to Qualified Medicare Beneficiary Plus (QMBP), Specified Low-Income Medicare Beneficiary (SLMB), and other SoonerCare services and eligibility

- (a) Long-term medical care for the categorically needy includes:
- (1) Care in a nursing facility, per Oklahoma Administrative Code (OAC) 317:35-19;
 - (2) Public and private intermediate care facility for individuals with intellectual disabilities (ICF/IID), per OAC 317:35-9;
 - (3) Persons age sixty-five (65) years or older in mental health hospitals, per OAC 317:35-9;
 - (4) Home and Community-Based Waiver Services for the Intellectually Disabled, per OAC 317:35-9;
 - (5) Home and Community-Based Waiver Services for the ADvantage program, per OAC 317:35-17; and
 - (6) State Plan Personal Care services, per OAC 317:35-15.
- (b) State Plan Personal Care provides services in the member's own home. Any time an individual is certified as eligible for long-term care SoonerCare coverage, the member is also eligible for other SoonerCare services. Another application is not required. Any time an aged, blind, or disabled individual is determined eligible for long-term care, a separate determination is made to check if the member meets eligibility conditions as a QMBP or an SLMB. Another application for QMBP or SLMB benefits is not required.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 17 Ok Reg 2410, eff 6-26-00 ; Amended at 20 Ok Reg 1958, eff 6-26-03 ; Amended at 20 Ok Reg 2775, eff 7-1-03 (emergency); Amended at 21 Ok Reg 2234, eff 6-25-04 ; Amended at 26 Ok Reg 549, eff 2-1-09 (emergency); Amended at 26 Ok Reg 2140, eff 6-25-09 ; Amended at 29 Ok Reg 1162, eff 6-25-12 ; Amended at 32 Ok Reg 1142, eff 8-27-15 ; Amended at 39 Ok Reg 1577, eff 9-12-22]

317:35-15-2. State Plan Personal Care (SPPC) services

- (a) SPPC services assist a member in carrying out Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs) directly related to the member's personal care needs. SPPC services prevent or minimize physical health regression or deterioration. SPPC services require a skilled nursing assessment to:
- (1) Assess a member's needs;
 - (2) Develop a care plan to meet the member's identified personal care needs;
 - (3) Manage care plan oversight; and
 - (4) Periodically reassess and update the care plan when necessary.
- (b) SPPC services do not include technical services, such as:
- (1) Suctioning;
 - (2) Tracheal care;
 - (3) Gastrostomy-tube feeding or care;
 - (4) Specialized feeding due to choking risk;
 - (5) Applying compression stockings;
 - (6) Bladder catheterization;

- (7) Colostomy irrigation;
- (8) Wound care;
- (9) Applying prescription lotions or topical ointments;
- (10) Range of motion exercises; or
- (11) Operating equipment of technical nature, such as a patient lift or oxygen equipment.

(c) SPPC members may receive services in limited types of living arrangements as per (1) through (5) of this subsection.

(1) SPPC members are not eligible to receive services while residing in an institutional setting including, but not limited to:

(A) Licensed facilities, such as a:

- (i) Hospital;
- (ii) Nursing facility;
- (iii) Licensed residential care facility; or
- (iv) Licensed assisted living facility; or

(B) In an unlicensed institutional living arrangement, such as a room and board home or facility.

(2) SPPC is not approved when the member lives in the personal care assistant's (PCA) or the individual personal care assistant's (IPCA) home, except with Oklahoma Human Services (OKDHS) Medicaid Services Unit approval.

(3) Members may receive SPPC services in the member's own home, apartment, or a family member's or friend's home or apartment. A home or apartment unit is defined as a self-contained living space having a lockable entrance to the unit including a bathroom and food storage and preparation amenities in addition to bedroom and living space.

(4) For SPPC members who are full-time students, a dormitory room qualifies as an allowable living arrangement to receive SPPC services.

(5) With prior OKDHS Health Care Management Nurse III approval SPPC services may be provided in an educational or employment setting to assist the member to achieve vocational goals identified in the care plan.

(d) A member may employ an IPCA to provide SPPC services. An IPCA may provide SPPC services when he or she is employed by a home care agency, provided the home care agency is certified and contracted with the Oklahoma Health Care Authority (OHCA) to provide SPPC services. Before providing SPPC services, OKDHS determines whether the IPCA is qualified to provide personal care services and the IPCA is not identified as formal or informal support for member. Persons eligible to serve as either IPCAs or PCAs:

- (1) Are at least eighteen (18) years of age;
- (2) Have no pending notation related to abuse, neglect, or exploitation as reported by the Oklahoma State Department of Health Nurse Aide Registry;
- (3) Are not included in the OKDHS Community Services Worker Registry;
- (4) Are not convicted of a crime and do not have a criminal background history or registry listings that prohibit employment per Title 63 of the Oklahoma Statutes Section 1-1944 through 1-

948;

(5) Demonstrate the ability to understand and carry out assigned tasks;

(6) Are not a legally responsible family member of the member being served, such as a spouse, legal guardian, or a minor child's parent;

(7) Have a verifiable work history or personal references, and verifiable identification; and

(8) Meet any additional requirements outlined in the contract and certification requirements with OHCA.

(e) SPPC services eligibility is contingent on a member requiring one (1) or more of the services offered at least monthly including personal care, meal preparation, housekeeping, laundry, shopping or errands, or specified special tasks to meet ADL or IADL assessed needs.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 15 Ok Reg 25, eff 9-18-97 (emergency); Amended at 15 Ok Reg 1554, eff 5-11-98 ; Amended at 17 Ok Reg 2410, eff 6-26-00 ; Amended at 20 Ok Reg 1958, eff 6-26-03 ; Amended at 24 Ok Reg 95, eff 8-2-06 (emergency); Amended at 24 Ok Reg 945, eff 5-11-07 ; Amended at 26 Ok Reg 549, eff 2-1-09 (emergency); Amended at 26 Ok Reg 2140, eff 6-25-09 ; Amended at 32 Ok Reg 1142, eff 8-27-15 ; Amended at 34 Ok Reg 726, eff 9-1-17 ; Amended at 38 Ok Reg 820, eff 7-1-21 (emergency); Amended at 39 Ok Reg 1577, eff 9-12-22]

317:35-15-3. Application for State Plan Personal Care (SPPC) services

(a) **Requests for SPPC services.** The SPPC application process initiates when an online application is completed for SPPC services. A written financial application is not required for an applicant who has an active SoonerCare case. A financial application for SPPC services is initiated when there is no active SoonerCare case. The Medicaid application is signed by the applicant, parent, spouse, guardian or someone acting on the applicant's behalf. All financial eligibility conditions are verified and documented in the case record. When current available information establishes eligibility, the information may be used by recording source and date of information. If the applicant also wishes to apply for a State Supplemental Payment, either the applicant or his or her guardian, or a person acting on the applicant's behalf, such as an authorized representative or power-of-attorney, signs the application form.

(b) **Application date.** The application date is when the benefits request is received and entered into the electronic system by OKDHS. Exceptions can occur when OKDHS has contracts with certain providers who accept and obtain applications and appropriate documentation. Once the documentation, for the SoonerCare eligibility determination, has been obtained, the contracted provider will forward the application and all applicable documentation to either the OKDHS county office or the Medicaid Services Unit-ADvantage Administration.

(c) **Eligibility status.** Financial and medical eligibility is established before services can be initiated.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 17 Ok Reg 2410, eff 6-26-00 ; Amended at 20 Ok Reg 1958, eff 6-26-03 ; Amended at 26 Ok Reg 549, eff 2-1-09 (emergency); Amended at 26 Ok Reg 2140, eff 6-25-09 ; Amended at 32 Ok Reg

317:35-15-4. State Plan Personal Care (SPPC) services medical eligibility determination

(a) **Eligibility.** The Oklahoma Human Services (OKDHS) Health Care Management Nurse (HCMN) III determines medical eligibility for SPPC services based on the Uniform Comprehensive Assessment Tool (UCAT) and the determination that the member has unmet care needs that require personal care assistance. SPPC services are initiated to support the regular care provided in the member's home. SPPC services are not intended to take the place of regular care, general maintenance tasks, or meal preparation provided by natural supports, such as spouses or other adults who live in the same household. Additionally, SPPC services are not furnished when they principally benefit the family unit. To be eligible for SPPC services, the applicant:

(1) Has adequate informal supports. This means there is adult supervision that is present or available to contribute to care or decision-making ability, as documented on the UCAT. To remain in his or her home without risk to his or her health, safety, and well-being, the applicant:

(A) Has the decision-making ability to respond appropriately to situations that jeopardize his or her health and safety, or has available supports that compensate for his or her lack of ability as documented on the UCAT; or

(B) Has his or her decision-making ability, lacks the physical capacity to respond appropriately to situations that jeopardize health and safety, and an OKDHS HCMN I or II informed him or her of potential risks and consequences of remaining in the home.

(2) Requires a care plan for planning and administering services delivered under a professional personnel's supervision;

(3) Has a physical impairment or combination of physical and mental impairments as documented on the UCAT. An applicant who poses a threat to himself or herself or others, as supported by professional or credible documentation, may not be approved for SPPC services. An individual who is actively psychotic or believed to be in danger of potential harm to himself or herself or others may not be approved;

(4) Does not have household members or persons who routinely visit the household who, as supported by professional or credible documentation, pose a threat of harm or injury to the applicant or other household visitors;

(5) Lacks the ability to meet personal care needs without additional supervision or assistance, or to communicate needs to others; and

(6) Requires assistance, not of a technical nature, to prevent or minimize physical health regression and deterioration.

(b) **Definitions.** The following words and terms, when used in this subsection, shall have the following meaning, unless the context clearly

indicates otherwise:

(1) **"Activities of Daily Living" (ADL)** means activities that reflect the applicant's or member's ability to perform self-care tasks essential for sustaining health and safety, such as:

- (A) Bathing;
- (B) Eating;
- (C) Dressing;
- (D) Grooming;
- (E) Transferring, including activities such as getting in and out of a tub or moving from bed to chair;
- (F) Mobility;
- (G) Toileting; and
- (H) Bowel or bladder control.

(2) **"ADLs score of three (3) or greater"** means the applicant or member cannot do at least one (1) ADL at all or needs some help with two (2) or more ADLs.

(3) **"Applicant or Member support very low"** means the applicant's or member's UCAT Support score is zero (0), this indicates, in the UCAT assessor's clinical judgment, the formal and informal sources are sufficient for the applicant's or member's present need level in most functional areas.

(4) **"Applicant or Member support low"** means the member's UCAT Support score is five (5), this indicates, in the UCAT assessor's clinical judgment, the support from formal and informal sources are nearly sufficient for the applicant's or member's present need level in most functional areas. The applicant or member, family, or informal supports are meeting most needs typically expected of family or household members to share or do for one another, such as general household maintenance. There is little risk of institutional placement with loss of current supports.

(5) **"Applicant or Member support moderate"** means the UCAT applicant or member score is fifteen (15), this indicates, in the UCAT assessor's clinical judgment, the formal and informal support is available, but overall, it is inadequate, changing, fragile, or otherwise problematic. The applicant or member requires additional assistance that usually includes personal care assistance with one (1) or more ADLs not available through Medicare, the Veterans Administration, or other federal entitlement programs. Informal caregiver support is considered questionable or unreliable due to one (1) or more criteria in (A) through (D) of this paragraph:

- (A) Care or support is required continuously with no relief or backup available;
- (B) Informal support lacks continuity due to conflicting responsibilities such as work or child care;
- (C) Persons with advanced age or disability provide care; or
- (D) Institutional placement can reasonably be expected with any loss of existing support.

(6) **"Applicant or Member support high"** means the applicant or member score is twenty-five (25) this indicates, in the UCAT assessor's clinical judgment, the formal and informal supports are not sufficient as there is very little or no support available to meet the applicant's or member's high degree of need.

(7) **"Community Services Worker"** means any non-licensed health professional employed by or under contract with a community services provider who provides, for compensation or as a volunteer, health-related services, training, or supportive assistance to frail elderly, disabled person(s), or person(s) with developmental disabilities.

(8) **"Community Services Worker Registry"** means an OKDHS established registry established by the OKDHS per Section (§) 1025.1 of Title 56 of the Oklahoma Statutes (O.S.) listing community services workers who have a final investigative finding of abuse, neglect, or exploitation, per 43A O.S. § 10-103, involving a frail elderly person, or person(s) with developmental or other disabilities was made by OKDHS or an administrative law judge.

(9) **"Instrumental Activities of Daily Living (IADL)"** means those daily activities that reflect the applicant or member's ability to perform household chores and tasks within the community essential for sustaining health and safety, such as:

- (A) Shopping;
- (B) Cooking;
- (C) Cleaning;
- (D) Managing money;
- (E) Using a phone;
- (F) Doing laundry;
- (G) Taking medication; and
- (H) Accessing transportation.

(10) **"IADLs score is at least six (6)"** means the applicant or member needs some help with at least three (3) IADLs or cannot do two (2) IADLs at all.

(11) **"IADLs score of eight (8) or greater"** means the applicant or member needs some help with at least four (4) IADLs or the member cannot do two (2) IADLs at all and needs some help with one (1) or more other IADLs.

(12) **"MSQ"** means the Mental Status Questionnaire.

(13) **"MSQ moderate risk range"** means a total weighted-score of seven (7) to eleven (11) that indicates an orientation-memory-concentration impairment or memory impairment.

(14) **"Nutrition moderate risk"** means a total weighted UCAT Nutrition score is eight (8) or greater that indicates poor appetite or weight loss combined with special diet requirements, medications, or difficulties in eating.

(15) **"Social Resource score is eight (8) or more"** means the applicant or member lives alone, has no informal support when he or she is sick or needs assistance, or has little or no contact with others.

(c) **Medical eligibility minimum criteria for SPPC.** The medical eligibility minimum criteria for SPPC services are the minimum UCAT

score criteria that an applicant or member meets for medical eligibility and are:

- (1) ADLs score is five (5) or greater; or has an IADLs score of eight (8) or greater; or Nutrition score is (8) or greater; or the MSQ score is seven (7) or greater; or the ADLs score is three (3) and IADLs score is at least six (6); and
- (2) Applicant or Member Support score is fifteen (15) or more; or Applicant or Member Support score is five (5) and the Social Resources score is eight (8) or greater.

(d) **Medical eligibility determination.** OKDHS HCMN III determines medical eligibility for SPPC servicesutilizing the UCAT.

(1) Categorical relationship is established for SPPC services financial eligibility determination.

(A) When categorical relationship to Aid to the Disabled is not established, but there is an extremely emergent need for personal care, and current medical information is not available, the local office authorizes a medical examination.

(B) When authorization is necessary, the county director issues Form 08MA016E, Authorization for Examination, and Form 08MA02E, Report of Physician's Examination, to a licensed medical or osteopathic health care professional, refer to Oklahoma Administrative Code (OAC) 317:30-5-1.

(C) The licensed health care professional cannot be in a medical facility internship, residency, or fellowship program or in the full-time employment of the Veterans Administration, United States Public Health Service, or other agency.

(D) The OKDHS county worker submits the information to the Level of Care Evaluation Unit (LOCEU) to request a medical eligibility determination for categorical relationship. LOCEU renders a decision on the categorical relationship using the Social Security Administration (SSA) definition. The OKDHS county worker is required to conduct a follow-up with SSA to ensure the SSA disability decision is also the LOCEU decision.

(2) Approved contract agencies or the ADvantage Administration (AA) may complete the electronic application. This alerts the social services specialist (SSS) of application date.

(3) Upon referral receipt, OKDHS SSS starts the financial eligibility determination.

(4) The OKDHS HCMN I or II is responsible for completing the UCAT assessment visit within ten (10) business days of the personal care application for the applicant who is SoonerCare eligible at the time of the request. The OKDHS HCMN I or II completes the assessment visit within twenty (20) business days of the referral for the applicant not determined SoonerCare eligible at the time of the request. When the application indicates the request is from an individual who resides at home and an immediate response is required to ensure the applicant's health and safety, to prevent an emergency situation, or to avoid

institutional placement, the UCAT assessment visit has top-scheduling priority.

(5) During the assessment visit, the OKDHS HCMN I or II completes the UCAT and reviews rights to privacy, fair hearing, provider choice, and the pre-service acknowledgement agreement with the member. The OKDHS HCMN I or II gives the applicant information about medical eligibility criteria and OKDHS long-term care service options. OKDHS HCMN I or II documents if the member wants to be considered for nursing facility level of care services or if the member is applying for a specific service program on the UCAT. When, based on the information obtained during the assessment, the OKDHS HCMN I or II determines if the member may be at risk for health and safety, an immediate referral is made to Adult Protective Services or Child Protective Services, as applicable. The referral is documented on the UCAT.

(A) When SPPC services are not sufficient to meet the applicant's or member's needs, the OKDHS HCMN I or II provides information about other community long-term care service options. The OKDHS HCMN I or II assists in accessing service options the applicant or member selects in addition to, or in place of, SPPC services.

(B) When multiple household members are applying for SoonerCare SPPC services, the UCAT assessment is done for all the household members at the same time.

(C) The OKDHS HCMN I or II provides the applicant or member with information about the qualified agencies in his or her local area that provide services and obtains the applicant's or member's primary and secondary agency choice. When the applicant or family declines to choose a primary personal care service agency, the a round-robin rotation system is used for agency selection. The OKDHS HCMN I or II documents the selected personal care provider agency's name.

(6) The OKDHS HCMN I or II completes the UCAT in the electronic system and the OKDHS HCMN III makes the medical eligibility determination. SPPC service eligibility is established on the date medical eligibility is approved and financial eligibility is established. This date serves as the certification date for services to be initiated.

(A) When the time length from the initial assessment to the date of service eligibility determination exceeds ninety (90) calendar days, a new UCAT assessment is required.

(B) The OKDHS HCMN III assigns a medical certification period of not more than thirty-six (36) months for persons eighteen (18) years of age and older or not more than twelve (12) months for persons younger than eighteen (18) years of age. The service plan period is for twelve (12) months.

(7) The SSS is notified via the electronic system of the personal care certification.

(8) Upon establishing SPPC certification, the OKDHS HCMN I or II notifies the applicant's or member's preferred provider agency, or when necessary, the secondary provider agency or the provider agency selected by the round robin rotation system. Within one (1) business day of provider agency acceptance, the OKDHS HCMN I or II submits the information via electronic system to the provider agency for plan development. Refer to OAC 317:35-15-8(a).

(9) Following the provider agency's SPPC plan development, and within three (3) business days of receipt from the provider agency, the OKDHS HCMN I or II reviews the documentation to ensure agreement with the plan. Once agreement is established, the plan is authorized or submitted to the OKDHS HCMN III for review.

(10) Within ten (10) business days of the SPPC plan receipt from the OKDHS HCMN I or II, the OKDHS HCMN III authorizes or denies the plan units. If the plan fails to meet standards for authorization, it is returned to the OKDHS HCMN I or II for further justification.

(11) Within one (1) business day of knowledge of the authorization, the OKDHS HCMN I or II submits the plan authorization to the provider agency via electronic system.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 15 Ok Reg 25, eff 9-18-97 (emergency); Amended at 15 Ok Reg 1554, eff 5-11-98 ; Amended at 17 Ok Reg 2410, eff 6-26-00 ; Amended at 21 Ok Reg 2252, eff 6-25-04 ; Amended at 26 Ok Reg 549, eff 2-1-09 (emergency); Amended at 26 Ok Reg 2140, eff 6-25-09 ; Amended at 32 Ok Reg 1142, eff 8-27-15 ; Amended at 34 Ok Reg 726, eff 9-1-17 ; Amended at 36 Ok Reg 945, eff 9-1-19 ; Amended at 38 Ok Reg 820, eff 7-1-21 (emergency); Amended at 39 Ok Reg 1577, eff 9-12-22]

317:35-15-5. General financial eligibility requirements for State Plan Personal Care

Financial eligibility for SPPC is determined using the rules on income and resources according to the eligibility group the member is related to. Income and resources are evaluated on a monthly basis for all members requesting payment for SPPC who are categorically related to Aged, Blind, or Disabled (ABD); maximum countable monthly income and resource standards for individuals related to ABD are found on Oklahoma Human Services (OKDHS) form 08AX001E (Appendix C-1), Schedule VI Qualified Medicare Beneficiary Plus program standards.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 17 Ok Reg 2410, eff 6-26-00 ; Amended at 26 Ok Reg 549, eff 2-1-09 (emergency); Amended at 26 Ok Reg 2140, eff 6-25-09 ; Amended at 30 Ok Reg 1209, eff 7-1-13 ; Amended at 38 Ok Reg 820, eff 7-1-21 (emergency); Amended at 39 Ok Reg 1577, eff 9-12-22]

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

Financial eligibility for State Plan Personal Care (SPPC) services for categorically needy individuals is determined as follows:

(1) **Financial eligibility for Modified Adjusted Gross Income (MAGI) eligibility groups.** See MAGI eligibility rules in Subchapter 6 of this Chapter to determine financial eligibility.

(2) **Financial eligibility or categorically related to Aged, Blind, and Disabled.** In determining income and resources for the member related to ABD, the "family" includes the individual and spouse, if any. To be categorically needy, the countable income is less than the categorically needy standard as shown on the OKDHS form 08AX001E (Appendix C-1), Schedule VI Qualified Medicare Beneficiary Plus standard. If a member and his or her spouse cease to live together for reasons other than institutionalization or receipt of a Home and Community Based Waiver, ADvantage or Developmental Disabilities services, income and resources are considered available to each other through the month in which they are separated. Mutual consideration ceases with the month after the month in which the separation occurs. Any amounts to the spouse after the mutual consideration has ended are considered.

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

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 5-27-97 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 17 Ok Reg 2410, eff 6-26-00 ; Amended at 19 Ok Reg 136, eff 9-1-01 (emergency); Amended at 19 Ok Reg 2149, eff 6-27-02 ; Amended at 20 Ok Reg 1958, eff 6-26-03 ; Amended at 20 Ok Reg 2775, eff 7-1-03 (emergency); Amended at 21 Ok Reg 2234, eff 6-25-04 ; Amended at 26 Ok Reg 549, eff 2-1-09 (emergency); Amended at 26 Ok Reg 2140, eff 6-25-09 ; Amended at 30 Ok Reg 1209, eff 7-1-13 ; Amended at 31 Ok Reg 73, eff 9-24-13 (emergency); Amended at 31 Ok Reg 1720, eff 9-12-14 ; Amended at 35 Ok Reg 1481, eff 9-14-18 ; Amended at 38 Ok Reg 820, eff 7-1-21 (emergency); Amended at 39 Ok Reg 1577, eff 9-12-22]

317:35-15-7. Certification for State Plan Personal Care

(a) **State Plan Personal Care (SPPC) certification period.** The first month of the SPPC certification period is the first month the member is determined financially and medically eligible for SPPC. When eligibility or ineligibility for SPPC is established, the local OKDHS office updates the computer-generated notice and the appropriate notice is mailed to the member.

(b) **Financial certification period.** The financial certification period for SPPC services is twelve (12) months. Eligibility redetermination is completed according to the categorical relationship.

(c) **Medical certification period.** A medical certification period of not more than thirty-six (36) months is assigned for a member who is approved for SPPC. The certification period for SPPC services is based on the Uniform Comprehensive Assessment Tool evaluation and clinical judgment of the Oklahoma Human Services HCMN III.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 15 Ok Reg 1896, eff 3-17-98 (emergency); Amended at 16 Ok Reg 1438, eff 5-27-99 ; Amended at 17 Ok Reg 2410, eff 6-26-00 ; Amended at 26 Ok Reg 549, eff 2-1-09 (emergency); Amended at 26 Ok Reg 2140, eff 6-25-09 ; Amended at 30 Ok Reg 1209, eff 7-1-13 ; Amended at 32 Ok Reg 1142,

317:35-15-8. Agency State Plan Personal Care (SPPC) service authorization and monitoring

(a) Within ten (10) business days of referral receipt for SPPC services, the personal care provider agency nurse completes an assessment of the member's personal care service needs and completes and submits a person-centered plan based on the member's needs to the Oklahoma Human Services (OKDHS) Health Care Management Nurse (HCMN) I or II. The plan includes the:

- (1) Adv/SPPC-Nurse Evaluation;
- (2) SPPC-Service Planning; and
- (3) SPPC Member Service Agreement.

(b) When more than one (1) person in the household is referred to receive SPPC or ADvantage services, all household members' plans are discussed and developed with the eligible members so service delivery is coordinated to achieve the most efficient use of resources. The number of SPPC service units authorized for each individual is distributed between all eligible family members. This ensures one (1) family member's absence does not adversely affect the family member(s) remaining in the home. When one (1) or more persons in the same household with a SPPC member is referred to or receives other formal services, such as ADvantage or Developmental Disability Services, then those services are coordinated as well.

(c) The personal care provider agency receives documentation from the OKDHS HCMN I or II for authorization to begin services. The agency provides a copy of the plan to the member upon initiating services.

(d) Prior to the provider agency placing a Personal Care Assistant (PCA) in the member's home or other service-delivery setting, an Oklahoma State Bureau of Investigation background check, an Oklahoma State Department of Health Registry check, and an OKDHS Community Services Worker Registry check is completed per Sections 1-1944 through 1-1948 of Title 63 of the Oklahoma Statutes. Payment is made for PCAs who provide SPPC services and meet criteria Oklahoma Administrative Code (OAC) 317:35-15-2(c) (1) through (8).

(e) The provider agency nurse monitors the member's care plan.

(1) The personal care provider agency nurse or staff contacts the member within five (5) business days of authorized document receipt in order to ensure services are implemented according to the authorized care plan.

(2) The provider agency nurse makes a monitoring visit using the Adv/SPPC Nurse Evaluation at least every six (6) months to assess the member's satisfaction with his or her care and to evaluate the care plan for adequacy of goals and authorized units. Whenever a monitoring visit is made, the provider agency nurse documents findings in the electronic system. The provider agency submits monitoring documentation to the OKDHS HCMN I or II for review within five (5) business days of the visit. A registered nurse (RN) conducts the monitoring visit when the PCA is performing hands-on personal care. A licensed practical nurse may only conduct the

monitoring visit when the PCA is not performing hands-on personal care. An RN also co-signs the progress notes.

(3) The provider agency nurse's requests to change the number of authorized units in the SPPC plan are submitted via the electronic system to the OKDHS HCMN III to approve or deny prior to changed number of authorized units implementation.

(4) Annually, or more frequently when the member's needs change, the provider agency nurse re-assesses the member's needs and develops a new plan to meet the member's needs. The provider agency nurse completes and submits the annual reassessment documents to the OKDHS HCMN I or II no sooner than sixty (60) calendar days before the existing service plan end-date, and no later than fourteen (14) calendar days prior to service.

(5) When the member is unstaffed, the provider agency nurse or staff communicates with the member and makes efforts to re-staff. When consecutively unstaffed for seven (7) calendar days, or fewer depending on the member's needs, the provider agency nurse or staff contacts the unstaffed member weekly by phone to actively monitor the member's health and safety and documents ongoing efforts to provide staff using the electronic system. When the member is unstaffed for thirty (30) days, the provider agency notifies the OKDHS HCMN I or II via the Case Note for SPPC thirty (30) day unstaffed note in the electronic system. The HCMN I or II contacts the member and when the member chooses, initiates a member transfer to another provider agency that can provide staff.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 15 Ok Reg 25, eff 9-18-97 (emergency); Amended at 15 Ok Reg 1554, eff 5-11-98 ; Amended at 17 Ok Reg 2410, eff 6-26-00 ; Amended at 18 Ok Reg 2969, eff 5-17-01 ; Amended at 19 Ok Reg 1071, eff 5-13-02 ; Amended at 20 Ok Reg 1069, eff 4-1-03 (emergency); Amended at 20 Ok Reg 1943, eff 6-26-03 ; Amended at 24 Ok Reg 95, eff 8-2-06 (emergency); Amended at 24 Ok Reg 945, eff 5-11-07 ; Amended at 26 Ok Reg 549, eff 2-1-09 (emergency); Amended at 26 Ok Reg 2140, eff 6-25-09 ; Amended at 30 Ok Reg 1259, eff 7-1-13 ; Amended at 32 Ok Reg 1142, eff 8-27-15 ; Amended at 34 Ok Reg 726, eff 9-1-17 ; Amended at 38 Ok Reg 820, eff 7-1-21 (emergency); Amended at 39 Ok Reg 1577, eff 9-12-22]

317:35-15-8.1. Agency State Plan Personal Care services; billing, and problem resolution

The ADvantage Administration (AA) certifies qualified personal care provider agencies and facilitates the execution of the agencies' SoonerCare (Medicaid) contracts on the Oklahoma Health Care Authority's (OHCA) behalf. OHCA checks the list of providers barred from Medicare/SoonerCare (Medicaid) participation to ensure that the personal care services agency is not listed.

(1) **Payment for State Plan Personal Care (SPPC).** Payment for SPPC services is made for care provided in the member's own home or in other limited living arrangement types, per Oklahoma Administrative Code (OAC) 317:35-15-2(b)(1 through 4).

(A) **Provider agency use.** To provide SPPC services, an agency must be licensed by the Oklahoma State

Department of Health, meets certification standards identified by Oklahoma Human Services (OKDHS), and possesses a current SoonerCare (Medicaid) contract.

(B) **Reimbursement.** SPPC services payment on a member's behalf is made according to the service type and number of authorized service units.

(i) The amount paid to provider agencies for each service unit is determined according to established SoonerCare (Medicaid) rates for the personal care services. Only authorized units contained in each eligible member's individual plan are eligible for reimbursement. Provider agencies serving more than one member residing in the same residence ensure the members' plans combine units in the most efficient manner to meet the needs of all eligible persons in the residence.

(ii) SPPC services payment is for tasks performed in accordance with the authorized care plan per OAC 317:30-5-951. Payment for personal care skilled nursing service is made on the member's behalf for assessment, evaluation, and associated service planning per nursing visit.

(iii) SPPC service time is documented through Electronic Visit Verification System (EVV), previously known as Interactive Voice Response Authentication (IVRA) system, when services are provided in the home.

(2) Issue resolution.

(A) The provider agency provides a written copy of their grievance process to each member at service commencement. The written grievance process includes the name and phone number of a provider agency contact person who is responsible for responding to such complaints and grievances. When the member is dissatisfied with the SPPC provider agency or the assigned PCA and has exhausted attempts to work with the agency's grievance process without resolution, the member is referred to the OKDHS State Plan Care Unit to attempt to resolve the issue(s). The member has the right to appeal to OHCA per OAC 317:2-1-2.

(B) When a PCA performance issue is identified, provider agency staff conducts a counseling conference with the member or the PCA as appropriate. Provider agency staff counsels the PCA regarding problems with his or her performance.

(3) Persons ineligible to serve as a PCA. Payment from SoonerCare funds for SPPC services may not be made to an individual who is a legally responsible family member of the member, such as a spouse, legal guardian, or parent of a minor child, when he or she is providing SPPC services.

[Source: Added at 20 Ok Reg 1069, eff 4-1-03 (emergency); Amended at 20 Ok Reg 1943, eff 6-26-03 ; Amended at 23 Ok Reg 817, eff 3-9-06 (emergency); Amended at 23 Ok Reg 2580, eff 6-25-06 ; Amended at 24 Ok Reg 95, eff 8-2-06 (emergency); Amended at 24 Ok Reg 945, eff 5-11-07 ; Amended at 26 Ok Reg 549, eff 2-1-09 (emergency); Amended at 26 Ok Reg 758, eff 4-1-09 (emergency); Amended at 26 Ok Reg 2140, eff 6-25-09 ; Amended at 26 Ok Reg 758, eff 4-1-09 (emergency); Amended at 27 Ok Reg 308, eff 11-3-09 (emergency); Amended at 27 Ok Reg 972, eff 5-13-10 ; Amended at 32 Ok Reg 1142, eff 8-27-15 ; Amended at 34 Ok Reg 726, eff 9-1-17 ; Amended at 38 Ok Reg 820, eff 7-1-21 (emergency); Amended at 39 Ok Reg 1577, eff 9-12-22]

317:35-15-8.2. State Plan Personal Care Eligible Provider Exception [REVOKED]

[Source: Added at 37 Ok Reg 1660, eff 9-14-20 ; Revoked at 38 Ok Reg 820, eff 7-1-21 (emergency); Revoked at 39 Ok Reg 1577, eff 9-12-22]

317:35-15-9. Financial eligibility redetermination for State Plan Personal Care

The Oklahoma Human Services social services specialist completes a financial eligibility redetermination before the end of the certification period. A notice is generated only if there is a change affecting the member's financial eligibility.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 15 Ok Reg 25, eff 9-18-97 (emergency); Amended at 15 Ok Reg 1554, eff 5-11-98 ; Amended at 26 Ok Reg 549, eff 2-1-09 (emergency); Amended at 26 Ok Reg 2140, eff 6-25-09 ; Amended at 32 Ok Reg 1142, eff 8-27-15 ; Amended at 38 Ok Reg 820, eff 7-1-21 (emergency); Amended at 39 Ok Reg 1577, eff 9-12-22]

317:35-15-10. Medical eligibility redetermination for State Plan Personal Care (SPPC) services

(a) **Medical eligibility redetermination.** The Oklahoma Human Services (OKDHS) Health Care Management Nurse (HCMN) III completes a medical redetermination before the end of the long-term care medical certification period.

(b) **Recertification.** The OKDHS HCMN I or II re-assesses the SPPC service members eighteen (18) years of age and older, for medical recertification based on the member's needs and level of caregiver support required, using the Uniform Comprehensive Assessment Tool (UCAT) at least every thirty-six (36) months. Members younger than eighteen (18) years of age, are re-evaluated by the OKDHS HCMN I or II using the UCAT on a twelve (12) month basis or sooner when needed. During this re-certification assessment, the OKDHS HCMN I or II informs the member of the state's other SoonerCare (Medicaid) long-term care options. The OKDHS HCMN I or II submits the re-assessment to the OKDHS HCMN III for recertification. Documentation is sent to the OKDHS area nurse no later than the tenth (10th) calendar day of the month certification expires. When the OKDHS HCMN III determines medical eligibility for SPPC services, a recertification review date is entered on the system.

(c) **Change in amount of units or tasks.** When the SPPC provider agency determines a need for a change in the amount of units or tasks in the service, a care plan is completed and submitted to OKDHS within five

(5) business days of identifying the assessed need. The OKDHS HCMN III approves or denies the change prior to implementation.

(d) **SPPC services voluntary closure.** When a SPPC member decides personal care services are no longer needed to meet his or her needs, a medical decision is not needed. The member is sent a Voluntary Withdrawal Request for confirmation and signature, and the request is entered into the electronic system upon receipt. A closure notification is submitted to the provider agency via the electronic system.

(e) **Resuming personal care services.** When a SPPC member approved for SPPC services is without services for less than ninety (90) calendar days, but the member has current medical and SoonerCare (Medicaid) financial eligibility approval, SPPC services may be resumed using the member's previously approved plan. The personal care provider agency nurse contacts the member to determine when changes in health or service needs occurred. When changes are identified, the provider agency nurse completes an assessment visit and submits a SPPC services skilled nursing need re-assessment within ten (10) business days of the resumed plan start date. When the member's needs dictate, the personal care provider agency may submit a request for a change in authorized SPPC service units. When no changes occur, the agency nurse documents the contact in the electronic system for the OKDHS HCMN I or II ten (10) business days of the resumed plan start date.

(f) **Financial ineligibility.** When the OKDHS social services specialist (SSS) determines a member does not meet SoonerCare (Medicaid) financial eligibility criteria, the OKDHS HCMN III is notified to initiate the closure process due to financial ineligibility. When OKDHS determines a member to be financially ineligible for SPPC services, they notify the member of the determination, and his or her right to appeal the decision in writing. A closure notification is submitted to the provider agency.

(g) **Closure due to medical ineligibility.** When OKDHS determines to be medically ineligible for SPPC services, they notify the member of the determination, and his or her right to appeal the decision, in writing. When medical eligibility redetermination is not made prior to current medical eligibility expiration, the existing medical eligibility certification is automatically extended until care level redetermination is established. For members:

(1) Who are not hospitalized or in an extended medical care facility, the existing medical eligibility certification is extended for a maximum sixty (60) calendar days from the date of the previous medical eligibility expiration date;

(2) Who are hospitalized or in an extended medical care facility, the existing medical eligibility certification is extended for thirty (30) calendar days from the date of discharge from the facility or for sixty (60) calendar days from the date of previous medical eligibility expiration date, whichever is longer;

(3) Whose medical eligibility redetermination is not made by applicable extended deadline, the member is determined to be medically ineligible; or

(4) Who no longer meet medical eligibility or cannot be located to complete the redetermination assessment, the HCMN I or II

notifies the HCMN III. The HCMN III updates the system's medical eligibility end date and notifies the HCMN I or II of effective end date. A closure notification is submitted to the provider agency.

(h) **State Plan Personal Care services termination.**

(1) State Plan Personal Care (SPPC) services may be discontinued when:

- (A) Professional documentation supports the member poses a threat to self or others;
- (B) Other household members or persons who routinely visit the household who, as professional or credible documentation supports, pose a threat to the member or other household visitors;
- (C) The member or the other household members use threatening, intimidating, degrading, or sexually inappropriate language or innuendo or behavior towards service providers, either in the home or through other contact or communications. Efforts to correct such behavior are unsuccessful as professional or credible documentation supports;
- (D) The member or family member fails to cooperate with SPPC service delivery or to comply with Oklahoma Health Care Authority (OHCA) or OKDHS rules as professional or credible documentation supports;
- (E) The member's health or safety is at risk as professional or credible documentation supports;
- (F) Additional services, either "formal" such as, paid by Sooner Care (Medicaid) or some other funding source or "informal" such as, unpaid are provided in the home. This eliminates the need for SoonerCare SPPC services;
- (G) The member's living environment poses a physical threat to self or others as professional or credible documentation supports, and measures to correct hazardous conditions or assist the person to move are unsuccessful or are not feasible; or
- (H) The member refuses to select or accept a provider agency or Personal Care Assistant (PCA) service for ninety (90) consecutive days as professional or credible documentation supports.

(2) For members receiving SPPC services, the provider agency submits documentation with the recommendation to discontinue services to OKDHS. The OKDHS HCMN I or II reviews the documentation and submits it to the OKDHS HCMN III for determination. The personal care provider agency or PCA and the local OKDHS social services specialist is notified of the decision to terminate services via the electronic system. The member is sent an official closure notice informing him or her of appropriate member rights to appeal the decision to discontinue services.

97 ; Amended at 15 Ok Reg 25, eff 9-18-97 (emergency); Amended at 15 Ok Reg 1554, eff 5-11-98 ; Amended at 17 Ok Reg 2410, eff 6-26-00 ; Amended at 20 Ok Reg 1958, eff 6-26-03 ; Amended at 24 Ok Reg 95, eff 8-2-06 (emergency); Amended at 24 Ok Reg 945, eff 5-11-07 ; Amended at 26 Ok Reg 549, eff 2-1-09 (emergency); Amended at 26 Ok Reg 2140, eff 6-25-09 ; Amended at 32 Ok Reg 1142, eff 8-27-15 ; Amended at 34 Ok Reg 726, eff 9-1-17 ; Amended at 36 Ok Reg 945, eff 9-1-19 ; Amended at 38 Ok Reg 820, eff 7-1-21 (emergency); Amended at 39 Ok Reg 1577, eff 9-12-22]

317:35-15-11. Case transfer between categories [REVOKED]

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 15 Ok Reg 25, eff 9-18-97 (emergency); Amended at 15 Ok Reg 1554, eff 5-11-98 ; Amended at 17 Ok Reg 2410, eff 6-26-00 ; Revoked at 26 Ok Reg 549, eff 2-1-09 (emergency); Revoked at 26 Ok Reg 2140, eff 6-25-09]

317:35-15-12. Case changes

Any time there are changes affecting the State Plan Personal Care case eligibility, computer generated notices are issued.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 39 Ok Reg 1577, eff 9-12-22]

317:35-15-13. Personal Care contractor; billing, training, and program administration [REVOKED]

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 15 Ok Reg 25, eff 9-18-97 (emergency); Amended at 15 Ok Reg 718, eff 12-15-97 (emergency); Amended at 15 Ok Reg 1554, eff 5-11-98 ; Amended at 17 Ok Reg 2410, eff 6-26-00 ; Amended at 18 Ok Reg 2969, eff 5-17-01 ; Amended at 19 Ok Reg 1071, eff 5-13-02 ; Revoked at 20 Ok Reg 1069, eff 4-1-03 (emergency); Revoked at 20 Ok Reg 1943, eff 6-26-03]

317:35-15-13.1. Individual personal care assistant (IPCA) service management

(a) An Individual Personal Care Assistant (IPCA) may be utilized to provide SPPC services when it is documented to be in the member's best interest to have an IPCA, or when there are no qualified personal care provider agencies available in the member's local area. Oklahoma Health Care Authority (OHCA) checks the list of providers barred from Medicare/Medicaid participation to ensure the IPCA is not listed.

(b) After SPPC services eligibility is established, and prior to implementation of SPPC services using an IPCA, the OKDHS Health Care Management Nurse I or II reviews the care plan with the member and IPCA and notifies them to begin SPPC services delivery. The OKDHS HCMN I or II maintains the original care plan and forwards a copy to the selected IPCA and member within one (1) business day of approval receipt.

(c) The HCMN I or II contacts the member within five (5) business days to ensure services are in place and meeting the member's needs. The HCMN I or II also monitors the care plan for members with an IPCA. For any member receiving SPPC services utilizing an IPCA, the OKDHS HCMN I or II makes a home visit at least every six (6) months beginning within ninety (90) calendar days from the date of service initiation. OKDHS HCMN I or II assesses the member's satisfaction with his or her

SPPC services and evaluates the care plan for adequacy of goals and units allocated. Requests for changes in the units authorized in the care plan are approved by the HCMN III prior to implementation.

[Source: Added at 20 Ok Reg 1069, eff 4-1-03 (emergency); Added at 20 Ok Reg 1943, eff 6-26-03 ; Amended at 24 Ok Reg 95, eff 8-2-06 (emergency); Amended at 24 Ok Reg 945, eff 5-11-07 ; Amended at 32 Ok Reg 1142, eff 8-27-15 ; Amended at 34 Ok Reg 726, eff 9-1-17 ; Amended at 38 Ok Reg 820, eff 7-1-21 (emergency); Amended at 39 Ok Reg 1577, eff 9-12-22]

317:35-15-13.2. Individual personal care assistants (IPCA) provider contractor; billing, training, and problem resolution

While the Oklahoma Health Care Authority (OHCA) is the contractor authorized under federal law, the Oklahoma Human Services (OKDHS) Health Care Management Nurse (HCMN) I or II initiates initial contracts with eligible members to provide SPPC services per Oklahoma Administrative Code (OAC) 317:35-15-2. OHCA is responsible for IPCA contract renewal.

(1) **IPCA payment.** Payment for SPPC services is made for care provided in the member's own home or in other limited types of living arrangements per OAC 317:35-15-2(b)(1) through (4). SPPC services may not be approved when the member lives in the Personal Care Assistant's (PCA) home, except with the approval of OKDHS Community Living, Aging and Protective Services.

(A) **Reimbursement.** Personal care payment for a member is made according to the number of personal care units identified in the service plan.

(i) The amount per unit paid to individual contractors is determined according to the established rates. A service plan is developed for each member in the home and service units are assigned to meet each member's needs. The service plans combine units efficiently to meet all eligible members needs in the household.

(ii) From the total amounts the IPCA bills in (i) of this subparagraph, OHCA, acting as agent for the member-employer, withholds the appropriate FICA tax percentage and sends it to the Internal Revenue Service as the individual contractor's contribution toward Social Security coverage. To ensure the Social Security account is credited, the individual contractor's Social Security number is entered correctly on each claim.

(iii) The contractor payment fee covers all SPPC services included on the service and care plans the OKDHS HCMN I or II develops. Payment is only made for eligible members' direct services and care. The OKDHS HCMN III, authorizes the number of service units the member receives.

(iv) A member may select more than one (1) IPCA. The service and care plan indicates when this is necessary.

(v) The IPCA may provide SoonerCare SPPC services for several households during one (1) week as long as the daily number of paid service units does not exceed eight (8) hours, thirty-two (32) units per day. Total weekly hours cannot exceed forty (40), one-hundred and sixty (160) units.

(B) IPCA wage or employment information release.

Any inquiry received by the local office requesting wage or employment information is forwarded to OHCA, Claims Resolution.

(2) IPCA member selection. Members or family members recruit, interview, conduct reference checks, and select applicants for IPCA consideration. Prior to placing an IPCA in the member's home, an Oklahoma State Bureau of Investigation (OSBI) background check and an OKDHS Community Services Worker Registry check are completed per Section 1-1944 through 1-1948 of Title 63 of the Oklahoma Statutes (O.S. 63 §§ 1-1944 through 1-948). The OKDHS HCMN I or II also checks the Certified Nurse Aide Registry. The OKDHS HCMN I or II affirms the applicant's name is not contained on any of the registries. The OKDHS HCMN I or II notifies OHCA when the applicant is on any registry.

(A) Persons eligible to serve as IPCAs. SPPC services payment is made to IPCAs who meet the criteria per OAC 317:35-15-2(c)(1) through (8).

(B) Persons ineligible to serve as IPCAs. SPPC services payment from SoonerCare funds may not be made to an individual who is the member's legally responsible family member, such as a spouse, legal guardian, or parent of a minor child of the member being served.

(i) Payment cannot be made to an OKDHS or OHCA employee. Payment cannot be made to an immediate family member of a an OKDHS employee who works in the same county without OKDHS Medicaid Services Unit approval. When a family member relationship exists between an OKDHS HCMN I or II and an IPCA in the same county, the OKDHS HCMN I or II cannot manage services for a member whose IPCA is his or her family member.

(ii) If it is determined that an OKDHS HCMN I or II or an OHCA employee is interfering in service provision for personal or family benefit, the employee is subject to disciplinary action.

(3) IPCA orientation. When a member selects an IPCA, the OKDHS HCMN I or II notifies the selected IPCA to complete the Oklahoma State Department of Health(OSDH) Form 805, Uniform Employment Application for Nurse Aide Staff, and the OKDHS Form 06PE039E, Employment Application Supplement, and for a qualification determination and orientationdetermination. For SPPC members, this process is the OKDHS HCMN I or II

responsibility. The IPCA can begin work after:

- (A) The member interviews him or her;
- (B) The OKDHS nurse orients him or her;
- (C) A contract (OHCA-0026) is executed with the OHCA;
- (D) The effective service date is established;
- (E) All registries are checked and the IPCA's name is not listed;
- (F) OSDH Nurse Aide Registry is checked and no notations are found; and
- (G) OSBI background check is completed.

(4) **IPCA training.** It is the OKDHS HCMN I or II responsibility to make sure the IPCA has the training needed to carry out the care plan prior to each member's service initiation.

(5) **Problem resolution related to IPCA performance.** When it comes to the OKDHS HCMN I or II attention there is a problem related to IPCA performance, a counseling conference is held between the member, OKDHS HCMN I or II, and IPCA. The OKDHS HCMN I or II counsels the IPCA regarding problems with his or her performance when doing so results in improved performance.

(6) **IPCA Provider Agreement termination.**

(A) An IPCA contract termination recommendation is submitted to OHCA and IPCA services are suspended immediately when the IPCA:

- (i) Performance poses a threat to the member's health and safety or to others; or
- (ii) Failed to comply with PCA Provider Agreement expectations and counseling is not appropriate or effective; or
- (iii) Name appears on the OKDHS Community Services Worker Registry or any registry listed in O.S. 63 § 1-1947, even when his or her name is not on the registry at the time of application or hiring.

(B) The OKDHS HCMN makes the IPCA termination recommendation to OKDHS Community Living, Aging and Protective Services Medicaid Services Unit (MSU), MSU then notifies the OHCA Legal Division of the recommendation. When the problem is related to abuse, neglect, or exploitation allegations OKDHS Adult Protective Services, State Attorney General's Medicaid Unit, OHCA, and OSDH are notified.

(C) When the problem is related to abuse, neglect, or exploitation allegations, the OKDHS HCMN follows the process, per OAC 340:100-3-39.

[Source: Added at 20 Ok Reg 1069, eff 4-1-03 (emergency); Added at 20 Ok Reg 1943, eff 6-26-03 ; Amended at 27 Ok Reg 308, eff 11-3-09 (emergency); Amended at 27 Ok Reg 635, eff 2-1-10 (emergency); Amended at 27 Ok Reg 1504, eff 6-11-10 ; Amended at 30 Ok Reg 1251, eff 7-1-13 ; Amended at 32 Ok Reg 1142, eff 8-27-15 ; Amended at 34 Ok Reg 726, eff 9-1-17 ; Amended at 38 Ok Reg 820, eff 7-1-21 (emergency); Amended at 39 Ok Reg 1577, eff 9-12-22]

317:35-15-14. Billing procedures for State Plan personal care

Billing procedures for State Plan Personal Care (SPPC) services are contained in the Oklahoma Medicaid Management Information Systems (OKMMIS) Billing and Procedure Manual. Questions regarding billing procedures that cannot be resolved through studying the manual are referred to the Oklahoma Health Care Authority (OHCA). SPPC contractors bill on CMS-1500 claim form. OHCA provides instructions to a contracted Individual Personal Care Assistant (IPCA) for claim completion at the contractor's orientation. The contracted provider submits a claim for each member. The contracted provider prepares claims for services provided and submits the claims to the fiscal agent responsible for ensuring claims are properly completed. All personal care contractors must have a unique provider number. New contracted providers are mailed the provider number after being placed on the claims processing contractor's provider file. All services provided in the member's home, including Personal Care and Nursing , and all work completed in the provider's office, are documented through the Electronic Visit Verification (EVV) system. The EVV system provides alternate backup solutions if the automated system is unavailable; however, in the event of an EVV system failure, the provider documents time in accordance with internal provider agency policy and procedures backup plan. This documentation is sufficient to account for both in-home and in-office services. The provider agency's backup procedures are only permitted when the EVV system is unavailable.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 15 Ok Reg 25, eff 9-18-97 (emergency); Amended at 15 Ok Reg 1554, eff 5-11-98 ; Amended at 20 Ok Reg 1958, eff 6-26-03 ; Amended at 26 Ok Reg 558, eff 2-1-09 (emergency); Amended at 26 Ok Reg 2149, eff 6-25-09 ; Amended at 32 Ok Reg 1142, eff 8-27-15 ; Amended at 34 Ok Reg 726, eff 9-1-17 ; Amended at 38 Ok Reg 820, eff 7-1-21 (emergency); Amended at 39 Ok Reg 1577, eff 9-12-22]

317:35-15-15. Social services referral

In many situations, members receiving medical services through SoonerCare (Medicaid) need social services. The OKDHS HCMN I or II may make referrals for social services to the OKDHS social services specialist (SSS) in the local office. In addition to these referrals, a member, or another individual acting on the member's behalf, may initiate a social services request.

(1) OKDHS SSS provides the indicated services, or makes referrals to the appropriate outside resources if the services are not available within OKDHS.

(2) OKDHS SSS provided services:

- (A) Enable members to attain or maintain good physical and mental health;
- (B) Assist members who receive care outside their own homes in planning for and returning to their own homes or to other alternate care;
- (C) Encourage the development and maintenance of family and community interests and ties;
- (D) Promote member's maximum independence in managing their own affairs;

- (E) Include protective services that evaluate the need for and arrange guardianship; and
- (F) Offer family planning services, including family assistance in acquiring means to responsible parenthood. Services are offered in making the necessary referral and follow-up.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 17 Ok Reg 2410, eff 6-26-00 ; Amended at 20 Ok Reg 1958, eff 6-26-03 ; Amended at 26 Ok Reg 549, eff 2-1-09 (emergency); Amended at 26 Ok Reg 2140, eff 6-25-09 ; Amended at 32 Ok Reg 1142, eff 8-27-15 ; Amended at 39 Ok Reg 1577, eff 9-12-22]

SUBCHAPTER 17. ADVANTAGE WAIVER SERVICES

317:35-17-1. Overview of long-term medical care services; relationship to Qualified Medicare Beneficiary Plus (QMBP), Specified Low-Income Medicare Beneficiary (SLMB), and other Medicaid (SoonerCare) services eligibility

- (a) Long-term medical care for the categorically needy includes:
- (1) Care in a long-term care facility per Oklahoma Administrative Code (OAC) 317:35-19;
 - (2) Care in a public or private intermediate care facility for the intellectually disabled (ICF/IID), per OAC 317:35-9;
 - (3) Care of persons sixty-five (65) years of age and older in mental health hospitals, per OAC 317:35-9;
 - (4) Home and Community-Based waiver services for persons with intellectual disabilities, per OAC 317:35-9;
 - (5) Personal Care services, per OAC 317:35-15; and
 - (6) Home and Community-Based waiver services (ADvantage waiver) for frail elderly, sixty-five (65) years of age and older; and a targeted group of adults with physical disabilities, twenty-one (21) to sixty-four (64) years of age and older, who do not have an intellectual disability or a cognitive impairment related to a developmental disability per OAC 317:35-17-3.
- (b) When an individual is certified as eligible for SoonerCare coverage of long-term care, he or she is also eligible for other SoonerCare services. ADvantage waiver members do not have a copayment for ADvantage services except for prescription drugs. For members residing in an ADvantage assisted living center, any income beyond one-hundred and fifty percent (150%) of the federal benefit rate is available to defray the cost of the assisted living services received. The member is responsible for payment to the assisted living services center provider for days of service, from the first day of each full-month in which services were received, until the vendor pay obligation is met. When an individual is aged, blind, or disabled and is determined eligible for long-term care, a separate eligibility determination must be made for QMBP or SLMB benefits. An ADvantage program member may reside in a licensed assisted living services center only when the assisted living services center is a certified ADvantage assisted living services center provider from whom the member is receiving ADvantage assisted living services.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 15 Ok Reg 3715, eff 5-18-98 (emergency); Amended at 16 Ok Reg 1438, eff 5-27-99 ; Amended at 17 Ok Reg 2410, eff 6-26-00 ; Amended at 18 Ok Reg 277, eff 11-21-00 (emergency); Amended at 18 Ok Reg 1139, eff 5-11-01 ; Amended at 20 Ok Reg 376, eff 1-1-03 (emergency); Amended at 20 Ok Reg 1979, eff 6-26-03 ; Amended at 26 Ok Reg 1008, eff 5-1-09 (emergency); Amended at 27 Ok Reg 973, eff 5-13-09 ; Amended at 29 Ok Reg 1172, eff 6-25-12 ; Amended at 34 Ok Reg 726, eff 9-1-17 ; Amended at 37 Ok Reg 1660, eff 9-14-20 ; Amended at 41 Ok Reg, Number 12, effective 1-30-24 (emergency)]

317:35-17-2. Level of care medical eligibility determination

The OKDHS area nurse, or nurse designee, determines medical eligibility for ADvantage program services based on the Uniform Comprehensive Assessment Tool (UCAT) III assessment and the determination that the member has unmet care needs that require

ADvantage or NF services to assure member health and safety. ADvantage services are initiated to support the informal care that is being provided in the member's home, or, that based on the UCAT, can be expected to be provided in the members's home upon discharge of the member from a NF or hospital. These services are not intended to take the place of regular care and general maintenance tasks or meal preparation typically shared or done for one another by spouses or other adults and who live in the same household. Additionally, services are not furnished if they principally benefit the family unit. When there is an informal (not paid) system of care available in the home, ADvantage service provision will supplement the system within the limitations of ADvantage Program policy to enable the family and/or significant others to continue caregiving over extended periods. When the ADvantage personal care attendant and member live within the same household, personal care will only be approved by agreement of the interdisciplinary service planning team and OKDHS AA approval that the personal care tasks are consistent with plan goals and have beneficial outcomes for the member.

(1) **Definitions.** The following words and terms when used in this subchapter, shall have the following meaning, unless the context clearly indicates otherwise:

(A) **"ADL"** means the activities of daily living. Activities of daily living are activities that reflect the member's ability to perform self-care tasks essential for sustaining health and safety such as:

- (i) bathing,
- (ii) eating,
- (iii) dressing,
- (iv) grooming,
- (v) transferring (includes getting in and out of a tub, bed to chair, etc.),
- (vi) mobility,
- (vii) toileting, and
- (viii) bowel/bladder control.

(B) **"ADLs score in high risk range"** means the member's total weighted UCAT ADL score is 10 or more which indicates the member needs some help with 5 ADLs or that the member cannot do 3 ADLs at all plus the member needs some help with 1 other ADL.

(C) **"ADLs score at the high end of the moderate risk range"** means member's total weighted UCAT ADL score is 8 or 9 which indicates the member needs help with 4 ADLs or the member cannot do 3 ADLs at all.

(D) **"Client Support high risk"** means member's UCAT Client Support score is 25 which indicates in the UCAT assessor's clinical judgment, excluding from consideration existing Ryan White CARE Act, Indian Health Service, Medicaid NF, ADvantage and/or State Plan Personal Care services, very little or no support is available from informal and formal sources and the overall total support is entirely inadequate to meet a high degree of medically

complex needs. Functional capacity is so limited as to require full time assistance and the stability of the care system is likely to fail. The member requires additional care that is not available through Medicare, Veterans Administration, or other Federal entitlement programs to prevent an imminent risk of life threatening health deterioration or institutional placement.

(E) "**Client Support low risk**" means member's UCAT Client Support score is 5 which indicates in the UCAT assessor's clinical judgment, excluding from consideration existing Ryan White CARE Act, Indian Health Service, Medicaid NF, ADvantage and/or State Plan Personal Care services, support from informal and formal sources is nearly sufficient/stable with minimal or few needs for formal services (i.e. some housekeeping only). The member/family/ informal supports are meeting most needs typically expected for family/household members to share or do for one another, i.e. general household maintenance. There is little risk of institutional placement even with a loss of current supports.

(F) "**Client Support moderate risk**" means member's UCAT Client Support score is 15 which indicates in the UCAT assessor's clinical judgment, excluding from consideration existing Ryan White CARE Act, Indian Health Service, Medicaid NF, ADvantage and/or State Plan Personal Care services, support from informal and formal sources is available, but overall, it is inadequate, changing, fragile or otherwise problematic and the member requires additional care that usually includes personal care assistance with one or more activity of daily living tasks and is not available through Medicare, Veterans Administration, or other federal entitlement programs. Support provided by informal caregivers is of questionable reliability due to one or more of the following:

- (i) Care/support is required continuously with no relief or backup available, or
- (ii) Informal support lacks continuity due to conflicting responsibilities such as job and/or child care, or
- (iii) Care/support is provided by persons with advanced age and/or disability, and
- (iv) Institutional placement can reasonably be expected with any loss of existing support.

(G) "**Cognitive Impairment**" means that the individual, as determined by the clinical judgment of the OKDHS Nurse or the AA, does not have the capability to think, reason, remember or learn skills required for self-care, communicating needs, directing care givers and/or using appropriate judgment for maintenance of their own health or safety. The clinical judgment of cognitive impairment is

based on MSQ performance in combination with a more general evaluation of cognitive function from interaction with the individual during the UCAT assessment.

(H) "**Developmental Disability**" means a severe, chronic disability of an individual that:

- (i) is attributable to a mental or physical impairment or combination of mental and physical impairments;
- (ii) is manifested before the individual attains age 22;
- (iii) is likely to continue indefinitely;
- (iv) results in substantial functional limitations in three or more of the following areas of major life activity:
 - (I) self-care;
 - (II) receptive and expressive language;
 - (III) learning;
 - (IV) mobility;
 - (V) self-direction;
 - (VI) capacity for independent living; and
 - (VII) economic self-sufficiency; and
- (v) reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, supports, or other assistance that is of lifelong or extended duration and is individually planned and coordinated.

(I) "**Environment high risk**" means member's UCAT Environment score is 25 which indicates in the UCAT assessor's clinical judgment, the physical environment is strongly negative or hazardous.

(J) "**Environment low risk**" means member's UCAT Environment score is 5 which indicates in the UCAT assessor's clinical judgment that, although aspects of the physical environment may need minor repair/improvement, the physical environment poses little risk to member's health and/or safety.

(K) "**Environment moderate risk**" means member's UCAT Environment score is 15 which indicates in the UCAT assessor's clinical judgment, many aspects of the physical environment are substandard or hazardous.

(L) "**Health Assessment high risk**" means member's UCAT health assessment score is 25 which indicates in the UCAT assessor's clinical judgment, the member has one or more chronic health conditions, whose symptoms are rapidly deteriorating, uncontrolled, or not well controlled and requiring a high frequency or intensity of medical care/oversight to bring under control and whose functional capacity is so limited as to require full time assistance or care performed daily, by, or under the supervision of professional personnel and has multiple unmet needs for services available only through the ADvantage program or

a Nursing Facility (NF) and requires NF placement immediately if these needs cannot be met by other means.

(M) "**Health Assessment low risk**" means member's health assessment score is 5 which indicates, in the UCAT assessor's clinical judgment, the member has one or more chronic, stable, health conditions, whose symptoms are controlled or nearly controlled, which benefit from available, or usually available, medical treatment or corrective measures, and may have an unmet need for a service available only through the ADvantage program or a Nursing Facility (NF) but is not likely to enter a NF if these needs are not met.

(N) "**Health Assessment moderate risk**" means member's UCAT Health Assessment score is 15 which indicates in the UCAT assessor's clinical judgment, the member has one or more chronic changing health conditions, whose symptoms are fragile or worsening and require medical care/oversight, to bring under control or to maintain in a stable, controlled state and has multiple unmet needs for services available only through the ADvantage program or a Nursing Facility (NF) and is likely to enter a NF if these needs are not met.

(O) "**IADL**" means the instrumental activities of daily living that reflect household chores and tasks within the community essential for sustaining health and safety such as:

- (i) shopping,
- (ii) cooking,
- (iii) cleaning,
- (iv) managing money,
- (v) using a telephone,
- (vi) doing laundry,
- (vii) taking medication, and
- (viii) accessing transportation.

(P) "**IADLs score in high risk range**" means member's total weighted UCAT IADL score is 12 or more which indicates the member needs some help with 6 IADLs or cannot do 4 IADLs at all.

(Q) "**Intellectual Disability**" means that the individual has, as determined by a standardized testing by trained professionals, substantial limitations in functional ability due to significantly sub-average intellectual functioning related to an event occurring before the age of 18.

(R) "**MSQ**" means the mental status questionnaire.

(S) "**MSQ score in high risk range**" means the member's total weighted UCAT MSQ score is 12 or more which indicates a severe orientation-memory-concentration impairment, or a severe memory impairment.

(T) "**MSQ score at the high end of the moderate risk range**" means the member's total weighted UCAT MSQ

score is (10) or (11) which indicates an orientation-memory-concentration impairment, or a significant memory impairment.

(U) "**Nutrition high risk**" means a total weighted UCAT Nutrition score is 12 or more which indicates the member has significant eating difficulties combined with poor appetite, weight loss, and/or special diet requirements.

(V) "**Progressive degenerative disease process that responds to treatment**" means a process such as, but not limited to, Multiple Sclerosis (MS), Parkinson's Disease, Human Immunodeficiency Virus (HIV), or Acquired Immunodeficiency Syndrome (AIDS), that, untreated, systematically impairs normal body function which leads to acute illness and/or disability that results in rapid and/or advanced effects beyond those of regular chronic disease degeneration but that reacts positively to a medically prescribed treatment intervention (usually medication) which arrests or significantly delays the destructive action of the process.

(W) "**Reauthorization**" means the official approval by the AA of an ADvantage member's Service Plan after the approval/authorization of the member's initial, or first year, Service Plan. At a minimum, reauthorization of an ADvantage member's Service Plan is required every 12 months.

(X) "**Recertification**" means the formal certification of medical and/or financial eligibility for an ADvantage member by OKDHS within ELDERS and IMS upon completion of the annual review.

(Y) "**Redetermination of eligibility**" means a subsequent determination of eligibility for an ADvantage member after the initial eligibility decision. Redetermination of financial and medical eligibility for ADvantage members is required at a minimum of once every 12 months. A redetermination of Program Eligibility, although not required, may occur when a significant change in the service plan is authorized or a significant change in the living arrangement occurs.

(Z) "**Social Resources high risk**" means a total weighted UCAT Social Resources score is 15 or more, which indicates the member lives alone, combined with none or very few social contacts and no supports in times of need.

(2) **Minimum UCAT criteria.** The minimum UCAT criteria for NF level of care criteria are:

(A) Care need: The UCAT documents need for assistance to sustain health and safety as demonstrated by:

(i) either the ADLs or MSQ score is in the high risk range; or

(ii) any combination of two or more of the following:

(I) ADLs score is at the high end of moderate risk range; or,

- (II) MSQ score is at the high end of moderate risk range; or,
- (III) IADLs score is in the high risk range; or,
- (IV) Nutrition score is in the high risk range; or,
- (V) Health Assessment is in the moderate risk range, and, in addition;

(B) Loss of independence: The UCAT documents absence of support or adequate environment to meet the needs to sustain health and safety as demonstrated by:

- (i) Member Support is moderate risk; or,
- (ii) Environment is high risk; or,
- (iii) Environment is moderate risk and Social Resources is in the high risk range; or, regardless of whether criteria under (A) of Care need and (B) Loss of independence;

(C) Expanded criteria: The UCAT documents that:

- (i) the member has a clinically documented progressive degenerative disease process that will produce health deterioration to an extent that the individual will meet OAC 317:35-17-2(2)(A) criteria if untreated; and
- (ii) the member previously has required Hospital or NF level of care services for treatment related to the condition; and
- (iii) a medically prescribed treatment regimen exists that will significantly arrest or delay the disease process; and
- (iv) only by means of ADvantage Program eligibility will the individual have access to the required treatment regimen to arrest or delay the disease process.

(3) **NF Level of Care Services.** To be eligible for NF level of care services, meeting the minimum UCAT criteria demonstrates the individual must:

- (A) require a treatment plan involving the planning and administration of services that require the skills of licensed or otherwise certified technical or professional personnel, and are provided directly or under the supervision of such personnel;
- (B) have a physical impairment or combination of physical, mental and/or functional impairments;
- (C) require professional nursing supervision (medication, hygiene and/or dietary assistance);
- (D) lack the ability to adequately and appropriately care for self or communicate needs to others;
- (E) require medical care and treatment in order to minimize physical health regression or deterioration;
- (F) require care that is not available through family and friends, Medicare, Veterans Administration, or other

federal entitlement program with the exception of Indian Health Services.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 15 Ok Reg 3715, eff 5-18-98 (emergency); Amended at 16 Ok Reg 1438, eff 5-27-99 ; Amended at 17 Ok Reg 2410, eff 6-26-00 ; Amended at 18 Ok Reg 277, eff 11-21-00 (emergency); Amended at 18 Ok Reg 1139, eff 5-11-01 ; Amended at 18 Ok Reg 2969, eff 5-17-01 ; Amended at 19 Ok Reg 1071, eff 5-13-02 ; Amended at 21 Ok Reg 2252, eff 6-25-04 ; Amended at 29 Ok Reg 1172, eff 6-25-12]

317:35-17-3. ADvantage program services

(a) The ADvantage program is a Medicaid Home and Community-Based waiver used to finance non-institutional, long-term care services for the elderly and a targeted group of physically disabled adults when there is a reasonable expectation that within a thirty (30) calendar day period, the person's health, due to disease process or disability, would without appropriate services, deteriorate and require long-term care (LTC) facility care to arrest the deterioration. Individuals may not be enrolled in ADvantage for the sole purpose of enabling them to obtain Medicaid eligibility. Eligibility for ADvantage program services is contingent on an individual requiring one (1) or more of the services offered in the waiver, at least monthly, to avoid institutionalization.

(b) The number of individuals who may receive ADvantage services is limited.

(1) To receive ADvantage program services, individuals must meet one of the categories in (A) through (D) of this paragraph. He or she must:

(A) Be sixty-five (65) years of age or older; or

(B) Be twenty-one (21) to sixty-four (64) years of age with a physical disability; or

(C) Be twenty-one (21) to sixty-four years of age with a developmental disability, provided he or she does not have a cognitive impairment (intellectual disability); or

(D) Be twenty-one (21) to sixty-four (64) years of age with a clinically documented, progressive, degenerative disease process that responds to treatment and previously required hospital or LTC facility level of care services to maintain the treatment regimen to prevent health deterioration.

(2) In addition, the individual must meet criteria in (A) through (C) of this paragraph. He or she must:

(A) Require long-term care facility level of care, per Oklahoma Administrative Code (OAC) 317:35-17-2;

(B) Meet service eligibility criteria, per OAC 317:35-17-3(f); and

(C) Meet program eligibility criteria, per OAC 317:35-17-3(g).

(c) ADvantage members are eligible for limited types of living arrangements. The specific living arrangements are set forth in (1) through (5) of this subsection.

(1) ADvantage program members are not eligible to receive services while residing in an unlicensed institutional living arrangement, such as a room and board home or facility; an institutional setting including, but not limited to, licensed facilities, such as a hospital, a LTC facility, licensed residential care facility, or licensed assisted living facility, unless the facility is an ADvantage assisted living center.

(2) Additional living arrangements in which members may receive ADvantage services are the member's own home, apartment, or independent-living apartment, or a family or friend's home or apartment. A home or apartment unit is defined as a self-contained living space having a lockable entrance to the unit and including a bathroom, food storage and preparation amenities in addition to the bedroom or living space.

(3) ADvantage program members may receive services in a shelter or similar temporary-housing arrangement that may or may not meet the definition of home or apartment in emergency situations, for a period not to exceed sixty (60) calendar days during which location and transition to permanent housing is sought.

(4) For ADvantage members who are full-time students, a dormitory room qualifies as an allowable living arrangement in which to receive ADvantage services while the member is a student.

(5) Members may receive ADvantage respite services in an LTC facility for a continuous period not to exceed thirty (30) calendar days.

(d) Home and Community-Based waiver services are outside of the scope of Medicaid State Plan services. The Medicaid waiver allows the Oklahoma Health Care Authority to offer certain Home and Community-Based services to an annually capped number of persons, who are categorically needy, per Oklahoma Human Services (OKDHS) Appendix C-1, Schedule VIII. B. 1., and without such services would be institutionalized. The estimated cost of providing an individual's care outside of the LTC facility cannot exceed the annual cost of caring for that individual in a LTC facility. When determining the ADvantage service plan cost cap for an individual, the comparable Medicaid cost to serve that individual in a LTC facility is estimated.

(e) Services provided through the ADvantage waiver are:

- (1) Case management;
- (2) Respite;
- (3) Adult day health care;
- (4) Environmental modifications;
- (5) Specialized medical equipment and supplies;
- (6) Physical, occupational, or speech therapy or consultation;
- (7) Advanced supportive and/or restorative assistance;
- (8) Nursing;
- (9) Skilled nursing;
- (10) Home-delivered meals;
- (11) Hospice care;

- (12) Medically necessary prescription drugs, within the limits of the ADvantage waiver;
- (13) Personal care, State Plan, or ADvantage personal care;
- (14) A Personal Emergency Response System (PERS);
- (15) Consumer Directed Personal Assistance Services and Supports (CD-PASS);
- (16) Institution Transition Services (Transitional Case Management);
- (17) Assisted living;
- (18) Remote Supports;
- (19) Assistive technology; and
- (20) SoonerCare medical services for individuals, twenty-one (21) years of age and over, within the State Plan scope.

(f) The OKDHS area nurse or nurse designee determines service eligibility prior to evaluating the Uniform Comprehensive Assessment Tool (UCAT) assessment for long-term care facility level of care. The criteria in (1) through (5) of this subsection are used to make the service eligibility determination, which includes:

- (1) An open ADvantage program waiver slot, as authorized by the Centers for Medicare and Medicaid Services (CMS), is available to ensure federal participation in payment for services to the individual. When Oklahoma Human Services Community Living, Aging and Protective Services (CAP) determines all slots are filled, the individual cannot be certified as eligible for ADvantage services, and his or her name is placed on a waiting list for entry when an open slot becomes available.
- (2) The ADvantage waiver-targeted service groups are individuals, who:

- (A) Are frail and sixty-five (65) years of age and older; or
- (B) Are Twenty-one (21) to sixty-four (64) years of age and physically disabled; or
- (C) When developmentally disabled and twenty-one (21) to sixty-four (64) years of age and do not have an intellectual disability or cognitive impairment related to the developmental disability; or
- (D) Are twenty-one (21) to sixty-four (64) years of age and not physically disabled but have a clinically documented, progressive, degenerative disease process that responds to treatment and previously required hospital or long-term care facility level of care services to maintain the treatment regimen to prevent health deterioration. The individual must meet criteria, per OAC 317:35-17-3(b)(2) (A) through (C).

(3) An individual is ineligible when posing a physical threat to self or others, as supported by professional documentation.

(4) An individual is ineligible when members of the household or persons who routinely visit the household pose a threat of harm or injury to the individual or other household visitors, as supported by professional documentation.

(5) An individual is ineligible when his or her living environment poses a physical threat to self or others, as supported by

professional documentation where applicable, and measures to correct hazardous conditions or assist the individual to move are unsuccessful or not feasible.

(g) The State, as part of the ADvantage waiver program approval process, ensures CMS that each member's health, safety, or welfare can be maintained in his or her home. When a member's identified needs cannot be met through provision of the 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 individual's health, safety, or welfare in his or her home cannot be ensured. The ADvantage Administration (AA) determines ADvantage program eligibility through the service plan approval process. An individual is deemed ineligible for the ADvantage program based on criteria (1) through (8) of this subsection.

(1) The individual's needs, as identified by the UCAT and other professional assessments, cannot be met through ADvantage program services, Medicaid State Plan services, or other formal or informal services.

(2) One (1) or more members of the individual's household pose a physical threat to themselves, or others as supported by professional documentation.

(3) The individual or other household members use threatening, intimidating, degrading, or use sexually inappropriate language or innuendo or behavior towards service providers, in the home or through other contact or communications, and significant efforts were attempted to correct such behavior, as supported by professional documentation or other credible documentation.

(4) The individual, or the individual's authorized agent, is uncooperative or refuses to participate in service development or service delivery and these actions result in unacceptable increases of risk to the individual's health, safety, or welfare in his or her home, as determined by the individual, the interdisciplinary team, or the AA.

(5) The individual's living environment poses a physical threat to self or others, as supported by professional documentation, and measures to correct hazardous conditions or assist the person to move are unsuccessful or are not feasible.

(6) The individual provides false or materially inaccurate information necessary to determine program eligibility or withholds information necessary to determine program eligibility.

(7) The individual does not require at least one ADvantage service monthly.

(8) The individual, his or her family member(s), associate(s), or any other person(s) or circumstances as relates to care and coordination in the living environment produces evidence of illegal drug activity or substances used illegally as intoxicants.

This includes:

(A) The use, possession, or distribution of illegal drugs;

(B) The abusive use of other drugs, such as medication prescribed by a doctor;

(C) The use of substances, such as inhalants including, but not limited to:

- (i) Typewriter correction fluid;
- (ii) Air conditioning coolant;
- (iii) Gasoline;
- (iv) Propane;
- (v) Felt-tip markers;
- (vi) Spray paint;
- (vii) Air freshener;
- (viii) Butane;
- (ix) Cooking spray;
- (x) Paint; and
- (xi) Glue;

(D) The observed intoxication, consumption, or sensory indicators, such as smell of the use of any drug or intoxicant by the individual, family members, associates, or any other person(s) present at the time care is provided may be construed as evidence indicative of illegal drug activity or intoxication. This includes drug use or intoxicated activity that is menacing to the member or staff providing services;

(E) The observance of drug paraphernalia or any instrument used in the manufacturing, production, distribution, sale, or consumption of drugs or substances including, but not limited to:

- (i) Smoking pipes used to consume substances other than tobacco;
- (ii) Roach clips containing marijuana cigarettes;
- (iii) Needles and other implements used for injecting drugs into the body;
- (iv) Plastic bags or other containers used to package drugs;
- (v) Miniature spoons used to prepare drugs; or
- (vi) Kits used in the production of synthetic controlled substances including descriptive materials that accompany the item, describing or depicting its use.

(F) Instructions, verbal or written, concerning the item or device including, but not limited to, the manner in which the object is labeled and displayed for sale;

(G) The typical use of such items in the community; or

(H) Testimony of an expert witness regarding use of the item.

(h) The case manager provides the AA with professional documentation or other credible documentation to support the recommendation for redetermination of program eligibility. The service providers continue providing services according to the person-centered service plan as provider safety permits until the individual is removed from the ADvantage program. As a part of the procedures requesting redetermination of program eligibility, CAP provides technical assistance to the provider for transitioning the individual to other services.

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

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 15 Ok Reg 3715, eff 5-18-98 (emergency); Amended at 16 Ok Reg 1438, eff 5-27-99 ; Amended at 17 Ok Reg 2410, eff 6-26-00 ; Amended at 18 Ok Reg 277, eff 11-21-00 (emergency); Amended at 18 Ok Reg 515, eff 1-1-01 (emergency); Amended at 18 Ok Reg 1139, eff 5-11-01 ; Amended at 18 Ok Reg 2969, eff 5-17-01 ; Amended at 19 Ok Reg 1071, eff 5-13-02 ; Amended at 20 Ok Reg 1958, eff 6-26-03 ; Amended at 21 Ok Reg 2252, eff 6-25-04 ; Amended at 22 Ok Reg 2741, eff 5-4-05 (emergency); Amended at 23 Ok Reg 168, eff 7-1-05 (emergency); Amended at 23 Ok Reg 1390, eff 5-25-06 ; Amended at 26 Ok Reg 263, eff 12-1-08 through 7-14-09 (emergency)¹; Amended at 27 Ok Reg 1481, eff 6-11-10 ; Amended at 28 Ok Reg 1542, eff 6-25-11 ; Amended at 29 Ok Reg 204, eff 11-22-11 (emergency); Amended at 29 Ok Reg 1172, eff 6-25-12 ; Amended at 30 Ok Reg 1262, eff 7-1-13 ; Amended at 34 Ok Reg 726, eff 9-1-17 ; Amended at 37 Ok Reg 1660, eff 9-14-20 ; Amended at 40 Ok Reg 2259, eff 9-11-23 ; Amended at 41 Ok Reg, Number 12, effective 1-30-24 (emergency)]

Editor's Note: ¹*This emergency action expired without being superseded by a permanent action. Upon expiration of an emergency amendatory action, the last effective permanent text is reinstated. Therefore, on 7-15-09 (after the 7-14-09 expiration of the emergency action), the text of 317:35-17-3 reverted back to the permanent text that became effective 5-25-06, as was last published in the 2006 Edition of the OAC, and remained as such until amended again by permanent action on 6-11-10.*

317:35-17-4. Application for ADvantage services

(a) **Application procedures for ADvantage services.** If waiver slots are available, the application process is initiated by the receipt of a UCAT, Part I or by an oral request for services. A written financial application is not required for an individual who has an active Medicaid case. A financial application for ADvantage services consists of the Medical Assistance Application form. The form is signed by the applicant, parent, spouse, guardian or someone else acting on the applicant's behalf.

(1) All conditions of financial eligibility must be verified and documented in the case record. When current information already available in the local office establishes financial eligibility, such information may be used by recording source and date of information. If the applicant also wishes to apply for a State Supplemental Payment, either the applicant or his/her guardian must sign the application form.

(2) When Medicaid application is being made, an assessment of resources must be completed. For applicants of the ADvantage waiver, those resources owned by the couple the month the application was made determines the spousal share of resources.

(b) **Date of application.**

(1) The date of application is:

- (A) the date the applicant or someone acting in his/her behalf signs the application in the county office; or
- (B) the date the application is stamped into the county office when the application is initiated outside the county

office; or

(C) the date when the request for Medicaid is made orally and the financial application form is signed later. The date of the oral request is entered in "red" above the date the form is signed.

(2) An exception is when OKDHS has contracts with certain providers to take applications and obtain documentation. After the documentation is obtained, the contracted provider forwards the application and documentation to the OKDHS county office of the applicant's county of residence for Medicaid eligibility determination. The application date is the date the applicant signed the application form for the provider.

(c) **ADvantage waiting list procedures.** ADvantage Program "available capacity" is the number of members that may be enrolled in the Program without exceeding, on an annualized basis, the maximum number authorized by the waiver to be served in the waiver year. Upon notification from the AA that 90% of the available capacity has been exceeded, OKDHS Aging Services Division (OKDHS/ASD) notifies OKDHS county offices and contract agencies approved to complete the UCAT, Parts I and II that, until further notice, requests for ADvantage services are not to be processed as applications, but referred to AA to be placed on a waiting list of requests for ADvantage services. As available capacity permits, but remaining in compliance with waiver limits of maximum capacity, and until an increase in ADvantage available capacity occurs, the AA selects in chronological order (first on, first off) requests for ADvantage from the waiting list to forward to the appropriate OKDHS county office for processing the application. When the waiver capacity exceeds the number on the waiting list and after all persons on the waiting list have been processed, waiting list procedures are suspended.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 15 Ok Reg 3715, eff 5-18-98 (emergency); Amended at 16 Ok Reg 1438, eff 5-27-99 ; Amended at 17 Ok Reg 2410, eff 6-26-00 ; Amended at 18 Ok Reg 277, eff 11-21-00 (emergency); Amended at 18 Ok Reg 1139, eff 5-11-01 ; Amended at 20 Ok Reg 1958, eff 6-26-03 ; Amended at 21 Ok Reg 2252, eff 6-25-04 ; Amended at 28 Ok Reg 1542, eff 6-25-11 ; Amended at 29 Ok Reg 1172, eff 6-25-12]

317:35-17-5. ADvantage program medical eligibility determination

The Oklahoma of Human Services OKDHS area nurse or nurse designee, makes the medical eligibility determination utilizing professional judgment, the Uniform Comprehensive Assessment Tool (UCAT), and any other available medical information.

(1) When ADvantage care services are requested or the application is received, the:

(A) OKDHS nurse completes the UCAT; and

(B) Social services specialist (SSS) contacts the applicant within three (3) business days to initiate the financial eligibility application process.

(2) Categorical relationship is established for ADvantage services eligibility determination. When a member's categorical relationship to a disability is not established, the local SSS

submits the same information, per Oklahoma Administrative Code (OAC) 317:35-5-4(2) to the Level of Care Evaluation Unit (LOCEU) of the Oklahoma Health Care Authority to request a medical categorical relationship eligibility determination. LOCEU decides on the categorical relationship to the disability using the Social Security Administration (SSA) definition. An SSS follow-up with SSA is required to ensure the disability decision agrees with the LOCEU decision.

(3) Community agencies and waiver service applicants may complete the application and forward to OKDHS.

(4) When an applicant is Medicaid eligible at the request time, an OKDHS nurse completes the UCAT assessment with the applicant within ten (10) business days of referral receipt for ADvantage services. The OKDHS nurse completes the UCAT assessment within twenty (20) business days of the date the Medicaid application is completed for new applicants.

(5) For initial level of care (LOC), the OKDHS nurse assesses the applicant through an electronic format such as phone or video conference, using the UCAT unless there are limiting factors which necessitate a face-to-face assessment.

(A) The OKDHS nurse determines LOC based upon the assessment outcome unless the applicant is medically ineligible. In this case, a face-to-face visit is scheduled to either validate the initial electronic format assessment or to provide additional documentation to support the applicant meeting medical LOC.

(B) Applicants are not denied access to the waiver solely based on an assessment completed through an electronic format.

(6) During the UCAT assessment, the OKDHS nurse informs the applicant of medical eligibility criteria and provides information about the different long-term care service options. The OKDHS nurse documents whether the applicant chooses nursing facility program services or ADvantage program services and makes an LOC and service program recommendation.

(7) The OKDHS nurse informs the applicant and family of agencies certified to deliver ADvantage case management and in-home care services in the local area to obtain the applicant's primary and secondary informed provider choice, ensuring adherence to conflict free case management requirements.

(A) ADvantage providers, or those who have an interest in or are employed by an ADvantage provider, do not provide case management or develop the person-centered service plan. The only exception is when the ADvantage Administration demonstrates there are no more than two (2) willing and qualified entities to provide case management and develop person-centered service plans in a geographic area, and those agencies also provide other ADvantage services.

(B) When the applicant or family declines to make a provider choice, the OKDHS nurse documents the decision

on the consents and rights document.

(C) OKDHS uses a rotating system to select agencies for the applicant from a list of all local, certified case management and in-home care providers, ensuring adherence to conflict free case management requirements.

(8) The OKDHS nurse documents chosen agency names, or the choice to decline to select agencies, and the applicant's agreement to receive waiver services.

(9) When the applicant's needs require an immediate interdisciplinary team (IDT) meeting with the case manager and home care provider agency nurse participation to develop a person-centered service plan, the OKDHS nurse documents the priority processing need.

(10) The OKDHS nurse forwards the completed UCAT to the area nurse or nurse designee for medical eligibility determination.

(11) When the OKDHS nurse determines the UCAT assessment indicates the member health and safety are at risk, OKDHS Adult Protective Services staff is notified immediately and the referral is documented on the UCAT.

(12) Within ten (10) business days of receipt of a complete ADvantage application, the area nurse or nurse designee determines medical eligibility using nursing facility LOC criteria and service eligibility criteria, per OAC 317:35-17-2 and 317:35-17-3, and enters the medical decision on the system.

(13) Upon SSS financial eligibility notification and medical eligibility approval for ADvantage entry from the area nurse or nurse designee, AA communicates with the case management provider to begin care and service plan development. AA provides the member's demographic and assessment information, and the number of case management and home care nurse evaluation units authorized for service plan development. When the member requires an immediate home visit to develop a person-centered plan, AA contacts the case management provider directly to confirm availability and request IDT priority.

(14) When a member is being discharged from a nursing facility or hospital and transferred home, services are in place to ensure the member's health and safety. The member's chosen case manager follows the ADvantage institutional transition case management procedures for care, and service plan development and implementation.

(15) A new medical LOC determination is required when a member requests any change in service setting, from:

(A) State Plan Personal Care (SPPC) services to ADvantage services;

(B) ADvantage to SPPC services;

(C) Nursing facility to ADvantage services; or

(D) ADvantage to nursing facility services.

(16) A new medical LOC determination is not required when a member requests ADvantage services re-activation after staying ninety (90) calendar days or less in a nursing facility when the member had previous ADvantage services and the ADvantage

certification period has not expired by the date the member is discharged.

(17) When a UCAT assessment is completed more than ninety (90) calendar days prior to submission to the area nurse or nurse designee for a medical decision, a new assessment is required.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 15 Ok Reg 3715, eff 5-18-98 (emergency); Amended at 16 Ok Reg 1438, eff 5-27-99 ; Amended at 17 Ok Reg 2410, eff 6-26-00 ; Amended at 18 Ok Reg 2969, eff 5-17-01 ; Amended at 19 Ok Reg 1071, eff 5-13-02 ; Amended at 20 Ok Reg 1958, eff 6-26-03 ; Amended at 21 Ok Reg 2252, eff 6-25-04 ; Amended at 29 Ok Reg 1172, eff 6-25-12 ; Amended at 33 Ok Reg 379, eff 1-13-16 (emergency); Amended at 33 Ok Reg 909, eff 9-1-16 ; Amended at 34 Ok Reg 726, eff 9-1-17 ; Amended at 39 Ok Reg 1577, eff 9-12-22]

317:35-17-6. Pre-admission screening [REVOKED]

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 17 Ok Reg 2410, eff 6-26-00 ; Revoked at 21 Ok Reg 2252, eff 6-25-04]

317:35-17-7. PASRR screening process [REVOKED]

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 15 Ok Reg 3715, eff 5-18-98 (emergency); Amended at 16 Ok Reg 1438, eff 5-27-99 ; Amended at 17 Ok Reg 2410, eff 6-26-00 ; Amended at 18 Ok Reg 277, eff 11-21-00 (emergency); Amended at 18 Ok Reg 1139, eff 5-11-01 ; Revoked at 21 Ok Reg 2252, eff 6-25-04]

317:35-17-8. Level II screen for PAS [REVOKED]

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Revoked at 14 Ok Reg 56, eff 4-30-96 (emergency); Revoked at 14 Ok Reg 1802, eff 5-27-97]

317:35-17-8.1. PASRR appeals process [REVOKED]

[Source: Added at 14 Ok Reg 56, eff 4-30-96 (emergency); Added at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 17 Ok Reg 2410, eff 6-26-00 ; Revoked at 21 Ok Reg 2252, eff 6-25-04]

317:35-17-9. General financial eligibility requirements for the ADvantage program

Financial eligibility for ADvantage services is determined using the rules on income and resources according to the category to which the individual is related. (See OAC 317:35-7-36 for categorically related to ABD.) Only individuals who are categorically related to ABD may be served through the ADvantage waiver.

(1) Income, resources and expenses are evaluated on a monthly basis for all individuals requesting payment for the ADvantage program.

(2) To be eligible for long-term care in the ADvantage program, the individual must be determined categorically needy according to the OKDHS Appendix C-1, Schedule VIII. B. 1. If the individual's gross income exceeds this standard, see OAC 317:35-5-41.6(a)(6)(B).

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 17 Ok Reg 2410, eff 6-26-00 ; Amended at 25 Ok Reg 130, eff 8-1-07 (emergency); Amended at 25 Ok Reg 1257, eff 5-25-08]

317:35-17-10. Determining financial eligibility/categorical relationship for the ADvantage program

Financial eligibility for the ADvantage program is determined as follows:

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

(A) The categorically needy standard on OKDHS Appendix C-1, Schedule VI, is applicable for individuals categorically related to ABD.

(B) If the individual is receiving ADvantage program services and has received services for 30 days or longer, the categorically needy standard in OKDHS Appendix C-1, Schedule VIII. B.1., is used. The 30-day requirement is considered to have been met even if it is interrupted by a hospital stay or the individual is deceased before the 30-day period ends. If the individual does not require services past the 30 days, the categorically needy standard in OKDHS Appendix C-1, Schedule VI., is used.

(2) Transfer of capital resources on or before August 10, 1993. Individuals who have transferred capital resources on or before August 10, 1993 and applying for or receiving ADvantage waiver services are subject to penalty if the individual, the individual's spouse, the guardian, or legal representative of the individual or individual's spouse, disposes of resources for less than fair market value during the 30 months immediately prior to eligibility for Title XIX if the individual is eligible at institutionalization. If the individual is not eligible for Title XIX at institutionalization, the individual is subject to penalty if a resource was transferred during the 30 months immediately prior to the date of application for Title XIX. Any subsequent transfer is also subject to the rules in this paragraph. When there have been multiple transfers of resources without commensurate return, all transferred resources are added together to determine the penalty period. The penalty consists of a period of ineligibility (whole number of months) determined by dividing the total uncompensated value of the resource by the average monthly cost (\$2,000) to a private patient in a nursing facility level of care in Oklahoma. The penalty period begins with the month the resource or resources were first transferred and cannot exceed 30 months. Uncompensated value is defined as the difference between the equity value and the amount received for the resource.

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

(i) the transfer was prior to July 1, 1988;

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

(I) the spouse;

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

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

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

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

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

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

(vi) the resource was transferred to the spouse (either community or institutionalized) or to

another person for the sole benefit of the spouse if

the resources are not subsequently transferred to still another person for less than fair market value;
or

(vii) the denial would result in undue hardship.

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

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

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

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

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

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

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

(B) For purposes of this paragraph, an "institutionalized" individual is one who is receiving ADvantage program services.

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

(D) The penalty period consists of a period of ineligibility (whole number of months) determined by dividing the total uncompensated value of the asset by the average monthly cost (\$2,000) to a private patient in an NF level of care in Oklahoma. In this calculation, any partial month is dropped. There is no limit to the length of the penalty

period for these transfers. Uncompensated value is defined as the difference between the fair market value at the time of transfer less encumbrances and the amount received for the resource.

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

- (i) by the individual or such individual's spouse;
- (ii) by a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or such individual's spouse;
- or
- (iii) by any person, including any court or administrative body acting at the direction or upon the request of the individual or such individual's spouse.

(F) A penalty would not apply if:

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

- (I) the spouse;
- (II) the individual's child who is under age 21 or is blind or totally disabled as determined by Social Security;
- (III) a sibling who has equity interest in the home and resided in the home for at least one year immediately prior to the institutionalization of the individual; or
- (IV) the individual's son or daughter who resided in the home and provided care for at least two years immediately prior to the individual's institutionalization.

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

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

community spouse's asset allowance.

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

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

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

(vii) the denial would result in undue hardship.

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

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

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

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

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

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

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

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

(A) For an institutionalized individual, the look-back date is 60 months before the first day the individual is both

institutionalized and has applied for SoonerCare. However, individuals that have purchased an Oklahoma Long-Term Care Partnership Program approved policy may be completely or partially exempted from this Section depending on the monetary extent of the insurance benefits paid.

(B) For purposes of this paragraph, an "institutionalized" individual is one who is receiving ADvantage program services.

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

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

(ii) the date on which the individual is:

(I) eligible for medical assistance; and

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

(D) The penalty period:

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

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

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

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

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

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

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

or

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

(G) Special Situations.

(i) Separate Maintenance or Divorce.

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

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

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

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

(ii) Inheritance from a spouse.

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

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

(H) A penalty would not apply if:

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

(I) the spouse; or

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

(III) a sibling who has equity interest in the home and resided in the home for at least one year immediately prior to the institutionalization of the individual; or
(IV) the individual's son or daughter who resided in the home and provided care for at least two years immediately prior to the individual's institutionalization.

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

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

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

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

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

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

clothing, shelter, or other necessities of life.

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

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

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

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

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

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

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

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

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

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

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

apportioned between the two institutionalized spouses.

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

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 17 Ok Reg 2410, eff 6-26-00 ; Amended at 20 Ok Reg 1958, eff 6-26-03 ; Amended at 24 Ok Reg 2135, eff 6-25-07 ; Amended at 25 Ok Reg 674, eff 12-18-07 (emergency); Amended at 25 Ok Reg 1227, eff 5-25-08]

317:35-17-11. Determining financial eligibility for ADvantage program services

Financial eligibility for individuals in ADvantage program services is determined according to whether or not a spouse remains in the home.

(1) **Individual without a spouse.** For an individual without a spouse, the following rules are used to determine financial eligibility.

(A) **Income eligibility.** To determine the income of the individual, the rules in (i) through (iii) of this subparagraph apply.

(i) If payment of income is made to the individual and another person(s), the income is considered in proportion to the individual's interest.

(ii) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

(iii) After determination of income, the gross income of the individual cannot exceed the categorically needy standard in OKDHS form 08AX001E, Schedule VIII. B. 1., to be eligible for ADvantage services. If the individual's gross income exceeds that standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC 317:35-5-41.6(a)(6)(B)].

(B) **Resource eligibility.** In order for an individual without a spouse to be eligible for ADvantage services, his/her countable resources cannot exceed the maximum resource standard for an individual listed in OKDHS form 08AX001E, Schedule VIII. D.

(C) **Vendor payment.** For individuals in the ADvantage program who live in a house, an apartment, or other independent living setting, there is not a spenddown

calculation as the member does not pay a vendor payment. For individuals in the ADvantage program who reside in an ADvantage Assisted Living Services Center, a vendor payment must be computed if the income exceeds 150% of the federal benefit rate. The member is responsible for payment to the Assisted Living Services Center provider for days of service from the first day of each month in which services have been received until the vendor payment obligation is met.

(D) **Equity in capital resources.** If the equity in the individual's capital resources is in excess of the maximum resource standards, certification is delayed up to 30 days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources can not reasonably be expected to come within standards in one month, the application is denied.

(2) **Individual with a spouse who receives ADvantage or HCBW/MR services, or is institutionalized in a NF or ICF/MR, or is 65 or over and in a mental health hospital.** For an individual with a spouse who receives ADvantage or HCBW/MR services, or is institutionalized in a NF or ICF/MR, or is 65 or over and in a mental health hospital, resources are determined for each individual as the amount owned by each individual plus one-half of the jointly owned resources of the couple. Once this separation of assets is made, a resource of either spouse is not considered available to the other during the receipt of ADvantage program services.

(A) **Income eligibility.** Income is determined separately for an individual and his/her spouse if the spouse is in the ADvantage or HCBW/MR program, or is institutionalized in a NF or ICF/MR, or is 65 or older and in a mental health hospital. The income of either spouse is not considered as available to the other during the receipt of ADvantage services. The rules in (i) - (v) of this subparagraph apply in this situation:

- (i) If payment of income is made solely to one or the other, the income is considered available only to that individual.
- (ii) If payment of income is made to both, one-half is considered for each individual.
- (iii) If payment of income is made to either one or both and another person(s), the income is considered in proportion to either spouse's interest (if payment is to that spouse) or one-half of the joint interest if no interest is specified.
- (iv) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

(v) After determination of income, the gross income of the individual cannot exceed the categorically needy standard in OKDHS form 08AX001E, Schedule VIII. B. 1., to be eligible for ADvantage services. If the individual's gross income exceeds this standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC 317:35-5-41.6(a)(6)(B)].

(B) **Resource eligibility.** In order for an individual with a spouse who receives ADvantage or HCBW/MR services, or is institutionalized in a NF or ICF/MR, or is 65 or older and in a mental health hospital to be eligible for ADvantage services, his/her countable resources cannot exceed the maximum resource standard for an individual listed in OKDHS form 08AX001E, Schedule VIII. D.

(C) **Vendor payment.** For individuals in the ADvantage program who live in a house, an apartment, or other independent living setting, there is not a spenddown calculation as the member does not pay a vendor payment. For individuals in the ADvantage program who reside in an ADvantage Assisted Living Services Center, a vendor payment must be computed if the income exceeds 150% of the federal benefit rate. The member is responsible for payment to the Assisted Living Services Center provider for days of service from the first day of each month in which services have been received until the vendor payment obligation is met.

(D) **Equity in capital resources.** If the equity in the individual's capital resources is in excess of the maximum resource standards, certification is delayed up to 30 days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources can not reasonably be expected to come within standards in one month, the application is denied.

(3) **Individual with a spouse in the home who is not in the ADvantage or HCBW/MR program.** When only one individual of a couple in their own home is in the ADvantage or HCBW/MR program, income and resources are determined separately. However, the income and resources of the individual who is not in the ADvantage or HCBW/MR program (community spouse) must be included on the application form. At redetermination of eligibility, the community spouse's income must be included in the review process. During any month that the individual is in ADvantage program services, the income of the community spouse is not considered available to that individual. The following rules are used to determine the income and resources of each:

(A) **Income eligibility.** To determine the income of both spouses, the rules in (i) - (v) of this subparagraph apply.

- (i) If payment of income is made solely to one or the other, the income is considered available only to that individual.
- (ii) If payment of income is made to both, one-half is considered for each individual.
- (iii) If payment of income is made to either one or both and another person(s), the income is considered in proportion to either spouse's interest (if payment is to that spouse) or one-half of the joint interest if no interest is specified.
- (iv) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.
- (v) After determination of income, the gross income of the individual in the ADvantage program services cannot exceed the categorically needy standard in OKDHS form 08AX001E, Schedule VIII. B. 1., to be eligible for care. If the individual's gross income exceeds this standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC 317:35-5-41.6(a)(6) (B)].

(B) **Resource eligibility.** To determine resource eligibility, it is necessary to determine the amount of resources for both spouses for the month of the individual's application for the ADvantage program. Of the resources available to the couple (both individual and joint ownership) an amount will be protected for the community spouse which will not be considered available to the spouse receiving ADvantage program services. The amount determined as the spousal share is used for all subsequent applications for SoonerCare, regardless of changes in the couple's resources. The protected spousal share cannot be changed for any reason.

- (i) The first step in the assessment process is to establish the total amount of resources for the couple during the month of application of the spouse into the ADvantage program services (regardless of payment source).
- (ii) The community spouse's share is equal to one-half of the total resources of the couple not to exceed the maximum amount of resource value that can be protected for the community spouse, as shown on OKDHS form 08AX001E, Schedule XI.
- (iii) The minimum resource standard for the community spouse, as established by the OHCA, is found on OKDHS form 08AX001E, Schedule XI. When the community spouse's share is less than the minimum standard, an amount may be deemed

from the other spouse's share to ensure the minimum resource standard for the community spouse. If the community spouse's share equals or exceeds the minimum resource standard, deeming cannot be done.

(iv) If deeming is necessary to meet the minimum resource standard for the community spouse, the amount that is deemed must be legally transferred to the community spouse within one year of the effective date of certification for SoonerCare. At the first redetermination of eligibility, the worker must document that the resources have been transferred. After the first year of SoonerCare eligibility, resources of the community spouse will not be available to the other spouse and resources cannot be deemed to the community spouse.

(v) After the month in which the institutionalized spouse and community spouse have met the resource standard and the institutionalized spouse is determined eligible for benefits, no resources of the community spouse, regardless of value, will be considered available to the institutionalized spouse. If the resources of the community spouse grow to exceed the original deemed amount, the State cannot require the community spouse to apply any of these excess resources toward the cost of the care of the institutionalized spouse.

(vi) When determining eligibility for SoonerCare, the community spouse's share of resources is protected and the remainder considered available to the spouse receiving ADvantage program services.

(vii) The resources determined in (i) - (vi) of this subparagraph for the individual receiving ADvantage program services cannot exceed the maximum resource standard for an individual as shown in OKDHS form 08AX001E, Schedule VIII. D.

(viii) Once the dollar value of the community spouse's share of resources is established for the month of the other spouse's entry into the ADvantage program service, that amount is used when determining resource eligibility for a subsequent SoonerCare application for Long-Term Care for either spouse.

(ix) Once a determination of eligibility for SoonerCare is made, either spouse is entitled to a fair hearing. A fair hearing regarding the determination of the community spouse's resource allowance is held within 30 days of the date of the request for the hearing. Either spouse is entitled to

a fair hearing if dissatisfied with a determination of:

- (I) the community spouse's monthly income allowance;
- (II) the amount of monthly income otherwise available to the community spouse;
- (III) determination of the spousal share of resource;
- (IV) the attribution of resources (amount deemed); or
- (V) the determination of the community spouse's resource allowance.

(x) The rules on determination of income and resources are applicable only when an individual receiving ADvantage program services is likely to remain under care for 30 consecutive days. The 30-day requirement is considered to have been met even if a hospital stay interrupts it or the individual is deceased before the 30-day period ends.

(C) Vendor payment. For individuals in the ADvantage program who live in a house, an apartment, or other independent living setting, there is not a spenddown calculation as the member does not pay a vendor payment. For individuals in the ADvantage program who reside in an ADvantage Assisted Living Services Center, after allowable deeming to the community spouse, a vendor payment must be computed if the income exceeds 150% of the federal benefit rate. The member is responsible for payment to the Assisted Living Services Center provider for days of service from the first day of each month in which services have been received until the vendor payment obligation is met.

(D) Excess resources. If the equity in the individual's capital resources is in excess of the maximum resource standards, certification is delayed up to 30 days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources cannot reasonably be expected to come within standards in one month, the application is denied.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 13 Ok Reg 1211, eff 9-8-95 (emergency); Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 13 Ok Reg 2537, eff 6-27-96 ; Amended at 14 Ok Reg 546, eff 12-24-96 (emergency); Amended at 14 Ok Reg 1814, eff 5-27-97 ; Amended at 17 Ok Reg 2410, eff 6-26-00 ; Amended at 21 Ok Reg 2252, eff 6-25-04 ; Amended at 25 Ok Reg 130, eff 8-1-07 through 7-14-08 (emergency)¹; Amended at 25 Ok Reg 2710, eff 7-25-08 ; Amended at 26 Ok Reg 1008, eff 5-1-09 (emergency); Amended at 27 Ok Reg 973, eff 5-13-09 ; Amended at 29 Ok Reg 1172, eff 6-25-12]

Editor's Note: ¹This emergency action expired on 7-14-08 before being superseded by a permanent action. Upon expiration of an emergency amendatory action, the last effective permanent text is reinstated. Therefore, on 7-15-08 (after the 7-14-08 expiration of the emergency action), the text of 317:35-17-11 reverted back to the permanent text that became effective 6-25-04, as was last published in the 2006 Edition of the OAC, and remained as such until amended by permanent action on 7-25-08.

317:35-17-12. Certification for ADvantage program services

- (a) **Application date.** When the applicant is determined eligible for ADvantage, his/her certification is effective the date that medical and financial eligibility was determined. When eligibility or ineligibility for ADvantage program services is established, the worker updates the authorization and the computer-generated notice is mailed to the member and ADvantage Administration (AA).
- (b) **Financial certification period** The financial certification period is twelve (12) months.
- (c) **Medical Certification period.** The medical certification period is twelve (12) months. Redetermination of medical eligibility by an Oklahoma Department of Human Services (DHS) nurse is:
- (1) completed annually in coordination with the annual reauthorization of the member's patient-centered service plan.
 - (2) completed when documentation is received that supports a reasonable expectation the member may not continue to meet medical eligibility criteria.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 17 Ok Reg 2410, eff 6-26-00 ; Amended at 21 Ok Reg 2252, eff 6-25-04 ; Amended at 25 Ok Reg 2710, eff 7-25-08 ; Amended at 26 Ok Reg 758, eff 4-1-09 (emergency); Amended at 27 Ok Reg 1507, eff 6-11-10 ; Amended at 29 Ok Reg 1172, eff 6-25-12 ; Amended at 35 Ok Reg 27, eff 11-1-17 (emergency); Amended at 35 Ok Reg 1479, eff 9-14-18]

317:35-17-13. Certification for ADvantage program services [REVOKED]

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Revoked at 14 Ok Reg 56, eff 4-30-96 (emergency); Revoked at 14 Ok Reg 1802, eff 5-27-97]

317:35-17-14. Case management services

- (a) Case management services involve ongoing assessment, service planning and implementation, service monitoring and evaluation, member advocacy, and discharge planning.
- (1) Within one-business (1-business) day of receipt of an ADvantage referral from the ADvantage Administration (AA), the case management supervisor assigns a case manager to the member. The case manager makes a home visit to review the ADvantage program; its purpose, philosophy, and the roles and responsibilities of the member, service provider, case manager,

and the Oklahoma Department of Human Services (DHS). The case manager will review and/or update the Uniform Comprehensive Assessment Tool (UCAT) Part III and discuss service needs and ADvantage service providers. The case manager notifies the member's primary physician, identified in the UCAT Part I, in writing that the member was determined eligible to receive ADvantage services. The notification is a preprint form that contains the member's signed permission to release this health information and requests physician's office verification of primary and secondary diagnoses and diagnoses code obtained from the UCAT Part III.

(2) Within fourteen-calendar (14-calendar) days of the receipt of an ADvantage referral, the case manager completes and submits a person-centered service plan for the member, signed by the member and the case manager, to the case manager supervisor for approval and submission to the AA. The case manager completes and submits the annual reassessment person-centered service plan documents no sooner than sixty-calendar (60-calendar) days before the existing service plan end-date but sufficiently in advance of the end-date to be received by the AA at least thirty (30) days before the end-date of the existing person-centered service plan. The case manager submits revisions for denied services to be resubmitted for approval within five-business (5-business) days to the AA. Within fourteen-calendar (14-calendar) days of receipt of a Service Plan Review (SPR) for short-term authorizations from the AA, the case manager submits corrected person-centered service plan documentation. Within five-business (5-business) days of assessed need, the case manager completes and submits a service plan addendum to the AA to amend current services on the person-centered service plan. The person-centered service plan is based on the member's service needs identified by the UCAT Part III, and includes only those ADvantage services required to sustain and/or promote the health and safety of the member. The case manager uses an interdisciplinary team (IDT) planning approach for person-centered service plan development. Except for extraordinary circumstances, the IDT meetings are held in the member's home. When home care is the primary service, the IDT includes, at a minimum, the member, a nurse from the ADvantage home care or assisted living provider chosen by the member, and the case manager. Otherwise, the member and case manager constitute a minimum IDT.

(3) The case manager identifies long-term goals, strengths and challenges for meeting goals, and service goals including plan objectives, actions steps and expected outcomes. The ADvantage case manager documents on the person-centered service plan the presence of two (2) or more ADvantage members residing in the same household and/or when the member and personal care provider reside together. The case manager documents on the Electronic Visit Verification (EVV) system in the member record any instance in which a member's health or safety would be at

risk when even one (1) personal care visit is missed. The case manager identifies services, service provider, funding source units and frequency of service and service cost, cost by funding source and total cost for ADvantage services. The member signs and indicates review/agreement with the person-centered service plan by indicating acceptance or non-acceptance of the plans. The member, the member's legal guardian or legally authorized representative signs the person-centered service plan in the presence of the case manager. The signatures of two (2) witnesses are required when the member signs with a mark. When the member refuses to cooperate in development of the person-centered service plan or when the member refuses to sign the person-centered service plan, the case management agency refers the case to the AA for resolution. Based on the UCAT Part III and/or case progress notes that document chronic uncooperative or disruptive behaviors, the DHS nurse or AA may identify members that require AA intervention through referral to the AA's Escalated Issues unit.

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

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

(4) Consumer-Directed Personal Assistance Services and Supports (CD-PASS) planning and supports coordination.

(A) CD-PASS offers ADvantage members personal choice and control over the delivery of their in-home support service, including who provides the services and how services are provided. Members or their legal representatives have singular "employer authority" in decision-making and are responsible to recruit, hire, train, supervise and when necessary, terminate the individuals who furnish their services. They also have "budget authority" to determine how expenditures of their expense

accounts are managed.

(B) Members who elect the CD-PASS service option receive support from Consumer-Directed Agent/Case Manager (CDA/CM) in directing their services. The CDA/CM liaison between the member and the program assists members, identifying potential requirements and supports as they direct their services and supports. ADvantage case management providers deliver required support and assign the CD-PASS members a case manager trained on the ADvantage CD-PASS service option, independent living philosophy, person centered service planning, the role of the member as employer of record, the individual budgeting process and service plan development guidelines. A case manager, who has completed specialized CD-PASS training, is referred to as a CDA/CM with respect to the service planning and support role when working with CD-PASS members. The CDA/CM educates the member about his or her rights and responsibilities as well as community resources, service choices and options available to the member to meet CD-PASS service goals and objectives.

(C) The ADvantage case management provider is responsible for ensuring that case managers serving members who elect to receive or are receiving the CD-PASS service option have successfully completed CD-PASS certification training in its entirety and have a valid CDA/CM certification issued by the AA.

(D) Consumer-directed, SoonerCare (Medicaid)-funded programs are regulated by federal laws and regulations setting forth various legal requirements with which states must comply. The ADvantage case management provider is responsible for ensuring that CDA/CMs in their employment provide services to CD-PASS members consistent with certification guidelines so as to be in keeping with federal, state, and Waiver requirements. Non-adherence may result in remediation for the case management provider, the case manager, or both, up to and including decertification.

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

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

representative.

(ii) An individual hired to provide CD-PASS services to a member may not be designated the authorized representative for the member.

(iii) The case manager reviews the designation of authorized representative, power of attorney, and legal guardian status on an annual basis and includes this in the reassessment packet to AA.

(F) The CDA/CM provides support to the member in the person-centered CD-PASS planning process. Principles of person-centered planning are listed in (i) through (v) of the subparagraph.

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

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

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

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

(v) Person-centered planning results in personally-defined outcomes.

(G) The CDA/CM encourages and supports the member, or as applicable his or her designated authorized representative, to lead, to the extent feasible, the CD-PASS service planning process for personal services assistance. The CDA/CM helps the member define support needs, service goals, and service preferences including access to and use of generic community resources. Consistent with member-direction and preferences, the CDA/CM provides information and helps the member locate and access community resources. Operating within the constraints of the Individual Budget Allocation (IBA) units, the CDA/CM assists the member translate the assessment of member needs and preferences into an individually tailored, person-centered service plan.

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

(I) The member determines with the PSA to be hired, a start date for PSA services. The member coordinates with the CDA/CM to finalize the person-centered service plan.

The start date must be after:

- (i) authorization of services;
- (ii) completion and approval of the background checks; and
- (iii) completion of the member employee packets.

(J) Based on outcomes of the planning process, the CDA/CM prepares an ADvantage person-centered service plan or plan amendment to authorize CD-PASS personal service assistance units consistent with this individual plan and notifies existing duplicative personal care service providers of the end-date for those services.

(K) When the plan requires an Advanced Personal Service Assistant (APSA) to provide assistance with health maintenance activities, the CDA/CM works with the member and, as appropriate, arranges for training by a skilled nurse for the member or member's family and the APSA to ensure that the APSA performs the specific health maintenance tasks safely and competently, when the:

- (i) member's APSA was providing Advanced Supportive Restorative Assistance to the member for the same tasks in the period immediately prior to being hired as the APSA, additional documentation of competence is not required; and
- (ii) member and APSA attest that the APSA was performing the specific health maintenance tasks to the member's satisfaction on an informal basis as a friend or family member for a minimum of two (2) months in the period immediately prior to being hired as the PSA, and no evidence contra-indicates the attestation of safe and competent performance by the APSA, additional documentation is not required.

(L) The CDA/CM monitors the member's well-being and the quality of supports and services and assists the member in revising the PSA services plan as needed. When the member's need for services changes due to a change in health/disability status and/or a change in the level of support available from other sources to meet needs, the CDA/CM, based upon an updated assessment, amends the person-centered service plan to modify CD-PASS service units appropriate to meet the additional need and submits the plan amendment to the AA for authorization and update of the member's IBA.

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

- (i) either party may contact via a toll free number the Member/Provider Relations Resource Center to obtain assistance with issue resolution;
- (ii) when the issue cannot be resolved with assistance from the Member/Provider Relations Resource Center or from CD-PASS Program

Management, the CD-PASS Program Management submits the dispute to the ADvantage Escalated Issues Unit for resolution. The Escalated Issues Unit works with the member and provider to reach a mutually-agreed upon resolution;

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

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

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

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

(ii) one (1) or more qualified substitute ADvantage agency service providers, adult day health, personal care, or nursing facility (NF) respite provider, and preparation for quick response to provide backup emergency services.

(O) To obtain authorizations for providers other than PSA and APSA identified as emergency backups, requests the AA authorize and facilitate member access to adult day health, agency personal care, or NF respite services.

(5) The case manager submits the person-centered service plan to the case management supervisor for review. The case management supervisor conducts the review/approval of the plans within two-business (2-business) days of receipt from the case manager or returns the plans to the case manager with notations of errors, problems, and concerns to be addressed. The case manager re-submits the corrected person-centered service plan to the case management supervisor within two-business (2-business) days. The case management supervisor returns the approved person-centered service plan to the case manager. Within one-business (1-business) day of receiving supervisory approval, the case manager submits, the person-centered service plan to the AA. Only priority service needs and supporting documentation may be submitted to the AA as a "Priority" case with justification attached. "Priority" service needs are defined as

services needing immediate authorization to protect the health and welfare of the member and/or avoid premature admission to the NF. Corrections to service conditions set by the AA are not considered a priority unless the health and welfare of the member would otherwise be immediately jeopardized and/or the member would otherwise require premature admission to a NF.

(6) Within one-business (1-business) day of notification of care plan and person-centered service plan authorization, the case manager communicates with the service plan providers and member to facilitate service plan implementation. Within five-business (5-business) days of notification of an initial person-centered service plan or a new reassessment service plan authorization, the case manager visits the member, gives the member a copy of the person-centered service plan and evaluates the service plan implementation progress. The case manager evaluates service plan implementation on the following minimum schedule:

- (A) within thirty-calendar (30-calendar) days of the authorized effective date of the person-centered service plan or service plan addendum amendment; and
- (B) monthly after the initial thirty-calendar (30-calendar) follow-up evaluation date.

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

(1) Except as provided by the process per Oklahoma Administrative Code (OAC) 317:30-5-761(6), family members may not receive payment for providing ADvantage waiver services. A family member is defined as an individual who is legally responsible for the member, such as the spouse or parent of a minor child.

(2) DHS AS may, per OAC 317:35-15-13, authorize personal care service provision by an Individual PCA, an individual contracted directly with OHCA. Legally responsible family members are not eligible to serve as Individual PCAs.

(3) When a complete service plan authorization or amendment request is received and the service plan is within cost-effectiveness guidelines, the AA authorizes or denies authorization within five-business (5-business) days of receipt of the request. When the service plan is not within cost-effectiveness guidelines, the plan is referred for administrative review to develop an alternative cost-effective plan or assist the member to access services in an alternate setting or program. When the request packet is incomplete, the AA notifies the case manager immediately and puts a hold on authorization until the requirements are received from case management.

(4) The AA authorizes the service plan by entering the authorization date. Notice of authorization of the service plan is available through the appropriate designated software or web-based solution. AA authorization determinations are provided to case management within one-business (1-business) day of the authorization date. A person-centered service plan may be authorized and implemented with specific services temporarily denied. The AA communicates to case management the conditions for approval of temporarily denied services. The case manager submits revisions for denied services to AA for approval within five-business (5-business) days.

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

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

(1) The service provider initiates the process for an increase or decrease in service to the member's person-centered service plan. The requested changes and justification are documented by the service provider and, when initiated by a direct care provider, are submitted to the member's case manager. When in agreement, the case manager submits the service changes within five-business (5-business) days of the assessed need. The AA authorizes or denies the person-centered service plan changes, per OAC 317:35-17-14.

(2) The member initiates the process for replacing personal care services with CD-PASS in geographic areas where CD-PASS services are available. The member may contact the AA or call the toll-free number to process requests for CD-PASS services.

(3) A significant change in the member's physical condition or caregiver support, one that requires additional goals, deletion of goals or goal changes, or requires a four-hour (4-hour) or more adjustment in services per week, requires an updated UCAT Part III reassessment by the case manager. The case manager develops an amended or new person-centered service plan, as appropriate, and submits the new amended person-centered service plan for authorization.

(4) One (1) or more of the following changes or service requests require an Interdisciplinary Team review and service plan goals amendment:

- (A) the presence of two (2) or more ADvantage members residing in the same household;
- (B) the member and personal care provider residing together; (C) a request for a family member to be a paid ADvantage service provider; or
- (D) a request for an individual PCA service provider.

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

(6) Providers of Home and Community Based Services (HCBS) for the member, or those who have an interest in or are employed by a provider of HCBS for the member, must not provide case management or develop the person-centered service plan, except when the State demonstrates the only willing and qualified entity to provide case management and develop person-centered service plans in a geographic area also provides HCBS.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 15 Ok Reg 3715, eff 5-18-98 (emergency); Amended at 16 Ok Reg 1438, eff 5-27-99 ; Amended at 17 Ok Reg 2410, eff 6-26-00 ; Amended at 18 Ok Reg 277, eff 11-21-00 (emergency); Amended at 18 Ok Reg 1139, eff 5-11-01 ; Amended at 18 Ok Reg 2969, eff 5-17-01 ; Amended at 19 Ok Reg 1071, eff 5-13-02 ; Amended at 20 Ok Reg 1958, eff 6-26-03 ; Amended at 21 Ok Reg 2252, eff 6-25-04 ; Amended at 22 Ok Reg 2741, eff 5-4-05 (emergency); Amended at 23 Ok Reg 1390, eff 5-25-06 ; Amended at 26 Ok Reg 758, eff 4-1-09 (emergency); Amended at 27 Ok Reg 311, eff 12-1-09 (emergency); Amended at 27 Ok Reg 977, eff 5-13-10 ; Amended at 29 Ok Reg 1172, eff 6-25-12 ; Amended at 30 Ok Reg 1262, eff 7-1-13 ; Amended at 31 Ok Reg 1742, eff 9-12-14 ; Amended at 32 Ok Reg 1154, eff 8-27-15 ; Amended at 34 Ok Reg 726, eff 9-1-17 ; Amended at 36 Ok Reg 945, eff 9-1-19]

317:35-17-15. Redetermination of eligibility for ADvantage services

(a) The worker must complete a redetermination of financial eligibility prior to the end of the certification period. A notice is generated only if there is a change which affects the member's financial responsibility.

(b) The ADvantage case manager or the OKDHS nurse must complete an annual UCAT reassessment that is reviewed for redetermination of medical eligibility prior to the end of the certification period.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 17 Ok Reg 2410, eff 6-26-00 ; Amended at 25 Ok Reg 2710, eff 7-25-08 ; Amended at 29 Ok Reg 1172, eff 6-25-12]

317:35-17-16. Member annual level of care re-evaluation and annual service plan reauthorization

(a) The ADvantage case manager reassesses the member's needs annually using the Uniform Comprehensive Assessment Tool (UCAT), then evaluates the member's progress toward person-centered service plan goals and objectives. The ADvantage case manager develops the annual person-centered service plan with the member and interdisciplinary team and submits the person-centered service plan to the ADvantage Administration (AA) for authorization. The ADvantage

case manager initiates the UCAT reassessment and develops the annual person-centered service plan at least forty (40) calendar days, but not more than sixty (60) calendar days, prior to the existing plan's end date. The ADvantage case manager provides AA the person-centered service plan reassessment documents no less than thirty (30) calendar days prior to the existing plan's end date. The reassessment documents include the person-centered service plan, UCAT, Nursing Assessment and Monitoring Tool and supporting documentation.

(b) For medical eligibility reassessment, Oklahoma Human Services (OKDHS) recertification nurse reviews the UCAT the ADvantage case manager submitted. When policy defined criteria for nursing facility LOC cannot be determined or justified from available documentation or through direct contact with the ADvantage case manager, the member is referred to the local OKDHS nurse. The OKDHS nurse then re-assesses the applicant using the UCAT through an electronic format such as a phone and video conference, unless there are limiting factors which necessitate a face-to-face assessment.

(1) The OKDHS nurse determines LOC based on the assessment's outcome unless the applicant is determined to be medically ineligible. In this case, a face-to-face visit is scheduled to either validate the electronic format assessment or provide additional documentation to support the applicant meeting medical LOC.

(2) Applicants are not medically denied access to the waiver solely based on an assessment completed through an electronic format.

(c) When medical eligibility redetermination is not made prior to the current medical eligibility expiration, the existing medical eligibility certification is automatically extended.

(1) For members who are not receiving inpatient acute care, long term acute care, rehab or skilled nursing services, the existing medical eligibility certification is extended for a maximum of sixty (60) calendar days from the date of the previous medical eligibility expiration date.

(2) For members who are receiving inpatient acute care, long term acute care, rehab or skilled nursing services, the existing medical eligibility certification is extended for thirty (30) calendar days from the facility discharge date, or for sixty (60) calendar days from the previous medical eligibility's date, whichever is longer.

(3) When the medical eligibility redetermination is not made by the applicable extended deadline, the member no longer meets medical eligibility. The area nurse or nurse designee updates the system's medical eligibility end date.

(d) When OKDHS determines a member no longer meets medical eligibility to receive waiver services, the:

(1) Area nurse or nurse designee updates the medical eligibility end date;

(2) AA communicates to the member's ADvantage case manager that the member no longer meets medical eligibility for ADvantage as of the eligibility determination effective date; and

(3) ADvantage case manager communicates with the member and when requested, assists with access to other services.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 15 Ok Reg 3715, eff 5-18-98 (emergency); Amended at 16 Ok Reg 1438, eff 5-27-99 ; Amended at 17 Ok Reg 2410, eff 6-26-00 ; Amended at 20 Ok Reg 1958, eff 6-26-03 ; Amended at 21 Ok Reg 2252, eff 6-25-04 ; Amended at 25 Ok Reg 2710, eff 7-25-08 ; Amended at 28 Ok Reg 1542, eff 6-25-11 ; Amended at 29 Ok Reg 1172, eff 6-25-12 ; Amended at 35 Ok Reg 1497, eff 9-14-18 ; Amended at 39 Ok Reg 1577, eff 9-12-22]

317:35-17-17. Supplemental process for expedited eligibility determination (SPEED) [REVOKED]

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 17 Ok Reg 2410, eff 6-26-00 ; Amended at 20 Ok Reg 1958, eff 6-26-03 ; Amended at 26 Ok Reg 758, eff 4-1-09 (emergency); Amended at 27 Ok Reg 1507, eff 6-11-10 ; Revoked at 29 Ok Reg 1172, eff 6-25-12]

317:35-17-18. ADvantage services during hospitalization or NF placement

When the member's DHS social worker, ADvantage case manager, or the AA is informed by the member, family, or service provider of a member's hospitalization or placement in a nursing facility (NF), that party determines the date of the member's institutionalization and communicates the date, name of the institution, reason for placement, and expected duration for placement to the other ADvantage Program Administrative partners. When a member requires hospital or NF services, the case manager assists the member access institutional care, periodically monitors the member's progress during the institutional stay and, as appropriate, updates the person-centered service plan and prepares services to start on the date the member is discharged from the institution and returns home. All case management units for institution transition services to plan for and coordinate service delivery and to assist the member to safely return home, even when provided while the person is in an institution, are considered delivered on and billed for the date the member returns home from institutional care.

(1) **Hospital discharge.** When the member returns home from a hospital or when notified of the member's anticipated discharge date, the case manager notifies relevant providers and the ADvantage Administration (AA), and coordinates the resumption of services.

(2) **Nursing Facility placement of less than 30-calendar days.** When the member returns home from a NF stay of 30-calendar or less or when notified of the member's anticipated discharge date, the case manager notifies relevant providers, the member's DHS worker and the AA of the discharge and coordinates the resumption of ADvantage services in the home.

(3) **Nursing Facility placement longer than 30-calendar days.** When the member is scheduled to be discharged and return home from a NF stay that is longer than 30-calendar the member's DHS worker, ADvantage case manager, or the AA, whoever first receives notification of the discharge, notifies other ADvantage Program Administrative partners to expedite the

restart of ADvantage services for the member. The member's case manager provides institution transition case management services to assist the member to re-establish him or herself safely in the home.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 15 Ok Reg 3715, eff 5-18-98 (emergency); Amended at 16 Ok Reg 1438, eff 5-27-99 ; Amended at 19 Ok Reg 338, eff 11-14-01 ; Amended at 19 Ok Reg 1071, eff 5-13-02 ; Amended at 20 Ok Reg 1958, eff 6-26-03 ; Amended at 26 Ok Reg 758, eff 4-1-09 (emergency); Amended at 27 Ok Reg 1507, eff 6-11-10 ; Amended at 29 Ok Reg 1172, eff 6-25-12 ; Amended at 34 Ok Reg 726, eff 9-1-17]

317:35-17-19. Closure or termination of ADvantage services

(a) **Voluntary closure of ADvantage services.** When the member requests a lower level of care than ADvantage services, or agrees that ADvantage services are no longer needed to meet his or her needs, a medical level of care decision by the area nurse or nurse designee, is not needed. The closure request is completed and signed by the member and the ADvantage case manager and sent to the ADvantage Administration (AA) to be placed in the member's case record. The AA notifies the Oklahoma Department of Human Services (DHS) area nurse or area nurse designee of the voluntary closure and effective date of closure. When the member's written request for closure cannot be secured, the ADvantage case manager documents in the member's case record the reasons for the voluntary termination of services and alternatives for services.

(b) **Closure due to financial or medical ineligibility.** The process for closure due to financial or medical ineligibility is described in this subsection.

(1) **Financial ineligibility.** When the local DHS office determines a member does not meet financial eligibility criteria, the DHS office notifies the area nurse or area nurse designee who closes the member's authorization and notifies the member and AA of financial ineligibility by system-generated mail. The AA notifies the member's providers of the decision. A medical eligibility redetermination is not required when a financial ineligibility period does not exceed the medical certification period.

(2) **Medical ineligibility.** When the DHS office is notified by the nurse or area nurse designee of a decision that the member is no longer medically eligible for ADvantage services, the DHS office notifies the member and AA of the decision. Refer to Oklahoma Administrative Code (OAC) 317:35-17-16 (d). The AA notifies the member's providers of the decision.

(c) **Closure due to other reasons.** Refer to OAC 317:35-17-3(e) - (h).

(d) **Resumption of ADvantage services.** When a member approved for ADvantage services is without services for less than ninety (90) calendar days and has a current medical and financial eligibility determination, services may be resumed using the previous authorized person-centered service plan. When a member requests to have his or her services restarted after ninety (90) calendar days, the member must request a new referral for services through the DHS county office or AA. When a member is determined eligible for ADvantage services and transitions

from a hospital or a nursing facility to a community setting, an ADvantage case manager may provide Institution Transition case management services to assist the member to establish or re-establish him or herself safely in the home.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 15 Ok Reg 3715, eff 5-28-98 (emergency); Amended at 16 Ok Reg 1438, eff 5-27-99 ; Amended at 17 Ok Reg 2410, eff 6-26-00 ; Amended at 20 Ok Reg 1958, eff 6-26-03 ; Amended at 21 Ok Reg 2252, eff 6-25-04 ; Amended at 29 Ok Reg 1172, eff 6-25-12 ; Amended at 35 Ok Reg 1497, eff 9-14-18]

317:35-17-20. Case transfer between categories [REVOKED]

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Revoked at 26 Ok Reg 758, eff 4-1-09 (emergency); Revoked at 27 Ok Reg 1507, eff 6-11-10]

317:35-17-21. Case changes

Any time there are changes which affect the long-term care case, computer generated notices are issued.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97]

317:35-17-21.1. ADvantage and agency Personal Care provider certification

ADvantage Administration (AA) forwards information on all certified ADvantage and Personal Care agency providers providing services in the specific OKDHS area to the area nurse and OKDHS county director. The provider information includes agency name, address, contact person for ADvantage/Personal Care programs, provider number, a list of ADvantage/Personal Care services the provider is certified to deliver, and other information as needed by OKDHS staff to achieve efficient service delivery. The AA certifies ADvantage case managers and case management supervisors. The AA maintains a master registry of certified ADvantage case management supervisors and case managers. Case manager certifications are based on successful completion of ADvantage case management training and demonstration of competency in case management and, for supervisors, case management supervision. As additional providers are certified in an OKDHS area or if a provider loses certification, AA provides appropriate notice to the area nurse and OKDHS county director in counties affected by the certification changes. The OHCA may execute agreements to provide care only with qualified individuals and agencies and facilities which are properly licensed or certified by the state licensing or certification agency and, as applicable, Title XIX certified. The agreement is initiated by application from the individual agency or facility. The agreement expires on a specified date, with termination of the agency license or certification, or automatically terminated on notice, with appropriate documentation, to OHCA that the individual agency or facility is not in compliance with Title XIX (or other federal long-term care) requirements. The AA certifies Title XIX

providers of ADvantage services with the exception of pharmacy and medical equipment and supply providers.

[Source: Added at 15 Ok Reg 3715, eff 5-18-98 (emergency); Added at 16 Ok Reg 1438, eff 5-27-99 ; Amended at 26 Ok Reg 758, eff 4-1-09 (emergency); Amended at 27 Ok Reg 1507, eff 6-11-10 ; Amended at 29 Ok Reg 1172, eff 6-25-12]

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

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

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

- (1) Service;
- (2) Service provider;
- (3) Units authorized; and
- (4) Begin- and end-dates of service authorization.

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

(d) All contracted providers for ADvantage Waiver services must submit billing to the OHCA, Soonercare using the appropriate designated software, or web-based solution for all claims transactions. When the designated system is unavailable, contracted providers submit billing directly to OHCA.

(e) Service time of personal care, case management, nursing, advanced supportive/restorative assistance, in-home respite, consumer-directed personal assistance services and supports, personal services assistance, and advanced personal services assistance is documented through the designated statewide Electronic Visit Verification System (EVV) when provided in the home. Providers are required to use the EVV system. Refer to OAC 317:30-3-34(7) for additional procedures for EVV system failure or EVV system unavailability.

(f) The provider must document the amount of time spent for each service, per Oklahoma Administrative Code (OAC) 317:30-5-763. For service codes that specify a time segment in their description, such as fifteen (15) minutes, each timed segment equals one (1) unit. Only time spent fulfilling the service for which the provider is authorized, per OAC 317:30-5-763 is authorized for time-based services. Providers do not bill for a unit of time when not more than one-half of a timed unit is performed, such as, when a unit is defined as fifteen (15) minutes, providers do not bill for services performed for less than eight (8) minutes. The rounding rules utilized by the EVV and web-based billing system to calculate the billable unit-amount of care, services provided for

duration of:

- (1) Less than eight (8) minutes cannot be rounded up and do not constitute a billable fifteen (15) minute unit; and
- (2) Eight (8) to fifteen (15) minutes are rounded up and do constitute a billable fifteen (15) minute unit.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 17 Ok Reg 2410, eff 6-26-00 ; Amended at 19 Ok Reg 338, eff 11-14-01 ; Amended at 19 Ok Reg 1071, eff 5-13-02 ; Amended at 20 Ok Reg 376, eff 1-1-03 (emergency); Amended at 20 Ok Reg 1979, eff 6-26-03 ; Amended at 26 Ok Reg 558, eff 2-1-09 (emergency); Amended at 26 Ok Reg 2149, eff 6-25-09 ; Amended at 27 Ok Reg 635, eff 2-1-10 (emergency); Amended at 27 Ok Reg 1504, eff 6-11-10 ; Amended at 31 Ok Reg 1746, eff 9-12-14 ; Amended at 34 Ok Reg 726, eff 9-1-17 ; Amended at 36 Ok Reg 945, eff 9-1-19 ; Amended at 38 Ok Reg 1076, eff 9-1-21]

317:35-17-23. 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 providers and contractors under Medicaid. In Oklahoma, the State Department of Health 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 Medicaid providers.

(1) Following its survey of each entity, the State Department of Health sends a copy of pertinent materials, showing its findings, to the Oklahoma Health Care Authority, Contract Services/Service Contracts Operations, who forwards pertinent materials to the DHS county office in the county where such facility is located.

(2) Each county office is responsible for permitting anyone, who requests permission to do so, to inspect and/or copy such findings, if this is done within the county office. Such request to see these materials may be specifically related to one provider or may be a request to see the available survey materials on all providers. The requests need not be made in writing and the person making the request need sign no document in order to obtain access to the materials. No one can be given permission to take any of these materials from the county office.

(3) These materials are to be filed in an administrative file. Only the material requested by the individual is made available to him/her. The county director is responsible for devising a plan for assuring that all such survey material made available to an individual is returned by him/her before he/she leaves the office.

(4) When a new survey report is received on an entity, the former survey report on that entity is to be destroyed. A permanent file of survey reports is maintained in the OHCA.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 17 Ok Reg 2410, eff 6-26-00]

317:35-17-24. Referral for social services

In many situations, social services are needed by adults who are receiving medical services through Medicaid. The OKDHS nurse may make referrals for social services to the social worker in the local office. In addition to these referrals, a request for social services may be initiated by a member or by another individual acting upon behalf of a member.

- (1) The social worker is responsible for providing the indicated services or for referral to the appropriate resource outside the Department if the services are not available within the Department.
- (2) Among the services provided by the social worker are:
 - (A) Services which will enable individuals to attain and/or maintain as good physical and mental health as possible;
 - (B) Services to assist patients who are receiving care outside their own homes in planning for and returning to their own homes or to other alternate care;
 - (C) Services to encourage the development and maintenance of family and community interest and ties;
 - (D) Services to promote maximum independence in the management of their own affairs;
 - (E) Protective services, including evaluation of need for and arranging for guardianship; and
 - (F) Appropriate family planning services which include assisting the family in acquiring means to responsible parenthood. Services are offered in making the necessary referral and follow-up.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 15 Ok Reg 3715, eff 5-18-98 (emergency); Amended at 16 Ok Reg 1438, eff 5-27-99 ; Amended at 17 Ok Reg 2410, eff 6-26-00 ; Amended at 20 Ok Reg 1958, eff 6-26-03 ; Amended at 29 Ok Reg 1172, eff 6-25-12]

317:35-17-25. Address Confidentiality Program

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

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

- (1) Confirm the member's ACP enrollment;
- (2) Remove the member's physical address from the waiver management database;
- (3) Notify the county worker and LTC RN of address change;
- (4) Maintain a confidential file with the physical address of the member; and
- (5) Provide the physical address to contracted providers when services must be provided to or in the home of the member.

[Source: Added at 31 Ok Reg 1747, eff 9-12-14]

317:35-17-26. Ethics of Care Committee

(a) The ADvantage Program Ethics of Care Committee (EOCC) reviews members cases when the ADvantage, State Plan Personal Care programs or a provider contracted to provide these services determines that a member's identified needs cannot be met through the provision of the ADvantage program or State Plan Personal Care program and other formal or informal services are not in place or immediately available to meet the members health and safety needs. The EOCC is a core group of designated representatives from Oklahoma Department of Human Services (DHS) Aging Services and Oklahoma Health Care Authority staff and are experts in State Medicaid programs, specifically ADvantage waiver and State Plan Personal Care, and experienced in addressing member issues as it pertains to policy, program, and service delivery.

(b) EOCC decisions are predicated upon four (4) guiding principles.

(1) **Sustainability of member services.** The overarching concern of EOCC is to ensure that all efforts are made to sustain the member's services when possible. EOCC explores options and renders a decision that maintains member safety while averting the primary issue of concern before the EOCC. This is done while assuring member health and safety as outlined in Oklahoma Administrative Code (OAC) 317:35-17-3 (h) (1-7).

(2) **Cultural competence.** EOCC considers the contextual details of the situation to promote needs and interests of ADvantage members and emphasizes understanding of the members culture and relevant circumstances.

(3) **Balance and reciprocity.** This assures member health and safety is reliant upon the member's cooperation and that of the member's community network, or informal supports. EOCC evaluates the viability of the member's resources to sustain health

and safety independent of Medicaid paid supports when making decisions.

(4) **Education and mitigation.** EOCC uses decision-making processes for determining program appropriateness for cases that are problematic or controversial with respect to being able to meet member needs within program constraints. The decision-making process engages expertise from any area of program function relevant to the case in question when necessary. When the case submitted for review is deemed invalid or lacking sufficient merit for review, EOCC rescinds the review until the case meets the appropriate criteria for review.

(c) EOCC reviews ADvantage and State Plan Personal Care cases, including but not limited to, when:

- (1) the member can no longer safely remain in the community;
- (2) the member shows a consistent pattern of non-compliance and non-cooperativeness that prevents delivery of the authorized person-centered service plan or care plan;
- (3) the provider's and/or DHS staff's safety cannot be assured due to the actions of the member, visit or another household member;
- (4) the services required to meet member needs are beyond the scope of defined waiver or State Plan Personal Care services;
- (5) the new ADvantage or State Plan Personal Care members meet financial and medical eligibility for the program, but require review for program appropriateness or community potential;
- (6) the previous dis-enrolled ADvantage or State Plan Personal Care members that request re-enrollment into the ADvantage or State Plan Personal Care programs;
- (7) the member scheduled for an administrative hearing in which the hearing officer requests EOCC review and input;
- (8) members under investigation or review by a federal authority;
- or
- (9) all cases in which administrative review and input are warranted.

(d) ADvantage Consumer Directed Personal Assistance Service and Supports (CD-PASS) service option cases are reviewed for the:

- (1) circumstances under review are not addressed by CD-PASS requirements for member eligibility;
- (2) a case scenario is not otherwise covered by an established process;
- (3) established processes of the CD-PASS program do not allow for an adequate resolution to the issues; or
- (4) CD-PASS eligibility impacts ADvantage eligibility, such as:
 - (A) eligibility is removed but that action may place the member at a greater risk; or
 - (B) a member and/or their legal agent are removed from CD-PASS services due to allegations of fraudulent or illegal actions that may result in the member's loss of ADvantage eligibility.

(e) EOCC review processes include:

- (1) ADvantage Administration (AA) Program Assistant Administrator for Member/Provider Relations department chairs

the EOCC. He or she is responsible to appoint qualified representatives to the EOCC committee;

- (2) committee members, case representatives, or presenters are required to adhere to Health Insurance Portability and Accountability Act and DHS confidentiality standards and be discreet when reviewing and discussing cases under consideration of all records and information disclosed in carrying out the duties and activities of the committee;
- (3) all cases that meet the defined criteria for EOCC review are submitted to AA Member/Provider Relations or Escalated Issues teams for processing and presentation;
- (4) the Escalated Issues team formally requests a meeting for EOCC case review and develop a meeting agenda and provide EOCC members with relevant supporting documentation of EOCC review prior to the scheduled meeting;
- (5) a quorum (half plus one committee member) is present to make a decision or recommendation on any case presented to the EOCC;
- (6) designees are not substituted for EOCC members;
- (7) the EOCC Chair is notified in advance when it becomes necessary for other parties to be invited due to their expertise on the subject matter;
- (8) case presenters are dismissed after their presentations are complete and the EOCC proceeds to mitigate the case;
- (9) upon completion of the committee discussion, the EOCC Chair calls for a vote. A majority vote carries the motion. When a tie ensues the Escalated Issues team Program Manager casts the deciding vote;
- (10) a member determined by EOCC to be ineligible for ADvantage or Medicaid State Plan Personal Care program services is notified in writing by DHS of the determination and of his or her right to appeal the decision; and
- (11) EOCC maintains all meeting minutes, decisions, court hearings, and files generated by our Escalated Issues department pertaining to the member indefinitely.

[Source: Added at 35 Ok Reg 1497, eff 9-14-18]

317:35-17-27. Incident reporting

(a) **Reporting requirement.** Certified ADvantage provider staff should report critical and non-critical incidents involving the health and welfare of ADvantage Waiver members to the Oklahoma Human Services Medicaid Services Unit (MSU).

(b) **Critical incidents.** Critical incidents are events with potential to cause significant risk or serious harm to an ADvantage member's safety or well-being. Critical Incidents Reports (CIR) are completed for:

- (1) Suspected maltreatment including abuse, neglect, or exploitation, per Section 10-103 of Title 43A of the Oklahoma Statutes (43A O.S. § 10-103);
- (2) Attempted suicide or suicidal ideation exhibition;

- (3) Unexpected or questionable death;
- (4) Falls or injuries requiring medical attention;
- (5) Residence loss due to disaster;
- (6) An interruption of needed medical supports;
- (7) Lost or missing members;
- (8) A medication error requiring medical attention;
- (9) Use of physical restraints; or
- (10) Allegations related to Personal Care Assistant (PCA) or Personal Service Assistant (PSA).

(c) **Non-critical incidents.** Non-critical incidents are events with potential to cause risk to an ADvantage member's safety and well-being, but do not rise to the critical incident level. Non-critical incidents include:

- (1) Falls or injuries that do not require medical attention;
- (2) Theft allegations;
- (3) Threatening or inappropriate behavior;
- (4) Substance abuse or use;
- (5) Serious allegations related to a provider agency; and
- (6) Law enforcement involvement due to challenging behaviors.

(d) **Incident notification requirements.** The reporting provider documents and submits to MSU incidents included in (b) and (c) of this Section in the electronic system on the CIR document, within one business day of becoming aware of the incident. The reporting provider notifies other persons or entities as required by law or regulation, including:

- (1) When a service recipient dies, per OAC 340:100-3-35; and
- (2) Investigative authorities immediately in cases of suspected maltreatment, as applicable, including:
 - (A) Local law enforcement;
 - (B) The Office of Client Advocacy when the alleged perpetrator is a community service worker, per OAC 340:2-3-33; and
 - (C) Adult Protective Services when the alleged perpetrator is not a community service worker per 43A O.S. § 10-104.

(e) **Internal Investigation.** The provider completes an internal investigation of all critical incidents, unless directed otherwise by an authorized government entity.

- (1) All provider investigative reports are submitted to the MSU within ten (10) working days after the initial CIR is completed.
- (2) The provider coordinates internal critical incident investigation and response efforts with governmental investigative authorities as required by law.
- (3) Provider supervisory staff run a monthly report from the electronic system to review all critical incidents submitted to the MSU. Doing so ensures proper handling and dispensation occurs, as required by the Centers for Medicare and Medicaid Services.

(f) **Escalated issues.** The Escalated Issues (EI) team reviews all CIR and determines whether the appropriate response occurred. EI coordinates their investigation and response efforts with governmental investigative authorities as required by law. For non-critical incident reports, EI reviews and works with the member, the member's informal support,

provider, and others to verify appropriate actions are taken to identify barriers to service, prevent future incidents, and assure continued member health and welfare. Investigation results are communicated to the member, legal guardian, or next of kin as appropriate.

(g) **Members and their representatives.** Upon entry into the program and at least annually, each member is provided with resources and contact information to self-report complaints, abuse, neglect, exploitation, or other issues.

[Source: Added at 39 Ok Reg 1577, eff 9-12-22]

SUBCHAPTER 18. PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

317:35-18-1. Programs of All-Inclusive Care for the Elderly (PACE)

This chapter establishes the requirements for approved SoonerCare contracted Program of All-Inclusive Care for the Elderly (PACE) providers to provide services to eligible elderly individuals through the Oklahoma Health Care Authority's (OHCA) PACE program.

[Source: Added at 23 Ok Reg 2583, eff 6-25-06 ; Amended at 29 Ok Reg 1189, eff 6-25-12]

317:35-18-2. Introduction

(a) Programs of All-Inclusive Care for the Elderly (PACE) provide home and community-based acute and long-term care services to eligible individuals who meet the medical requirements for nursing facility care and can be served safely and appropriately in the community. PACE is optional in a State Medicaid program. PACE is jointly funded and administered by the Centers for Medicare and Medicaid Services and the state of Oklahoma. The PACE provider receives a monthly capitation payment and is at full risk for the delivery of all medically necessary services for the individual. For eligible individuals who elect to participate in the PACE program, the OHCA will make capitation payments for individuals who are only eligible for Medicaid or who are dually eligible for Medicaid and Medicare. OHCA will contract with providers for the PACE program in the geographic areas as specified and approved in the provider PACE application. The PACE program will provide medically necessary services to both American Indian/Alaska Native (AI/AN) and non-Indian Medicaid eligible individuals.

(b) Rules applicable to the operation of the PACE program are contained in 42 Code of Federal Regulations (CFR), Part 460. These regulations, as currently written or amended in the future, are incorporated by reference as the rule base for operating the PACE program in Oklahoma.

[Source: Added at 23 Ok Reg 2583, eff 6-25-06 ; Amended at 29 Ok Reg 1189, eff 6-25-12]

317:35-18-3. Definitions

The words and terms used in this Subchapter have the following meanings, unless the context clearly indicates otherwise:

- (1) **"American Indian/Alaska Native (AI/AN)"** means an individual of Native American descent who has or is eligible for a Certificate of Degree of Indian Blood (CDIB) card;
- (2) **"Capitation"** means the per member per month (pmpm) amount that the Oklahoma Health Care Authority pays PACE providers for PACE compensable services.
- (3) **"Interdisciplinary Team (IDT)"** means the team of persons who interact and collaborate to assess PACE participants and plan for their care as set forth in 42 CFR 460.102. The IDT may also include the PACE participant's personal representative or advocate.
- (4) **"Participant"** means an individual enrolled in a PACE program.
- (5) **"Program agreement"** means the three-party agreement between the PACE provider, Centers for Medicare & Medicaid Services (CMS), and OHCA.
- (6) **"Provider"** means the non-profit or for-profit entity that delivers required PACE services under an agreement with OHCA and CMS.
- (7) **"Service area"** means the geographic area served by the provider agency, according to the program agreement.
- (8) **"State Administering Agency (SAA)"** means the Oklahoma Health Care Authority.

[Source: Added at 23 Ok Reg 2583, eff 6-25-06 ; Amended at 29 Ok Reg 1189, eff 6-25-12 ; Amended at 37 Ok Reg 1650, eff 9-14-20]

317:35-18-4. Provider regulations

- (a) The provider must comply with provisions of this Subchapter, and the regulations in 42 CFR, Part 460.
- (b) The provider agency must be licensed by the State of Oklahoma as an adult day care center.
- (c) The provider must meet all applicable local, state, and federal regulations.
- (d) The provider must maintain an inquiry log of all individuals requesting Programs of All-Inclusive Care for the Elderly (PACE) services. This log will be available to the OHCA at all times. The log must include:
 - (1) type of contact;
 - (2) date of contact;
 - (3) name and phone number of the individual requesting services;
 - (4) name and address of the potential participant; and
 - (5) date of enrollment, or reason for denial if the individual is not enrolled.

[Source: Added at 23 Ok Reg 2583, eff 6-25-06 ; Amended at 29 Ok Reg 1189, eff 6-25-12]

317:35-18-5. Eligibility criteria

(a) To be eligible for participation in Programs of All-Inclusive Care for the Elderly (PACE), the applicant must:

- (1) Be age fifty-five (55) years or older;
- (2) Live in a PACE service area;
- (3) Be determined by the state to meet nursing facility level of care; and
- (4) Be determined by the PACE interdisciplinary team (IDT) as able to be safely served in the community at the time of enrollment. If the PACE provider denies enrollment because the IDT determines that the applicant cannot be served safely in the community, the PACE provider must:
 - (A) Notify the applicant in writing of the reason for the denial;
 - (B) Refer the applicant to alternative services as appropriate;
 - (C) Maintain supporting documentation for the denial and notify the Centers for Medicare and Medicaid Services and the Oklahoma Health Care Authority (OHCA) of the denial and submit that documentation to the OHCA for review; and
 - (D) Advise the applicant orally and in writing of the grievance and appeals process.

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

- (1) Meet categorical relationship for the aged, blind, or disabled [refer to Oklahoma Administrative Code (OAC) 317:35-5-4];
- (2) Be eligible for Title XIX services if institutionalized as determined by the Oklahoma Department of Human Services (OKDHS)
- (3) Be eligible for SoonerCare State Plan services;
- (4) Meet the same financial eligibility criteria as set forth for the SoonerCare ADvantage program per OAC 317:35-17-10 and 317:30-17-11; and
- (5) Meet appropriate medical eligibility criteria.

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

- (1) When PACE services are requested:
 - (A) The PACE nurse or OKDHS nurse is responsible for completing the UCAT assessment.
 - (B) The PACE intake staff is responsible for aiding the PACE enrollee in contacting OKDHS to initiate the financial eligibility application process.
- (2) The nurse completes the UCAT, Part III visit with the PACE enrollee, in the participant's home, within ten (10) days of receipt of the referral for PACE services.
- (3) The nurse sends the UCAT, Part III to the designated OHCA nurse staff member for review and level of care determination.
- (4) A new medical level of care determination may be required when a member requests any of the following changes in service programs:

- (A) From PACE to ADvantage;
- (B) From PACE to State Plan Personal Care Services;
- (C) From Nursing Facility to PACE;
- (D) From ADvantage to PACE if previous UCAT was completed more than six (6) months prior to member requesting PACE enrollment; or
- (E) From PACE site to PACE site.

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

[Source: Added at 23 Ok Reg 2583, eff 6-25-06 ; Amended at 29 Ok Reg 1189, eff 6-25-12 ; Amended at 31 Ok Reg 1748, eff 9-12-14 ; Amended at 33 Ok Reg 911, eff 9-1-16 ; Amended at 36 Ok Reg 956, eff 9-1-19 ; Amended at 38 Ok Reg 1078, eff 9-1-21]

317:35-18-6. PACE program benefits

(a) The PACE program offers a comprehensive benefit plan. A provider agency must provide a participant all the services listed in Section (§) 460.92 of Title 42 of the Code of Federal Regulations (C.F.R.) that are approved by the interdisciplinary team (IDT). The PACE benefit package for all participants, regardless of the source of payment, must include but is not limited to the following:

- (1) All SoonerCare-covered services, as specified in the State's approved Medicaid State Plan;
- (2) IDT and treatment planning;
- (3) Primary care, including physician and nursing services;
- (4) Social work services;
- (5) Restorative therapies, including physical therapy, occupational therapy, and speech-language pathology services;
- (6) Personal care and supportive services;
- (7) Nutritional counseling;
- (8) Recreational therapy;
- (9) Transportation;
- (10) Meals;
- (11) Medical specialty services including, but not limited to the following:
 - (A) Anesthesiology;
 - (B) Audiology;
 - (C) Cardiology;
 - (D) Dentistry;
 - (E) Dermatology;
 - (F) Gastroenterology;
 - (G) Gynecology;
 - (H) Internal medicine;
 - (I) Nephrology;
 - (J) Neurosurgery;
 - (K) Oncology;
 - (L) Ophthalmology;
 - (M) Oral surgery;
 - (N) Orthopedic surgery;

- (O) Otorhinolaryngology;
 - (P) Plastic surgery;
 - (Q) Pharmacy consulting services;
 - (R) Podiatry;
 - (S) Psychiatry;
 - (T) Pulmonary disease;
 - (U) Radiology;
 - (V) Rheumatology;
 - (W) General surgery;
 - (X) Thoracic and vascular surgery; and
 - (Y) Urology.
- (12) Laboratory tests, x-rays, and other diagnostic procedures;
- (13) Drugs and biologicals;
- (14) Prosthetics, orthotics, medical supplies, equipment, and appliances, corrective vision devices, such as eyeglasses and lenses, hearing aids, dentures, and repair and maintenance of these items;
- (15) Acute inpatient care, including the following:
- (A) Ambulance;
 - (B) Emergency room care and treatment room services;
 - (C) Semi-private room and board;
 - (D) General medical and nursing services;
 - (E) Medical surgical/intensive care/coronary care unit;
 - (F) Laboratory tests, x-rays, and other diagnostic procedures;
 - (G) Drugs and biologicals;
 - (H) Blood and blood derivatives;
 - (I) Surgical care, including the use of anesthesia;
 - (J) Use of oxygen;
 - (K) Physical, occupational, respiratory therapies, and speech-language pathology services; and
 - (L) Social services.
- (16) Nursing facility (NF) care, including:
- (A) Semi-private room and board;
 - (B) Physician and skilled nursing services;
 - (C) Custodial care;
 - (D) Personal care and assistance;
 - (E) Drugs and biologicals;
 - (F) Physical, occupational, recreational therapies, and speech-language pathology, if necessary;
 - (G) Social services; and
 - (H) Medical supplies, equipment, and appliances.
- (17) Other services determined necessary by the IDT to improve and maintain the participant's overall health status.
- (b) The following services are excluded from coverage under PACE:
- (1) Any service that is not authorized by the IDT, even if it is a required service, unless it is an emergency service.
 - (2) In an inpatient facility, private room and private duty nursing (PDN) services (unless medically necessary), and non-medical items for personal convenience such as telephone charges and radio or television rental (unless specifically authorized by the

IDT as part of the participant's plan of care).

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

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

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

(A) In accordance with 42 C.F.R. § 424.122 through 42 C.F.R. §424.124, and

(B) As permitted under the State's approved Medicaid State Plan.

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

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

[Source: Added at 23 Ok Reg 2583, eff 6-25-06 ; Amended at 29 Ok Reg 1189, eff 6-25-12 ; Amended at 31 Ok Reg 1748, eff 9-12-14 ; Amended at 37 Ok Reg 857, eff 8-1-20 (emergency); Amended at 38 Ok Reg 1079, eff 9-1-21]

317:35-18-7. Programs of All-Inclusive for the Elderly (PACE) organization's appeals process

(a) Internal appeals:

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

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

(b) External appeals may be filed through the OHCA legal division and follow the process outlined in Oklahoma Administrative Code (OAC) 317:2-1-2.

(c) Expedited appeals process (refer to 42 CFR § 460.122).

(1) A PACE organization must have an expedited appeals process for situations in which the participant believes that his or her life, health, or ability to regain or maintain maximum function could be seriously jeopardized, absent provision of the service in dispute.

(2) Except as provided in paragraph (c)(3) of this section, the PACE organization must respond to the appeal as expeditiously as the participant's health condition requires, but no later than seventy-two (72) hours after it receives the appeal.

(3) The PACE organization may extend the seventy-two (72) hour timeframe by up to fourteen (14) calendar days for either of the

following reasons:

- (A) The participant requests the extension; or
- (B) The organization justifies to the State administering agency (OHCA) the need for additional information and how the delay is in the interest of the participant.
- (4) Supporting documentation must be submitted to (OHCA) once it has been determined that they will be unable to respond to the appeal within the seventy-two (72) hour timeframe.

[Source: Added at 23 Ok Reg 2583, eff 6-25-06 ; Amended at 29 Ok Reg 1189, eff 6-25-12 ; Amended at 31 Ok Reg 1748, eff 9-12-14 ; Amended at 38 Ok Reg 1078, eff 9-1-21]

317:35-18-8. Enrollment

- (a) The provider determines whether the applicant meets PACE enrollment requirements.
- (b) The enrollment effective date is the first day of the month after the provider receives the signed enrollment form.
- (c) Enrollment continues until the participant's death, regardless of changes in health status, unless either of the following actions occur:
 - (1) The participant voluntarily disenrolls and/or elects to transfer to other eligible PACE program.
 - (2) The participant is involuntarily disenrolled.

[Source: Added at 23 Ok Reg 2583, eff 6-25-06 ; Amended at 33 Ok Reg 911, eff 9-1-16]

317:35-18-9. Continuation of enrollment

- (a) At least annually, OHCA must reevaluate whether a participant continues to meet the level of care required for PACE eligibility.
- (b) At least annually, OKDHS will reevaluate the participant's financial eligibility for SoonerCare.
 - (1) Waiver of Annual level of Care Reassessment. If the individual meets the state's medical eligibility criteria and the individual has an irreversible or progressive diagnosis or a terminal illness that could reasonably be expected to result in death in the next six months, and OHCA determines that there is no reasonable expectation of improvement or significant change in the condition because of severity of a chronic condition or the degree of impairment of functional capacity, OHCA will permanently waive the annual recertification requirement and the participant will be deemed to be continually eligible for PACE. The assessment form must have sufficient documentation to substantiate the participant's prognosis and functional capacity.
 - (2) Deemed Continued Eligibility. If it is determined that a PACE participant no longer meets the medical criteria for nursing facility level of care, the participant will be deemed to continue to be eligible for PACE until the next annual reassessment, if, in the absence of PACE services, it is reasonable to expect that the participant would meet the nursing facility level of care criteria within the next six months.
- (c) Participant enrollment continues when OHCA in consultation with the PACE organization, makes a determination of continued eligibility based

on a review of the participant's medical record and plan of care. The participant's medical record and plan of care must support deemed continued eligibility.

[Source: Added at 23 Ok Reg 2583, eff 6-25-06 ; Amended at 29 Ok Reg 1189, eff 6-25-12 ; Amended at 31 Ok Reg 1748, eff 9-12-14]

317:35-18-10. Disenrollment (voluntary and involuntary)

(a) A participant may voluntarily disenroll from PACE at any time without cause however, the effective date of disenrollment must be the last day of the month that the participant elects to disenroll.

(b) A participant may be involuntarily disenrolled for any of the following reasons:

(1) The participant/caregiver or guardian fails to pay, or to make satisfactory arrangements to pay, any premium due the PACE organization after a 30-day grace period.

(2) The participant/caregiver or guardian engages in disruptive or threatening behavior, as described in subsection (c) of this section.

(3) The participant moves out of the PACE program service area or is out of the service area for more than 30 consecutive days, unless the PACE organization agrees to a longer absence due to extenuating circumstances.

(4) The participant is determined to no longer meet the SoonerCare nursing facility level of care requirements and is not deemed eligible.

(5) The PACE program agreement with CMS and OHCA is not renewed or is terminated.

(6) The PACE organization is unable to offer health care services due to the loss of State licenses or contracts with outside providers.

(c) A participant may be involuntarily disenrolled for disruptive or threatening behavior. For purposes of this section, a participant who engages in disruptive or threatening behavior refers to a participant who exhibits either of the following:

(1) A participant whose behavior jeopardizes his or her health or safety, or the safety of others; or

(2) A participant with decision-making capacity who consistently refuses to comply with his or her individual plan of care or the terms of the PACE enrollment agreement.

(d) If a PACE organization proposes to disenroll a participant who is disruptive or threatening, the organization must document the following information in the participant's medical record:

(1) The reasons for proposing to disenroll the participant.

(2) All efforts to remedy the situation.

(e) A participant may be disenrolled involuntarily for noncompliant behavior.

(1) PACE organization may not disenroll a PACE participant on the grounds that the participant has engaged in noncompliant behavior if the behavior is related to a mental or physical condition of the participant, unless the participant's behavior

jeopardizes his or her health or safety, or the safety of others.

(2) For purposes of this section, noncompliant behavior includes repeated noncompliance with medical advice and repeated failure to keep appointments.

(f) Before an involuntary disenrollment is effective, OHCA will review the participant's medical record and determine in a timely manner that the PACE organization has adequately documented acceptable grounds for disenrollment.

[Source: Added at 23 Ok Reg 2583, eff 6-25-06 ; Amended at 25 Ok Reg 2766, eff 7-1-08 (emergency); Amended at 26 Ok Reg 1075, eff 5-11-09 ; Amended at 29 Ok Reg 1189, eff 6-25-12]

317:35-18-11. Data collection and reporting

The PACE provider must:

- (1) collect data to comply with reporting requirements in provider application;
- (2) generate and maintain monthly reports from collected data;
- (3) make the reports available to the OHCA; and
- (4) comply with all data requests as specified by the OHCA within 30 days of such requests.

[Source: Added at 23 Ok Reg 2583, eff 6-25-06 ; Amended at 29 Ok Reg 1189, eff 6-25-12]

317:35-18-12. Medicaid Payments

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

(b) The payment amount represents:

- (1) is less than the amount that would otherwise have been paid under the State plan if the participants were not enrolled under the PACE program.
- (2) Takes into account the comparative frailty of PACE participant.
- (3) is a fixed amount regardless of changes in the participant's health status.

(c) The PACE organization must accept the capitation payment amount as payment in full for Medicaid participants.

[Source: Added at 31 Ok Reg 1748, eff 9-12-14]

SUBCHAPTER 19. NURSING FACILITY SERVICES

317:35-19-1. Implementation of gatekeeping in NF [REVOKED]

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Revoked at 15 Ok Reg 3715, eff 5-18-98 (emergency); Revoked at 16 Ok Reg 1438, eff 5-27-99]

317:35-19-2. Nursing Facility (NF) program medical eligibility determination

The Oklahoma Department of Human Services (DHS) area nurse or nurse designee, determines medical eligibility for NF services based on the DHS nurse's Uniform Comprehensive Assessment Tool (UCAT) Part III assessment of the client's needed level of care, the outcome of the Level II Preadmission Screening and Resident Review (PASRR), when completed, and his or her professional judgment. The Oklahoma Health Care Authority (OHCA) Level of Care Evaluation Unit (LOCEU) makes some determinations when the PASRR is involved. Refer to Oklahoma Administrative Code (OAC) 317:35-19-7.1(3) for NF level of care medical eligibility requirements.

(1) When NF care services are requested prior to admission, the same rules related to medical eligibility determination identified in OAC 317:35-17-5 for ADvantage services are followed.

(2) The DHS nurse reviews the PASRR Level I in the OHCA system; completes the UCAT III; and enters the date OHCA received the PASRR Level I (LTC-300R) from the NF and admission date to the NF; medical eligibility effective date and notes any Level II PASRR results if available in the UCAT Part III. This information is submitted to the DHS area nurse for medical eligibility determination.

(3) PASRR requirements are identified in OAC 317:35-19-8 and 317:35-19-9.

(4) When it is not possible for the UCAT Part III assessment to be completed prior to admission, the NF is responsible for notifying the DHS of the admission. Notification is mailed or faxed on DHS Form 08MA083E, Notification Regarding Patient In A Nursing Facility, Intermediate Care Facility for the Intellectually Disabled or Hospice, and Management Recipient Funds to the local DHS county office. Upon receipt, the DHS county office processes Forms 08MA083E and 08MA084E and completes and forwards the Form 08MA038E, Notice Regarding Financial Eligibility to the NF. Identified sections of the UCAT Part III reflecting the domains for meeting medical criteria are completed for applicants residing in the NF at the time of assessment. The area nurse or nurse designee, confirms the date of medical eligibility and records it in the system. The facility is responsible for performing the PASRR Level I screen and consulting with OHCA staff to determine when a need exists for a Level II screen. The DHS nurse completes the assessment within fifteen-business (15-business) days of PASRR clearance when the individual's needs are included in an active DHS coded case. When the individual's needs are not included in an active case, the assessment is completed within twenty-business (20-business) days of PASRR clearance.

(5) The area nurse or nurse designee, evaluates the PASRR Level I screen and the UCAT Part III in consultation with the DHS nurse when the completed LTC-300R and/or facility documentation shows a need exists for a possible Level II screen. The area nurse or nurse designee consults with OHCA staff as necessary.

(6) The area nurse or nurse designee, evaluates the UCAT Parts I and III, to determine if the applicant meets the medical eligibility criteria for NF level of care. Individuals may be medically-

certified for NF level of care for various lengths of time depending on the client's needs. The area nurse or nurse designee, enters the medical eligibility decision and, when required, the medical certification review date into Aging Services Division Electronic Data Entry and Retrieval System (ELDERS) within ten-business (10-business) days. A medical eligibility redetermination is not required when a client is discharged from the NF for a period not to exceed ninety-calendar (90-calendar) days and the original certification is current.

(7) When the DHS nurse recommends NF level of care and the client is determined by the area nurse or nurse designee, not to be medically eligible for NF level of care, the DHS nurse can submit additional information to the area nurse or nurse designee. When necessary, a visit by the DHS nurse to obtain additional information is initiated at the recommendation of the area nurse or nurse designee.

(8) Categorical relationship must be established for determination of eligibility for NF services. When categorical relationship to disability has not been established, the worker submits the same information, per OAC 317:35-5-4(2) to the LOCEU to request a determination of eligibility for categorical relationship. LOCEU renders a decision on categorical relationship to the disabled applicant using the Social Security Administration (SSA) definition. A follow-up with the SSA by the DHS worker is required to ensure the SSA disability decision agrees with the LOCEU decision.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 15 Ok Reg 3715, eff 5-28-98 (emergency); Amended at 16 Ok Reg 1438, eff 5-27-99 ; Amended at 17 Ok Reg 2410, eff 6-26-00 ; Amended at 20 Ok Reg 1958, eff 6-26-03 ; Amended at 21 Ok Reg 2252, eff 6-25-04 ; Amended at 34 Ok Reg 726, eff 9-1-17 ; Amended at 36 Ok Reg 945, eff 9-1-19]

317:35-19-3. Services in a Nursing Facility (NF)

(a) Nursing facility services are those services furnished pursuant to a physician's orders which require the skills of technical or professional personnel, e.g., registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists or audiologists. The care is provided by nursing facilities licensed under state law to provide, on a regular basis, health related care and services to individuals who do not require hospitalization but whose physical or mental condition requires care and services above the level of room and board which can be made available to them only through a nursing facility. To be eligible for nursing facility services, the UCAT demonstrates the individual must:

(1) require a treatment plan involving the planning and administration of services which require skills of licensed technical or professional personnel that are provided directly or under the supervision of such personnel and are prescribed by the physician;

(2) have a physical impairment or combination of physical and mental impairments;

(3) require professional nursing supervision (medication, hygiene and dietary assistance);

(4) lack the ability to care for self or communicate needs to others; and

(5) require medical care and treatment in a nursing facility to minimize physical health regression and deterioration. A physician's order and results from a standardized assessment which evaluates type and degree of disability and need for treatment must support the individual's need for NF level of care. Only standardized assessments approved by the OHCA and administered in accordance with Medicaid approved procedures shall be used to make the NF level of care determination.

(b) If the individual experiences mental illness or an intellectual disability or a related condition, payment cannot be made for services in a nursing facility unless the individual has been assessed through the PASRR process and the appropriate MR or MI authority has determined that nursing facility services are required. If it is determined that the client also requires specialized services, the state must provide or arrange for the provision of such services. These determinations must be made prior to the patient's admission to the nursing facility. Payment cannot be made for an individual who is in imminent danger of harm to self or others.

(c) Payment is made to licensed nursing facilities that have agreements with the OHCA.

(d) Nursing facility clients are eligible for ADvantage waiver services and must be informed by the LTC nurse of the ADvantage waiver and given the option to apply for ADvantage services.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 17 Ok Reg 2410, eff 6-26-00 ; Amended at 29 Ok Reg 1162, eff 6-25-12]

317:35-19-4. Medicaid recovery

(a) **General overview.** The Omnibus Budget Reconciliation Act of 1993 mandates the state to seek recovery against the estate of certain Title XIX members who received medical care on or after July 1, 1994, and who were 55 years of age or older when the care was received. The payment of Title XIX by the Oklahoma Health Care Authority (OHCA) on behalf of a member who is an inpatient of a nursing facility, intermediate care facility for the mentally retarded or other medical institution creates a debt to the OHCA subject to recovery by legal action either in the form of a lien filed against the real property of the member and/or a claim made against the estate of the member. Only Title XIX received on or after July 1, 1994, will be subject to provisions of this part. Recovery for payments made under Title XIX for nursing care is limited by several factors, including the family composition at the time the lien is imposed and/or at the time of the member's death and by the creation of undue hardship at the time the lien is imposed or the claim is made against the estate. [See OAC 317:35-5-41.8(a)(3)(H) for consideration of home property as a countable resource.] State Supplemental Payments are not considered when determining the countable income. The types of medical

care for which recovery can be sought include:

- (1) nursing facility services,
- (2) home and community based services,
- (3) related hospital services,
- (4) prescription drug services,
- (5) physician services, and
- (6) transportation services.

(b) **Recovery through lien.** The Oklahoma Health Care Authority (OHCA) may file and enforce a lien, after notice and opportunity for a hearing, against the real property of a member who is an inpatient in a nursing facility, ICF/MR or other medical institution in certain instances.

(1) **Exceptions to filing a lien.**

(A) A lien may not be filed on the home property if the member's family includes:

- (i) a surviving spouse residing in the home;
- (ii) a child or children age 20 or less lawfully residing in the home;
- (iii) a disabled child or children of any age lawfully residing in the home; or
- (iv) a brother or sister of the member who has an equity interest in the home and has been residing in the home for at least one year immediately prior to the member's admission to the nursing facility and who has continued to live there on a continuous basis since that time.

(B) If an individual covered under an Oklahoma Long-Term Care Partnership Program approved policy received benefits for which assets or resources were disregarded as provided for in OAC 317:35-5-41.9, the Oklahoma Health Care Authority will not seek recovery from the individual for the amount of assets or resources disregarded.

(2) **Reasonable expectation to return home.** A lien may be filed only after it has been determined, after notice and opportunity for a hearing, that the member cannot reasonably be expected to be discharged and return to the home. To return home means the member leaves the nursing facility and resides in the home on which the lien has been placed for a period of at least 90 days without being re-admitted as an inpatient to a facility providing nursing care. Hospitalizations of short duration that do not include convalescent care are not counted in the 90 day period. Upon certification for Title XIX for nursing care, OKDHS provides written notice to the member that a one-year period of inpatient care constitutes a determination by the OKDHS that there is no reasonable expectation that the member will be discharged and return home for a period of at least three months. The member or the member's representative is asked to declare intent to return home by signing the OKDHS Form 08MA024E, Acknowledgment of Intent to Return Home/Medicaid Recovery Program. Intent is defined here as a clear statement of plans in addition to other evidence and/or corroborative statements of others. Should the intent be to return home, the

member must be informed that a one-year period of care at a nursing facility or facilities constitutes a determination that the member cannot reasonably be expected to be discharged and return home. When this determination has been made, the member receives a notice and opportunity for hearing. This notification occurs prior to filing of a lien. At the end of the 12-month period, a lien may be filed against the member's real property unless medical evidence is provided to support the feasibility of his/her returning to the home within a reasonable period of time (90 days). This 90-day period is allowed only if sufficient medical evidence is presented with an actual date for the return to the home.

(3) **Undue hardship waiver.** When enforcing a lien or a recovery from an estate [see (C) of this Section] would create an undue hardship, a waiver may be granted. Undue hardship exists when enforcing the lien would deprive the individual of medical care such that the individual's health or life would be endangered. Undue hardship exists when application of the rule would deprive the individual or family members who are financially dependent on him/her for food, clothing, shelter, or other necessities of life. Undue hardship does not exist, however, where the individual or his/her family is merely inconvenienced or where their lifestyle is restricted because of the lien or estate recovery being enforced. Decisions on undue hardship waivers are made at OKDHS State Office, Family Support Services Division, Health Related and Medical Services Section. Upon applying for an undue hardship waiver, an individual will receive written notice, in a timely process, whether an undue hardship waiver will be granted. If an undue hardship waiver is not granted, the individual will receive written notice of the process under which an adverse determination can be appealed. The OHCA Legal Division staff will receive notification on all undue hardship waiver decisions.

(4) **Filing the lien.** After it has been determined that the member cannot reasonably be expected to be discharged from the nursing facility and return home and the member has been given notice of the intent to file a lien against the real property and an opportunity for a hearing on the matter, a lien is filed by the Oklahoma Health Care Authority, Third Party Liability Unit, for record against the legal description of the real property in the office of the county clerk of the county in which the property is located. A copy of the lien is sent by OHCA to the member or his/her representative. The lien must contain the following information:

(A) the name and mailing address of the member, member's spouse, legal guardian, authorized representative, or individual acting on behalf of the member,

(B) the amount of Title XIX paid at the time of the filing of the lien and a statement that the lien amount will continue to increase by any amounts paid thereafter for XIX on the member's behalf,

(C) the date the member began receiving compensated inpatient care at a nursing facility or nursing facilities, intermediate care facility for the mentally retarded or other medical institution,

(D) the legal description of the real property against which the lien will be recorded, and

(E) the address of the Oklahoma Health Care Authority.

(5) **Enforcing the lien.** The lien filed by the OHCA for Title XIX correctly received may be enforced before or after the death of the member. But it may be enforced only:

(A) after the death of the surviving spouse of the member or until such time as the surviving spouse abandons the homestead to reside elsewhere;

(B) when there is no child of the member, natural or adopted, who is 20 years of age or less residing in the home;

(C) when there is no adult child of the member, natural or adopted, who is blind or disabled as defined in, OAC 317:35-1-2 residing in the home;

(D) when no brother or sister of the member is lawfully residing in the home, who has resided there for at least one year immediately before the date of the member's admission to the nursing facility, and has resided there on a continuous basis since that time; and

(E) when no son or daughter of the member is lawfully residing in the home who has resided there for at least two years immediately before the date of the member's admission to the nursing facility, and establishes to the satisfaction of the OKDHS that he or she provided care to the member which permitted the member to reside at home rather than in an institution and has resided there on continuous basis since that time.

(6) **Dissolving the lien.** The lien remains on the property even after transfer of title by conveyance, sale, succession, inheritance or will unless one of the following events occur:

(A) The lien is satisfied. The member or member's representative may discharge the lien at any time by paying the amount of lien to the OHCA. Should the payment of the debt secured by the lien be made to the county office, the payment is forwarded to OHCA/Third Party Liability, so that the lien can be released within 50 days. After that time, the member or the member's representative may request in writing that it be done. This request must describe the lien and the property with reasonable certainty. By statute, a fine may be levied against the lien holder if it is not released in a timely manner.

(B) The member leaves the nursing facility and resides in a property to which the lien is attached, for a period of more than 90 days without being re-admitted to a facility providing nursing care, even though there may have been

no reasonable expectation that this would occur. If the member is re-admitted to a nursing facility during this period, and does return to his/her home after being released, another 90 days must be completed before the lien can be dissolved.

(7) **Capital resources.** Rules on the determination of capital resources for individuals related to the aged, blind, or disabled (See OAC 317:35-5-41 through 317:35-5-41.7) apply to the proceeds received for the property in excess of the amount of the lien after the lien is satisfied.

(c) **Recovery from estates.**

(1) If the member was age 55 or older when the nursing care was received, adjustment or recovery may be made only after the death of the individual's spouse, if any, and at a time when there are no surviving children age 20 or less and no surviving disabled children of any age living in the home. Oklahoma Statutes contain stringent time frames concerning when and how claims against an estate in probate are filed and paid. Therefore, timely updating of computer input forms indicating the death of the member is crucial to insure the OHCA's ability to file timely against the estate.

(2) The estate consists of all real and personal property and other assets included in member's estate as defined by Title 58 of the Oklahoma Statutes. Although county staff ordinarily will not be responsible for inventorying or assessing the estate, assets and property that are not considered in determining eligibility should be documented in the case record.

(3) After updating of computer input form indicating member's death, a computer generated report is sent to OHCA/Third Party Liability (TPL). This report will serve as notification to OHCA/TPL to initiate estate recovery.

(4) Undue hardship waivers may be granted for estate recovery as provided in (b)(3) of the Section.

(5) If an individual covered under an Oklahoma Long-Term Care Partnership Program approved policy received benefits for which assets or resources were disregarded as provided for in OAC 317:35-5-41.9, the Oklahoma Health Care Authority will not seek recovery from the individual's estate for the amount of assets or resources disregarded.

[Source: Added at 12 Ok Reg 753, eff 7-14-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 13 Ok Reg 1521, eff 3-27-96 (emergency); Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 15 Ok Reg 564, eff 9-18-97 (emergency); Amended at 15 Ok Reg 1554, eff 5-11-98 ; Amended at 24 Ok Reg 2135, eff 6-25-07 ; Amended at 25 Ok Reg 130, eff 8-1-07 (emergency); Amended at 25 Ok Reg 1227, eff 5-25-08 ; Amended at 27 Ok Reg 1680, eff 5-14-10 (emergency); Amended at 28 Ok Reg 1537, eff 6-25-11]

317:35-19-5. Application for nursing facility care; forms

(a) **Application procedures for nursing facility care.** An application for Nursing Facility (NF) level of care consists of the Medical Assistance Application form. The form is signed by the client, parent, spouse, guardian or someone else acting on the client's behalf.

(1) All conditions of eligibility must be verified and documented in the case record. When current information already available in the local office establishes eligibility, such information may be used by recording source and date of information.

(2) At the request of an individual in an NF or the community spouse, if application for Medicaid is not being made, an assessment of the resources available to each spouse is made by use of DHS form MA-11, Assessment of Assets. Documentation of resources must be provided by the individual and/or spouse. This assessment reflects all countable resources of the couple (owned individually or as a couple) and establishes the spousal share to be protected when subsequent determination of Medicaid eligibility is made. A copy of Form MA-11 is provided to each spouse for planning in regard to future eligibility. A copy is retained in the county office in case of subsequent application.

(3) If assessment by Form MA-11 was not done at the time of entry into the nursing home, assessment by use of Form MA-11 must be done at the time of application for Medicaid. The spousal share of resources is determined for the month of entry into the nursing home. If the individual applies for Medicaid at the time of entry into the nursing home, Form MA-11 is not appropriate. However, the spousal share must be determined using the resource information provided on the Medicaid application form and computed using Form MA-12, Title XIX Worksheet.

(b) Date of application. When application is made in the county office, the date of application is the date the applicant or someone acting on his/her behalf signs the application form. When the application is initiated outside the county office, the date of application is the date the application is stamped into the county office. When a request for Medicaid services is first made by an oral request and the application form is signed later, the date of the oral request is entered in "red" above the date the form is signed. The date of the oral request is the date of application. An exception is when DHS has contracts with certain providers to take applications and obtain documentation. After the documentation is obtained, the application and documentation are forwarded to the DHS county office of the client's county of residence for Medicaid eligibility determination. Under this circumstance, the application date is the date the client signed the application form for the provider.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 17 Ok Reg 2410, eff 6-26-00]

317:35-19-6. Application procedures for NF

Individuals may apply for nursing home care at the OKDHS human services center (HSC) of their choice. A written application is not required for an individual who has an active SoonerCare case. For NF, OKDHS Form 08MA083E, Notification Regarding Patient in a Nursing Facility, Intermediate Care Facility for the Mentally Retarded or Hospice form, when received in the HSC, also constitutes an application request

and is handled the same as an oral request.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 17 Ok Reg 2410, eff 6-26-00 ; Amended at 26 Ok Reg 408, eff 1-1-09 (emergency); Amended at 26 Ok Reg 2139, eff 6-25-09]

317:35-19-7. Determination of medical eligibility for care in NF [REVOKED]

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Revoked at 14 Ok Reg 56, eff 4-30-96 (emergency); Revoked at 14 Ok Reg 1802, eff 5-27-97]

317:35-19-7.1. Level of care medical eligibility determination

The OKDHS area nurse, or nurse designee (OHCA, LOCEU makes some determinations when PASRR is involved), determines medical eligibility for the ADvantage program or nursing facility services based on the LTC nurse's UCAT III assessment, outcome of the Level II PASRR, if completed, and professional judgment.

(1) **Definitions.** The following words and terms when used in this subchapter, shall have the following meaning, unless the context clearly indicates otherwise:

(A) **"ADL"** means the activities of daily living. Activities of daily living are activities that reflect the client's ability to perform self-care tasks essential for sustaining health and safety such as:

- (i) bathing,
- (ii) eating,
- (iii) dressing,
- (iv) grooming,
- (v) transferring (includes getting in and out of a tub, bed to chair, etc.),
- (vi) mobility,
- (vii) toileting, and
- (viii) bowel/bladder control.

(B) **"ADLs score in high risk range"** means the client's total weighted UCAT ADL score is 10 or more which indicates the client needs some help with 5 ADLs or that the client cannot do 3 ADLs at all plus the client needs some help with 1 other ADL.

(C) **"ADLs score at the high end of the moderate risk range"** means the client's total weighted UCAT ADL score is 8 or 9 which indicates the client needs help with 4 ADLs or that the client cannot do 3 ADLs at all.

(D) **"Client Support high risk"** means the client's UCAT Client Support score is 25 which indicates in the UCAT assessor's clinical judgment that, excluding from consideration existing Ryan White CARE Act, Indian Health Service, Medicaid NF, ADvantage and/or State Plan Personal Care services, very little or no support is available from informal and formal sources and the client

requires additional care that is not available through Medicare, Veterans Administration, or other federal entitlement programs.

(E) "**Client Support moderate risk**" means the client's UCAT Client Support score is 15 which indicates in the UCAT assessor's clinical judgment, excluding from consideration existing Ryan White CARE Act, Indian Health Service, Medicaid NF, ADvantage and/or State Plan Personal Care services, support from informal and formal sources is available, but overall, it is inadequate, changing, fragile or otherwise problematic and the client requires additional care that is not available through Medicare, Veterans Administration, or other federal entitlement programs.

(F) "**Environment high risk**" means the client's UCAT Environment score is 25 which indicates in the UCAT assessor's clinical judgment, the physical environment is strongly negative or hazardous.

(G) "**Environment moderate risk**" means the client's UCAT Environment score is 15 which indicates in the UCAT assessor's clinical judgment, many aspects of the physical environment are substandard or hazardous.

(H) "**IADL**" means the instrumental activities of daily living.

(I) "**IADLs score in high risk range**" means the client's total weighted UCAT IADL score is 12 or more which indicates the client needs some help with 6 IADLs or cannot do 4 IADLs at all.

(J) "**ICN**" means the client's individual care needs.

(K) "**ICN Score**" means the sum of the MSQ, Health Assessment, Nutrition, ADL and IADL scores.

(L) "**Instrumental activities of daily living**" means those activities that reflect the client's ability to perform household chores and tasks within the community essential for sustaining health and safety such as:

- (i) shopping,
- (ii) cooking,
- (iii) cleaning,
- (iv) managing money,
- (v) using a telephone,
- (vi) doing laundry,
- (vii) taking medication, and
- (viii) accessing transportation.

(M) "**MSQ**" means the mental status questionnaire.

(N) "**MSQ score in high risk range**" means the client's total weighted UCAT MSQ score is 12 or more which indicates a severe orientation-memory-concentration impairment, or a severe memory impairment.

(O) "**MSQ score at the high end of the moderate risk range**" means the client's total weighted UCAT MSQ score is 10 or 11 which indicates an orientation-memory-

concentration impairment, or a significant memory impairment.

(P) "**Nutrition high risk**" means a total weighted UCAT Nutrition score is 12 or more which indicates the client has significant eating difficulties combined with poor appetite, weight loss, and/or special diet requirements.

(Q) "**Social Resources high risk**" means a total weighted UCAT Social Resources score is 15 or more which indicates the client lives alone combined with none or very few social contacts and no supports in times of need.

(2) **Minimum UCAT criteria.** The minimum UCAT criteria for NF level of care are:

(A) The UCAT documents need for assistance to sustain health and safety as demonstrated by:

(i) either the ADLs or MSQ score is in the high risk range; or,

(ii) any combination of two or more of the following:

(I) ADLs score is at the high end of moderate risk range; or,

(II) MSQ score is at the high end of moderate risk range; or,

(III) IADLs score is in the high risk range;

or,
(IV) Nutrition score is in the high risk range; or,

(V) Health Assessment is in the moderate risk range, and, in addition,

(B) The UCAT documents absence of support or adequate environment to meet the needs to sustain health and safety as demonstrated by:

(i) Client Support is moderate risk; or,

(ii) Environment is high risk; or,

(iii) Environment is moderate risk and Social Resources is in the high risk range.

(3) **NF Level of Care Services.** To be eligible for NF level of care services, meeting the minimum UCAT criteria demonstrates the individual must:

(A) require a treatment plan involving the planning and administration of services that require skills of licensed technical or professional personnel, are provided directly or under the supervision of such personnel;

(B) have a physical impairment or combination of physical and mental impairments;

(C) require professional nursing supervision (medication, hygiene and/or dietary assistance);

(D) lack the ability to care for self or communicate needs to others;

(E) require medical care and treatment to minimize physical health regression and deterioration;

- (F) require care that is not available through family and friends, Medicare, Veterans Administration, or other federal entitlement program with the exception of Indian Health Service; and,
- (G) require care that cannot be met through Medicaid state plan services, including Personal Care, if financially eligible.

[Source: Added at 14 Ok Reg 56, eff 4-30-96 (emergency); Added at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 15 Ok Reg 3715, eff 5-18-98 (emergency); Amended at 16 Ok Reg 1438, eff 5-27-99 ; Amended at 17 Ok Reg 2410, eff 6-26-00 ; Amended at 21 Ok Reg 2252, eff 6-25-04]

317:35-19-8. Preadmission screening and resident review

- (a) Federal regulations govern the State's responsibility for Preadmission Screening and Resident Review (PASRR) of individuals with mental illness and intellectual disabilities. PASRR applies to the screening or reviewing of all individuals for mental illness, intellectual disability, or related conditions who apply to or reside in a Title XIX certified nursing facility (NF), regardless of the source of payment for the NF services and/or the individual's or resident's known diagnoses. Individuals referred for admission to a NF must be screened for a major mental disorder, diagnosable under the most current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). The NF must independently evaluate the Level I PASRR screen regardless of who completes the form and determine whether or not to admit an individual to the facility. If an individual is admitted inappropriately, the NF is subject to recoupment of Medicaid funds and penalties imposed by the Centers for Medicare and Medicaid Services (CMS). Federal financial participation (FFP) may not be paid until results of any needed PASRR Level II evaluations are received. PASRR is a requirement for nursing facilities with dually certified (both Medicare and Medicaid) beds. There are no PASRR requirements for Medicare skilled beds that are not dually certified, nor is PASRR required for individuals seeking residency in an intermediate care facility for individuals with intellectual disabilities (ICF/IID).
- (b) For Medicaid applicants, medical and financial eligibility determinations are also required.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 17 Ok Reg 2410, eff 6-26-00 ; Amended at 23 Ok Reg 2586, eff 6-25-06 ; Amended at 29 Ok Reg 1162, eff 6-25-12 ; Amended at 34 Ok Reg 721, eff 9-1-17 ; Amended at 36 Ok Reg 957, eff 9-1-19]

317:35-19-9. PASRR screening process

(a) Level I screen for PASRR.

- (1) OHCA Form LTC-300R, Nursing Facility Level of Care Assessment, must be completed by an authorized NF official or designee. An authorized NF official or designee must consist of one of the following:
 - (A) The NF administrator or co-administrator;

(B) A licensed nurse, social service director, or social worker from the facility; or

(C) A licensed nurse, social service director, or social worker from the hospital.

(2) Prior to admission, the authorized NF official must evaluate the properly completed OHCA Form LTC-300R and the Minimum Data Set (MDS), if available, as well as all other readily available medical and social information, to determine if there currently exists any indication of mental illness (MI), intellectual disability (ID), or other related condition, or if such condition existed in the applicant's past history. Form LTC-300R constitutes the Level I PASRR Screen and is utilized in determining whether or not a Level II is necessary prior to allowing the member to be admitted.

(3) The NF is responsible for determining from the evaluation whether or not the member can be admitted to the facility. A "yes" response to any question from Form LTC-300R, Section E, will require the NF to contact the Level of Care Evaluation Unit (LOCEU) for a consultation to determine if a Level II assessment is needed. The facility is also responsible for consulting with the LOCEU regarding any mental illness, an intellectual disability, or related condition information that becomes known either from completion of the MDS or throughout the resident's stay. The original Form LTC-300R must be submitted to the LOCEU by mail within ten (10) days of the resident's admission. SoonerCare payment may not be made for a resident whose LTC-300R requirements have not been satisfied in a timely manner.

(4) Upon receipt and review of the PASRR eligibility information packet, the LOCEU may, in coordination with the Oklahoma Department of Human Services (OKHDS) area nurse, re-evaluate whether a Level II PASRR assessment may be required. If a Level II assessment is not required, as determined by the LOCEU, the area nurse, or nurse designee, documents this and continues with the process of determining medical eligibility. If a Level II is required, a medical decision is not made until the area nurse is notified of the outcome of the Level II assessment. The results of the Level II assessment are considered in the medical eligibility decision. The area nurse, or nurse designee, makes the medical eligibility decision within ten (10) working days of receipt of the medical information when a Level II assessment is not required. If a Level II assessment is required, the area nurse makes the decision within five working days if appropriate.

(b) Pre-admission Level II assessment for PASRR. The authorized official is responsible for consulting with the OHCA LOCEU in determining whether a Level II assessment is necessary. The decision for Level II assessment is made by the LOCEU.

(1) Any one of the following three (3) circumstances will allow a member to enter the NF without being subjected to a Level II PASRR assessment:

(A) The member has no current indication of mental illness or an intellectual disability or other related condition and there is no history of such condition in the member's past;

(B) The member does not have a diagnosis of an intellectual disability or related condition; or
(C) The member has indications of mental illness or an intellectual disability or other related condition, but is not a danger to self and/or others, and is being released from an acute care hospital as part of a medically prescribed period of recovery (Exempted Hospital Discharge). If an individual is admitted to an NF based on Exempted Hospital Discharge, it is the responsibility of the NF to ensure that the individual is either discharged by the 30th day or that a Level II has been requested and is in process. Exempted Hospital Discharge is allowed only if all of the following three (3) conditions are met:

- (i) The individual must be admitted to the NF directly from a hospital after receiving acute inpatient care at the hospital (not including psychiatric facilities);
- (ii) The individual must require NF services for the condition for which he/she received care in the hospital; and
- (iii) The attending physician must certify before admission to the facility that the individual is likely to require less than thirty (30) days of nursing facility services. The NF will be required to furnish documentation to the OHCA upon request.

(2) If the member has current indications of mental illness or an intellectual disability or other related condition, or if there is a history of such condition in the member's past, the member cannot be admitted to the NF until the LOCEU is contacted to determine if a Level II PASRR assessment must be performed. Results of any Level II PASRR assessment ordered must indicate that NF care is appropriate prior to allowing the member to be admitted.

(3) The OHCA Level of Care Evaluation Unit authorizes Advance Group Determinations for the MI and ID Authorities in the categories listed in the following categories listed in (A) through (C) of this paragraph. Preliminary screening by the LOCEU should indicate eligibility for NF level of care prior to consideration of the provisional admission.

(A) **Provisional admission in cases of delirium.** Any person with mental illness, an intellectual disability or related condition who is not a danger to self and/or others, may be admitted to a Title XIX certified NF if the individual is experiencing a condition that precludes screening, i.e., effects of anesthesia, medication, unfamiliar environment, severity of illness, or electrolyte imbalance.

- (i) A Level II evaluation is completed immediately after the delirium clears. LOCEU must be provided with written documentation by a physician that supports the individual's condition which allows

provisional admission as defined in (i) of this subparagraph.

(ii) Payment for NF services will not be made after the provisional admission ending date. If an individual is determined to need a longer stay, the individual must receive a Level II evaluation before continuation of the stay may be permitted and payment made for days beyond the ending date.

(B) Provisional admission in emergency situations.

Any person with a mental illness, an intellectual disability or related condition, who is not a danger to self and/or others, may be admitted to a Title XIX certified NF for a period not to exceed seven days pending further assessment in emergency situations requiring protective services. The request for Level II evaluation must be made immediately upon admission to the NF if a longer stay is anticipated. LOCEU must be provided with written documentation from Adult Protective Services or the facility which supports the individual's emergency admission. Payment for NF services will not be made beyond the emergency admission ending date.

(C) Respite care admission. Any person with mental illness, an intellectual disability or related condition, who is not a danger to self and/or others, may be admitted to a Title XIX certified NF to provide respite to in-home caregivers to whom the individual is expected to return following the brief NF stay. Respite care may be granted up to fifteen (15) consecutive days per stay, not to exceed thirty (30) days per calendar year.

(i) In rare instances, such as illness of the caregiver, an exception may be granted to allow thirty (30) consecutive days of respite care. However, in no instance can respite care exceed thirty (30) days per calendar year.

(ii) Respite care must be approved by LOCEU staff prior to the individual's admission to the NF. The NF provides the LOCEU with written documentation concerning circumstances surrounding the need for respite care, the date the individual wishes to be admitted to the facility, and the date the individual is expected to return to the caregiver. Payment for NF services will not be made after the respite care ending date.

(c) PASRR Level II resident review. The resident review is used primarily as a follow-up to the pre-admission assessment.

(1) The facility's routine resident assessment will identify those individuals previously undiagnosed as intellectually disabled or mentally ill. A new condition of intellectual disabilities or mental illness must be referred to LOCEU by the NF for determination of the need for the Level II. The facility's failure to refer such individuals for a Level II assessment may result in recoupment of

funds and/or penalties from CMS.

(2) A Level II resident review may be conducted the following year for each resident of a NF who was found to experience a serious mental illness with no primary diagnosis of dementia on his or her pre-admission Level II to determine whether, because of the resident's physical and mental condition, the resident requires specialized services.

(3) A Level II resident review may be conducted for each resident of a NF who has mental illness or an intellectual disability or other related condition when there is a significant change in the resident's mental condition. If such a change should occur in a resident's condition, it is the responsibility of the facility to have a consultation with the LOCEU concerning the need to conduct a resident review.

(4) Individuals who were determined to have a serious mental illness on their last PASRR Level II evaluation will receive a resident review at least within one year of the previous evaluation.

(d) Results of pre-admission Level II assessment and Resident Review. Through contractual arrangements between the OHCA and the Mental Illness/Intellectual Disabilities Authorities/ Community Mental Health Centers, individualized assessments are conducted and findings presented in written evaluative reports. The reports recommend if NF services are needed, if specialized services or less than specialized services are needed, and if the individual meets the federal PASRR definition of mental illness or intellectual disability or related conditions. Evaluative reports are delivered to the OHCA's LOCEU within federal regulatory and state contractual timelines to allow the LOCEU to process formal, written notification to member, guardian, NF and significant others.

(e) Evaluation of pre-admission Level II or Resident Review assessment to determine Medicaid medical eligibility for long term care. The determination of medical eligibility for care in a NF is made by the area nurse (or nurse designee) unless the individual has an intellectual disability or related condition or a serious mental illness. The procedures for obtaining and submitting information required for a decision are outlined in this subsection. When an active long term care member enters the facility and nursing care is being requested:

(1) The pre-admission screening process must be performed and must allow the member to be admitted.

(2) The facility will notify the local county office by the OKDHS Form 08MA083E, Notification Regarding Patient in a Nursing Facility, Intermediate Care Facility for the Mentally Retarded or Hospice and Form 08MA084E, Management of Recipient's Funds, of the member's admission.

(3) The local county office will send the NF the OKDHS Form 08MA038E, Notice Regarding Financial Eligibility, indicating actions that are needed or have been taken regarding the member.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 15 Ok Reg 3715, eff 5-18-98 (emergency); Amended at 16 Ok Reg 1438, eff 5-27-99 ; Amended at 17 Ok Reg 2410, eff 6-26-00 ; Amended at 21 Ok Reg 2252, eff 6-25-04 ; Amended at 23 Ok Reg 2586, eff 6-25-06 ; Amended at 24 Ok Reg 2866, eff 6-1-07 (emergency); Amended at 25 Ok Reg 1227, eff 5-25-08 ; Amended at 29 Ok Reg 1162, eff 6-25-12 ; Amended at 34 Ok Reg 721, eff 9-1-17]

317:35-19-10. Level II screen for PAS [REVOKED]

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Revoked at 14 Ok Reg 56, eff 4-30-96 (emergency); Revoked at 14 Ok Reg 1802, eff 5-27-97]

317:35-19-11. Annual Resident Review (ARR) [REVOKED]

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Revoked at 14 Ok Reg 56, eff 4-30-96 (emergency); Revoked at 14 Ok Reg 1802, eff 5-27-97]

317:35-19-12. Level I screen for ARR [REVOKED]

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Revoked at 14 Ok Reg 56, eff 4-30-96 (emergency); Revoked at 14 Ok Reg 1802, eff 5-27-97]

317:35-19-13. Level II screen for ARR [REVOKED]

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Revoked at 14 Ok Reg 56, eff 4-30-96 (emergency); Revoked at 14 Ok Reg 1802, eff 5-27-97]

317:35-19-14. New admissions, readmissions, interfacility transfers, and same level of care program transfers

The Preadmission Screening process does not apply to readmission of an individual back to the same NF following a continuous medical hospital stay. There is no specific time limit on the length of absence from the nursing facility for the hospitalization. Inter-facility transfers are also subject to preadmission screening. In the case of transfer of a resident from an NF to a hospital or to another NF, the transferring NF is responsible for ensuring that copies of the resident's most recent PASRR Form LTC-300R and any PASRR evaluations accompany the transferring resident. The receiving NF must submit an updated Form LTC-300R that reflects the resident's current status to LOCEU within 10 days of the transfer. Failure to do so could result in recoupment of funds.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 17 Ok Reg 2410, eff 6-26-00 ; Amended at 22 Ok Reg 108, eff 7-1-04 (emergency); Amended at 22 Ok Reg 2527, eff 7-11-05 ; Amended at 23 Ok Reg 2586, eff 6-25-06 ; Amended at 24 Ok Reg 2866, eff 6-1-07 (emergency); Amended at 25 Ok Reg 1227, eff 5-25-08]

317:35-19-15. PASARR tracking system [REVOKED]

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Revoked at 14 Ok Reg 56, eff 4-30-96 (emergency); Revoked at 14 Ok Reg 1802, eff 5-27-97]

317:35-19-16. PASRR appeals process

(a) Any individual who has been adversely affected by any Preadmission Screening and Resident Review (PASRR) determination made by the State in the context of either a preadmission screening or an annual resident review may appeal that determination by requesting a fair hearing. If the individual does not consider the PASRR decision a proper one, the individual or their authorized representative must contact the local county Oklahoma Department of Human Services (DHS) office to discuss a hearing. Forms for requesting a fair hearing (DHS Form 13MP001E, Request for a Fair Hearing), as well as assistance in completing the forms, can be obtained at the local county DHS office. Any request for a hearing must be made no later than thirty (30) days following the date of written notice. Appeals of these decisions are available under Oklahoma Administrative Code (OAC) 317:2-1-2. There is no distinction between the SoonerCare and non-SoonerCare patient; therefore, all individuals seeking an appeal have the same rights, regardless of source of payment. Level I determinations are not subject to appeal.

(b) When the individual is found to experience Mental Illness (MI), Intellectual Disability (ID), or related condition through the Level II screen, the PASRR determination made by the ID/MI authorities cannot be countermanded by the Oklahoma Health Care Authority, either in the claims process or through other utilization control/review processes, or by the Oklahoma State Department of Health. Only appeals determinations made through the fair hearing process may overturn a PASRR determination made by the ID/MI authorities.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 17 Ok Reg 2410, eff 6-26-00 ; Amended at 23 Ok Reg 817, eff 3-9-06 (emergency); Amended at 23 Ok Reg 2586, eff 6-25-06 ; Amended at 24 Ok Reg 2866, eff 6-1-07 (emergency); Amended at 25 Ok Reg 1227, eff 5-25-08 ; Amended at 36 Ok Reg 958, eff 9-1-19]

317:35-19-17. Determination of continued medical eligibility for care in a nursing facility [REVOKED]

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Revoked at 14 Ok Reg 56, eff 4-30-96 (emergency); Revoked at 14 Ok Reg 1802, eff 5-27-97]

317:35-19-18. Change in level of long-term medical care

(a) When a member is receiving Personal Care services and requests nursing facility care or when a member is in a nursing facility and requests Personal Care services, a new Uniform Comprehensive Assessment Tool (UCAT) is required. The UCAT is updated if the member is in the nursing facility and requests ADvantage waiver services. No new medical decision is needed. Also, no new medical decision is needed for admission to a nursing facility from home if the period of absence from the nursing facility is less than 90 days. No new medical decision is needed if the member loses financial eligibility but maintains medical eligibility by having a current medical decision and by remaining in the facility during the period of financial ineligibility.

(b) When there is a decision that a member approved for one level of long term care is eligible for a different level of care, the local office is advised

by update of the file. If the change is from facility care to Personal Care, a new UCAT, Part III care plan, service plan, and other required forms are submitted to the area nurse, or nurse designee. If the Personal Care member requests a decision regarding facility care prior to admission to a facility, the LTC nurse is responsible for submitting the UCAT, Part III, and Form LTC-300R to the area nurse, or nurse designee for a decision. When the area nurse, or nurse designee, determines that a nursing care member no longer needs this level of care, payment may be continued while the member, or other responsible person, makes other arrangements. The length of such continuation of payment depends upon the circumstances, but must allow time for the appropriate advance notice to the member and cannot exceed 60 days from the date of the decision.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 15 Ok Reg 3715, eff 5-18-98 (emergency); Amended at 16 Ok Reg 1438, eff 5-27-99 ; Amended at 17 Ok Reg 2410, eff 6-26-00 ; Amended at 20 Ok Reg 1958, eff 6-26-03 ; Amended at 21 Ok Reg 2252, eff 6-25-04 ; Amended at 24 Ok Reg 2866, eff 6-1-07 (emergency); Amended at 25 Ok Reg 1227, eff 5-25-08]

317:35-19-19. General financial eligibility requirements for NF and skilled nursing care

(a) **Financial eligibility for NF care.** Financial eligibility for NF care is determined using the rules on income and resources according to the eligibility group to which the individual is related.

(1) Income, resources and expenses are evaluated on a monthly basis for all individuals requesting payment for NF care. Each individual requesting payment for NF care is allowed a personal needs allowance.

(2) To be eligible for long-term care in an NF, the individual must be determined categorically needy according to the standards appropriate to the categorical relationship.

(3) If the individual's gross income exceeds the categorically needy standard as shown on OKDHS Appendix C-1, Schedule VIII. B. 1., refer to OAC 317:35-5-41.6(a)(6)(B) for rules on establishing a Medicaid Income Pension Trust.

(4) When eligibility for long-term care has been determined, the spenddown amount is determined based on type of care, categorical relationship, community spouse, etc.

(5) The spenddown is applied to the vendor payment on the first NF claim(s) received on behalf of the individual.

(6) For an individual eligible for long-term care in a NF, the individual's share of the vendor payment is not prorated over the month. As SoonerCare is the payer of last resort, the full amount of the member's share of the vendor payment must first be applied to the facility's charges before SoonerCare reimbursement begins.

(b) **Financial eligibility for skilled nursing.** Skilled Nursing Care is covered as part of the Medicare Part A coverage. For members who are currently receiving this benefit through the QMB program, no further action is needed. For individuals who do not have an active SoonerCare

case, an application is processed to receive the Medicare crossover and deductible benefits. Income eligibility is based on the categorically needy standard in OKDHS Appendix C-1, Schedule VI., for the first 30 days. After the initial 30 days, income eligibility is based on the categorically needy standard in OKDHS Appendix C-1, Schedule VIII. B. 1.

(1) QMB eligible individuals in skilled nursing care are allowed the resource standard as shown on OKDHS Appendix C-1, Schedule VI, but must meet the SoonerCare resource standard as shown on OKDHS Appendix C-1, Schedule VIII. D., for NF level of care. For individuals with no active case, use the resource standard shown on OKDHS Appendix C-1, Schedule VIII. D.

(2) Rules concerning transfer of assets do not apply to skilled level of care.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 17 Ok Reg 2410, eff 6-26-00 ; Amended at 18 Ok Reg 132, eff 10-7-00 (emergency); Amended at 18 Ok Reg 1139, eff 5-11-01 ; Amended at 19 Ok Reg 76, eff 9-20-01 ; Amended at 19 Ok Reg 1071, eff 5-13-02 ; Amended at 20 Ok Reg 1958, eff 6-26-03 ; Amended at 25 Ok Reg 130, eff 8-1-07 (emergency); Amended at 25 Ok Reg 1257, eff 5-25-08 ; Amended at 30 Ok Reg 1209, eff 7-1-13]

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

Financial eligibility for NF medical care is determined as follows:

(1) **Financial eligibility for MAGI eligibility groups.** See MAGI eligibility rules in Subchapter 6 of this Chapter to determine financial eligibility for MAGI eligibility groups.

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

(A) The categorically needy standard on OKDHS Appendix C-1, Schedule VI., is applicable for individuals related to ABD. If the individual is in an NF and has received services for 30 days or longer, the categorically needy standard in OKDHS Appendix C-1, Schedule VIII. B.1., is used. If the individual leaves the facility prior to the 30 days, or does not require services past the 30 days, the categorically needy standard in OKDHS Appendix C-1, Schedule VI., is used. The rules on determination of income and resources are applicable only when an individual has entered a NF and is likely to remain under care for 30 consecutive days. The 30-day requirement is

considered to have been met even if it is interrupted by a hospital stay or the individual is deceased before the 30-day period ends.

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

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

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

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

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

(I) the spouse;

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

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

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

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

than eligibility.

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

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

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

(vii) The denial would result in undue hardship.

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

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

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

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

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

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

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

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

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

transfers, all transferred assets are added together to determine the penalty.

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

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

- (i) by the individual or such individual's spouse;
- (ii) by a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or such individual's spouse;
- or
- (iii) by any person, including any court or administrative body acting at the direction or upon the request of the individual or such individual's spouse.

(F) A penalty would not apply if:

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

- (I) the spouse;
- (II) the individual's child under age 21 or who is blind or totally disabled as determined by Social Security;
- (III) a sibling who has equity interest in the home and resided in the home for at least one year immediately prior to the institutionalization of the individual; or
- (IV) the individual's son or daughter who resided in the home and provided care for at least two years immediately prior to the individual's institutionalization.

(ii) the individual can show satisfactorily that the intent was to dispose of assets at fair market value or that the transfer was exclusively for a purpose other than eligibility. It is presumed that any transfer of assets made for less than fair market value was made in order to qualify the individual for SoonerCare. In order to rebut this presumption, the individual must present compelling evidence that a transfer was made for reasons other than to qualify for SoonerCare. It is not sufficient for an

individual to claim that assets were transferred solely for the purposes of allowing another to have them with ostensibly no thought of SoonerCare if the individual qualifies for SoonerCare as a result of the transfer.

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

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

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

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

(vii) the denial would result in undue hardship.

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

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

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

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

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

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

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

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

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

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

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

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

(ii) the date on which the individual is:

(I) eligible for medical assistance; and

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

(D) The penalty period:

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

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

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

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

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

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

- (i) by the individual or such individual's spouse;
- (ii) by a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or such individual's spouse;
- or
- (iii) by any person, including any court or administrative body acting at the direction or upon the request of the individual or such individual's spouse.

(G) Special Situations.

(i) Separate Maintenance or Divorce.

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

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

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

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

(ii) Inheritance from a spouse.

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

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

(H) A penalty would not apply if:

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

(I) the spouse;

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

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

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

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

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

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

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

"Sole benefit" means that the amount transferred will be used for the benefit of the spouse (either community or institutionalized) during his or her expected life.

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

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

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

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

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

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

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

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

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

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

- (i) Documentation must be provided to show each co-owner's contribution;
- (ii) The funds contributed by the applicant or SoonerCare member end up in an account owned solely by the applicant or member.

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

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

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 15 Ok Reg 564, eff 9-18-97 (emergency); Amended at 15 Ok Reg 1554, eff 5-11-98 ; Amended at 15 Ok Reg 3715, eff 5-18-98 (emergency); Amended at 16 Ok Reg 1438, eff 5-27-99 ; Amended at 17 Ok Reg 2410, eff 6-26-00 ; Amended at 19 Ok Reg 136, eff 9-1-01 ; Amended at 19 Ok Reg 2149, eff 6-27-02 ; Amended at 20 Ok Reg 1958, eff 6-26-03 ; Amended at 21 Ok Reg 2252, eff 6-25-04 ; Amended at 24 Ok Reg 2135, eff 6-25-07 ; Amended at 25 Ok Reg 674, eff 12-18-07 (emergency); Amended at 25 Ok Reg 1227, eff 5-25-08 ; Amended at 30 Ok Reg 1209, eff 7-1-13 ; Amended at 31 Ok Reg 73, eff 9-24-13 (emergency); Amended at 31 Ok Reg 1720, eff 9-12-14 ; Amended at 35 Ok Reg 1481, eff 9-14-18]

317:35-19-21. Determining financial eligibility for care in nursing facility

(a) Financial eligibility and vendor payment calculations for individuals in an nursing facility (NF) are determined according to whether or not a spouse remains in the home.

(1) **Individual without a spouse.** For an individual without a spouse, the following rules are used to determine financial eligibility.

(A) **Income eligibility.** To determine the income of the individual without a spouse, the rules in (i) - (iii) of this subparagraph apply.

- (i) If payment of income is made to the individual and another person(s), the income is considered in proportion to the individual's interest.
- (ii) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.
- (iii) After determination of income, the gross income of the individual cannot exceed the

categorically needy standard in Oklahoma Department of Human Services (OKDHS) Form 08AX001E (Appendix C-1), Schedule VIII. B. 1., to be eligible for NF services. If the individual's gross income exceeds this standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [Oklahoma Administrative Code (OAC) 317:35-5-41.6(a)(6)(B)].

(B) **Resource eligibility.** In order for an individual without a spouse to be eligible for NF services, his/her countable resources cannot exceed the maximum resource standard listed in OKDHS Form 08AX001E (Appendix C-1), Schedule VIII. D.

(C) **Vendor payment.** When eligibility for NF care has been determined, the vendor payment is computed. For an individual eligible for long-term care in a NF, the individual's share of the vendor payment is not prorated over the month. As SoonerCare is the payer of last resort, the full amount of the member's share of the vendor payment must first be applied to the facility's charges before SoonerCare reimbursement begins. See (b) of this Section for calculation of the vendor payment after financial eligibility has been determined.

(D) **First month.** For the first month of care, the following procedures apply when determining the vendor payment:

(i) When an individual enters the facility on the first day of the month, all countable income is considered with the facility maintenance standard allowed.

(ii) When an individual enters the facility after the first day of the month, all countable income is considered with the own home standard allowed in computation of the vendor payment. Only the remaining income actually available is used to compute the vendor payment.

(E) **Equity in capital resources.** If the equity in capital resources is in excess of the standards, certification is delayed up to thirty (30) days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources, along with excess income to be considered against the vendor payment, are in excess of one (1) month's vendor payment, the application is denied.

(2) **Individual with a spouse who is institutionalized in a NF or ICF/IID, or who receives ADvantage or HCBW/IID services, or is sixty-five (65) or over and in a mental health hospital.** For an individual with a spouse who is institutionalized in a NF or ICF/IID, or who receives ADvantage or HCWB/IID

services, or is sixty-five (65) or over and in a mental health hospital, resources are determined for each individual as the amount owned by each individual plus one-half of the jointly owned resources of the couple. Once this separation of assets is made, a resource of either spouse is not considered available to the other during institutionalization.

(A) **Income eligibility.** To determine income for an individual whose spouse is institutionalized in a NF or ICF/IID, or who receives ADvantage or HCBW/IID services, or is sixty-five (65) or over and in a mental health hospital, income determination is made individually. The income of either spouse is not considered as available to the other during institutionalization for determination of financial eligibility. See (b) of this Section for post-eligibility calculation of the vendor payment and the community spouse income allowance, if applicable. The rules in (i) - (v) of this subparagraph apply in this situation.

(i) If payment of income is made solely to one (1) or the other, the income is considered available only to that individual.

(ii) If payment of income is made to both, one-half is considered for each individual.

(iii) If payment of income is made to either one (1) or both and another person(s), the income is considered in proportion to either spouse's interest (if payment is to that spouse) or one-half of the joint interest if no interest is specified.

(iv) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

(v) After determination of income, the gross income of the individual cannot exceed the categorically needy standard in OKDHS Form 08AX001E (Appendix C-1), Schedule VIII. B. 1., to be eligible for Nursing Facility services. If the individual's gross income exceeds this standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC 317:35-5-41.6(a)(6) (B)].

(B) **Resource eligibility.** In order for an individual with a spouse who is institutionalized in a NF or ICF/IID, receives ADvantage or HCBW/IID services, or is sixty-five (65) or older and in a mental health hospital to be eligible for NF services, his/her countable resources cannot exceed the maximum resource standard for an individual listed in OKDHS Form 08AX001E (Appendix C-1), Schedule VIII. D.

(C) **Vendor payment.** When eligibility for NF services has been determined, the spenddown calculation is used to compute the vendor payment. For an individual eligible for long-term care in a NF, the individual's share of the vendor

payment is not prorated over the month. As SoonerCare is the payer of last resort, the full amount of the member's share of the vendor payment must first be applied to the facility's charges before SoonerCare reimbursement begins. See (b) of this Section for calculation of the vendor payment after financial eligibility has been determined.

(D) **First month.** For the first month of care, the following procedures apply when determining the vendor payment:

(i) When an individual enters the facility on the first day of the month, all countable income is considered with the facility maintenance standard allowed.

(ii) When an individual enters the facility after the first day of the month, all countable income is considered with the own home standard allowed in computation of the vendor payment. Only the remaining income actually available is used to compute the vendor payment.

(E) **Equity in capital resources.** If the equity in capital resources is in excess of the standards, certification is delayed up to thirty (30) days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources, along with excess income to be considered against the vendor payment, are in excess of one (1) month's vendor payment, the application is denied.

(3) **Individual with a spouse remaining in the home who does not receive ADvantage or HCBW/IID services.** When an individual and spouse are separated due to the individual entering an NF, income and resources are determined separately. However, the income and resources of the community spouse must be included on the application form. At redetermination of eligibility, the community spouse's income must be included in the review process. During any month that the individual is in the NF, income of the community spouse is not considered available to that individual. The following rules are used to determine the income and resources of each:

(A) **Income eligibility.** To determine the income of both spouses, the following rules in this subparagraph apply:

(i) If payment of income is made solely to one (1) or the other, the income is considered available only to that individual.

(ii) If payment of income is made to both, one-half is considered for each individual.

(iii) If payment of income is made to either one (1) or both and another person(s), the income is considered in proportion to either the spouse's interest (if payment is to that spouse) or one-half of

the joint interest if no interest is specified.

(iv) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

(v) If the individual's gross income exceeds the categorically needy standard as shown on OKDHS Form 08AX001E (Appendix C-1), Schedule VIII. B. 1., refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC 317:35-5-41.6(a)(6)(B)].

(B) Resource eligibility. To determine resource eligibility, it is necessary to determine the amount of resources for both spouses for the month of the individual's entry into the nursing facility. Of the resources available to the couple (both individual and joint ownership) an amount will be protected for the community spouse which will not be considered available to the spouse in the NF. OKDHS Form 08MA011E, Assessment of Assets, is used for the assessment prior to application for SoonerCare. The amount determined as the spousal share is used for all subsequent applications for SoonerCare, regardless of changes in the couple's resources. The protected spousal share cannot be changed for any reason. When application for SoonerCare is made at the same time the individual enters the NF, OKDHS Form 08MA012E, Title XIX Worksheet, is used in lieu of OKDHS Form 08MA011E.

(i) The first step in the assessment process is to establish the total amount of resources for the couple during the first month of the entry of the spouse into the NF.

(ii) The community spouse's share is equal to one-half of the total resources of the couple not to exceed the maximum amount of resource value that can be protected for the community spouse, as shown on OKDHS Form 08AX001E (Appendix C-1), Schedule XI.

(iii) The minimum resource standard for the community spouse, as established by the Oklahoma Health Care Authority (OHCA), is found on OKDHS Form 08AX001E (Appendix C-1), Schedule XI.

When the community spouse's share is less than the minimum standard, an amount may be deemed from the other spouse's share to ensure the minimum resource standard for the community spouse. If the community spouse's share equals or exceeds the minimum resource standard, deeming cannot be done.

(iv) If deeming is necessary to meet the minimum resource standard for the community spouse, the amount that is deemed must be legally transferred to the community spouse within one (1) year of the

effective date of certification for SoonerCare. At the first redetermination of eligibility, the worker must document that the resources have been transferred. After the first year of SoonerCare eligibility, resources of the community spouse will not be available to the other spouse and resources cannot be deemed to the community spouse.

(v) After the month in which the institutionalized spouse and community spouse have met the resource standards and the institutionalized spouse is determined eligible for benefits, no resources of the community spouse, regardless of value, will be considered available to the institutionalized spouse. If the resources of the community spouse grow to exceed the original deemed amount, the State cannot require the community spouse to apply any of these excess resources toward the cost of the care of the institutionalized spouse.

(vi) When determining eligibility for SoonerCare, the community spouse's share of resources is protected and the remainder considered available to the spouse in the NF.

(vii) The resources determined above for the individual in the NF cannot exceed the maximum resource standard for an individual as shown in OKDHS Form 08AX001E (Appendix C-1), Schedule VIII. D.

(viii) Once the dollar value of the community spouse's share of resources is established for the month of the other spouse's entry into NF, that amount is used when determining resource eligibility for a subsequent SoonerCare application for NF.

(ix) Once a determination of eligibility for SoonerCare is made, either spouse is entitled to a fair hearing. Any such hearing regarding the determination of the community spouse's resource allowance is held within thirty (30) days of the date of the request for the hearing. Either spouse is entitled to a fair hearing if dissatisfied with a determination of:

(I) The community spouse's monthly income allowance;

(II) The amount of monthly income otherwise available to the community spouse;

(III) Determination of the spousal share of resource;

(IV) The attribution of resources (amount deemed); or

(V) The determination of the community spouse's resource allowance.

(x) The rules on determination of income and resources are applicable only when an individual has entered an NF and is likely to remain under care for thirty (30) consecutive days. The thirty (30) day requirement is considered to have been met even if it is interrupted by a hospital stay or the individual is deceased before the thirty (30) day period ends.

(xi) The rules on resources included in this Section apply only to those cases in which an individual begins a continuous period of care in an NF on or after September 30, 1989.

(xii) If the individual was admitted prior to September 30, 1989, there is not a protected amount for the community spouse. Resources are separated according to spousal ownership with one-half of jointly owned resources counted for each. In this instance, each spouse's resources are considered separately and the resources of the community spouse do not affect the eligibility of the spouse in the NF.

(C) **Vendor payment.** After the institutionalized spouse has been determined eligible for long-term care, the vendor payment is computed. For an individual eligible for long-term care in a NF, the individual's share of the vendor payment is not prorated over the month. As SoonerCare is the payer of last resort, the full amount of the member's share of the vendor payment must first be applied to the facility's charges before SoonerCare reimbursement begins. See (b) of this Section for calculation of the vendor payment after financial eligibility has been determined.

(D) **Excess resources.** If the equity in capital resources is in excess of the standards but less than the amount of one (1) month's vendor payment, certification is delayed up to thirty (30) days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources, along with excess income to be considered against the vendor payment, are in excess of the vendor payment, the application is denied.

(b) Calculation of the vendor payment after financial eligibility for care in a NF has been determined is performed according to whether or not a spouse remains in the home. For the purpose of calculating the community spouse income allowance, spouses receiving ADvantage or HCBW/IID services are considered community spouses.

(1) The formula for determining the vendor payment for individuals without a spouse or other dependents is:

- (A) Countable income;
- (B) Minus the institutional or own home standard; and
- (C) Minus the actual monthly payments being made for medical insurance premiums including Medicare premiums; and
- (D) Minus incurred expenses for necessary medical and remedial care not covered under Medicaid, as set forth in the Oklahoma State Medicaid Plan.

(i) In order to be allowed to be deducted, expenses must:

- (I) Have been incurred during the three (3) month period immediately preceding the month of application;
- (II) Have been prescribed by a medical professional;
- (III) Be certified as being medically necessary by a treating physician, physician assistant, or advanced practice registered nurse working within the scope of his or her licensure; and
- (IV) Be no more than the least of the fee recognized by Medicaid, Medicare, or the average cost allowed by a commercial health insurance plan in Oklahoma.

(ii) The following expenses are not allowed to be deducted:

- (I) Expenses incurred as the result of the imposition of a transfer penalty;
- (II) Expenses for which a third party (including Medicaid) is liable, even if provided by an out-of-state network provider;
- (III) Expenses resulting from the failure to obtain prior approval from applicable private insurance, Medicare, or Medicaid, due to the service being medically unnecessary;
- (IV) Expenses that had been the subject of a prior authorization denial by Medicaid, due to lack of medical necessity; and
- (V) Health insurance premiums paid by an individual who is not a financially responsible relative, for which repayment is not expected.

(2) The own home standard is the categorically needy standard found on OKDHS Form 08AX001E (Appendix C-1), Schedule VI.

(3) The computation for the community spouse's share of resources for individuals with a spouse remaining in the home is the total countable resources divided by two (2). This amount cannot exceed the maximum resource standard. If it is less than the minimum resource standard, resources are deemed from the

institutionalized spouse to the community spouse, up to the minimum standard.

(4) The formula for determining the vendor payment for an individual with a spouse remaining in the home, regardless of whether the spouse receives ADvantage or HCBW/IID services, is:

(A) Determine the institutionalized spouse's monthly income as described in Paragraph (b)(1) of this Section.

(B) Determine how much of the institutionalized spouse's income can be deemed to the community spouse:

(i) Subtract the community spouse's gross income from the maximum monthly income standard on OKDHS Form 08AX001E (Appendix C-1), Schedule XI.

(ii) The resulting amount is the maximum amount that can be deemed from the institutionalized spouse to the community spouse.

(C) The amount actually deemed from the institutionalized spouse to the community spouse is subtracted from the institutionalized spouse's monthly income as described in Paragraph (b)(1) of this Section. Any amount remaining is the vendor payment if there are no minor dependent children, parents, or siblings residing with the community spouse.

(D) If there are minor dependent children, parents, or siblings residing with the community spouse, the formula for determining their allowance is:

(i) Divide the maximum monthly income standard from OKDHS Form 08AX001E (Appendix C-1), Schedule XI by 3;

(ii) Subtract the gross income of each dependent child, parent, or sibling residing with the community spouse from the amount in (i);

(iii) If there is more than one (1) dependent, add the amounts from (ii) together;

(iv) This amount is deemed to the dependents residing with the community spouse.

(E) The amount actually deemed to the dependents residing with the community spouse is subtracted from the amount determined in Subparagraph (b)(4)(C) of this Section. Any amount of the institutionalized spouse's income remaining is the vendor payment.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 13 Ok Reg 1211, eff 9-8-95 (emergency); Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 13 Ok Reg 2537, eff 12-24-96 ; Amended at 14 Ok Reg 546, eff 12-24-96 (emergency); Amended at 14 Ok Reg 1814, eff 5-27-97 ; Amended at 15 Ok Reg 3715, eff 5-18-98 (emergency); Amended at 16 Ok Reg 1438, eff 5-27-99 ; Amended at 17 Ok Reg 2410, eff 6-26-00 ; Amended at 19 Ok Reg 76, eff 9-20-01 ; Amended at 20 Ok Reg 1958, eff 6-26-03 ; Amended at 25 Ok Reg 130, eff 8-1-07 (emergency); Amended at 25 Ok Reg 1257, eff 5-25-08 ; Amended at 30 Ok Reg 1251, eff 7-1-13 ; Amended at 37 Ok Reg 1652, eff 9-14-20]

317:35-19-22. Certification for Nursing Facility (NF)

(a) **Application date.** The date of the application for NF care is most important in determining the date of eligibility. If the applicant is found eligible for SoonerCare, certification may be made retroactive for any service provided on or after the first day of the third month prior to the month of application and for future months.

(b) **Time limited approvals for nursing care.** A medical certification period of a specific length may be assigned for an individual who is categorically related to Aged, Blind and Disabled or Aid to Families with Dependent Children. This time limit is noted on the system. It is the responsibility of the nursing facility to notify the area nurse thirty (30) days prior to the end of the certification period if an extension of approval is required by the client. Based on the information from the NF the area nurse, or nurse designee, determines whether or not an update of the Uniform Comprehensive Tool (UCAT) is necessary for the extension. The area nurse, or nurse designee, coordinates with appropriate staff for any request for further UCAT assessments.

(c) **Certification period for long-term medical care.** A financial certification period of twelve (12) months is assigned for an individual who is approved for long-term care.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 15 Ok Reg 3715, eff 5-18-98 (emergency); Amended at 16 Ok Reg 1438, eff 5-27-99 ; Amended at 17 Ok Reg 2410, eff 6-26-00 ; Amended at 20 Ok Reg 1958, eff 6-26-03 ; Amended at 21 Ok Reg 2252, eff 6-25-04 ; Amended at 23 Ok Reg 268, eff 9-1-05 (emergency); Amended at 23 Ok Reg 1378, eff 5-25-06 ; Amended at 30 Ok Reg 1209, eff 7-1-13 ; Amended at 35 Ok Reg 27, eff 11-1-17 (emergency); Amended at 35 Ok Reg 1479, eff 9-14-18]

317:35-19-22.1. Discharge planning

Nursing facilities are responsible for the discharge planning of residents. In some instances the NF may be unable to successfully plan the discharge of the private pay resident who has exhausted financial resources to pay for NF care. When a private pay applicant who has exhausted resources is denied medical eligibility, and the NF is unable to successfully plan for discharge, the NF may request the assistance of the social worker, LTC nurse, or APS worker to participate on an interdisciplinary team to develop an appropriate discharge plan, or to request reconsideration of medical eligibility. Other persons who may participate on the interdisciplinary team are the physician, social worker, discharge planner, ombudsman, family members or responsible party and the resident. The NF is responsible for convening an Interdisciplinary Team meeting. A DHS team member documents the outcome of the team meeting and submits it to the DHS area nurse for consideration of submission to the Medicaid Director of the Oklahoma Health Care Authority.

[Source: Added at 14 Ok Reg 56, eff 4-30-96 (emergency); Added at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 15 Ok Reg 3715, eff 5-18-98 (emergency); Amended at 16 Ok Reg 1438, eff 5-27-99 ; Amended at 17 Ok Reg 2410, eff 6-26-00]

317:35-19-23. Redetermination of eligibility for NF care

A redetermination of financial eligibility must be completed prior to the end of the certification period. A notice is generated only if there is a

change which affects the client's financial responsibility.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97]

317:35-19-24. Case transfer between categories

If it becomes necessary to transfer a Medicaid long-term care case from one category to another because of change of age, income, or marital status, a new application is not required. If someone other than the client or guardian signed the original application form and the transfer is to a money payment case, an application with the client's signature is required. The new case is certified retaining the original certification date and redetermination date, using the appropriate code for transfer from the old category and the appropriate effective date which coincides with the closure of the previous case category. Recipients and appropriate medical providers are notified of the new case number and category by computer generated notice.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 17 Ok Reg 2410, eff 6-26-00]

317:35-19-25. Case changes

Any time there are changes which affect the long-term care case, computer generated notices are issued.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 14 Ok Reg 1802, eff 5-27-97]

317:35-19-26. Payment to NF

The OHCA may execute agreements to provide care only with facilities which are properly licensed by the state licensing agency. The agreement is initiated by application from the facility and expires on a specified date, or with termination of the facility license, or shall be automatically terminated on notice to this Authority that the facility is not in compliance with Medicaid (or other federal long-term care) requirements.

(1) In the event that a facility changes ownership, the agreement with the previous owner may be extended to the new owner, pending certification of the new owner to provide care to individuals during the change of ownership. In the event that the new owner is not showing good faith in pursuit of certification, the OHCA will begin planning for alternate placement of Medicaid patients. The county office is immediately notified of any relevant change in facility status.

(2) Payment for long-term care is made only for those individuals who have been approved by the Department of Human Services for such care. The amount of payment is based on the actual time the individual received care (including therapeutic leave) from a nursing facility during any given month. Payment for nursing care

cannot be made for any period during which the care has been temporarily interrupted for reasons other than therapeutic leave. Therapeutic leave is any planned leave other than hospitalization that is for the benefit of the patient. Therapeutic leave must be clearly documented in the patient's plan of care before payment for a reserved bed can be made by the OHCA.

(3) Effective July 1, 1994, the nursing facility may receive payment for a maximum of seven days of therapeutic leave per calendar year for each eligible individual to reserve the bed.

(4) The Statement of Compensable Therapeutic Leave Only form is used by the facility to record use of therapeutic leave. This form is to be made available by the local office to the nursing facility upon request.

(5) No payment shall be made for hospital leave.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 13 Ok Reg 927, eff 8-1-95 (emergency); Amended at 13 Ok Reg 415, eff 1-1-96 (emergency); Amended at 14 Ok Reg 56, eff 4-30-96 (emergency); Amended at 13 Ok Reg 1677, eff 5-27-96 ; Amended at 14 Ok Reg 1802, eff 5-27-97 ; Amended at 17 Ok Reg 2410, eff 6-26-00 ; Amended at 33 Ok Reg 907, eff 9-1-16]

317:35-19-27. Billing procedures for NF

Billing procedures for NF are contained in the Medical Services Provider Manuals with procedures developed for each type of medical provider. Questions regarding billing procedures which cannot be resolved through a study of these manuals should be referred to the OHCA.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95]

317:35-19-28. Management of client's funds while receiving care in NF

When an individual has been approved for long-term care in a facility, the administrator of the facility where he/she is receiving care completes the Management of Recipient's Funds form and when applicable, the form is signed according to instructions on the form.

(1) If the recipient requests the administrator to hold the recipient's funds, the administrator of the facility completes the Management of Recipient's Funds form to acknowledge receipt of money and other items of value. As long as the recipient remains in the facility, the administrator is responsible for completing this form each time funds or other items of value, other than monthly income, are received. The form also serves to acknowledge the agreement to an accounting of funds expended in behalf of the recipient and as a source document for posting credits and debits to Form ABCDM-99, Ledger Sheet for Recipient's Account.

(2) The administrator of the facility prepares Form ABCDM-99 for each recipient for whom he/she is holding funds or other items of value. He/she is obligated to keep an accurate accounting of all receipts and expenditures and the amount of money on hand at all times. Form ABCDM-99 is to be available for inspection at all

times.

(3) As a part of each redetermination of eligibility for a recipient for whom the administrator is holding funds or other items, the worker secures from the administrator a current Accounting Recipient's Personal Funds and Property form. This form is also prepared by the administrator of the facility when the recipient dies or leaves the facility for some other reason and is routed to the county office within five days from the last day the recipient was in residence.

(4) If the facility operator does not handle the recipient's funds, the worker is responsible for determining who does handle the funds, the amount of the funds and for recording this in the case narrative.

(5) If there is indication that, prior to the next regular determination of eligibility, the amount of the recipient's resources is likely to increase or decrease, the worker is responsible for taking the necessary action to assure continued eligibility on the part of the recipient.

(6) A copy of the Management of Recipient's Funds form must be on file in the local office for each recipient for whom Title XIX funds are being used for payment of care.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95]

317:35-19-29. 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 NF under Medicaid. In Oklahoma, the State Department of Health is the agency responsible for surveying NF to obtain information for use by the Federal Government in determining whether these facilities meet the standards required for participation as Medicare and Medicaid providers.

(1) Following its survey of each facility, the State Department of Health sends a copy of pertinent materials, showing its findings, to the Oklahoma Health Care Authority, Contract Services/Service Contract Operations, who forwards pertinent materials to the DHS county office in the county where such facility is located.

(2) Each county office is responsible for permitting anyone, who requests permission to do so, to inspect and/or copy such findings, if this is done within the county office. Such request to see these materials may be specifically related to one provider or may be a request to see the available survey materials on all providers. The requests need not be made in writing and the person making the request need sign no document in order to obtain access to the materials. No one can be given permission to take any of these materials from the county office.

(3) These materials are to be filed in an administrative file. Only the material requested by the individual is made available to

him/her. The county director is responsible for devising a plan for assuring that all such survey material made available to an individual is returned by him/her before he/she leaves the office. (4) When a new survey report is received on a facility, the former survey report on that facility is to be destroyed. A permanent file of survey reports is maintained in the OHCA.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 17 Ok Reg 2410, eff 6-26-00]

317:35-19-30. Referral for social services

In many situations, social services are needed by adults who are receiving medical services through Medicaid. The LTC nurse may make referrals for social services to the social worker in the local office by use of Form K-13, Information/Referral Social Services. In addition to these referrals, a request for social services may be initiated by a client or by another individual acting upon behalf of a client.

- (1) The social worker is responsible for providing the indicated services or for referral to the appropriate resource outside the DHS if the services are not available within the DHS.
- (2) Among the services provided by the social worker are:
 - (A) Services which will enable individuals to attain and/or maintain as good physical and mental health as possible;
 - (B) Services to assist patients who are receiving care outside their own homes in planning for and returning to their own homes or to other alternate care;
 - (C) Services to encourage the development and maintenance of family and community interest and ties;
 - (D) Services to promote maximum independence in the management of their own affairs;
 - (E) Protective services, including evaluation of need for and arranging for guardianship; and
 - (F) Appropriate family planning services which include assisting the family in acquiring means to responsible parenthood. Services are offered in making the necessary referral and follow-up.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 17 Ok Reg 2410, eff 6-26-00]

317:35-19-31. Special procedures for release of adults in mental health hospitals to Nursing Facilities

- (a) **Procedures.** Adult patients in state mental health hospitals being considered for release to nursing facilities due to their physical conditions may be predetermined eligible for Medicaid.
- (b) **Responsibility of mental hospitals.** The mental health hospital social and reimbursement staff works with the Social Security Administration to secure the approval for Supplemental Security Income (SSI) for individuals not currently eligible who may qualify for SSI. They will also assist the patient with the application for Medicaid medical services. By forwarding the completed Medical Assistance Application

form and the Capital Resources Information form to the county office, the determination of financial eligibility by the DHS county social worker can proceed at the same time that SSA is determining SSI eligibility. If the individual has other income (Social Security, VA, etc.) and does not qualify for SSI, the mental health hospital social and reimbursement staff evaluates the known resources. If the resources do not exceed the maximum as shown on DHS Appendix C-1, Schedule VIII. D., individuals may be referred for a decision of eligibility for care in a nursing facility and, if necessary, categorical relationship. If the individual appears to meet the requirements as set out in this Subchapter, the mental health hospital social and reimbursement staff will submit a copy of the admitting history and physical progress notes, psychiatric examination and a physician's recommendation for a specific level of care, based on the individual's physical condition, to the Department of Mental Health and Substance Abuse Services, Central Office, Long-Term Care Division for review. If release to an NF appears appropriate, the medical information is submitted to LOCEU at the same time that the application forms are submitted to the county.

(c) **Responsibility of LOCEU.** The LOCEU reviews the hospital records, the social summary, the physician's recommendation for level of care as well as categorical relationship, if necessary. A Level II PASRR screen is initiated by LOCEU at this point, if indicated. The MEDATS file is updated advising the DHS county office of LOCEU decision.

(d) **Responsibility of county office.** The county office (in the county where the hospital is located) has the responsibility for the case number assignment, placing the case in application status and the subsequent determination of financial eligibility. The case is not certified until the patient enters an approved nursing facility.

(1) Once the patient is determined financially and medically eligible a letter (including the assigned case number) is sent to the Department of Mental Health and Substance Abuse Services, Central Office, Long-Term Care Division.

(2) If the patient is determined to be ineligible, the denial is teleprocessed and a computer generated notice sent to the client or responsible person.

(e) **Release from mental health hospital to an NF.** After the hospital receives the letter from the county office with anticipated approval for Medicaid, the arrangements for release to the nursing facility will proceed. The hospital will supply the NF with appropriate medical and social information and a copy of the DHS letter concerning the financial and medical eligibility.

(1) The NF, upon acceptance of the patient, forwards the DHS form ABCDM-83, Notification Regarding Patient in a Nursing Facility, Intermediate Care Facility for the Mentally Retarded or Hospice (with the assigned case number) to the DHS county office where the NF is located.

(2) If the NF is in a different county than the hospital, the county of the facility requests the transfer of the case record. The certification is teleprocessed prior to the transfer of the case record.

[Source: Added at 12 Ok Reg 753, eff 1-6-95 through 7-14-95 (emergency); Added at 12 Ok Reg 3133, eff 7-27-95 ; Amended at 17 Ok Reg 2410, eff 6-26-00]

SUBCHAPTER 21. OKLAHOMA CARES BREAST AND CERVICAL CANCER TREATMENT PROGRAM

317:35-21-1. Oklahoma Cares Breast and Cervical Cancer Treatment (BCC) program

(a) The Breast and Cervical Cancer Prevention and Treatment Act of 2000 (BCCPTA) allows states to provide Medicaid to uninsured women under age sixty-five (65) who are in need of treatment for breast and/or cervical cancer. A medical eligibility evaluation is performed through the Centers for Disease Control (CDC) and Prevention's National Breast and Cervical Cancer Early Detection Program (NBCCEDP). If the evaluation determines the woman is in need of treatment for breast and/or cervical cancer, including pre-cancerous conditions and early stage, recurrent or metastatic cancer the case is forwarded to Oklahoma Health Care Authority (OHCA) for final medical eligibility determination.

(b) To receive Breast and Cervical Cancer (BCC) Treatment services, the woman must meet all of the following conditions.

(1) The woman must have been screened for BCC under the CDC Breast and Cervical Cancer Early Detection Program [see Oklahoma Administrative Code (OAC) 317:35-21-3] established under Title XV of the Public Health Service Act, and upon screening examination found to be in need of treatment, including an abnormal finding that is potentially indicative of a cancerous or precancerous condition or found to have an early stage, recurrent or metastatic cancer of the breast or cervix. (see OAC 317:35-21-5).

(2) The woman must:

(A) not have creditable insurance coverage that covers the treatment of breast or cervical cancer (see OAC 317:35-21-4),

(B) not be eligible for any other categorically needy SoonerCare eligibility group,

(C) be under sixty-five (65) years of age,

(D) be a US citizen or qualified alien (see OAC 317:35-5-25 for citizenship/alien status and identity verification requirements),

(E) be a resident of Oklahoma,

(F) declare her Social Security number,

(G) assign her rights to Third Party Liability if she has insurance that is not creditable, and

(H) declare her household income for the purpose of determining eligibility for services under the SoonerCare program.

[Source: Added at 22 Ok Reg 409, eff 1-1-05 (emergency); Added at 22 Ok Reg 2528, eff 7-11-05 ; Amended at 24 Ok Reg 2116, eff 6-25-07 ; Amended at 28 Ok Reg 1546, eff 6-25-11 ; Amended at 36 Ok Reg 959, eff 9-1-19]

317:35-21-2. Scope of coverage

The Oklahoma Cares Breast and Cervical Treatment program provides the full scope of SoonerCare coverage. Coverage is not limited to treatment of breast and/or cervical cancer.

[Source: Added at 22 Ok Reg 409, eff 1-1-05 (emergency); Added at 22 Ok Reg 2528, eff 7-11-05 ; Amended at 28 Ok Reg 1546, eff 6-25-11]

317:35-21-3. CDC screening

(a) To be eligible for the BCC program, a woman must be screened under the CDC Breast and Cervical Cancer Early Detection Program. A woman is considered screened under the CDC program if her screening was provided all or in part by CDC Title XV funds, or the service was rendered by a provider funded at least in part by CDC Title XV funds, and/or if she is screened by another provider whose screening activities are pursuant to CDC Title XV of the Public Health Service Act.

(b) Prior to certification of the BCC application an OHCA Care Management nurse must review the application and clinical data to verify the BCC applicant meets medical eligibility criteria for the BCC program.

(c) Upon verification by OHCA Care Management, the application is forwarded to the eligibility coordinator to verify the BCC applicant was screened by a CDC provider and meets criteria for the program as outlined in OAC 317:35-21-1.

[Source: Added at 22 Ok Reg 409, eff 1-1-05 (emergency); Added at 22 Ok Reg 2528, eff 7-11-05 ; Amended at 28 Ok Reg 1546, eff 6-25-11 ; Amended at 36 Ok Reg 959, eff 9-1-19]

317:35-21-4. Creditable coverage

(a) Creditable coverage when used in this subchapter means any insurance that pays for medical bills incurred for the diagnosis and/or treatment of breast or cervical cancer. A woman having any one of the following types of coverage is considered to have creditable coverage and would normally be ineligible for the BCC program:

- (1) Coverage under a group health plan;
- (2) Health insurance coverage, i.e., benefits consisting of medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer;
- (3) Medicare Part A and/or B;
- (4) SoonerCare;
- (5) Armed Forces insurance; and/or
- (6) A state health risk pool.

(b) If a woman has limited coverage, such as limited drug coverage or limits on the number of outpatient visits, or high deductibles, she is still considered to have creditable coverage. However, if she has a policy with limited scope coverage such as those that only cover dental, vision, or

long term care, or a policy that covers only a specific disease or illness, she is not considered to have creditable coverage, unless the policy provides coverage for breast or cervical cancer.

(c) There may be some circumstances when a woman has creditable coverage but that coverage does not actually cover treatment of breast or cervical cancer. In instances such as pre-existing condition exclusions, or when the annual or lifetime limit on benefits has been exhausted, a woman is not considered to have creditable coverage for this treatment. In these types of circumstances the woman may be eligible for BCC services if she meets all other eligibility criteria.

(d) There is no requirement that a woman be uninsured for any specific length of time before she is found eligible for SoonerCare under this program. If a woman loses creditable coverage for any reason and satisfies all other eligibility requirements for the BCC program, it is possible for her to become immediately eligible for coverage in this program.

(e) The existence of creditable coverage will be verified by the OHCA eligibility coordinator.

[Source: Added at 22 Ok Reg 409, eff 1-1-05 (emergency); Added at 22 Ok Reg 2528, eff 7-11-05 ; Amended at 28 Ok Reg 1546, eff 6-25-11 ; Amended at 36 Ok Reg 959, eff 9-1-19]

317:35-21-5. In need of treatment

In need of treatment, when used in this subchapter, means an abnormal screen determined as a result of a screening for BCC under the CDC BCC Early Detection Program established under Title XV of the Public Health Service Act, indicating pre-cancerous conditions and early stage, recurrent or metastatic cancer. Services include diagnostic services for an abnormal finding that may be necessary to determine the extent and proper course of treatment, as well as definitive cancer treatment itself. Women who are determined to require only routine monitoring services for precancerous breast or cervical condition (e.g., breast examinations, mammograms, pelvic exams and pap smears) are not considered to be "in need of treatment". The American Society for Colposcopy and Cervical Pathology Consensus and National Comprehensive Cancer Network guidelines are used to make the "in need of treatment" determination.

[Source: Added at 22 Ok Reg 409, eff 1-1-05 (emergency); Added at 22 Ok Reg 2528, eff 7-11-05 ; Amended at 28 Ok Reg 1546, eff 6-25-11 ; Amended at 36 Ok Reg 959, eff 9-1-19]

317:35-21-6. Age requirements

To be eligible for the BCC program, a woman must be under sixty-five (65) years of age. If a woman turns sixty-five (65) during the certification period, eligibility ends effective the last day of her birth month. The eligibility coordinator assists the woman in determining if eligibility may continue in another SoonerCare category.

[Source: Added at 22 Ok Reg 409, eff 1-1-05 (emergency); Added at 22 Ok Reg 2528, eff 7-11-05 ; Amended at 28 Ok Reg 1546, eff 6-25-11 ; Amended at 36 Ok Reg 959, eff 9-1-19]

317:35-21-7. Citizenship and Residence

The requirements for citizenship/alien status and identity verification and residence found at OAC 317:35-5-25 and 317:35-5-26 apply to the BCC treatment program.

[Source: Added at 22 Ok Reg 409, eff 1-1-05 (emergency); Added at 22 Ok Reg 2528, eff 7-11-05 ; Amended at 24 Ok Reg 2116, eff 6-25-07]

317:35-21-8. Social security number

Federal regulations require a woman furnish her Social Security number at the time of application for the Oklahoma Cares Breast and Cervical Cancer Treatment program.

[Source: Added at 22 Ok Reg 409, eff 1-1-05 (emergency); Added at 22 Ok Reg 2528, eff 7-11-05 ; Amended at 28 Ok Reg 1546, eff 6-25-11]

317:35-21-9. Income

(a) There is no income limit imposed by State or Federal law for the BCC program. However, the CDC Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act does allow CDC program grantees to set maximum income limits.

(b) Income limits are established for women receiving BCC program services through SoonerCare. The woman is required to declare her household income so that the eligibility coordinator may determine if she qualifies for the program or is otherwise SoonerCare eligible.

[Source: Added at 22 Ok Reg 409, eff 1-1-05 (emergency); Added at 22 Ok Reg 2528, eff 7-11-05 ; Amended at 28 Ok Reg 1546, eff 6-25-11 ; Amended at 36 Ok Reg 959, eff 9-1-19]

317:35-21-10. Resources

There is no resource test for the Breast and Cervical Cancer Treatment program.

[Source: Added at 22 Ok Reg 409, eff 1-1-05 (emergency); Added at 22 Ok Reg 2528, eff 7-11-05]

317:35-21-11. Certification for BCC

(a) In order for a woman to receive BCC treatment services, she must first be screened for BCC under the CDC Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act and found to be in need of treatment. Once determined to be in need of treatment, the CDC screener determines that the woman:

- (1) does not have creditable health insurance coverage,
- (2) is under age sixty-five (65),
- (3) is a US citizen or qualified alien (see OAC 317:35-5-25),
- (4) is a self-declared Oklahoma resident,
- (5) has provided her social security number,
- (6) is willing to assign medical rights to Third Party Liability, and
- (7) has declared all household income.

(b) If all of the conditions in subchapter (a) are met, the CDC screener assists the woman in completing the BCC application (OHCA BCC-1). The

completed BCC-1 along with the documentation of clinical findings, (i.e., history and physical findings, pathology reports, radiology reports and other pertinent data) is forwarded to the OHCA Care Management Unit.

(c) An OHCA Care Management nurse verifies that the member meets the medical eligibility criteria described in OAC 317:35-21-1 (a) and meets the "in need of treatment" criteria set forth in OAC 317:35-21-1(b)1 and 317:35-21-5. If this criteria is not met or the appropriate clinical documentation is not included, the application will be denied and the OHCA will send a notice of ineligibility to the applicant. Abnormal findings do not include women who are at high risk or who could appropriately receive risk reduction therapy, but have no evidence of cancer or a precancerous condition. If it is determined that the woman does not have cancer or a precancerous condition, a future application for the BCC program must be based on a different finding of abnormality than the previous application data.

(d) If all medical eligibility criteria are met, the application will be forwarded to the eligibility coordinator for further determination of eligibility.

(e) The eligibility coordinator verifies that the screener is a CDC screener. The eligibility coordinator also establishes whether or not the woman is otherwise eligible for SoonerCare. If the woman is not otherwise eligible for SoonerCare, she is certified for the BCC program. If the woman is eligible under another SoonerCare category, the application is certified in the other Medicaid category.

(f) If a woman does not cooperate in determining her eligibility for other SoonerCare programs, her BCC application is denied and the appropriate notice is computer generated. For example, if a woman otherwise eligible for SoonerCare, related to the low income families with children category, refuses to cooperate with child support enforcement without good cause would not be eligible for the BCC program.

(g) If a woman in treatment for breast or cervical cancer contacts the OHCA and has not been through the CDC screening process, she is referred to the Oklahoma Cares toll free number (866-550-5585) for assistance.

(h) An individual determined eligible for the BCC program may be certified the first day of the month of application. If the individual had a medical service prior to the application date, certification will occur the first day of the first, second or third month prior to the month of application, in accordance with the date of the medical service, provided the date of certification is not prior to the CDC Screen.

[Source: Added at 22 Ok Reg 409, eff 1-1-05 (emergency); Added at 22 Ok Reg 2528, eff 7-11-05 ; Amended at 24 Ok Reg 2116, eff 6-25-07 ; Amended at 27 Ok Reg 1481, eff 6-11-10 ; Amended at 28 Ok Reg 1546, eff 6-25-11 ; Amended at 36 Ok Reg 959, eff 9-1-19]

317:35-21-12. Changes after certification/continued need for treatment

(a) A woman found to be in need of treatment as the result of an abnormal BCC screen has sixty (60) days from the date of the application to complete the initial appointment for a diagnostic procedure and an additional sixty (60) days to complete any additional diagnostic testing

required or to initiate compensable treatment for a cancerous or pre-cancerous condition. The exception to the time limit is evidence of a lack of appointment availability. Upon completion of the diagnostic testing, OHCA is provided a medical report of the findings.

(1) If the woman is found not to have breast or cervical cancer including pre-cancerous conditions and early stage, recurrent or metastatic cancer for which she is in need of treatment or fails to have diagnostic testing or begin treatment within the time frames described in OAC 317:35-21-12(a), the case is closed by OHCA and appropriate notification is computer generated.

(2) If a medical report necessary to determine continued treatment is not received from a provider within ten (10) working days after a request is made by OHCA, the report is considered negative and the case is closed by OHCA and appropriate notification is computer generated.

(b) If the woman in need of treatment refuses SoonerCare compensable treatment or diagnostic services and does not plan to pursue the care in the time frames described in OAC 317:35-21-12(a), the case is closed by OHCA and appropriate notification is computer generated.

(c) In the event a woman is unable to initiate or complete diagnostic services due to a catastrophic illness or injury occurring after certification, SoonerCare will remain open with the approval of a Chief Medical Officer or his/her designee.

(d) If it is determined at any time during the certification period by either the woman's treating physician or by a Chief Medical Officer or his or her designee that the woman is no longer in need of treatment for breast or cervical cancer or a precancerous condition, the eligibility coordinator closes the case and appropriate notification is computer generated.

(e) If it is determined at any time during the certification period that the woman has creditable health insurance coverage, the eligibility coordinator closes the case and appropriate notification is computer generated.

(f) If the eligibility coordinator later determines that the woman is otherwise eligible for SoonerCare, the worker takes necessary actions to certify her for the appropriate category of SoonerCare coverage.

[Source: Added at 22 Ok Reg 409, eff 1-1-05 (emergency); Added at 22 Ok Reg 2528, eff 7-11-05 ; Amended at 24 Ok Reg 152, eff 10-8-06 (emergency); Amended at 24 Ok Reg 951, eff 5-11-07 ; Amended at 28 Ok Reg 1546, eff 6-25-11 ; Amended at 36 Ok Reg 959, eff 9-1-19]

317:35-21-13. Redetermination

A periodic redetermination of eligibility is required every 12 months. The computer generated redetermination form is mailed to the woman during her 11th month of eligibility. The woman is responsible for having her SoonerCare provider complete the statement certifying that she continues to be in need of treatment and for providing any other information necessary to redetermine eligibility.

(1) If the completed forms are not returned, the case is closed and appropriate notice is computer generated.

(2) When the completed forms are returned timely and the woman remains eligible for the BCC program, the computer is updated to

show her continued eligibility.

[Source: Added at 22 Ok Reg 409, eff 1-1-05 (emergency); Added at 22 Ok Reg 2528, eff 7-11-05 ; Amended at 28 Ok Reg 1546, eff 6-25-11 ; Amended at 30 Ok Reg 1209, eff 7-1-13]

317:35-21-14. Appeals and reconsiderations

(a) Applicants who wish to appeal a denial decision made by the OHCA may submit form LD-1 to the OHCA within thirty (30) days of receipt of the decision notification. If the form is not received at the OHCA within the required time frame, the appeal will not be heard. More information on the appeals process is provided at OAC 317:2-1-2(a).

(b) Reconsiderations to the OHCA may be requested by a CDC screener if missing documentation, which could potentially result in a determination of eligibility, has been obtained. The missing documentation must be presented within thirty (30) days of the date of the notice of denial.

[Source: Added at 28 Ok Reg 1546, eff 6-25-11 ; Amended at 36 Ok Reg 959, eff 9-1-19]

SUBCHAPTER 22. PREGNANCY RELATED BENEFITS COVERED UNDER TITLE XXI

317:35-22-1. Pregnancy related benefits covered under Title XXI

(a) The revision of the definition of child at 42 CFR 457.10, allows states to cover pregnancy related services under Title XXI, individuals who would not otherwise qualify for services under SoonerCare. This coverage is intended to benefit newborn children who are Oklahoma residents at birth.

(b) To receive pregnancy related services under Title XXI, the pregnant woman must:

- (1) be otherwise ineligible for any other categorically SoonerCare eligibility group;
- (2) reside in Oklahoma with the intent to remain, at the time services are rendered;
- (3) have household income at or below 185% FPL; and
- (4) not be covered by creditable insurance, the term creditable insurance means coverage under a group health plan or other health insurance as defined in the Health Insurance Portability and Accountability Act (HIPAA).

(c) All services are subject to post payment review by the OHCA or its designated agent.

[Source: Added at 25 Ok Reg 430, eff 1-1-08 (emergency); Added at 25 Ok Reg 1227, eff 5-25-08 ; Amended at 29 Ok Reg 1153, eff 6-25-12]

317:35-22-2. Scope of coverage for Title XXI Pregnancy

(a) Pregnancy related services provided are prenatal, delivery, postnatal care when included in the global delivery fee, and other related services that are medically necessary to optimize pregnancy outcomes within the defined program benefits.

(b) Medical visits for other related services to evaluate and/or treat conditions that may adversely impact the pregnancy are covered. All visits shall require medical review to deem whether the medical visit is within the scope of coverage.

[Source: Added at 25 Ok Reg 430, eff 1-1-08 (emergency); Added at 25 Ok Reg 1227, eff 5-25-08 ; Amended at 33 Ok Reg 892, eff 9-1-16 ; Amended at 34 Ok Reg 196, eff 11-22-16 (emergency); Amended at 34 Ok Reg 719, eff 9-1-17 ; Amended at 37 Ok Reg 1664, eff 9-14-20]

317:35-22-2.1. Non-covered services

Services and benefits provided to evaluate and/or treat maternal conditions that are not related to or impact the pregnancy outcome.

[Source: Added at 25 Ok Reg 430, eff 1-1-08 (emergency); Added at 25 Ok Reg 1227, eff 5-25-08 ; Amended at 36 Ok Reg 962, eff 9-1-19 ; Amended at 39 Ok Reg 448, eff 1-1-22 (emergency); Amended at 39 Ok Reg 1594, eff 9-12-22]

317:35-22-3. Need for pregnancy related services for the unborn child

The woman must be pregnant and not eligible under OAC 317:35-5-6.

[Source: Added at 25 Ok Reg 430, eff 1-1-08 (emergency); Added at 25 Ok Reg 1227, eff 5-25-08]

317:35-22-4. Citizenship

Citizenship is not a factor of eligibility for the pregnant individual. However, as this coverage is intended to benefit the newborn child who will be a U.S. citizens at birth, the pregnant individual will not qualify for this coverage if she intends to leave Oklahoma before the child is born.

[Source: Added at 25 Ok Reg 430, eff 1-1-08 (emergency); Added at 25 Ok Reg 1227, eff 5-25-08]

317:35-22-5. Social Security number

Social Security Number and Alienage is not a factor of eligibility for pregnant individuals who are covered under this program.

[Source: Added at 25 Ok Reg 430, eff 1-1-08 (emergency); Added at 25 Ok Reg 1227, eff 5-25-08]

317:35-22-6. Income

Income is determined in accordance with OAC 317:35-10 for individuals categorically related to pregnancy related benefits covered under Title XXI.

[Source: Added at 25 Ok Reg 430, eff 1-1-08 (emergency); Added at 25 Ok Reg 1227, eff 5-25-08]

317:35-22-7. Resources

There is no resource test for pregnancy related services covered under Title XXI.

[Source: Added at 25 Ok Reg 430, eff 1-1-08 (emergency); Added at 25 Ok Reg 1227, eff 5-25-08]

317:35-22-8. Period of eligibility

The individual who is covered for pregnancy related benefits under Title XXI retains eligibility for the prenatal period and delivery of the child. Eligibility is terminated at the end of the month of the delivery or upon termination of the pregnancy.

[Source: Added at 25 Ok Reg 430, eff 1-1-08 (emergency); Added at 25 Ok Reg 1227, eff 5-25-08]

317:35-22-9. Notification of eligibility

When eligibility for the pregnancy benefits covered under Title XXI is established, the appropriate notice is computer generated to the member.

[Source: Added at 25 Ok Reg 430, eff 1-1-08 (emergency); Added at 25 Ok Reg 1227, eff 5-25-08 ; Amended at 26 Ok Reg 2150, eff 6-25-09 ; Amended at 27 Ok Reg 711, eff 2-4-10 (emergency); Amended at 27 Ok Reg 1471, eff 6-11-10]

317:35-22-10. Denials

If denied the computer input form is updated and the appropriate notice is computer generated to the applicant.

[Source: Added at 25 Ok Reg 430, eff 1-1-08 (emergency); Added at 25 Ok Reg 1227, eff 5-25-08 ; Amended at 26 Ok Reg 2150, eff 6-25-09]

317:35-22-11. Closures

SoonerCare cases are closed at any time during the certification period that the member becomes ineligible. A computer-generated notice is sent to the member.

[Source: Added at 25 Ok Reg 430, eff 1-1-08 (emergency); Added at 25 Ok Reg 1227, eff 5-25-08 ; Amended at 26 Ok Reg 2150, eff 6-25-09 ; Amended at 27 Ok Reg 711, eff 2-4-10 (emergency); Amended at 27 Ok Reg 1471, eff 6-11-10]

SUBCHAPTER 23. LIVING CHOICE PROGRAM

317:35-23-1. Living Choice program

The 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.

[Source: Added at 26 Ok Reg 266, eff 12-1-08 (emergency); Added at 26 Ok Reg 1076, eff 5-11-09]

317:35-23-2. Eligibility criteria

Adults with disabilities or long-term illnesses, members with intellectual disabilities and members with physical disabilities are eligible to transition into the community through the Living Choice program if they meet all of the criteria in paragraphs (1) through (7) of this subsection.

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

(2) He/she must reside in a nursing facility or a qualified long term care facility, or a public or private Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) for at least sixty (60) consecutive days prior to the proposed transition date. If any portion of the sixty (60) days includes time in a skilled nursing facility, those days cannot be counted toward the sixty (60) day requirement, if the member received Medicare post-hospital extended care rehabilitative services.

(3) He/she must have at least one (1) day of Medicaid paid long-term care services prior to transition.

(4) If transitioning from an out of state institution, he/she must be SoonerCare eligible.

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

(6) 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 a locking entrance/exit, 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 four (4) unrelated individuals reside.

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

(8) He/she must not be a resident of a nursing facility or ICF/IID in lieu of incarceration.

[Source: Added at 26 Ok Reg 266, eff 12-1-08 (emergency); Added at 26 Ok Reg 1076, eff 5-11-09 ; Amended at 28 Ok Reg 273, eff 11-15-10 (emergency); Amended at 28 Ok Reg 1549, eff 6-25-11 ; Amended at 29 Ok Reg 1193, eff 6-25-12 ; Amended at 35 Ok Reg 10, eff 8-10-17 (emergency); Amended at 35 Ok Reg 1500, eff 9-14-18 ; Amended at 39 Ok Reg 449, eff 12-21-21 (emergency); Amended at 39 Ok Reg 1594, eff 9-12-22 ; Amended at 41 Ok Reg, Number 14, effective 3-8-24 (emergency)]

317:35-23-3. Participant disenrollment

- (a) A member is disenrolled from the program if he/she:
- (1) is admitted to a hospital, nursing facility, ICF/IID, residential care facility or behavioral health facility for more than thirty (30) consecutive days;
 - (2) is incarcerated;
 - (3) is determined to no longer meet SoonerCare financial eligibility for home and community based services;
 - (4) 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) moves out of state.
- (b) Payment cannot be made for an individual who is in imminent danger of harm to self or others.

[Source: Added at 26 Ok Reg 266, eff 12-1-08 (emergency); Added at 26 Ok Reg 1076, eff 5-11-09 ; Amended at 29 Ok Reg 1193, eff 6-25-12 ; Amended at 35 Ok Reg 10, eff 8-10-17 (emergency); Amended at 35 Ok Reg 1500, eff 9-14-18]

317:35-23-4. Re-enrollment

(a) Members in the Living Choice Program

- (1) The member remains eligible during periods of institutionalization as long as the stay does not exceed 30 days.
- (2) A member with an institutional stay longer than 30 days may re-enroll in the program without re-establishing the 90 day institutional residency requirement if:
 - (A) the necessity for the institutionalization is documented in the revised individual transition plan; and
 - (B) the member can safely return to the community as determined by the transition coordinator, the member and the transition planning team.
- (3) The re-enrolled member is eligible to receive services for any remaining days up to the 365 day limit.

(b) Members no longer in the Living Choice Program.

- (1) Members who have completed 365 days in the Living Choice Program and have been re-institutionalized for a minimum of 90 consecutive days may be eligible for re-enrollment in the Living Choice Program. Before re-enrollment of a former member, a re-evaluation of the former member's plan of care must be completed and a determination made if the plan of care could not be carried out as a result of:
 - (A) medical and/or behavioral changes resulting in the necessity of readmission into the inpatient facility;
 - (B) the lack of community services to support the member that were identified in the original plan of care; or
 - (C) the plan of care was not supported by the delivery of quality services.
- (2) After determining the basis for re-institutionalization and creation of a new plan of care that ensures the health and safety of the former member, he/she may be re-enrolled for an additional

365 days.

[**Source:** Added at 26 Ok Reg 266, eff 12-1-08 (emergency); Added at 26 Ok Reg 1076, eff 5-11-09 ;
Amended at 29 Ok Reg 1193, eff 6-25-12]

CHAPTER 40. DEVELOPMENTAL DISABILITIES SERVICES

[Authority: 63 O.S., §§ 5003 through 5016; 10 O.S., § 1415(C)(D)]
[Source: Codified 5-27-96]

SUBCHAPTER 1. GENERAL PROVISIONS

317:40-1-1. Home and Community-Based Services (HCBS) Waivers for persons with intellectual disabilities or certain persons with related conditions

(a) **Applicability.** This Section applies to services funded through Medicaid HCBS Waivers per Oklahoma Administrative Code (OAC) 317:35-9-5 and Section 1915(c) of the Social Security Act. Specific Waivers are the In-Home Supports Waiver (IHSW) for Adults, IHSW for Children, Community Waiver, and Homeward Bound Waiver.

(b) **Program provisions.** Each individual requesting services provided through an HCBS Waiver and his or her family or guardian, are responsible for:

- (1) Accessing with the Oklahoma Department of Human Services (OKDHS) staff assistance, all benefits available under Oklahoma's Medicaid State Plan or other payment sources prior to accessing funding for those same services under an HCBS Waiver program;
- (2) Cooperating in the determination of medical and financial eligibility including prompt reporting of changes in income or resources;
- (3) Choosing between services provided through an HCBS Waiver or institutional care; and
- (4) Reporting any changes in address or other contact information to OKDHS within thirty (30) calendar days.

(c) **Waiver eligibility.** To be eligible for Waiver services, an applicant must meet the criteria established in (1) of this Subsection and the criteria for one (1) of the Waivers established in (1) through (8) of this Subsection.

(1) **HCBS Waiver services.** Services provided through an HCBS Waiver are available to Oklahoma residents meeting SoonerCare (Medicaid) eligibility requirements established by law, regulatory authority, and policy within funding available through state or federal resources. To be eligible and receive services funded through any of the Waivers listed in (a) of this Section, an applicant must meet conditions, per OAC 317:35- 9-5. The applicant:

- (A) Must be determined financially eligible for SoonerCare, per OAC 317:35-9-68;
- (B) May not simultaneously be enrolled in any other Medicaid Waiver program or receiving services in an institution including a hospital, rehabilitation facility, mental health facility, nursing facility, or residential care home per Section (§) 1-820 of Title 63 of the Oklahoma Statutes (O.S.), or Intermediate Care facility for

individuals with intellectual disabilities (ICF/IID);
(C) May not be receiving Developmental Disabilities Services (DDS) state-funded services, such as the Family Support Assistance Payment, Respite Voucher Program, sheltered workshop services, community integrated employment services, or assisted living without Waiver supports, per OAC 340:100-5-22.2; and
(D) Must also meet other Waiver-specific eligibility criteria.

(2) **In-Home Supports Waivers (IHSW).** To be eligible for services funded through the IHSW, an applicant must:

- (A) Meet all criteria listed in (c) of this Section; and
- (B) Be determined by the Social Security Administration (SSA) to have a disability and a diagnosis of intellectual disability; or
- (C) Be determined to have a disability and a diagnosis of intellectual disability as defined in the Diagnostic and Statistical Manual of Mental Disorders by the Oklahoma Health Care Authority (OHCA) Level of Care Evaluation Unit (LOCEU);
- (D) Be three (3) years of age or older;
- (E) Be determined by the OHCA LOCEU to meet the ICF/IID Institutional Level of Care requirements, per OAC 317:30-5-122; and
- (F) Reside in:

- (i) A family member's or friend's home;
- (ii) His or her own home;
- (iii) An OKDHS Child Welfare Services (CWS) foster home; or
- (iv) A CWS group home; and
- (vii) Have critical support needs that can be met through a combination of non-paid, non-Waiver, and SoonerCare (Medicaid) resources available to the individual; and HCBS Waiver resources within the annual per capita Waiver limit, agreed on between the State of Oklahoma and the Centers for Medicare and Medicaid Services (CMS).

(3) **Community Waiver.** To be eligible for services funded through the Community Waiver, the applicant must:

- (A) Meet all criteria listed in (c) of this Section;
- (B) Be determined by the SSA to have a disability and a diagnosis of intellectual disability; or
- (C) Have an intellectual disability as defined in the Diagnostic and Statistical Manual of Mental Disorders or a related condition by DDS and be covered under the State's alternative disposition plan, adopted under Section 1919(e)(7)(E) of the Social Security Act; or
- (D) Be determined to have a disability and a diagnosis of intellectual disability as defined in the Diagnostic and Statistical Manual of Mental Disorders or the OHCA LOCEU; and

- (E) Be three (3) years of age or older; and
- (F) Be determined by the OHCA LOCEU, to meet ICF/IID Institutional Level of Care requirements, per OAC 317:30-5-122; and
- (G) Have critical support needs that can be met by the Community Waiver and cannot be met by IHSW services or other service alternatives, as determined by the DDS director or designee.

(4) **Homeward Bound Waiver.** To be eligible for services funded through the Homeward Bound Waiver, the applicant must:

- (A) Be certified by the United States District Court for the Northern District of Oklahoma as a member of the plaintiff class in *Homeward Bound et al. v. The Hissom Memorial Center*, Case No. 85-C-437-E;
- (B) Meet all criteria for HCBS Waiver services listed in (c) of this Section; and
- (C) Be determined by SSA to have a disability and a diagnosis of intellectual disability; or
- (D) Have an intellectual disability as defined in the Diagnostic and Statistical Manual of Mental Disorders or a related condition, per OAC 317:35-9-45 as determined by DDS, and to be covered under the State's alternative disposition plan adopted under Section 1919(e)(7)(E) of the Social Security Act; or
- (E) Have a disability as defined in the Diagnostic and Statistical Manual of Mental Disorders by the OHCA/LOCEU; and
- (F) Meet ICF/IID Institutional Level of Care requirements, per OAC 317:30-5-122, as determined by the OHCA LOCEU.

(5) **Evaluations and information.** Applicants desiring services through any of the Waivers listed in (a) of this Section participates in diagnostic evaluations and provides information necessary to determine HCBS Waiver services eligibility, including:

- (A) A psychological evaluation, by a licensed psychologist that includes:
 - (i) A full-scale, functional and/or adaptive assessment; and
 - (ii) A statement of age of onset of the disability; and
 - (iii) Intelligence testing that yields a full-scale, intelligence quotient.

- (I) Intelligence testing results obtained at sixteen (16) years of age and older are considered valid of the current status, provided they are compatible with current behavior. Intelligence testing results obtained between seven to sixteen (7 to 16) years of age are considered current for four (4) years when the full-scale intelligence quotient is less than forty (40) and for two

(2) years when the intelligence quotient is forty (40) or above.

(II) DDS may require a current psychological evaluation when a significant change of condition, disability, or psychological status is noted;

(B) A social service summary, current within twelve (12) months of the requested approval date that includes a developmental history; and

(C) A medical evaluation, current within one (1) calendar year of the requested approval date; and

(D) A completed Form LTC-300, ICF/IID Level of Care Assessment; and

(E) Proof of disability per SSA guidelines. When a disability determination is not made by SSA, OHCA LOCEU may make a disability determination using SSA guidelines.

(6) **Eligibility determination.** OHCA reviews the diagnostic reports listed in (2) of this subsection and makes an eligibility determination for DDS HCBS Waivers.

(7) **State's alternative disposition plan.** For individuals who are determined to have an intellectual disability or a related condition by DDS per the State's alternative disposition plan adopted under Section 1919(e)(7)(E) of the Social Security Act, DDS reviews the diagnostic reports listed in (2) of this subsection and, on behalf of OHCA, makes a determination of eligibility for DDS HCBS Waiver services and ICF/IID level of care.

(8) **Member's choice.** A determination of need for ICF/IID Institutional Level of Care does not limit the opportunities of the person receiving services to participate in community services. Individuals are assured of the opportunity to exercise informed choice in the selection of services.

(d) **Request list.** When state DDS resources are unavailable to add individuals to services funded through an HCBS Waiver, persons are placed on a statewide Request for Waiver Services List.

(1) The Request for Waiver Services List is maintained in chronological order, based on the date of receipt of a written request for services on Form 06MP001E, Request for Developmental Disabilities Services. The applicant must submit the required documentation, per Form 06MP001E, Request for Developmental Disabilities Services, for initial consideration of potential eligibility. Active United States Armed Forces personnel, who have a pending HCBS Waiver application in another state for an immediate family member, may be placed on the list with the date they applied in the other state. The person's name is added to the list when he or she provides proof of application date from the other state.

(2) The Request for Waiver Services List for persons requesting services provided through an HCBS Waiver is administered by DDS uniformly throughout the state.

(3) An individual applicant is removed from the Request for Waiver Services List, when he or she:

- (A) Is found to be ineligible for services;
- (B) Cannot be located by OKDHS;
- (C) Does not provide OKDHS-requested information or fails to respond;
- (D) Is not an Oklahoma resident at the requested Waiver approval date; or
- (E) Declines an offer of Waiver services.

(4) An applicant removed from the Request for Waiver Services List, because he or she could not be located, may submit a written request to be reinstated to the list. The applicant is returned to the same chronological place on the Request for Waiver Services List, provided he or she was on the list prior to January 1, 2015.

(e) **Applications.** When resources are sufficient for initiation of HCBS Waiver services, DDS ensures action regarding a request for services occurs within forty-five (45) calendar days. When action is not taken within the required forty-five (45) calendar days, the applicant may seek resolution, per OAC 340:2-5-61.

(1) Applicants are allowed sixty (60) calendar days to provide information requested by DDS to determine eligibility for services.

(2) When requested information is not provided within sixty (60) calendar days, the applicant is notified that the request was denied, and he or she is removed from the Request for Waiver Services List.

(f) **Admission protocol.** Initiation of services funded through an HCBS Waiver occurs in chronological order from the Request for Waiver Services List, per (d) of this Section based on the date of DDS receipt of a completed request for services, as a result of the informed choice of the person requesting services or the individual acting on the member's behalf, and upon determination of eligibility, per (c) of this Section. Exceptions to the chronological requirement may be made, when:

(1) An emergency situation exists in which the health or safety of the person needing services or of others is endangered and there is no other resolution to the emergency. An emergency exists, when:

- (A) The person is unable to care for himself or herself and:
 - (i) the person's caretaker, 43A O.S. § 10-103:
 - (I) Is hospitalized;
 - (II) Moved into a nursing facility;
 - (III) Is permanently incapacitated; or
 - (IV) Died; and
 - (ii) There is no caretaker to provide needed care to the individual; or
 - (iii) An eligible person is living at a homeless shelter or on the street;
- (B) OKDHS finds the person needs protective services due to ongoing physical, sexual, or emotional abuse or neglect in his or her present living situation, resulting in serious jeopardy to the person's health or safety;

(C) The behavior or condition of the person needing services is such that others in the home are at risk of being seriously harmed by the person. For example, when the person is routinely physically assaultive to the caretaker or others living in the home and sufficient supervision cannot be provided to ensure the safety of those in the home or community; or

(D) The person's medical, psychiatric, or behavioral challenges are such that the person is seriously injuring or harming himself or herself, or is in imminent danger of doing so.

(2) The Legislature appropriated special funds with which to serve a specific group or a specific class of individuals, per HCBS Waiver provisions;

(3) Waiver services may be required for people who transition to the community from a public ICF/IID or children in OKDHS custody receiving services from OKDHS. Under some circumstances Waiver services related to accessibility may be authorized in advance of transition, but may not be billed until the day the member leaves the ICF/IID and enters the Waiver; or

(4) Individuals subject to the provisions of Public Law 100-203 residing in nursing facilities for at least 30-continuous months prior to January 1, 1989, and are determined by Preadmission Screening and Resident Review (PASRR) evaluation conducted per Title 42 Section 483.100 of the Federal Code of Regulations to have an intellectual disability or a related condition, who are covered under the State's alternative disposition plan adopted under Section 1919(e)(7)(E) of the Social Security Act, and choose to receive services funded through the Community or Homeward Bound Waiver.

(g) Movement between DDS HCBS Waiver programs. A person's movement from services funded through one (1) DDS-administered HCBS Waiver to services funded through another DDS-administered HCBS Waiver is explained in this subsection.

(1) When a member receiving services funded through the IHSW for children becomes eighteen (18) years of age, services through the IHSW for adults becomes effective.

(2) Change to services funded through the Community Waiver from services funded through the IHSW occurs only when:

(A) A member has critical health and safety support needs that cannot be met by IHSW services, non-Waiver services, or other resources as determined by the DDS director or designee; and

(B) Funding is available, per OAC 317:35-9-5.

(3) Change to services funded through the IHSW from services funded through the Community Waiver may only occur when a member's history of annual service utilization was within the IHSW per capita allowance.

(4) When a member served through the Community Waiver has support needs that can be met within the per capita Waiver allowance of the applicable IHSW and through a combination of

non-Waiver resources, the individual may choose to receive services through the IHSW.

(h) **Continued eligibility for HCBS Waiver services.** Eligibility for members receiving services provided through the HCBS Waiver is re-determined by the OHCA LOCEU when a determination of disability was not made by the Social Security Administration. The OHCA LOCEU determines categorical relationship to the SoonerCare disabled category according to Social Security Administration guidelines. OHCA LOCEU also approves the level of care, per OAC 317:30-5-122, and confirms a diagnosis of intellectual disability per the Diagnostic and Statistical Manual of Mental Disorders.

(1) DDS may require a new psychological evaluation and re-determination of eligibility at any time when a significant change of condition, disability, or psychological status is noted.

(2) Annual review of eligibility requires a medical evaluation that is current within one year of the requested approval date. The medical evaluation must be submitted by the member or the individual acting on his or her behalf thirty (30) calendar days prior to the Plan of Care expiration.

(i) **HCBS Waiver services case closure.** Services provided through an HCBS Waiver are terminated, when:

(1) A member or the individual acting on the member's behalf chooses to no longer receive Waiver services;

(2) A member is incarcerated;

(3) A member is financially ineligible to receive Waiver services;

(4) A member is determined by SSA to no longer have a disability qualifying the individual for services under these Waivers;

(5) A member is determined by the OHCA LOCEU to no longer be eligible;

(6) A member moves out of state or the custodial parent or guardian of a member who is a minor moves out of state;

(7) A member is admitted to a nursing facility, ICF/IID, residential care facility, hospital, rehabilitation facility, or mental health facility for more than thirty (30) consecutive calendar days;

(8) The guardian of a member who is a minor or adjudicated adult fails to cooperate during the annual review process, per OAC 340:100-5-50 through 340:100-5-58;

(9) The guardian of a member who is a minor or adjudicated adult fails to cooperate in the implementation of the OKDHS rule or service delivery in a manner that places the health or welfare of the member at risk, after efforts to remedy the situation through Adult Protective Services or Child Protective Services were not effective;

(10) The member is determined to no longer be SoonerCare eligible;

(11) There is sufficient evidence the member or the individual acting on the member's behalf engaged in fraud or misrepresentation, failed to use resources as agreed on in the Individual Plan, or knowingly misused public funds associated with these services;

(12) The member or the individual acting on the member's behalf either cannot be located, did not respond, or did not allow case management to complete plan development or monitoring activities as required, per OAC 340:100-3-27, and the member or the individual acting on the member's behalf:

(A) Does not respond to the notice of intent to terminate;

or

(B) The response prohibits the case manager from being able to complete plan development or monitoring activities as required, per OAC 340:100-3-27;

(13) The member or the individual acting on the member's behalf fails to cooperate with the case manager to implement a Fair Hearing decision;

(14) It is determined services provided through an HCBS Waiver are no longer necessary to meet the member's needs and professional documentation provides assurance the member's health, safety, and welfare can be maintained without Waiver supports;

(15) The member or the individual acting on the member's behalf fails to cooperate with service delivery;

(16) A family member, the individual acting on the member's behalf, other individual in the member's household, or persons who routinely visit, pose a threat of harm or injury to provider staff or official OKDHS representatives; or

(17) A member no longer receives a minimum of one (1) Waiver service per month and DDS is unable to monitor the member on a monthly basis.

(j) **Reinstatement of services.** Waiver services are reinstated when:

(1) The situation resulting in case closure of a Hissom class member is resolved;

(2) A member is incarcerated for ninety (90) calendar days or less;

(3) A member is admitted to a nursing facility, ICF/IID, residential care facility, hospital, rehabilitation facility, or mental health facility for ninety (90) calendar days or less; or

(4) A member's SoonerCare eligibility is re-established within ninety (90) calendar days of the SoonerCare ineligibility date.

[Source: Added at 18 Ok Reg 285, eff 11-21-00 (emergency); Added at 18 Ok Reg 1168, eff 5-11-01 ; Amended at 21 Ok Reg 512, eff 1-1-04 (emergency); Amended at 21 Ok Reg 2276, eff 6-25-04 ; Amended at 22 Ok Reg 2531, eff 7-11-05 ; Amended at 26 Ok Reg 2151, eff 6-25-09 ; Amended at 28 Ok Reg 1550, eff 6-25-11 ; Amended at 29 Ok Reg 1194, eff 6-25-12 ; Amended at 32 Ok Reg 544, eff 1-20-15 (emergency); Amended at 32 Ok Reg 1158, eff 8-27-15 ; Amended at 33 Ok Reg 912, eff 9-1-16 ; Amended at 34 Ok Reg 746, eff 9-1-17 ; Amended at 38 Ok Reg 1081,]

317:40-1-2. Authorization for Residential Supports in the Community Waiver

(a) **Applicability.** The rules in this Section apply to services provided through the Community Waiver, specifically:

(1) those services identified in OAC 340:100-5-22.1, Community Residential Supports; and

(2) group home services.

(b) **General Information.** Waiver services are provided to supplement, and do not replace, existing non-Waiver, natural, or informal supports a service recipient receives. Waiver services support the service recipient to remain with his or her family and in the community. Service recipients and their Teams must examine all other service options prior to seeking residential supports. The criteria in subsection (c) of this Section are used to determine the necessity of residential supports.

(c) **Necessity of Residential Supports.** If the service recipient is unable to care for himself or herself, the Team may request residential supports if the supports requested comply with OAC 340:100-3-33.1, Criteria to establish service necessity, and:

- (1) there is no caretaker to provide needed care to the service recipient;
- (2) the service recipient's caretaker, as defined in Section 10-103 of Title 43A of the Oklahoma Statutes:
 - (A) has moved into a nursing facility;
 - (B) is age 70 or older;
 - (C) is permanently incapacitated; or
 - (D) has died;
- (3) there is a risk of abuse or neglect to a service recipient in the current home as evidenced by:
 - (A) recurrent involvement of the Oklahoma Department of Human Services Division of Children and Family Services (DCFS) or Adult Protective Services (APS) as documented by the case manager that indicates the service recipient's health and safety cannot be assured and attempts to resolve the situation are not effective with DCFS or APS involvement; or
 - (B) removal from the home by DCFS or APS;
- (4) direct support services required to enable a service recipient to remain in his or her current home exceed the cost of residential supports;
- (5) the behavior of the service recipient is such that others are at risk of being seriously harmed by the service recipient, and sufficient supervision cannot be provided to ensure the safety of those in the home or community as evidenced by:
 - (A) documentation from DCFS or APS;
 - (B) medical records from previous injuries;
 - (C) incident reports or other documentation from service providers; or
 - (D) police reports;
- (6) the service recipient's medical, psychiatric, or behavioral challenges are such that the service recipient is seriously injuring or harming himself or herself, or is in imminent danger of doing so as evidenced by any of the items listed in subparagraphs (A) through (D) of paragraph (5) of this subsection;
- (7) the Legislature has appropriated special funds to serve a specific group or a specific class of individuals;
- (8) as a temporary resolution to an emergency situation as defined in subsection (e) of this Section; or

(9) if residential supports are approved as part of a transition plan for a person leaving an ICF/MR.

(d) **Approval of Residential Supports.** When the Team requests residential supports, the case manager submits the documentation of relevant factors from subsection (c) of this Section to the Developmental Disabilities Services Division (DDSD) division director or designee. The director or designee approves or denies the request prior to the delivery of residential supports.

(e) **Emergency temporary residential supports.** Emergency temporary residential supports are authorized as described in this subsection.

(1) When an emergency situation exists in which temporary residential supports are requested by the Team, the case manager submits the justification for the services and a signed proposal developed by DDSD and the caregiver to the DDSD division director or designee. The proposal must include:

- (A) criteria of what must occur for the service recipient to return to his or her home;
- (B) a projected timeframe for the service recipient to return to his or her home; and
- (C) an acknowledgment by the caregiver that residential services are temporary.

(2) The division director or designee reviews the documentation and approves or denies the request prior to the delivery of emergency temporary residential supports.

(3) If an extension is required, the case manager submits additional information regarding the need for the extension and the new projected date for the service recipient to return to his or her home. Any extensions which are granted must also:

- (A) be approved prior to service delivery;
- (B) be time limited; and
- (C) include criteria for return home.

(f) **Appeals.** The denial of a request for residential supports may be appealed through the hearing process described in OAC 340:2-5-61.

(g) **Options.** When community residential supports, as defined in OAC 340:100-5-22.1, are needed, as described in OAC 340:100-3-33.1, the service recipient or guardian selects a community residential option that meets the needs of the service recipient, taking into consideration the available resources.

(1) The options are:

- (A) Specialized Foster, as described in OAC 317:40-5-50 through 40-5-76;
- (B) Group Home services, as described in Oac 317:40-5-152;
- (C) Agency Companion, as described in OAC 317:40-5-1 through 40-5-39;
- (D) Daily Living Supports, as described in OAC 317:40-5-150 and OAC 317:40-5-152; and
- (E) Prader-Willi services.

(2) The Team plans community residential supports to meet the service recipient's needs in accordance with:

- (A) DDS community residential supports rules found at OAC 340:100-5-22.1; and
- (B) the program policy established for the specific community residential option cited in paragraph (1) of this subsection.

[Source: Added at 23 Ok Reg 1396, eff 5-25-06]

317:40-1-3. Requirements for Home and Community-Based settings

(a) The Oklahoma Department of Human Services Developmental Disabilities Services Home and Community-Based Services (HCBS) Waiver settings have the following qualities defined in federal regulation per Section 441.301(c)(4) of Title 42 of the Code of Federal Regulations [42 CFR § 441.301(c)(4)] based on the needs of the individual defined in his or her Individual Plan (Plan).

- (1) The setting is integrated and supports full access of individuals receiving HCBS Waivers to the greater community, including opportunities to:
 - (A) seek employment and work in competitive, integrated settings;
 - (B) engage in community life;
 - (C) control personal resources; and
 - (D) receive services in the community, to the same degree as individuals not receiving Medicaid HBCS Waiver Services.
- (2) The setting is selected by the member from options including non-disability settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and based on individual needs and preferences.
- (3) For residential settings, the member must have income available for room and board.
- (4) The setting ensures the member's rights of privacy, dignity, respect, and freedom from coercion and restraint.
- (5) The setting optimizes individual initiative, autonomy, and independence in making life choices including, but not limited to:
 - (A) daily activities;
 - (B) the physical environment; and
 - (C) with whom to interact.
- (6) The setting facilitates individual choice regarding services and supports, including who provides them.

(b) In a provider-owned or controlled residential setting, in addition to the attributes specified above, the additional conditions listed in (1) through (8) of this subsection must be met.

- (1) The unit or dwelling is a specific, physical place, owned, rented, or occupied under a legally-enforceable agreement by the member receiving services.
- (2) The member has the same responsibilities and protections from eviction, that tenants have per the Residential Landlord and

Tenant Act, Section 101 et. seq. of Title 41 of the Oklahoma Statutes (41 O.S. § 101, et. seq.)

(3) In settings where landlord tenant laws do not apply, the provider agency completes a lease, residency agreement, or other form of written agreement for each member. The document provides protections that address eviction processes and appeals comparable to those provided in the Residential Landlord and Tenant Act, 41 O.S. § 101, et seq.

(4) Each member has privacy in his or her sleeping or living unit, where:

- (A) units have entrance doors lockable by the member, with only appropriate staff having keys to doors;
- (B) members sharing units have a choice of roommates;
- and
- (C) members have freedom to furnish and decorate sleeping or living units within the lease or other agreement.

(5) Each member has the freedom and support to control his or her own schedule, activities, and access to food at any time.

(6) Members are able to have visitors of his or her choosing, at any time.

(7) The setting is physically accessible to the member.

(8) Any modifications of the additional conditions specified in this subsection, must be supported by a specific, assessed need, justified in the person-centered plan and includes:

- (A) an identified individualized assessed need;
- (B) documentation of the positive interventions and supports used prior to any modifications to the person-centered plan;
- (C) documentation of less intrusive methods tried, including those that did not work;
- (D) a clear description of the condition, proportionate to the specific assessed need;
- (E) regular collection and review of data to measure the ongoing effectiveness of the modification;
- (F) established time limits for periodic reviews to determine if the modification continues to be necessary or can be terminated;
- (G) the informed consent of the member; and
- (H) an assurance the interventions and supports will cause no harm to the member.

(c) Any setting that isolates members from the broader community of individuals not receiving HCBS is not considered an HCBS. Settings that are not HCBS per 42 CFR § 441.301(c)(5)(v) include:

- (1) a nursing facility;
- (2) an institution for mental diseases;
- (3) an intermediate care facility for individuals with intellectual disabilities;
- (4) a hospital; or
- (5) any other locations with qualities of an institutional setting per 42 CFR § 441.301(c)(5)(v).

317:40-1-4. Remote support (RS)

(a) **General Information.** RS services are intended to promote a member's independence. RS services are provided in the member's home, family home, or employment site to reduce reliance on in person support while ensuring the member's health and safety. RS services are included in the member's Individual Plan (Plan) and arrangements for this service are made through the case manager. Authorization to provide RS must be obtained from the Developmental Disabilities Services (DDS) division director or designee.

(1) RS services are:

- (A) Based on the member's needs as documented and supported by the Plan and Person-Centered Assessment;
- (B) The least-restrictive option and the member's preferred method to meet an assessed need;
- (C) Provided when all adult members of the household; his or her guardians, when applicable; and Personal Support Team (Team) agree to the provision of RS services as documented in the Plan; and
- (D) Reviewed by the Team after sixty (60) calendar days of initial installation to determine continued appropriateness and approval of services.

(2) RS services are not a system to provide surveillance or for staff convenience.

(b) **Service description.** RS is monitoring of an adult member; allowing for live, two-way communication with him or her in his or her residence or employment site, by monitoring staff using one or more of the systems in one (1) through eight (8) of this subsection.

- (1) Live-video feed.
- (2) Live-audio feed.
- (3) Motion-sensing monitoring.
- (4) Radio-frequency identification.
- (5) Web-based monitoring.
- (6) Personal Emergency Response System .
- (7) Global positioning system monitoring devices.
- (8) Any other device approved by the DDS director or designee.

(c) **General provider requirements.** RS service providers must have a valid Oklahoma Health Care Authority (OHCA) SoonerCare (Medicaid) provider agreement to provide agency-based RS services to Oklahoma Human Services (OKDHS) DDS Home and Community-Based Services (HCBS) Waiver members. Requests for applications to provide RS are made to and approved by OKDHS DDS State Office.

(1) An assessment for RS services is completed:

- (A) Annually;
- (B) Prior to RS implementation; and
- (C) As required by ongoing progress and needs assessments.

- (2) Each member is required to identify at least two (2) emergency response staff. The member's emergency response staff are documented in his or her Plan.
- (3) RS observation sites are not located in a member's residence.
- (4) The use of camera or video equipment in the member's bedroom or other private area is prohibited.
- (5) RS services are provided in real time by awake staff at a monitoring base using the appropriate connection, not by a recording. While RS is provided the RS staff does not have duties other than RS.
- (6) RS equipment used in the member's residence includes a visual indicator to the member that the system is on and operating.
- (7) RS provider agencies must immediately notify in writing, the member's residential provider agency, vocational provider agency, assigned DDS case manager, or guardian of activity in the household that could potentially compromise the member's health or safety.
- (8) Emergency response provider agency staff records are maintained, per Oklahoma Administrative Code (OAC) 340:100-3-40.
- (9) RS provider records are maintained for seven (7) calendar years or until any pending litigation involving the service recipient is completed, whichever occurs last and include at a minimum:
 - (A) The member's name;
 - (B) The staff's name who delivered the service;
 - (C) Service dates;
 - (D) Service begin and end times;
 - (E) Provider's location;
 - (F) Description of services provided or observation note;
 - (G) Method of contact with member; and
 - (H) The member's current photograph.
- (10) RS providers must have:
 - (A) Safeguards in place including, but not limited to:
 - (i) A battery or generator to insure continued coverage during an electrical outage at the member's home and monitoring facility;
 - (ii) Back-up procedures at the member's home and monitoring site for:
 - (I) Prolonged power outage;
 - (II) Fire;
 - (III) Severe weather;
 - (IV) The member's personal emergency; and
 - (iii) The ability to receive alarm notifications, such as home security, smoke, or carbon monoxide at each residence monitored, as assessed by the Team as necessary for health and safety; and
 - (B) Two-way audio communication allowing staff monitors to effectively interact with, and address the member's needs in each residence;

(C) A secure Health Insurance Portability and Accountability Act (HIPAA)-compliant network system requiring data authentication, authorization, and encryption to ensure access to computer vision, audio, sensor, or written information is limited to authorized staff or Team members per the Plan;

(D) A current file for each member receiving RS services including:

- (i) The member's photograph;
- (ii) The member's Plan;
- (iii) The member's demographics; and
- (iv) Any other pertinent data to ensure the member's safety; and

(E) Capability to maintain all video and make it available to OKDHS staff upon request for a minimum of twelve (12) calendar months. OKDHS may require an extended timeframe when necessary.

(d) RS staff requirements. RS staff:

- (1) May not have any assigned duties other than oversight and member support at the time they are monitoring;
- (2) Receive member specific training per the member's Plan prior to providing support to a member;
- (3) Assess urgent situations at a member's home or employment site and call 911 first when deemed necessary; then contact the member's residential provider agency or employment provider agency designated emergency response staff; or the member's natural support designated emergency response person while maintaining contact with the member until persons contacted or emergency response personnel arrive on site;
- (4) Implement the member's Plan as written by the Team and document the member's status at least hourly;
- (5) Completes and submits incident reports, per OAC 340:100-3-34, unless emergency backup staff is engaged;
- (6) Provides simultaneous support to no more than thirty (30) members;
- (7) Is eighteen (18) years of age and older; and
- (8) Is employed by an approved RS agency.

(e) Emergency response requirement.

(1) Emergency response staff is employed by a provider agency with a valid OHCA SoonerCare (Medicaid) provider agreement to provide residential services, vocational services or habilitation training specialist (HTS) services to OKDHS DDS HCBS Waiver members and:

- (A) May not have any assigned duties other than oversight and support of members at the time they are assigned as response staff;
- (B) Receives all trainings required, per OAC 340:100-3-38.1, for members in residential settings; OAC 340:100-3-38.2 for members in employment settings; or OAC 340:100-3-38.3, for members in non-residential settings per the Plan prior to providing support;

(C) Provides a response on site at the member's residence or employment site within twenty (20) minutes when contacted by RS staff unless a shorter timeframe is indicated in the member's Plan;

(D) Has an on-call back-up person who responds when the primary response staff engaged at another home or employment site is unable to respond within the specified time frame;

(E) Provides written or verbal acknowledgement of a request for assistance from the RS staff;

(F) Completes and document emergency drills with the member quarterly when services are provided in the member's home;

(G) Implements the Plan as written and document each time they are contacted to respond, including the nature of the intervention and the duration;

(H) Completes incident reports, per OAC 340:100-3-34; and

(I) Is eighteen (18) years of age and older.

(2) Natural emergency response persons:

(A) Are unpaid family members or other interested parties who agree to become, and are approved as, an emergency response person by the member's Team;

(B) Are available to respond in the case of an emergency within twenty (20) minutes from the time they are contacted by RS staff, unless a shorter response time is indicated in the Plan;

(C) Have an on-call back-up person who responds when the primary response staff is unable to respond within the specified time frame;

(D) Provide written or verbal acknowledgement of a request for assistance from RS staff; and

(E) Are eighteen (18) years of age and older.

(f) **Service limitations.** RS is limited to twenty-four (24) hours per day. RS is not provided simultaneously with HTS, homemaker, respite, intensive personal supports, daily living supports, per OAC 340:100-5-22.1, or employment services, per OAC 340:100-17. RS may not be provided to members receiving specialized foster care or agency companion services, per OAC 340:100-5.22.1, or group home services, per OAC 340:100-6.

(1) Services not covered include, but are not limited to:

(A) Direct care staff monitoring;

(B) Services to persons under the age of eighteen (18); or

(C) Services provided in any setting other than the member's primary residence or employment site.

(2) RS services are shared among OKDHS DDS Waiver members of the same household in a residential setting. RS provider agencies may only bill for one (1) member of a household at a time. Only one (1) RS provider per household.

(3) Assistive technology purchases are authorized, per OAC 317:40-5-100.

- (g) **RS Discontinuation.** RS services can be discontinued:
- (1) When the member and member's Team determine it is appropriate to discontinue RS services. When RS services are terminated, the RS provider agency coordinates termination of service with the member's residential or vocational provider agency and Team to ensure a safe transition. When a member requests the termination of RS services while RS is being provided, the RS staff:
 - (A) Notifies the provider to request an emergency response staff;
 - (B) Leaves the system operating until the emergency response staff arrives; and
 - (C) Turns off the system once relieved by the emergency response staff; or
 - (2) At the discretion of the RS provider when services do not meet the health or behavioral needs of the individual.
 - (A) A thirty (30) calendar day termination notice must be provided to the member and the Team prior to discontinuing services so alternative services can be arranged.
 - (B) Services must continue to be provided to the service recipient until the Team confirms all essential services are in place.

[Source: Added at 38 Ok Reg 1081, eff 9-1-21 ; Amended at 40 Ok Reg 2262, eff 9-11-23]

SUBCHAPTER 3. [RESERVED]

SUBCHAPTER 5. MEMBER SERVICES

PART 1. AGENCY COMPANION SERVICES

317:40-5-1. Purpose of Agency Companion Services [REVOKED]

[Source: Added at 13 Ok Reg 605, eff 9-8-95 (emergency); Added at 13 Ok Reg 1679, eff 5-27-96 ; Amended at 15 Ok Reg 3855, eff 7-1-98 (emergency); Amended at 16 Ok Reg 1445, eff 5-27-99 ; Amended at 22 Ok Reg 2531, eff 7-11-05 ; Revoked at 26 Ok Reg 2151, eff 6-25-09]

317:40-5-2. Guidelines to staff [EXPIRED]

[Source: Added at 13 Ok Reg 605, eff 9-8-95 through 5-26-96 (emergency)¹]

Editor's Note: ¹*This emergency rule was superseded on 5-27-96 by 18 permanent rules numbered at 317:40-5-3 through 317:40-5-15 and 317:40-5-35 through 317:40-5-39.*

317:40-5-3. Agency companion services (ACS)

(a) ACS are:

(1) Provided by agencies that have a provider agreement with the Oklahoma Health Care Authority;

(2) Provider Agency independent contractors and provide a shared living arrangement developed to meet the member's specific needs that include supervision, supportive assistance, and training in daily living skills, and integrates the member into the shared experiences of a family in a home owned or rented by the companion;

(3) Available to members eighteen (18) years of age or older who are eligible for services through Community or Homeward Bound Waivers. Persons under eighteen (18) years of age may be served with approval from Oklahoma Human Services (OKDHS) Developmental Disabilities Services (DDS) director or designee; and

(4) Based on the member's need for residential services, per Oklahoma Administrative Code (OAC) 340:100-5-22, and support as described in the member's Individual Plan (Plan), per OAC 340:100-5-50 through 340:100-5-58.

(b) Households are limited to one (1) individual companion provider. Exceptions for two individual companion providers are allowed in a household when each provides companion services to different members. Exceptions may be approved by the DDS director or designee. Agency companions may not simultaneously serve more than four (4) members through any combination of companion or respite services. An agency companion:

(1) Has an approved home profile, per OAC 317:40-5-3, and contract with a DDS-approved provider agency;

(2) May provide companion services for one (1) member.

Exceptions to serve as companion for two (2) members may be approved by the DDS director or designee. Exceptions for up to two (2) members may be approved when members have an existing relationship and to separate them would be detrimental to their well-being and the companion demonstrates the skill and ability required to serve as companion for two (2) members.

Exceptions for additional members may be granted when the DDS director or designee determines an emergency situation exists and there is no other resolution, and the companion demonstrates the skill and ability required to serve as a companion;

(3) May not provide companion services to more than two (2) household members at any time; and

(4) May not have employment, volunteer activities, or personal commitments that prevent the companion from fulfilling his or her responsibilities to the member, per OAC 317:40-5.

(A) The companion may have employment when:

(i) Employment is approved in advance by the DDS area residential services programs manager;

(ii) The companion's employment does not require on-call duties and occurs during time the member is engaged in outside activities such as school, employment or other routine scheduled meaningful activities; and

(iii) The companion ensures the employment is such that the member's needs are met by the companion if the member's outside activities are disrupted.

(B) If, after receiving approval for employment, authorized DDS staff determines the employment interferes with the care, training, or supervision needed by the member, the companion must terminate, within thirty (30) calendar days:

(i) His or her employment; or

(ii) His or her contract as an agency companion.

(C) Homemaker, habilitation training specialist, and respite services are not provided for the companion to maintain employment.

(c) Each member may receive up to sixty (60) calendar days per year of therapeutic leave without reduction in the agency companion's payment.

(1) Therapeutic leave:

(A) Is a SoonerCare (Medicaid) payment made to the contract provider to enable the member to retain services; and

(B) Is claimed when the:

(i) Member does not receive ACS for twenty-four

(24) consecutive hours due to:

(I) A visit with family or friends without the companion;

(II) Vacation without the companion; or

(III) Hospitalization regardless of whether the companion is present; or

(ii) Companion uses authorized respite time; and

(C) Is limited to no more than fourteen (14) consecutive, calendar days per event, not to exceed sixty (60) calendar days per Plan of Care (POC) year; and

(D) Cannot be carried over from one (1) POC year to the next.

(2) The therapeutic leave daily rate is the same amount as the ACS per diem rate.

(3) The provider agency pays the agency companion the payment he or she would earn if the member were not on therapeutic leave.

(d) The companion may receive a combination of hourly or daily respite per POC year equal to seven-hundred and twenty (720) hours.

(1) The daily respite rate is used when respite is provided for a full twenty-four (24) hour day. A day is defined as the period between 12:00 am and 11:59 pm.

(2) The hourly respite rate is used when respite is provided for a partial day.

(3) The provider may serve more than one (1) member through shared staffing, but may not bill HTS or the hourly respite rate for multiple members at the same time.

(e) Habilitation training specialist (HTS) services:

(1) May be approved by the DDS director or designee when providing ACS with additional support represents the most cost-effective placement for the member when there is an ongoing pattern of the member not:

(A) Sleeping at night; or

(B) Working or attending employment, educational, or day services; and

(2) May be approved when a time-limited situation exists in which the companion provider is unable to provide ACS, and the provision of HTS maintains the placement or provides needed stability for the member, and must be reduced when the situation changes;

(3) Must be reviewed annually or more frequently as needed, which includes a change in agencies or individual companion providers; and

(4) Must be documented by the Personal Support Team (Team) and the Team must continue efforts to resolve the need for HTS.

(f) The contractor model does not include funding for the provider agency for the provision of benefits to the companion.

(g) The agency receives a daily rate based on the member's level of support. Levels of support for the member and corresponding payment are:

(1) Determined by authorized DDS staff per levels described in OAC 317:40-5-3(g)(2)(A) through (C); and

(2) Re-evaluated when the member has a change in individual companion providers.

(A) **Close level of support.** Close level of support is authorized when the member requires assistance in at least two (2) of the services in (i) through (iii) of this subparagraph.

(i) Minimal to extensive assistance to complete daily living skills, such as bathing, dressing, eating, and toileting.

(ii) Extensive assistance with medication administration, money management, shopping, housekeeping, meal preparation, scheduling appointments, arranging transportation or other activities.

(iii) Assistance with health, medication, or behavior interventions that may include the need for specialized training, equipment, and diet.

(B) **Enhanced level of support.** Enhanced level of support is authorized when the member requires the level of assistance outlined in (g)(2)(A) and meets at least one (1) of the criteria in (i) through (iii) of this subparagraph.

The member:

(i) Is totally dependent on others for:

(I) Completion of daily living skills, such as bathing, dressing, eating, and toileting; and

(II) Medication administration, money management, shopping, housekeeping,

meal preparation, scheduling appointments, and arranging transportation or other activities; or

(ii) Demonstrates ongoing complex medical issues requiring specialized training courses, per OAC 340:100-5-26; or

(iii) Has behavioral issues that require a protective intervention protocol (PIP) with a restrictive or intrusive procedure, per OAC 340:100-1-2. The PIP must:

(I) Be approved by the Statewide Human Rights Behavior Review Committee, per OAC 340:100-3-14; or

(II) Have received temporary approval, per OAC 340:100-5-57.

(C) **Pervasive level of support.** Pervasive level of support is authorized when the member is in OKDHS Child Welfare Services custody and efforts to place in traditional foster care have failed due to the extensive level of support required by the member. It is reevaluated only when the member is eighteen (18) years of age or older and his or her individual companion provider changes.

(i) This level of support may continue to be authorized when the member requires:

(I) The level of assistance outlined in (g)(2) (B); and

(II) Additional professional level support to remain in an agency companion setting due to pervasive behavioral or emotional challenges.

(ii) Providers of this level of support:

(I) Deliver direct support to the companion by a licensed or certified behavioral health professional with a minimum of a master's degree;

(II) Provide ongoing support and training to the companion, offering best practice approaches in dealing with specific members;

(III) Provide professional level and ongoing support as part of the ACS and not billed as a separate service. Waiver services may be authorized for the development of a PIP, per OAC 340:100-5-57; and

(IV) Market, recruit, screen, and train potential companions for the identified member.

(h) Authorization for payment of ACS is contingent upon receipt of:

(1) The applicant's approval letter authorizing ACS for the identified member;

- (2) An approved relief and emergency back-up plan addressing a back-up location and provider;
- (3) The Plan;
- (4) The POC; and
- (5) The date the member is scheduled to move to the companion's home. When a member transitions from a DDS placement funded by a pier diem the incoming provider may request eight (8) hours of HTS for the first day of service.

(i) The Plan reflects the amount of room and board the member pays to the companion. The provider must use the room and board reimbursement payment to meet the member's needs. Items purchased with the room and board reimbursement payment include housing and food.

(j) The room and board payment may include all but one-hundred and fifty dollars (\$150) per month of the member's income, up to a maximum of ninety (90) percent of the current minimum Supplemental Security Income payment for a single individual.

[Source: Added at 13 Ok Reg 1679, eff 5-27-96 ; Amended at 15 Ok Reg 3855, eff 7-1-98 (emergency); Amended at 16 Ok Reg 1445, eff 5-27-99 ; Amended at 22 Ok Reg 2531, eff 7-11-05 ; Amended at 24 Ok Reg 952, eff 5-11-07 ; Amended at 25 Ok Reg 2767, eff 6-1-08 (emergency); Amended at 26 Ok Reg 2151, eff 6-25-09 ; Amended at 27 Ok Reg 1509, eff 6-11-10 ; Amended at 29 Ok Reg 1199, eff 6-25-12 ; Amended at 32 Ok Reg 615, eff 2-9-15 (emergency); Amended at 32 Ok Reg 1170, eff 8-27-15 ; Amended at 38 Ok Reg 1081, eff 9-1-21 ; Amended at 40 Ok Reg 2262, eff 9-11-23]

317:40-5-4. Selection of Agency Companion Services provider [REVOKED]

[Source: Added at 13 Ok Reg 1679, eff 5-27-96 ; Amended at 15 Ok Reg 3837, eff 7-1-98 (emergency); Amended at 16 Ok Reg 1445, eff 5-27-99 ; Amended at 22 Ok Reg 2531, eff 7-11-05 ; Revoked at 32 Ok Reg 615, eff 2-9-15 (emergency); Revoked at 32 Ok Reg 1170, eff 8-27-15]

317:40-5-5. Agency companion services (ACS) provider requirements and responsibilities

- (a) The member or legal guardian, the provider agency, or Oklahoma Human Services (OKDHS) Developmental Disabilities Services (DDS) case manager may identify an applicant to be screened for approval to serve as a companion.
- (b) DDS approval for a person to provide contracted Agency Companion Services (ACS) requires the applicant to:
 - (1) Be twenty-one (21) years of age or older;
 - (2) Attend DDS or provider agency ACS orientation;
 - (3) Contract with a provider agency that has a current contract with Oklahoma Health Care Authority (OHCA) to provide ACS;
 - (4) Complete the DDS application packet within the required time period, per Oklahoma Administrative Code (OAC) 317:40-5-40, and to submit the packet to designated DDS staff or the provider agency staff;
 - (5) Cooperate with designated DDS or provider agency staff in the development and completion of the home profile approval process, per OAC 317:40-5-40; and

(6) Complete all training per OAC 340:100-3-38, including medication administration training, and all provider agency pre-employment training, per OAC 317:40-5-40.

(c) Companions are required to meet all applicable standards outlined in this subchapter and competency-based training, per OAC 340:100-3-38. The provider agency ensures all companions meet the criteria in this Section.

(d) The companion's failure to follow any rules or standards, promote the member's independence, or follow the Personal Support Team's (Team) recommendation(s) results in problem resolution, per OAC 340:100-3-27, for the companion, and when warranted, results in revocation of approval of the companion.

(e) The companion:

(1) Ensures no other adult or child is cared for in the home on a regular or part-time basis, including other OKDHS placements, family members, or friends without prior written authorization from DDS area residential services programs manager or state office residential services programs manager;

(2) Meets transportation requirements per OAC 317:40-5-103. Neither the companion nor the provider agency may claim transportation reimbursement for vacation travel;

(3) Transports or arranges member transportation to and from school, employment programs, recreational activities, medical appointments, and therapy appointments;

(4) Delivers services in a manner that contributes to the member's enhanced independence, self-sufficiency, community inclusion, and well-being;

(5) Participates in the member's Team and assists in developing the member's Individual Plan (Plan) for service provision;

(6) Develops, implements, evaluates, and revises training strategies that correspond to the Plan's relevant outcomes. The companion may request assistance from the case manager or program coordinator. The companion documents monthly data and health care summaries and submits them to the provider agency program coordination staff;

(7) Delivers services at appropriate times as directed in the Plan;

(8) Does not deliver services that duplicate the services public school districts provide pursuant to the Individuals with Disabilities Education Act (IDEA);

(9) Respects the member's chosen religious faith and assists the member in religious participation. No member is expected to attend any religious service against his or her wishes;

(10) Participates in, and supports visitation and contact with, the member's natural family, guardian, and friends, when the member desires visitation;

(11) Obtains permission from the member's assigned legal guardian and notifies the family, the provider agency program coordination staff, and the case manager prior to:

(A) Traveling out-of-state;

(B) Overnight visits; or

- (C) The member's involvement in any publicity, including the following: advertising, promotions, marketing campaigns, or involvement with the media;
- (12) Serves as the member's health care coordinator, per OAC 340:100-5-26;
- (13) Ensures the member's monthly room and board contribution is used toward household operation costs;
- (14) Assist the member in accessing entitlement programs for which the member may be eligible and maintains records required for the member's ongoing eligibility;
- (15) Works closely with the provider agency program coordination staff and the DDS case manager, to ensure all aspects of the member's program are implemented to the satisfaction of the member, the member's family or legal guardian, when appropriate, and the member's Team;
- (16) Assist the member to achieve his or her maximum level of independence;
- (17) Submits all necessary information regarding the member to the provider agency program coordination staff in a timely manner;
- (18) Ensures the member's confidentiality is maintained per, OAC 340:100-3-2;
- (19) Supports the member in forming and maintaining friendships with neighbors, co-workers, and peers, including people who do not have disabilities;
- (20) Implements training and provides supports that enable the member to actively join in community life;
- (21) Does not serve as the member's representative payee without a written exception from the DDS area residential services programs manager or state office residential services program manager.
- (A) The written exception and approved DDS home profile are retained in the member's home record.
- (B) When serving as payee, the companion complies with OAC 340:100-3-4 requirements;
- (22) Ensures the member's funds are safeguarded;
- (23) Obtains prior approval from the member's representative payee when making a purchase of over fifty dollars (\$50) with the member's funds;
- (24) Allows provider agency and DDS staff to make announced and unannounced visits to the home;
- (25) Develops an evacuation plan for the home using OKDHS Form 06AC020E, Evacuation/Escape Plan, and conducts training with the member;
- (26) Conducts fire and weather drills, per OAC 340:100-5-22.1, using OKDHS Form 06AC021E, Fire and Weather Drill Record;
- (27) Develops and maintains a personal possession inventory for personal possessions and adaptive equipment, using OKDHS Form 06AC022E, Personal Possession Inventory;
- (28) Supports the member's employment program by:

- (A) Ensuring the member wears appropriate work attire;
 - and
 - (B) Contacting the member's employer as outlined by the Team and in the Plan;
- (29) Is responsible for the member's meals and entertainment costs during recreational and leisure activities. Activities are affordable to the member. Concerns about affordability are presented to the Team for resolution;
- (30) For vulnerable adults, reports of suspected maltreatment including abuse, verbal abuse, sexual abuse, neglect, financial neglect, or exploitation, per Section 10-104 of Title 43A of the Oklahoma Statutes (43A O.S. § 10 - 104), are submitted to OKDHS Office of Client Advocacy;
- (31) For children, reports of abuse, neglect, sexual abuse, or sexual exploitation, per 10A O.S. § 1-2-101, are submitted to the Child Abuse and Neglect Hotline at 1-800-522-3511;
- (32) Follows all applicable promulgated OHCA and DDS rules including:
- (A) OAC 340:100-3-27;
 - (B) OAC 340:100-3-34;
 - (C) OAC 340:100-3-38;
 - (D) OAC 340:100-3-40;
 - (E) OAC 340:100-5-22.1;
 - (F) OAC 340:100-5-26;
 - (G) OAC 340:100-5-32;
 - (H) OAC 340:100-5-33; and
 - (I) OAC 340:100-5-50 through 340:100-5-58.
- (33) Is neither the member's spouse nor, when the member is a minor child, the member's parent. A family member serving as a companion must meet all requirements listed in this Subchapter; and
- (34) Is not the chief executive officer of a provider agency.

[Source: Added at 13 Ok Reg 1679, eff 5-27-96 ; Amended at 15 Ok Reg 3837, eff 7-1-98 (emergency); Amended at 16 Ok Reg 1445, eff 5-27-99 ; Amended at 22 Ok Reg 2531, eff 7-11-05 ; Amended at 26 Ok Reg 2151, eff 6-25-09 ; Amended at 26 Ok Reg 3033, eff 7-21-09 (emergency); Amended at 27 Ok Reg 981, eff 5-13-10 ; Amended at 29 Ok Reg 1199, eff 6-25-12 ; Amended at 30 Ok Reg 1268, eff 7-1-13 ; Amended at 32 Ok Reg 615, eff 2-9-15 (emergency); Amended at 32 Ok Reg 1170, eff 8-27-15 ; Amended at 38 Ok Reg 1081, eff 9-1-21 ; Amended at 39 Ok Reg 1595, eff 9-12-22]

317:40-5-6. Agency Companion contractor requirements [REVOKED]

[Source: Added at 13 Ok Reg 1679, eff 5-27-96 ; Amended at 15 Ok Reg 3837, eff 7-1-98 (emergency); Amended at 16 Ok Reg 1445, eff 5-27-99 ; Amended at 22 Ok Reg 2531, eff 7-11-05 ; Amended at 32 Ok Reg 615, eff 2-9-15 (emergency); Amended at 32 Ok Reg 1170, eff 8-27-15 ; Revoked at 39 Ok Reg 1595, eff 9-12-22]

317:40-5-7. Process for approval or disapproval of Agency Companion Services applicants [REVOKED]

[Source: Added at 13 Ok Reg 1679, eff 5-27-96 ; Amended at 15 Ok Reg 3837, eff 7-1-98 (emergency); Amended at 16 Ok Reg 1445, eff 5-27-99 ; Revoked at 22 Ok Reg 2531, eff 7-11-05]

317:40-5-8. Agency companion services service authorization budget [REVOKED]

[Source: Added at 13 Ok Reg 1679, eff 5-27-96 ; Amended at 15 Ok Reg 3855, eff 6-24-98 (emergency); Amended at 16 Ok Reg 1445, eff 5-27-99 ; Amended at 22 Ok Reg 2531, eff 7-11-05 ; Amended at 25 Ok Reg 2767, eff 6-1-08 (emergency); Amended at 26 Ok Reg 1077, eff 5-11-09 ; Amended at 27 Ok Reg 1509, eff 6-11-10 ; Amended at 28 Ok Reg 1550, eff 6-25-11 ; Revoked at 29 Ok Reg 1199, eff 6-25-12]

317:40-5-9. Payment authorization for Agency Companion Services [REVOKED]

[Source: Added at 13 Ok Reg 1679, eff 5-27-96 ; Amended at 15 Ok Reg 3837, eff 7-1-98 (emergency); Amended at 16 Ok Reg 1445, eff 5-27-99 ; Amended at 22 Ok Reg 2531, eff 7-11-05 ; Amended at 29 Ok Reg 1199, eff 6-25-12 ; Revoked at 32 Ok Reg 615, eff 2-9-15 (emergency); Revoked at 32 Ok Reg 1170, eff 8-27-15]

317:40-5-10. Agency companion services (ACS) annual review [REVOKED]

[Source: Added at 13 Ok Reg 1679, eff 5-27-96 ; Amended at 15 Ok Reg 3837, eff 7-1-98 (emergency); Amended at 16 Ok Reg 1445, eff 5-27-99 ; Amended at 22 Ok Reg 2531, eff 7-11-05 ; Revoked at 32 Ok Reg 615, eff 2-9-15 (emergency); Revoked at 32 Ok Reg 1170, eff 8-27-15]

317:40-5-11. Termination of Agency Companion placement

(a) Oklahoma Department of Human Services Developmental Disabilities Services (DDS) staff may terminate an individual agency companion (AC) placement for reasons including, but not limited to the:

- (1) member's decision to move to a different residence;
- (2) request of the companion;and
- (3) personal support team determines the AC placement is no longer the most appropriate placement for the member;

(b) Upon termination of the placement the Team meets to develop an orderly transition plan and arranges for the member's property to be moved as necessitated by the transition plan.

(c) Termination of an individual companion placement may also occur in conjunction with denial of a home profile per OAC 317:40-5-40.

[Source: Added at 13 Ok Reg 1679, eff 5-27-96 ; Amended at 15 Ok Reg 3837, eff 7-1-98 (emergency); Amended at 16 Ok Reg 1445, eff 5-27-99 ; Amended at 22 Ok Reg 2531, eff 7-11-05 ; Amended at 27 Ok Reg 1509, eff 6-11-10 ; Amended at 32 Ok Reg 615, eff 2-9-15 (emergency); Amended at 32 Ok Reg 1170, eff 8-27-15]

317:40-5-12. Selection of a provider agency [REVOKED]

[Source: Added at 13 Ok Reg 1679, eff 5-27-96 ; Amended at 15 Ok Reg 3837, eff 7-1-98 (emergency); Amended at 16 Ok Reg 1445, eff 5-27-99 ; Revoked at 22 Ok Reg 2531, eff 7-11-05]

317:40-5-13. Agency Companion Services provider agency responsibilities

(a) The agency providing Agency Companion Services (ACS) complies with Oklahoma Health Care Authority and Oklahoma Department of Human Services (DHS) policies and procedures governing all aspects of service provision.

- (b) The provider agency is responsible for all contract provider related activities detailed in this Subchapter.
- (c) In the event the provider agency wishes to discontinue services immediately due to an emergency, the provider agency cooperates with the DHS Developmental Disabilities Services (DDS) to secure alternative services in the least restrictive environment.
- (d) The provider agency ensures that services provided meet requirements of Oklahoma Administrative Code (OAC) 340:100-5-22.1, unless other requirements are stated in this Section.
- (e) When the provider agency serves as the member's representative payee, the provider agency must adhere to OAC 340:100-3-4.1 requirements.
- (f) The provider agency acts immediately to remedy any situation posing a risk to the health, well-being, or provision of specified services to the member.
- (1) The provider agency's program coordination staff completes and submits incident and injury reports to DDS per OAC 340:100-3-34.
 - (2) A companion's contract is immediately terminated when a provider agency becomes aware a companion's name appears on the Community Services Worker Registry per OAC 340:100-3-39.
- (g) The provider agency ensures only one member is served in a provider home. Exceptions may be approved by the DDS area manager or designee.
- (h) Team members, including the provider agency program coordinator, companion, member, legal guardian, advocate, and DDS case manager work together to resolve issues to ensure the member's needs are met and the shared living arrangement is successful.
- (i) The choice of provider agency is made by the member or his or her legal guardian.
- (j) When a member transfers from a provider agency, the outgoing provider agency ensures the member has a 30 calendar-day supply of medication and a seven-day supply of food, household, and personal supplies.
- (k) Provider agency's program coordination staff responsibilities are to:
- (1) visit the provider home daily during the first week of placement;
 - (2) make a minimum of three face to face visits per month per OAC 340:100-5-22.1;
 - (3) allow the member's needs to determine the frequency of all other visits;
 - (4) coordinate and submit quarterly reports to the provider agency for submission to the DDS area office; and
 - (5) communicate regularly with the DDS case manager regarding any changes in the household or any other program issues or concerns.
- (l) The provider agency, companion, member, and guardian develop a back-up plan identifying respite staff and an alternate location in the event the home becomes uninhabitable. The back-up plan:
- (1) is submitted to the DDS case manager for approval;

(2) describes expected and emergency back-up support and program monitoring for the home; and

(3) is incorporated into the member's Individual Plan (Plan).

(m) The respite provider is:

(1) knowledgeable about the member;

(2) trained to implement the member's Plan;

(3) trained per OAC 340:100-3-38;

(4) responsible for the cost of the member's meals and entertainment during recreation and leisure activities. Activities selected must be affordable to the member and respite staff.

Concerns about affordability are presented to the Team for resolution.

(n) The spouse or other adult residing in the home is considered a natural support and may provide ACS in the absence of the companion, when trained per OAC 340:100-3-38.12.

(o) The spouse or other adult residing in the home cannot serve as paid respite staff.

[Source: Added at 13 Ok Reg 1679, eff 5-27-96 ; Amended at 15 Ok Reg 3837, eff 7-1-98 (emergency); Amended at 16 Ok Reg 1445, eff 5-27-99 ; Amended at 22 Ok Reg 2531, eff 7-11-05 ; Amended at 29 Ok Reg 1199, eff 6-25-12 ; Amended at 32 Ok Reg 615, eff 2-9-15 (emergency); Amended at 32 Ok Reg 1170, eff 8-27-15]

317:40-5-14. Department case manager role and responsibilities [REVOKED]

[Source: Added at 13 Ok Reg 1679, eff 5-27-96 ; Amended at 15 Ok Reg 3837, eff 7-1-98 (emergency); Amended at 16 Ok Reg 1445, eff 5-27-99 ; Revoked at 22 Ok Reg 2531, eff 7-11-05]

317:40-5-15. Department Agency Companion Services (ACS) staff role and responsibilities [REVOKED]

[Source: Added at 3 Ok Reg 1679, eff 5-27-96 ; Amended at 15 Ok Reg 3837, eff 7-1-98 (emergency); Amended at 16 Ok Reg 1445, eff 5-27-99 ; Revoked at 22 Ok Reg 2531, eff 7-11-05]

PART 3. GUIDELINES TO STAFF

317:40-5-35. Home profile [REVOKED]

[Source: Added at 13 Ok Reg 1679, eff 5-27-96 ; Revoked at 15 Ok Reg 3837, eff 7-1-98 (emergency); Revoked at 16 Ok Reg 1445, eff 5-27-99]

317:40-5-36. Annual review [REVOKED]

[Source: Added at 13 Ok Reg 1679, eff 5-27-96 ; Revoked at 15 Ok Reg 3837, eff 7-1-98 (emergency); Revoked at 16 Ok Reg 1445, eff 5-27-99]

317:40-5-37. Investigations of alleged abuse or neglect of a consumer in a home [REVOKED]

[Source: Added at 13 Ok Reg 1679, eff 5-27-96 ; Amended at 15 Ok Reg 3837, eff 7-1-98 (emergency); Amended at 16 Ok Reg 1445, eff 5-27-99 ; Revoked at 22 Ok Reg 2531, eff 7-11-05]

317:40-5-38. Evaluation process [REVOKED]

[Source: Added at 13 Ok Reg 1679, eff 5-27-96 ; Amended at 15 Ok Reg 3837, eff 7-1-98 (emergency); Amended at 16 Ok Reg 1445, eff 5-27-99 ; Revoked at 22 Ok Reg 2531, eff 7-11-05]

317:40-5-39. Plan of action [REVOKED]

[Source: Added at 13 Ok Reg 1679, eff 5-27-96 ; Amended at 15 Ok Reg 3837, eff 7-1-98 (emergency); Amended at 16 Ok Reg 1445, eff 5-27-99 ; Revoked at 22 Ok Reg 2531, eff 7-11-05]

317:40-5-40. Home profile process

(a) **Applicability.** This Section establishes procedures for Developmental Disabilities Services (DDS) home profile process. A home profile is required for:

- (1) Agency companion services (ACS);
- (2) Specialized Foster Care (SFC) services;
- (3) Respite services delivered in the provider's home;
- (4) Approving services in a home shared by a non-relative provider and a member; and
- (5) Any other situation that requires a home profile.

(b) **Pre-screening.** Designated DDS staff provides the applicant with program orientation and completes pre-screening activities that include, but are not limited to:

- (1) Facts description;
- (2) An explanation of:
 - (A) Home and Community-Based Services (HCBS) program's guiding principles;
 - (B) The home profile process;
 - (C) Basic provider qualifications;
 - (D) Health, safety, and environmental issues; and
 - (E) Training required per Oklahoma Administrative Code (OAC) 340:100-3-38; and
- (3) Gathering relevant information about the applicant and applicant's family, including household members, addresses, contact information, and motivation to provide services; and
- (4) An explanation of the background investigation that is conducted on the applicant and on any adult or child living in the applicant's home.
 - (A) Background investigations are conducted at the time of application and include, but are not limited to:
 - (i) An Oklahoma State Bureau of Investigation (OSBI) name and criminal records history search, including the Oklahoma Department of Public Safety, Sex Offender Registry, Mary Rippey Violent Offender Registries, and Nurse Aide and Non-technical Services Worker Registry;

(ii) Federal Bureau of Investigation (FBI) national criminal history search, which is based on the applicant's fingerprints and any adult household member's fingerprints; except when an exception is necessary as outlined in (I) through (II) of this subsection.

(I) When fingerprints are low quality, as determined by OSBI, FBI, or both, and make it impossible for the national crime information databases to provide results. In this instance, a name-based search, state, national, or both, may be authorized.

(II) When the DDS State Office residential staff requests an exception from an individual who has a severe physical condition precluding the individual from being fingerprinted, a name-based search, state, national, or both may be authorized.

(iii) A search of any involvement as a party in a court action;

(iv) A search of all OKDHS records, including Child Welfare Services records, Community Services Worker Registry, and Restricted Registry;

(v) A search of all applicable out-of-state child abuse and neglect registries for any applicant or adult household member who has not lived in Oklahoma continuously for the past five (5) years. A home is not approved without the results out-of-state child abuse and neglect registry check for all adult household members living in the home. When a child abuse and neglect registry is not maintained in the applicable state, an information request is made to the applicable state; and

(vi) A search of Juvenile Justice Information System records for any child older than thirteen (13) years of age in the applicant's household.

(B) An application is denied when the applicant or any person residing in the applicant's home:

(i) Has a criminal conviction of, or pled guilty or no contest to:

(I) Physical assault, battery, or a drug-related offense in the five(5) year period preceding the application date;

(II) Child abuse or neglect;

(III) Domestic abuse;

(IV) A crime against a child, including, but not limited to, child pornography;

(V) A crime involving violence, including, but not limited to, rape, sexual assault, or homicide, including manslaughter,

- excluding physical assault and battery; or
- (ii) Does not meet OAC 340:100-3-39 requirements;

(c) **Home profile process.** When the applicant meets the prescreening requirements, the initial home profile process described in (1) through (8) of this subsection is initiated.

(1) The applicant provides required information for home profile completion.

(2) When an incomplete form or other information is returned to DDS, designated DDS staff sends a letter to the provider or provider agency identifying information needed to complete the required forms. The home profile is not completed until all required information is provided to DDS.

(3) Designated DDS staff completes the home profile when all required forms are completed and provided to DDS.

(4) For each reference the applicant provides, designated DDS staff documents the completed reference check results.

(5) Designated DDS staff, through interviews, visits, and phone calls, gathers information required to complete the home profile.

(6) DDS staff review policies and responsibility areas with the applicant and DDS staff and the applicant acknowledge the review in writing.

(7) The DDS area residential services programs manager sends the applicant:

(A) A provider approval letter confirming the applicant is approved to serve as a provider; or

(B) A denial letter stating the application and home profile are denied.

(8) DDS staff records the completion dates of each part of the home profile process.

(d) **Home standards.** In order to qualify and remain in compliance, the applicant's or provider's home must meet the provisions in (1) through (11) of this subsection.

(1) **General conditions.**

(A) The home, buildings, and furnishings are comfortable, clean, and in good repair, and the grounds are maintained. There is no accumulating garbage, debris, rubbish or offensive odors.

(B) The home must:

(i) Be accessible to school, employment, church, day programming, recreational activities, health facilities, and other community resources as needed;

(ii) Have adequate heating, cooling, and plumbing;

(iii) Provide space for the member's personal possessions and privacy; and

(iv) Allow adequate space for the occupants' recreational and social needs.

(C) Provisions for the member's safety are present, as needed, including:

(i) Guards and rails on stairways;

(ii) Wheelchair ramps;

- (iii) Widened doorways;
- (iv) Grab bars;
- (v) Appropriate lifting equipment as needed for safe transfers;
- (vi) Access to safe bathing and toileting;
- (vii) Adequate lighting;
- (viii) Anti-scald devices; and
- (ix) Heat and air conditioning equipment guarded and installed in accordance with manufacturer requirements. Home modifications and equipment may be provided through HCBS Waivers operated by DDS.

(D) Providers must not permit members to access or use swimming or other pools, hot tubs, saunas, ponds, or spas on the premises without supervision. Swimming pools, hot tubs, saunas, ponds, or spas are equipped with sufficient safety barriers or devices designed to prevent accidental injury or unsupervised access.

(E) The household is covered by homeowner's or renter's insurance including personal liability insurance.

(2) Sanitation.

(A) Sanitary facilities are adequate and safe, including toilet and bathing facilities, water supply, and garbage and sewer disposal.

(B) When a septic tank or other non-municipal sewage disposal system is used, it is in good working order.

(C) Garbage and refuse is stored in readily cleanable containers, pending weekly removal.

(D) There is adequate control of insects and rodents, including doors and windows with ventilation screens in good repair.

(E) Universal precautions for infection control are followed in the member's care. Hands and other skin surfaces are washed immediately and thoroughly when contaminated with blood or other body fluids.

(F) Laundry equipment, if in the home, is located in a safe, well-ventilated, and clean area, with the dryer vented to the outside.

(3) Bathrooms. A bathroom must:

(A) Provide for individual privacy and have a finished interior;

(B) Be clean and free of objectionable odors; and

(C) Have a bathtub or shower, flush toilet, and sink in good repair, and hot and cold water in sufficient supply to meet the member's hygiene needs.

(i) A sink is located near each toilet.

(ii) For members who are non-ambulatory or who have limited mobility, a toilet, shower and sink are provided on each floor where their rooms are located.

(iii) There must be at least one (1) toilet, one (1) sink, and one (1) bathtub or shower for every six (6) household occupants, including the provider and family.

(4) Bedrooms. A bedroom:

(A) Has been constructed for that purpose when the home was built or remodeled under permit;

(B) Is provided for each member.

(i) The DDS are residential services program manager may make exceptions to allow members to share a bedroom when DDS determines sharing a bedroom is in the members' best interests.

(ii) A member must not share a bedroom with more than one (1) other member;

(iii) Minor members must not share bedrooms with an adult member. Exceptions may be approved by the DDS Area Field Administrator when (I) through (III) of this section are met. Additional exceptions to these rules may be approved by the division director or designee:

(I) The minor is at least sixteen (16) years of age;

(II) The adult member does not present a risk of harm to the minor; and

(III) The members are sharing a room at the time the older member turns eighteen (18) years of age;

(C) Has two (2) means of egress and a minimum of eighty (80) square feet of usable floor space for each member or one-hundred and twenty (120) square feet for two (2) members. The home's provider, family members, or other occupants must not sleep in areas designated as common use living areas, nor share bedrooms with members.

(i) Exceptions to allow non-members and members to share a bedroom may be approved by the Division Director or designee when:

(I) The member agrees and the agreement is documented in the IP annually;

(II) Neither the member nor the non-member are determined to be at risk or harm; and

(III) Neither the member nor the non-member are eighteen (18) years or older; and

(ii) Consideration is given to age, gender, support needs, behavioral health needs, number of restrooms available in the home, and total household square footage.

(D) Is finished with standard construction walls or partitions that go from floor to ceiling;

(E) Is adequately ventilated, heated, cooled, and lighted;

(F) Includes an individual bed for each member consisting of a frame, box spring when other support is not included in the frame, and a mattress at least thirty-six (36) inches wide, unless a specialized bed is required to meet identified needs. Cots, rollaway beds, couches, futons, air mattresses, and folding beds are not used for members. The division director or designee may make exceptions for temporary respite when the Personal Support Team (Team) is able to demonstrate that privacy can be maintained.

(i) Each bed has clean bedding in good condition consisting of a mattress pad, bedspread, two (2) sheets, pillow, pillowcase, and blankets adequate for the weather.

(ii) Sheets and pillowcases are laundered at least weekly or more often if necessary.

(iii) Waterproof mattress covers are used for members who are incontinent;

(G) Has sufficient space for each member's clothing and personal effects, including hygiene and grooming supplies.

(i) Members are allowed to keep and use reasonable amounts of personal belongings and have private, secure storage space.

(ii) The provider assists the member in furnishing and decorating the member's bedroom.

(iii) Window coverings are in good condition and allow privacy for members;

(H) Is on ground level for members with impaired mobility or who are non-ambulatory; and

(I) Is in close enough proximity to the provider to alert the provider to nighttime needs or emergencies, or be equipped with an alert system.

(5) Food.

(A) Adequate storage is available to maintain food at the proper temperature, including a properly working refrigerator such that, and to keep food protected from dirt and contamination to prevent spoilage.

(B) Utensils, dishes, glassware, and food supplies not stored in bedrooms, bathrooms, or living areas.

(C) Utensils, dishes, and glassware are washed and stored to prevent contamination.

(D) Food storage and preparation areas and equipment must be clean, free of offensive odors, and in good repair.

(6) Phone.

(A) There is a working phone in the home that is available and accessible for the member's use, including during periods of time when the member is home alone.

(B) Phone numbers to the home and providers are kept current and provided to DDS and, when applicable, the provider agency.

(7) Safety.

- (A) Buildings must meet all applicable state building, mechanical, and housing codes.
- (B) Heating, in accordance with manufacturer's specifications, and electrical equipment, including wood stoves, are installed in accordance with all applicable fire and life safety codes. Such equipment is used and maintained properly and kept in good repair.
 - (i) Fireplaces are required to have protective glass screens or metal mesh curtains attached at top and bottom.
 - (ii) Unvented portable oil, gas, or kerosene heaters are prohibited.
- (C) Extension cord wiring is not used in place of permanent wiring.
- (D) Hardware for all exit and interior doors must have an obvious operation method that cannot be locked against egress.

(8) Emergencies.

- (A) Working smoke detectors are provided in each bedroom, adjacent hallways, and in two (2) story homes, at the top of each stairway. Alarms are equipped with a device that has a low battery warning when battery operated.
- (B) At least one (1) working fire extinguisher is in a readily accessible location.
- (C) A working flashlight is available for emergency lighting on each floor of the home.
- (D) The provider:
 - (i) Maintains a working carbon monoxide detector in the home;
 - (ii) Maintains the home's written evacuation plan evacuation training with the member;
 - (iii) Conducts fire drills quarterly and severe weather drills twice per year;
 - (iv) Makes fire and severe weather drill documentation available for DDS review;
 - (v) Has a written back-up plan for temporary housing in the event of an emergency; and
 - (vi) Is responsible for re-establishing a residence if the home becomes uninhabitable.
- (E) A first aid kit is available in the home.
- (F) The home's address is clearly visible from the street.

(9) Special hazards.

- (A) Firearms and other dangerous weapons are stored in a locked permanent enclosure. Ammunition is stored in a separate locked location. Providers are prohibited from assisting members to obtain, possess, or use dangerous or deadly weapons, per OAC 340:100-5-22.1.
- (B) Flammable and combustible liquids and hazardous materials are safely and properly stored in original, properly labeled containers.

(C) Cleaning supplies, medical sharps containers, poisons, and insecticides are properly stored in original, properly labeled containers in a safe area away from food, food preparation areas, dining areas, and medications.

(D) Illegal substances are not permitted on the premises.

(10) **Vehicles.**

(A) All vehicles used to transport members meet local and state requirements for accessibility, safe transit, licensing, inspection, insurance, and capacity.

(B) Drivers have valid and appropriate driver licenses.

(11) **Medication.** Medication for the member is stored, per OAC 340:100-5-32.

(12) **Pets.** Sanitation for household pets and other domestic animals is required to prevent health hazards.

(A) For all household pets, proof of rabies and/or other vaccinations as required by a licensed veterinarian is maintained on the premises.

(B) Pets not confined in enclosures must not jeopardize the safety of residents and visitors to the home.

(C) Animals and pets are in good health, do not show evidence of carrying disease, and do not present a threat to member health, safety, or welfare.

(D) Appropriate supervision is required when the member is in the presence of household animals and pets.

(E) If an animal or pet bites a member, the provider ensures the member receives medical treatment when appropriate, contacts designated DDS staff as soon as the member is safe, and completes an incident report per OAC 340:100-3-34.

(e) **Evaluating the applicant and home.** The initial home profile evaluation includes, but is not limited to:

(1) Evaluating the applicant's:

(A) Interest and motivation;

(B) Life skills;

(C) Children;

(D) Methods of behavior support and discipline;

(E) Marital status, background, and household composition;

(F) Income and money management; and

(G) Teamwork and supervision, back-up plan, and relief use; and

(2) Assessment and recommendation. DDS staff:

(A) Evaluates the applicant's ability to provide services;

(B) Assesses the applicant's overall compatibility with the service recipient, ensuring the lifestyles and personalities of each are compatible for the shared living arrangement.

The applicant:

(i) Expresses a long term commitment to the service member unless the applicant will only be providing respite services;

- (ii) Demonstrates the skills to meet the member's needs;
- (iii) Expresses an understanding of the commitment required as a service provider;
- (iv) Expresses an understanding of the impact the arrangement will have on personal and family life;
- (v) Demonstrates the ability to establish and maintain positive relationships, especially during stressful situations; and
- (vi) Demonstrates the ability to work collaboratively and cooperatively with others in a team process;

(C) Only approves applicants who can fulfill service provider expectations; and

(D) Ensures that when the applicant does not meet standards, per OAC 317:40-5-40, the final recommendation includes:

- (i) A basis for the denial decision;
- (ii) An effective date for determining the applicant does not meet standards; and
- (iii) Reasons for denying a request to be a provider. Reasons may include, but are not limited to:

(I) A lack of stable, adequate income to meet the applicant's own or total family needs, or poor management of the available income;

(II) A physical facility that is inadequate to accommodate the addition of a member to the home or presents health or safety concerns;

(III) The applicant's age, health, or any other condition that impedes his or her ability to provide appropriate care for a member;

(IV) Relationships in the applicant's household that are unstable and unsatisfactory;

(V) The applicant's, other family member's or household member's mental health of the applicant or other family or household member that impedes the applicant's ability to provide appropriate care for a member;

(VI) The applicant's failure to complete verifications in a timely manner as requested, or the applicant's provision of incomplete, inconsistent, or untruthful information;

(VII) The home is determined unsuitable for the member requiring placement;

(VIII) Confirmed abuse, neglect, or exploitation of any person;

- (IX) Confidentiality breach;
- (X) Applicant or provider involvement in criminal activity or criminal activity in the home;
- (XI) Failures to complete training, per OAC 340:100-3-38;
- (XII) Home's failure to meet standards per subsection (d) of this Section;
- (XIII) Failure to follow applicable OKDHS or Oklahoma Health Care Authority (OHCA) rules;
- (XIV) References who are guarded or have reservations in recommending the applicant; and
- (XV) The applicant's failure to complete the application in a timely manner.

(E) Notifies the applicant in writing of the home profile's final approval or denial; and

(F) Completes a final written assessment when an application is canceled or withdrawn prior to the home profile's completion. The written assessment includes the:

- (i) Reason the application was canceled or withdrawn;
- (ii) DDS staff impression of the applicant based on information obtained; and
- (iii) Effective cancellation or withdrawal date.

Written notice is sent to the applicant to confirm application cancellation or withdrawal, and a copy is included in local and State Office records.

(f) Unrelated habilitation training specialist (HTS) staff home.

Designated DDS staff and provider agency staff work together to complete a home evaluation when the member lives with an unrelated HTS staff.

(1) The provider agency:

- (A) Obtains pre-employment screening in compliance with OAC 340:100-3-39;
- (B) Obtains background checks for all household residents in accordance with (b) (4) of this Section; and
- (C) Assesses HTS fitness for work; and the

(2) Designated DDS staff:

- (A) Assesses household members' appropriateness;
- (B) Develops an evacuation plan;
- (C) Reviews policy, procedures, and responsibilities with the HTS;
- (D) Ensures pet vaccinations are current;
- (E) Evaluates any other conditions that may affect the health or safety of a member's care; and
- (F) Completes a home safety inspection initially and annually, then as needed.

(g) Evaluation frequency. Home profile evaluations are completed for an applicant's initial approval or denial. After an initial approval, a home

profile review is conducted annually and as needed for compliance and continued approval. DDS area residential services staff conducts at least biannual home visits to SFC providers. The annual home profile review is a comprehensive review of the living arrangement, the provider's continued ability to meet standards, and the member's and home's needs to ensure ongoing compliance with home standards. A home profile review is conducted when a provider notifies DDS of his or her intent to move to a new residence. DDS staff assesses the home to ensure the new home meets home standards and is suitable to meet the member's needs. The annual home profile review:

- (1) Includes information specifically related to the provider's home and is documented, as an annual review;
- (2) Includes a medical examination report completed a minimum of every three (3) years following the initial approval, unless medical circumstances warrant more frequent completion;
- (3) Includes information from the DDS case manager, the Child Welfare specialist, Adult Protective Services, and Office of Client Advocacy staff, and the provider agency program coordinator when applicable;
- (4) Includes information from the service member indicating satisfaction with service and a desire to continue the arrangement;
- (5) Includes service areas where improvement is needed;
- (6) Includes service areas where progress was noted or were of significant benefit to the member;
- (7) Ensures background investigation, per OAC 317:40-5-40(b), is repeated every year, except for the OSBI and FBI national criminal history search;
- (8) Ensures the FBI national criminal history search, per OAC 317:40-5-40(b)(4)(A)(ii), is repeated every five (5) years;
- (9) When applicable, ensures written notification of continued provider approval to providers and agencies; and
- (10) Includes written notification to providers and agencies when the provider or agency fails to comply with the home standards, per OAC 317:40-5-40, including correction deadlines for the identified standards.

(h) **Home profile denial.** Reasons a home profile review may be denied include, but are not limited to, reasons stated in subsection (e) (2) (D) (iii) (I through XIII) of this Section and :

- (1) Provider's failure to complete tasks related to problem resolution, as agreed, per OAC 340:100-3-27;
- (2) Provider's failure to complete an action plan, as agreed, per OAC 317:40-5-63;
- (3) Failure to provide for the service member's care and well-being;
- (4) Failure or continued failure to implement the member's Individual Plan, per OAC 340:100-5-50 through 100-5-58;
- (5) Failure to report changes in the household;
- (6) Decline in the provider's health to the point he or she can no longer meet the service member's needs;

(7) Provider employment without prior DDS area residential services programs manager approval; or

(8) Domestic disputes that cause emotional distress to the member.

(i) **Placement termination.** When an existing placement is terminated for any reason:

(1) The Team meets to develop an orderly transition plan; and

(2) DDS staff ensures the member's and state property are removed promptly and appropriately by the member or his or her designee.

[Source: Added at 22 Ok Reg 2531, eff 7-11-05 ; Amended at 25 Ok Reg 2714, eff 7-25-08 ; Amended at 28 Ok Reg 1550, eff 6-25-11 ; Amended at 32 Ok Reg 615, eff 2-9-15 (emergency); Amended at 32 Ok Reg 1170, eff 8-27-15 ; Amended at 38 Ok Reg 1081, eff 9-1-21 ; Amended at 39 Ok Reg 1595, eff 9-12-22]

PART 5. SPECIALIZED FOSTER CARE STANDARDS

317:40-5-50. Purpose of Specialized Foster Care (SFC)

(a) SFC provides up to twenty-four (24) hours per day of in-home residential habilitation services funded through the Community Waiver or the Homeward Bound Waiver. SFC serves individuals three (3) years of age and older. SFC provides an individualized living arrangement in a family setting including up to twenty-four (24) hours per day of supervision, supportive assistance, and training in daily living skills.

(b) SFC is provided in a setting that best meets the member's specialized needs.

(c) Members in SFC have a written plan that addresses visitation, reunification, or permanency planning, and which may also address guardianship as the member approaches eighteen (18) years of age.

(d) As per the requirements in (1) through (4) of this subsection, SFC providers:

(1) Are approved through the home profile process described in Oklahoma Administrative Code (OAC) 317:40-5-40;

(2) Have a current Home and Community-Based Services (HCBS) Waiver contract with the Oklahoma Health Care Authority; and

(3) Have a current Fixed Rate Foster Home Contract for room and board reimbursement with Developmental Disabilities Services (DDS) when:

(A) The SFC member is a child; or

(B) Required by the adult SFC recipient's Personal Support Team (Team).

(e) A child in Oklahoma Human Services (OKDHS) or tribal custody who is determined eligible for HCBS Waiver services, per OAC 317:40-1-1, is eligible to receive SFC services if the child's special needs cannot be met in a Child Welfare Services (CWS) foster home.

(1) SFC provides a temporary, stable, nurturing, and safe home environment for the child while OKDHS plans for reunification with the child's family.

(2) In the event reunification is not achievable, SFC may be provided on a long-term basis while other more permanent living arrangements are sought.

(3) When the court has established a specific visitation plan, the CWS specialist informs the SFC provider, the member, the DDS case manager, and the natural family of the visitation plan.

(A) The SFC provider cooperates with the visitation plan between the child and family as prescribed by the court or the member's Team.

(B) The reunification effort is the joint responsibility of the:

- (i) CWS worker;
- (ii) DDS case manager;
- (iii) Natural family; and
- (iv) SFC family.

(C) For children in OKDHS custody, CWS and DDS work together to determine the need for guardianship. When it has been established that a legal guardian is in the child's best interest, both programs work together to locate a guardian.

(f) SFC is a temporary service provided to children who are not in OKDHS custody when SFC services are needed to prevent institutionalization.

(1) SFC is intended to allow relief for the member's family that cannot be satisfied by respite services provisions or other in-home supports.

(2) SFC provides a nurturing, substitute home environment for the member while plans are made to reunify the family.

(3) Visitation with the family is a part of the reunification efforts for non-custody children. Visitation must not be intrusive to the SFC home.

(4) Parents of a child receiving SFC services must comply with the requirements listed in (A) through (D) of this paragraph.

(A) Natural or adoptive parents retain the responsibility for their child's ongoing involvement and support while the child is in SFC.

- (i) The parents are required to sign a written agreement allowing OKDHS to serve as the representative payee for the child's Social Security Administration (SSA) benefits, other government benefits, and court-authorized child support.
- (ii) SSA and other government benefits, and child support are used to pay for room and board.. HCBS services do not pay for room and board.

(B) Parental responsibilities of a child receiving voluntary SFC are to:

- (i) Provide respite to the SFC provider;
- (ii) Provide transportation to and from parental visitation;
- (iii) Provide a financial contribution toward their child's support;

- (iv) Provide in kind supports, such as disposable undergarments, if needed, clothing, recreation, birthday and holiday presents, school supplies, and allowances or personal spending money;
- (v) Follow the visitation plan as outlined by the member's Team, per OAC 317:40-5-52;
- (vi) Maintain ongoing communication with the member and SFC provider by letters, telephone calls, video conferencing, or email;
- (vii) Be available in an emergency;
- (viii) Work toward reunification when appropriate;
- (ix) Provide written consent for medical treatments as appropriate;
- (x) Attend medical appointments, when possible, and keep informed of the member's health status;
- (xi) Participate in the member's education plan per Oklahoma State Department of Education regulations; and
- (xii) Be present for all Team meetings.

(C) When moving out of Oklahoma, parents of a child receiving voluntary SFC are responsible for taking their minor child with them, since the child is no longer eligible for services because he or she is no longer an Oklahoma resident.

(D) For children eighteen (18) years of age and younger, the case manager reports to CWS if the family moves out of Oklahoma without taking their child with them or if the family cannot be located.

(g) SFC is an appropriate living arrangement for many adults. The decision to use SFC for an adult is based on the member's need for residential support as described in the member's Individual Plan (Plan).

(1) In general, SFC is appropriate for members who have not experienced family life. A child served in SFC may continue to receive services in the home indefinitely after turning eighteen (18) years of age.

(2) The member who receives SFC services lives in the provider's home.

(3) Visitation with the adult member's family is encouraged and arranged according to the member's preference. Visitation is not intrusive to the SFC home.

(h) When natural or other unpaid supports are not available, the SFC provider may request respite support.

(1) Respite units do not replace the responsibilities of the SFC provider on a regular basis.

(2) All respite units must be justified in the member's Plan process.

(3) No more than seven-hundred and twenty (720) hours annually may be authorized unless approved by the DDS director or designee.

(A) The daily respite rate is used when respite is provided for a full twenty-four (24) hour day. A day is defined as the

period between 12:00 a.m. and 11:59 p.m..

(B) The hourly respite rate is used when respite is provided for a partial day.

(C) The provider may serve more than one (1) member through shared staffing, but may not bill habilitation training specialist (HTS) services or the hourly respite rate for multiple members at the same time.

(4) No spouse or other adult living in the provider household may serve as paid respite staff.

(5) Consideration is given to authorizing additional respite hours when providing additional relief represents the most cost-effective placement for the member and:

(A) There are multiple members living in the home;

(B) The member has an on-going pattern of not sleeping at night; or

(C) The member has an on-going pattern of not working or attending employment services, in spite of continuing efforts by the Team.

(i) HTS services may be approved by the DDS director or designee when providing SFC with additional staffing support represents the most cost-effective placement for the member when:

(1) There is an ongoing pattern of not sleeping at night; or

(2) There is an ongoing pattern of not working or attending employment, educational, or day services;

(3) There are multiple members living in the home;

(4) A time-limited situation exists in which the foster parent is unable to provide SFC, and the provision of HTS maintains the placement or provides needed stability for the member, and must be reduced when the situation changes;

(5) Must be reviewed annually or more frequently as needed; and

(6) Must be documented by the Team and the Team must continue efforts to resolve the need for HTS.

(j) A member may receive therapeutic leave for no more than fourteen (14) consecutive days per event, not to exceed sixty (60) calendar days per Plan of Care year.

(1) The payment for a day of therapeutic leave is the same amount as the per diem rate for SFC services.

(2) Therapeutic leave is claimed when the member does not receive SFC services for twenty-four (24) consecutive hours from 12:00 am to 11:59 pm because of:

(A) A visit with family or friends without the SFC provider;

(B) Vacation without the SFC provider; or

(C) Hospitalization.

[Source: Added at 15 Ok Reg 3855, eff 7-1-98 (emergency); Added at 16 Ok Reg 1445, eff 5-27-99 ; Amended at 22 Ok Reg 2559, eff 7-11-05 ; Amended at 39 Ok Reg 1595, eff 9-12-22 ; Amended at 40 Ok Reg 2262, eff 9-11-23]

317:40-5-51. Scope of Specialized Foster Care [REVOKED]

[Source: Added at 15 Ok Reg 3855, eff 7-1-98 (emergency); Added at 16 Ok Reg 1445, eff 5-27-99 ; Amended at 22 Ok Reg 2559, eff 7-11-05 ; Revoked at 39 Ok Reg 1595, eff 9-12-22]

317:40-5-52. Visitation and reunification in Specialized Foster Care [REVOKED]

[Source: Added at 15 Ok Reg 3855, eff 7-1-98 (emergency); Added at 16 Ok Reg 1445, eff 5-27-99 ; Amended at 22 Ok Reg 2559, eff 7-11-05 ; Revoked at 39 Ok Reg 1595, eff 9-12-22]

317:40-5-53. Management of unacceptable behavior [REVOKED]

[Source: Added at 15 Ok Reg 3855, eff 7-1-98 (emergency); Added at 16 Ok Reg 1445, eff 5-27-99 ; Amended at 21 Ok Reg 1327, eff 5-27-04 ; Revoked at 22 Ok Reg 2559, eff 7-11-05]

317:40-5-54. Selection of Specialized Foster Care provider [REVOKED]

[Source: Added at 15 Ok Reg 3855, eff 7-1-98 (emergency); Added at 16 Ok Reg 1445, eff 5-27-99 ; Amended at 22 Ok Reg 2559, eff 7-11-05 ; Revoked at 39 Ok Reg 1595, eff 9-12-22]

317:40-5-55. Specialized Foster Care (SFC) provider responsibilities

(a) **General responsibilities.** The SFC providers responsibilities are listed in (a) through (c) of this Section. Each provider:

- (1) Is required to meet all applicable standards per OAC 317:40-5-40;
- (2) Is required to receive competency-based training per OAC 340:100-3-38. The provider keeps all required training current and submits documentation to the SFC specialist at the time training is completed;
- (3) Is an active participant of the member's Personal Support Team (Team) and assists in developing the member's Individual Plan (Plan), per OAC 340:100-5-50 through 100-5-58;
- (4) Documents and notifies the case manager of any changes in the member's behavior or medical conditions within one working day. The SFC provider completes incident reports and submits them to the Developmental Disabilities Services (DDS) case manager per OAC 340:100-3-34;
- (5) Is available to the member at any time;
- (6) Has primary responsibility to provide SFC services to the member. The SFC provider does not have employment unless the employment is pre-approved by the DDS area residential services programs manager or the State Office residential services programs manager;
 - (A) The provider must be available before and after school or vocational programs and as needed during the day due to holidays or illnesses;
 - (B) After receiving employment approval, if the provider's employment interferes with the member's care, training, or supervision, the provider must determine if he or she

wants to terminate the employment or have the member moved from the home; and

(C) DDS does not authorize homemaker, habilitation training specialist, or respite services in order for the SFC provider to perform employment.

(7) Does not deliver services that duplicate public school district mandated services that are provided pursuant to the Individuals with Disabilities Education Act (IDEA-B);

(8) Allows the member to have experiences, both in and out of the home, to enhance the member's development, learning, growth, independence, community inclusion, and well-being, while assisting the member to achieve his or her maximum level of independence;

(9) Ensures confidentiality is maintained regarding the member per OAC 340:100-3-2;

(10) Is sensitive to, and assists the member in participating in, the member's religious faith. No member is expected to attend any religious service against his or her wishes;

(11) Arranges for, and ensures the member obtains, a dental examination at least annually, and is responsible for obtaining regular and emergency medical services as needed;

(12) Has a valid Oklahoma driver license and maintains a motor vehicle in working order, per OAC 317:40-5-103;

(13) Transports, or arranges transportation for the member, using adapted transportation when appropriate, per OAC 317:40-5-103, the SFC provider:

(A) May enter into a transportation contract;

(B) Assures availability and use of an approved and appropriate child auto restraint system as required by law in transporting children and, in cases of adults receiving services, any additional safety devices identified as necessary in the Plan; and

(C) Does not claim transportation reimbursement for vacation travel or any other transportation service not covered per OAC 317:40-5-103.

(14) Assures the member is clean, appropriately dressed, and on time for activities and appointments;

(15) Ensures no other adult or child is cared for or resides in the home on a regular or part-time basis who is not approved through the home profile review process or without prior approval from the DDS area residential services programs manager;

(16) Does not provide services to more than three (3) individuals regardless of service type provided, including SFC, Welfare Services foster care, respite, baby-sitting, or other such services. Any exception to this paragraph must be approved in writing by the DDS director or designee prior to authorization or service delivery;

(17) Permits DDS staff to conduct monitoring and home visits. In order to assure standards are maintained, some visits are unannounced. The visits occur at least monthly and are not intended to be intrusive but to ensure the member's safety and

well-being;

(18) Encourages and cooperates in planning visits in the SFC home by the member's relatives, guardians, or friends. Member visits to his or her friends' or relative's homes must be approved by the member's legally authorized representative;

(19) Is prohibited from signing an authorization for school personnel to use physical discipline or corporal punishment;

(20) Notifies the DDS social services specialist (SSS) when the need arises for substitute supervision in an emergency, per OAC 317:40-5-59. When the provider is out of the home for a short duration, a natural support in the home can provide time-limited substitute supervision;

(A) A natural support is defined as an adult relative or spouse of the specialized foster parent who resides in the home;

(B) The Team approves the natural support and defines when this support may be accessed;

(C) Persons considered a natural support must complete training, per OAC 340:100-3-38.12;

(D) Persons acting as a natural support may only provide supervision for brief, intermittent time periods and do so without payment;

(E) When the Team determines it to be appropriate, the SFC provider may select a volunteer to serve as a substitute caregiver for a member eighteen (18) years of age and younger. The volunteer resides outside the home, has no waiver contract, is not employed by a contracted agency, and has an established relationship with the member;

(i) A volunteer is defined as an adult, at least twenty-one (21) years of age, who is the SFC provider's a friend, relative, or neighbor;

(ii) A volunteer may provide support for up to two (2) consecutive days. The member may not be in volunteer care for more than three (3) days total in a thirty (30) calendar day period;

(iii) The SFC provider ensures the volunteer possesses the maturity and skills necessary to address the member's needs;

(iv) The foster care provider notifies the DDS SSS within one (1) business day when volunteer respite is used and includes address, contact information and length of stay;

(v) When the member is also a child in OKDHS or tribal custody, the SFC provider gives the volunteer contact information for the DDS SSS, case manager, and child welfare specialist (CWS) as well as his or her own contact information;

(vi) A volunteer must not be someone who has been excluded by OKDHS; and

(vii) The volunteer is not subject to background check or home profile requirements unless the stay will exceed two (2) consecutive days.

(F) When the Team determines it to be appropriate, the SFC provider may select a camp, retreat, or conference program as a substitute caregiver for the member when the member wishes to attend the program. A camp, retreat, or conference program is defined as a day or overnight program with adult supervision for children, teenagers, or adults conducted for educational, athletic, or cultural development. The SFC provider:

- (i) Ensures the program has the essential skills and supports to meet the member's needs;
- (ii) Notifies the DDS SSS prior to the member attending the program; and
- (iii) Provides the program with contact information for the foster care provider, DDS SSS, case manager, and CWS when the member is also a child in OKDHS or tribal custody.

(21) Provides written thirty (30) calendar day notice to the member and DDS case manager when it is necessary for a member to be moved from the home;

(22) Does not serve as the member's representative;

(23) Ensures the member's funds are properly safeguarded;

(24) Assists the member in accessing and using entitlement programs for which the member may be eligible;

(25) Must use the room and board reimbursement payment to meet the member's needs, per the Fixed Rate Foster Home Contract;

(A) The provider retains a copy of the current Fixed Rate Foster Home Contract in the home at all times;

(B) Items purchased with the room and board reimbursement include, but are not limited to:

- (i) Housing;
- (ii) Food;
- (iii) Clothing;
- (iv) Care;
- (v) Incidental expenses such as:
 - (I) Birthday and Christmas gifts;
 - (II) Haircuts;
 - (III) Personal grooming equipment;
 - (IV) Allowances;
 - (V) Toys;
 - (VI) School supplies and lunches;
 - (VII) School pictures;
 - (VIII) Costs of recreational activities;
 - (IX) Special clothing items required for dress occasions and school classes such as gym shorts and shirts;
 - (X) Extracurricular athletic and other equipment, including uniforms, needed for

the member to pursue his or her particular interests or job;

(XI) Prom and graduation expenses including caps, gowns, rings, pictures, and announcements;

(XII) Routine transportation expenses involved in meeting the member's medical, educational, or recreational needs, unless the provider has a transportation contract;

(XIII) Non-prescription medication; and

(XIV) Other maintenance supplies required by the member.

(C) All items purchased for the member with the room and board payment are the member's property. Purchased items are documented on OKDHS Form 06AC022E, Personal Possession Inventory, and are provided to the member when a residence change of residence occurs; and

(D) The room and board payment is made on a monthly basis and is prorated based on the actual days the member is in the home on the initial and final months of residence.

(26) Maintains Form 06AC022, Personal Possession Inventory, for each member living in the home;

(27) Maintains the member's home record, per OAC 340:100-3-40;

(28) Immediately reports to the DDS SSS all changes in the household including, but not limited to:

(A) Phone number;

(B) Address;

(C) Marriage or divorce;

(D) Persons moving into or out of the home;

(E) Provider's health status;

(F) Provider's employment; and

(G) Provider's income.

(29) Maintains home owner's or renter's insurance, including applicable liability coverages, and provides a copy to the DDS SSS;

(30) Serves as the health care coordinator, and follows the rules per OAC 340:100-5-26; and

(31) Follows all applicable OKDHS and Oklahoma Health Care Authority rules, included but not limited to:

(A) OAC 340:100-3-27;

(B) OAC 340:100-5-32; and

(C) OAC 340:100-5-33.

(b) Responsibilities specific to SFC providers serving children. The provider is charged with the same general legal responsibility as any parent. The SFC provider exercises reasonable and prudent behavior in his or her actions and in the supervision and support of the child. The SFC provider:

(1) Works with the DDS case manager and CWS staff when the provider needs respite for a child in OKDHS or tribal custody;

- (2) Participates in developing the Individual Education Plan (IEP) and may serve as surrogate parent when appropriate;
- (3) Obtains permission and legal consent from the child's custodial parent or guardian and DDS case manager prior to traveling out-of-state for an overnight visit. If the child is in OKDHS or tribal custody, CWS permission is also secured;
- (4) Obtains permission and legal consent from the child's custodial parent or guardian and DDS case manager prior to the child's involvement in any publicity. If the child is in OKDHS or tribal custody, CWS permission is also secured; and
- (5) The provider reports any suspected abuse, neglect, sexual abuse, or sexual exploitation of children to CWS, per 10A O.S. § 1-2-101 and OAC 340:2-3-33.

(c) Responsibilities specific to SFC providers serving adults.

Additional SFC provider responsibilities for serving adults are given in this Subsection.

- (1) The SFC provider obtains permission from the member's legal guardian, when applicable, and notifies the DDS case manager, prior to:
 - (A) Traveling out-of-state for an overnight visit; or
 - (B) The member's involvement in any publicity.
- (2) When the member is his or her own payee or has a representative payee, the SFC provider ensures the monthly service contribution, as identified in a written agreement between the member and the SFC provider, is used toward the cost of food, rent, and household expenses.
 - (A) The member's minimum monthly contribution is \$300.00 per month.
 - (B) Changes in the member's monthly contribution are made on an individualized basis by the member's Team.
- (3) The SFC provider reports any suspected abuse, verbal abuse, sexual abuse, neglect, financial neglect or exploitation to:
 - (A) The Office of Client Advocacy for a vulnerable adult receiving Home and Community-Based Services (HCBS) when the alleged perpetrator is a community service worker, per OAC 340:2-3-33; or
 - (B) Adult Protective Services for a vulnerable adult when the alleged perpetrator is not a community service worker through HCBS, per 43A O.S. § 10-104.

[Source: Added at 15 Ok Reg 3855, eff 7-1-98 (emergency); Added at 16 Ok Reg 1445, eff 5-27-99 ; Amended at 22 Ok Reg 2559, eff 7-11-05 ; Amended at 23 Ok Reg 3192, eff 6-7-06 (emergency); Amended at 24 Ok Reg 958, eff 5-11-07 ; Amended at 28 Ok Reg 1550, eff 6-25-11 ; Amended at 30 Ok Reg 1268, eff 7-1-13 ; Amended at 39 Ok Reg 1595, eff 9-12-22]

317:40-5-56. Responsibilities of the parents of individuals in voluntary specialized foster care [REVOKED]

[Source: Added at 15 Ok Reg 3855, eff 7-1-98 (emergency); Added at 16 Ok Reg 1445, eff 5-27-99 ; Amended at 22 Ok Reg 2559, eff 7-11-05 ; Revoked at 39 Ok Reg 1595, eff 9-12-22]

317:40-5-57. Developmental Disabilities Services DDS Specialized Foster Care (SFC) case management roles and responsibilities

In addition to other identified roles and responsibilities, the DDS case manager is responsible for:

- (1) Reporting any significant changes with the member or the SFC household to the DDS social service specialist (SSS);
- (2) The member's guardianship needs;
- (3) Pre-placement visits when approved by the DDS SSS;
- (4) Reviewing the member's backup plan, per Oklahoma Administrative Code (OAC) 317:40-5-59;
- (5) Reporting policy violations to the DDS SSS per OAC 317:40-5-63, and assists the DDS SSS in developing the provider's action plan when appropriate;
- (6) Ensuring the SFC provider documents the member's personal belongings on Oklahoma Human Services (OKDHS) Form 06AC022, Personal Possession Inventory, including adaptive equipment;
- (7) Attending court hearings for children in OKDHS and tribal custody;
- (8) Forwarding quarterly progress reports to the OKDHS Child Welfare Services (CWS) specialist for children in OKDHS custody;
- (9) Notifying the CWS or legally authorized representative of needed medical consents for pre-planned or emergency services; and
- (10) Completing the appropriate section of OKDHS Form 06AC024E, SFC/Agency Companion Services (ACS) Annual Review, and providing the information to the DDS SSS.

[Source: Added at 15 Ok Reg 3855, eff 7-1-98 (emergency); Added at 16 Ok Reg 1445, eff 5-27-99 ; Amended at 22 Ok Reg 2559, eff 7-11-05 ; Amended at 39 Ok Reg 1595, eff 9-12-22]

317:40-5-58. Developmental Disabilities Services (DDS) Social Services Specialist (SSS) roles and responsibilities

DDS SSS staff have the responsibility for:

- (1) SFC applicant orientation and prescreening;
- (2) Making contact with the potential SFC provider within five (5) working days of receiving a completed application to schedule interviews and start the home profile process, per OAC 317:40-5-40;
- (3) Completing the home profile within ninety (90) calendar days after application assignment. The DDS SSS documents the reason for any delay beyond ninety (90) calendar days;
- (4) Maintaining regular contact with the SFC provider by making a monitoring visit every six (6) months and completing OKDHS Form 06AC023E, Monitoring Report;
- (5) Completing OKDHS Form 06AC024E, Specialized Foster Care/Agency Companion Annual Review (DDS-24) for the annual re-evaluation of each SFC provider home by the renewal date;
- (6) Attending member's Personal Support Team meetings as necessary;

- (7) Responding to SFC and respite care requests;
- (8) Providing technical assistance and training to SFC providers regarding claims and problem resolutions, such as:
 - (A) Payments;
 - (B) Family dynamics;
 - (C) DDS policy;
 - (D) Setting up the in-home record per OAC 340:100-3-40;
 - (E) Setting up the SFC provider record; and
 - (F) SFC provider training.
- (9) Making unannounced home visits to ensure homes and providers are in compliance with DDS policy;
- (10)
 - Providing SFC providers with technical assistance and training regarding room and board responsibilities.
- (11) Completing or obtaining the authorization for SFC services on OKDHS Form 06AC075E, Authorization Form Parent or Guardian for Specialized Foster Care Placement and Medical Care of Client, that:
 - (A) Is signed by the parent or legal guardian for members not in OKDHS or tribal custody who are requesting SFC services; and
 - (B) Allows for authorization of routine or emergency medical care and provides insurance information.

[Source: Added at 15 Ok Reg 3855, eff 7-1-98 (emergency); Added at 16 Ok Reg 1445, eff 5-27-99 ; Amended at 22 Ok Reg 2559, eff 7-11-05 ; Amended at 39 Ok Reg 1595, eff 9-12-22]

317:40-5-59. Back-up Plan for members receiving Specialized Foster Care (SFC)

Prior to a member moving into SFC, the SFC provider and the Developmental Disabilities Services (DDS) social services specialist (SSS) develop a Back-up Plan. The DDS SSS communicates the Back-Up Plan in writing to the DDS case manager for incorporation into the Individual Plan.

- (1) The Back-up Plan identifies the person(s) who provides emergency back-up supports.
- (2) The member's natural family is considered as the first resource for the Back-up Plan at no cost to Oklahoma Human Services (OKDHS), unless the member is in OKDHS or tribal custody.
- (3) The Back-up Plan contains the name(s) and current phone number(s) of the person(s) providing back-up service.
- (4) When paid SFC providers are necessary, the Back-up Plan explains specifically where the service is to be provided.
 - (A) If back-up service is to be provided outside the SFC home:
 - (i) By a volunteer or at a camp, retreat, or conference center, the Personal Support Team's process must be followed as described in OAC 317:40-5-56; or

(ii) In a contracted SFC provider's home, a home profile must be completed for the back-up staff per OAC 317:40-5-40.

(B) If back-up service is to be provided in the SFC home, the person providing this service must have completed all necessary requirements to become a paid SFC provider, including:

(i) An Oklahoma State Bureau of Investigation (OSBI) name and criminal history records search, including the Department of Public Safety, Sex Offender, and Mary Rippe Violent Offender registries;

(ii) A Federal Bureau of Investigation national criminal history search, based on the substitute applicant's fingerprints;

(iii) A search of any involvement as a party in a court action that may impact the member's safety or stability that includes:

(I) Victims protective order; or

(II) Bankruptcy;

(iv) A search of all OKDHS records, including Child Welfare Services' records;

(v) A search of all applicable out-of-state child abuse and neglect registries for any applicant who has not lived continuously in Oklahoma for the past five years. The applicant is not approved without the results of the out-of-state maintained child abuse and neglect registry checks, if a registry is maintained in the applicable state;

(vi) Community Services Worker registry check;

(vii) Oklahoma statutorily mandated liability insurance coverage, and a valid driver license; and

(viii) Completion of required DDS training per OAC 340:100-3-38.4.

(C) The Back-up Plan details where the member and SFC provider will stay if the SFC provider's home is not habitable. If there is a fee to stay in the alternate location, the provider pays the fee and is not reimbursed by DDS.

(5) The Back-up Plan is jointly reviewed at least monthly by the DDS SSS and the SFC provider to ensure the Back-up Plan continues to be appropriate and current.

(6) The SFC provider is responsible for reporting any needed changes in the Back-up Plan to the DDS SSS.

(7) The DDS SSS reports any changes in the Back-up Plan to the DDS case manager.

[Source: Added at 15 Ok Reg 3855, eff 7-1-98 (emergency); Added at 16 Ok Reg 1445, eff 5-27-99 ; Amended at 22 Ok Reg 2559, eff 7-11-05 ; Amended at 28 Ok Reg 1550, eff 6-25-11 ; Amended at 29 Ok Reg 1199, eff 6-25-12 ; Amended at 39 Ok Reg 1595, eff 9-12-22]

317:40-5-60. Relief support for providers of Specialized Foster Care [REVOKED]

[Source: Added at 15 Ok Reg 3855, eff 7-1-98 (emergency); Added at 16 Ok Reg 1445, eff 5-27-99 ; Amended at 22 Ok Reg 2559, eff 7-11-05 ; Revoked at 40 Ok Reg 2262, eff 9-11-23]

317:40-5-61. Investigations of alleged abuse or neglect of a service recipient in a specialized foster care home [REVOKED]

[Source: Added at 15 Ok Reg 3855, eff 7-1-98 (emergency); Added at 16 Ok Reg 1445, eff 5-27-99 ; Amended at 22 Ok Reg 2559, eff 7-11-05 ; Revoked at 30 Ok Reg 1268, eff 7-1-13]

317:40-5-62. Specialized Foster Care (SFC) policy violations or program concerns

- (a) Developmental Disabilities Services DDS SFC staff begin an evaluation upon receipt of a complaint or observation of SFC provider policy violations or concerns.
- (b) Concerns may include the SFC provider's:
 - (1) Use of judgment;
 - (2) Provision of program supervision;
 - (3) Non-compliance with Oklahoma Human Services or Oklahoma Health Care Authority policy or contract; or
 - (4) Other related issues.
- (c) When abuse, neglect, or exploitation is suspected, appropriate authorities are contacted, as specified in OAC 317:40-5-61.
- (d) The evaluation includes interviews with:
 - (1) The service recipient;
 - (2) The DDS case manager;
 - (3) The provider;
 - (4) Any other person(s) living in the home; and
 - (5) Any other person(s) who may have relevant information.
- (e) When the evaluation findings indicate policy or contract concerns or violations, the DDS social services specialist (SSS), and the SFC provider meet to develop a Plan of Action for correcting the concerns or violations. The DDS SSS notifies the DDS case manager of the agreed Plan of Action when the case manager is responsible for monitoring to ensure the Plan of Action is accomplished.
- (f) When the provider fails to complete the Plan of Action, the DDS SSS consults the area residential services programs manager to determine if the home should be closed, per OAC 317:40-5-64.

[Source: Added at 15 Ok Reg 3855, eff 7-1-98 (emergency); Added at 16 Ok Reg 1445, eff 5-27-99 ; Amended at 22 Ok Reg 2559, eff 7-11-05 ; Amended at 39 Ok Reg 1595, eff 9-12-22]

317:40-5-63. Plan of action in Specialized Foster Care

- (a) When a program concern or a violation of policy or contract is found in a Specialized Foster Care (SFC) home, a Plan of Action, (DDS-28) is initiated.
- (b) The Plan of Action:
 - (1) is a joint effort between the provider and SFC staff;

- (2) ensures that necessary services to the service recipient are not interrupted;
 - (3) states recommendations regarding the continued use of the provider home;
 - (4) is time limited; and
 - (5) is agreed upon by DDS and the provider.
- (c) Unless the Plan of Action is initiated for short-term outcome, reviews of the Plan of Action are conducted, at a minimum, each 90 days. DDS staff and the provider participate in the review.
- (d) If new allegations occur or circumstances change while the Plan of Action is in place, an evaluation is made of the existing plan to redefine the action steps, time frames, and recommendations, if necessary.
- (e) At the completion of the Plan of Action, a resolution is documented to confirm the agreed upon action steps that have been completed.
- (f) If, at the completion of the Plan of Action, all action steps are not completed, but a satisfactory resolution is obtained, an addendum explaining the situation is attached to the Plan of Action.
- (g) If the provider is unwilling or unable to satisfactorily complete the Plan of Action:
- (1) the provider's home is recommended for closure;
 - (2) alternative placement is located for the service recipient; and
 - (3) the provider is given a written 30 day closure notice.
- (h) A provider with an active plan of action cannot serve additional service recipients or provide respite until the plan is successfully completed.

[Source: Added at 15 Ok Reg 3855, eff 7-1-98 (emergency); Added at 16 Ok Reg 1445, eff 5-27-99 ; Amended at 22 Ok Reg 2559, eff 7-11-05]

317:40-5-64. Termination of a Specialized Foster Care Provider

- (a) In the event that a provider fails to provide services as required by rules or contract, Developmental Disabilities Services Division (DDS) notifies the Oklahoma Health Care Authority (OHCA) and the Oklahoma Department of Human Services (OKDHS) Contracts Unit, to terminate the Specialized Foster Care (SFC) provider's contract. Such termination is not an exclusive remedy but is in addition to any other rights and remedies provided by law.
- (b) Possible reasons for termination of a provider include, but are not limited to:
- (1) provider request;
 - (2) non-cooperation in determining compliance with standards, policy, or contract;
 - (3) confirmed abuse, neglect, or exploitation of any other person;
 - (4) breach of confidentiality;
 - (5) involvement in criminal activity or criminal activity in the home;
 - (6) failure to provide for the care and well-being of the member;
 - (7) continued failure to implement the member's Plan;
 - (8) failure to complete and maintain required provider training;
 - (9) failure to report changes in the household;
 - (10) continued failure to follow OKDHS or OHCA rules;

- (11) decline of the provider's health to the point that he or she can no longer meet the needs of the member;
- (12) employment by the provider without prior approval by the area program manager for residential services;
- (13) domestic disputes that may result in emotional instability of the member;
- (14) failure to complete a plan of action, per OAC 317:40-5-63, as agreed; or
- (15) failure or inability of the home to meet standards per OAC 317:40-5-40.

(c) **Termination Process.** When necessary to terminate a SFC provider, the steps described in this Subsection are taken.

- (1) DDS staff documents in the provider case narrative, a summary of the reasons for termination and the effective date.
- (2) The DDS area manager or designee notifies the case manager and case manager supervisor to notify legally responsible person(s) and identify other living arrangements, if applicable, for the member.
- (3) The DDS programs manager for residential services sends a 30-day written notice of the termination to the provider.
 - (A) A copy of the 30-day notice is sent to:
 - (i) the case manager;
 - (ii) case management supervisor;
 - (iii) DDS area manager;
 - (iv) DDS State Office; and
 - (v) Children and Family Services Division (CFSD), if applicable.
 - (B) A copy of the narrative is sent with the written notice to DDS State Office;
- (4) DDS State Office notifies the OHCA and the OKDHS Contracts Unit to terminate the provider's contract.

[Source: Added at 15 Ok Reg 3855, eff 7-1-98 (emergency); Added at 16 Ok Reg 1445, eff 5-27-99 ; Amended at 22 Ok Reg 2559, eff 7-11-05 ; Amended at 27 Ok Reg 1509, eff 6-11-10]

317:40-5-65. Change of placement for children and foster parent notification [REVOKED]

[Source: Added at 15 Ok Reg 3855, eff 7-1-98 (emergency); Added at 16 Ok Reg 1445, eff 5-27-99 ; Revoked at 22 Ok Reg 2559, eff 7-11-05]

317:40-5-66. Dispute and grievance procedures for Specialized Foster Care providers

(a) **Legal Base.** Section 7213 of Title 10 of the Oklahoma Statutes directs the Oklahoma Department of Human Services (Department) to establish grievance procedures for Specialized Foster Care (SFC) providers that resolve disputes quickly, informally, at the lowest possible level, but that provide for access to impartial arbitration by personnel within the central office. Resolution of grievances must be prompt and within established time frames. Each SFC provider shall have the right, without fear of reprisal or discrimination, to present grievances with

respect to the provision of SFC services.

(b) **Inquiries.** Not all SFC provider inquiries or requests for explanation are to be considered as disputes that need a written supervisory review or the initiation of the grievance procedure. Most inquiries or requests are handled within the regular relationship between the SFC specialist and SFC provider within 5 working days.

(c) **Unresolved complaints or disputes.** When a complaint or dispute between the DDS staff member and the SFC provider cannot be resolved, the SFC provider is entitled to a supervisory review regarding the issue within 10 working days. If the supervisory review does not resolve the dispute with the SFC provider, then a grievance can be initiated by the provider in accordance with OAC 340:2-3-50.

[Source: Added at 15 Ok Reg 3855, eff 7-1-98 (emergency); Added at 16 Ok Reg 1445, eff 5-27-99 ; Amended at 22 Ok Reg 2559, eff 7-11-05]

317:40-5-67. Specialized Foster Care provider rights

(a) Section 7206.1 of Title 10 of the Oklahoma Statutes directs the Oklahoma Department of Human Services to establish a statement of SFC providers' rights.

(b) The rights of SFC providers include, but are not limited to, the right to:

- (1) be treated with dignity, respect, and consideration as a professional member of the team;
- (2) be given appropriate, ongoing training to develop and enhance the provider's skills;
- (3) be informed about ways to contact the state agency in order to receive information and assistance to access supportive services for any child in the SFC provider's care;
- (4) receive timely financial reimbursement for providing SFC services;
- (5) be notified of any costs or expenses for which the SFC provider may be eligible for reimbursement;
- (6) be provided a clear, written explanation of the individual treatment and service plan concerning the child in the SFC provider's home;
- (7) receive, at any time during which a child is placed with the SFC provider, additional or necessary information that is relevant to the care of the child;
- (8) be notified of scheduled permanency planning review meetings concerning the child in order to actively participate in the case planning and decision-making process regarding the child;
- (9) provide input concerning the plan of services for the service recipient and to have that input be given full consideration in the same manner as information presented by any other professional on the team;
- (10) communicate with other professionals who work with the service recipient within the context of the team including, but not limited to, therapists, physicians, and teachers;

- (11) be given, in a timely and consistent manner, any information regarding the child and the child's family that is pertinent to the care and needs of the service recipient and to the making of a permanency plan for the service recipient. Disclosure of information shall be limited to that information that is authorized by the provisions of Article V of the Oklahoma Children's Code for foster parents and Article VII of the Oklahoma Juvenile Code;
- (12) be given reasonable notice of any change in or addition to the services provided to the service recipient pursuant to the service recipient's Plan;
- (13) be given written notice of:
 - (A) plans to terminate the placement of the child with the SFC provider unless it is deemed an emergency, and
 - (B) the reason for the changes or termination in placement;
- (14) be notified by the court in a timely and complete manner of all court hearings, including:
 - (A) notice of the date and time of any court hearing;
 - (B) the name of the judge or hearing officer hearing the case;
 - (C) the location of the hearing; and
 - (D) the court docket number of the case;
- (15) be informed of decisions made by the court, or the state agency concerning the child;
- (16) be considered as a preferred placement option when a child who was formerly placed with the SFC provider is to reenter SFC services at the same level and type of care, if that placement is consistent with the best interest of the child and other children in the SFC provider's home;
- (17) be provided a fair, timely, and impartial investigation of complaints concerning the SFC provider's certification;
- (18) be provided the opportunity to request and receive a hearing regarding decisions that affect certification retention;
- (19) have timely access to the state agency's appeals process and the right to be free from acts of harassment and retaliation by any other party when exercising the right to appeal;
- (20) be given the number of the statewide toll-free Foster Parent Hotline; and
- (21) file a grievance in accordance with the Developmental Disabilities Services Division (DDSD) Specialized Foster Care Grievance policy, OAC 317:40-5-66; and
- (22) be informed of the process for filing a grievance.

[Source: Added at 15 Ok Reg 3855, eff 7-1-98 (emergency); Added at 16 Ok Reg 1445, eff 5-27-99 ; Amended at 22 Ok Reg 2559, eff 7-11-05]

PART 7. STANDARDS AND GUIDELINES FOR SPECIALIZED FOSTER CARE

317:40-5-75. Standards for Specialized Foster Care and respite homes [REVOKED]

[Source: Added at 15 Ok Reg 3855, eff 7-1-98 (emergency); Added at 16 Ok Reg 1445, eff 5-27-99 ; Revoked at 22 Ok Reg 2559, eff 7-11-05]

317:40-5-76. Guidelines for home profile [REVOKED]

[Source: Added at 15 Ok Reg 3855, eff 7-1-98 (emergency); Added at 16 Ok Reg 1445, eff 5-27-99 ; Revoked at 22 Ok Reg 2559, eff 7-11-05]

PART 9. SERVICE PROVISIONS

317:40-5-100. Assistive technology (AT) devices and services

(a) **Applicability.** This Section applies to AT services and devices authorized by Oklahoma Human Services (OKDHS) Developmental Disabilities Services (DDS) through Home and Community-Based Services (HCBS) Waivers.

(b) **General information.**

(1) AT devices include the purchase, rental, customization, maintenance, and repair of devices, controls, and appliances. AT devices include:

- (A) Visual alarms;
- (B) Telecommunication devices;
- (C) Telephone amplifying devices;
- (D) Devices for the protection of health and safety of members who are deaf or hard of hearing;
- (E) Tape recorders;
- (F) Talking calculators;
- (G) Specialized lamps;
- (H) Magnifiers;
- (I) Braille writers;
- (J) Braille paper;
- (K) Talking computerized devices;
- (L) Devices for the protection of health and safety of members who are blind or visually impaired;
- (M) Augmentative and alternative communication devices including language board and electronic communication devices;
- (N) Competence-based cause and effect systems, such as switches;
- (O) Mobility and positioning devices including:
 - (i) Wheelchairs;
 - (ii) Travel chairs;
 - (iii) Walkers;
 - (iv) Positioning systems;
 - (v) Ramps;
 - (vi) Seating systems;
 - (vii) Standers;

- (viii) Lifts;
 - (ix) Bathing equipment;
 - (x) Specialized beds;
 - (xi) Specialized chairs; and
- (P) Orthotic and prosthetic devices, including:
- (i) Braces;
 - (ii) Prescribed modified shoes;
 - (iii) Splints; and
- (Q) Environmental controls or devices;
- (R) Items necessary for life support, and devices necessary for the proper functioning of such items, including durable and non-durable medical equipment not available through SoonerCare (Medicaid);
- (S) Enabling technology devices to protect the member's health and safety or support increased independence in the home, employment site or community can include, but are not limited to:
- (i) Motion sensors;
 - (ii) Smoke and carbon monoxide alarms;
 - (iii) Bed or chair sensors;
 - (iv) Door and window sensors;
 - (v) Pressure sensors in mats on the floor;
 - (vi) Stove guards or oven shut off systems;
 - (vii) Live web-based remote supports;
 - (viii) Cameras;
 - (ix) Medication dispenser systems;
 - (x) Software to operate accessories included for environmental control;
 - (xi) Software applications;
 - (xii) Personal Emergency Response Systems or mobile;
 - (xiii) Emergency Response Systems;
 - (xiv) Global positioning system monitoring devices;
 - (xv) Radio frequency identification;
 - (xvi) Computers, smart watches and tablets; and
 - (xvii) Any other device approved by the DDS director or designee;
- (T) Eye glasses lenses, frames or visual aids.
- (2) AT services include:
- (A) Sign language interpreter services for members who are deaf;
 - (B) Reader services;
 - (C) Auxiliary aids;
 - (D) Training the member and provider in the use and maintenance of equipment and auxiliary aids;
 - (E) Repair of AT devices;
 - (F) Evaluation of the member's AT needs; and
 - (G) Eye examinations.
- (3) AT devices and services must be included in the member's Individual Plan (Plan), prescribed by a physician, or appropriate medical professional with a SoonerCare (Medicaid) contract, and

arrangements for this HCBS service must be made through the member's case manager.

(4) AT devices are provided by vendors with a durable medical equipment or other appropriate contract with the Oklahoma Health Care Authority (OHCA).

(5) AT devices and services are authorized per requirements of the Oklahoma Central Purchasing Act, other applicable statutory provisions, Oklahoma Administrative Code (OAC) 580:15 and OKDHS-approved purchasing procedures.

(6) AT services are provided by an appropriate professional services provider with a current HCBS contract with OHCA and current, unrestricted licensure and certification with their professional board, when applicable.

(7) AT devices or services may be authorized when the device or service:

(A) Has no utility apart from the needs of the person receiving services;

(B) Is not otherwise available through SoonerCare (Medicaid) an AT retrieval program, the Oklahoma Rehabilitation Services, or any other third party or known community resource;

(C) Has no less expensive equivalent that meets the member's needs;

(D) Is not solely for family or staff convenience or preference;

(E) Is based on the assessment and Personal Support Team (Team) consideration of the member's unique needs;

(F) Is of direct medical or remedial benefit to the member;

(G) Enables the member to maintain, increase, or improve functional capabilities;

(H) Is supported by objective documentation included in a professional assessment, except as specified, per OAC 317:40-5-100;

(I) Is within the scope of AT, per OAC 317:40-5-100;

(J) Is the most appropriate and cost effective bid, when applicable; or

(K) Exceeds a cost of seventy-five dollars (\$75) AT devices or services with a cost of seventy-five dollars (\$75) or less, are not authorized through DDS HCBS Waivers.

(8) The homeowner must sign a written agreement for any AT equipment that attaches to the home or property.

(c) **Assessments.** Recommendations for enabling technology devices are completed by the DDS programs manager for remote supports or their designee. Assessments for AT devices or services are performed by a licensed, professional service provider and reviewed by other providers whose services may be affected by the device selected. A licensed, professional service provider must:

(1) Determine if the member's identified outcome can be accomplished through the creative use of other resources, such as:

(A) Household items or toys;

- (B) Equipment loan programs;
 - (C) Low-technology devices or other less intrusive options;
 - or
 - (D) A similar, more cost-effective device; and
- (2) Recommend the most appropriate AT based on the member's:
- (A) Present and future needs, especially for members with degenerative conditions;
 - (B) History of use of similar AT, and his or her current ability to use the device; and
 - (C) Outcomes; and
- (3) Complete an assessment, including a decision making review and device trial that provides supporting documentation for purchase, rental, customization, or fabrication of an AT device. Supporting documentation must include:
- (A) A device review;
 - (B) Availability of the device rental with discussion of advantages and disadvantages;
 - (C) How frequently and in what situations the device is used in daily activities and routines;
 - (D) How the member and caregiver(s) are trained to safely use the AT device; and
 - (E) The features and specifications of the device necessary for the member, including rationale for why other alternatives are not available to meet the member's needs; and
- (4) Upon DDS staff's request, provide a current, unedited video or photographs of the member using the device, including recorded trial time frames.

(d) **Repairs and placement part authorization.** AT device repairs or parts replacements, do not require a professional assessment or recommendation. DDS resource development staff with AT experience may authorize repairs and replacement of parts for previously recommended AT.

(e) **AT device retrieval.** When a member no longer needs an AT device, OKDHS DDS staff may retrieve the device.

(f) **Team decision-making process.** The member's Team reviews the licensed professional's assessment and decision-making review. The Team ensures the recommended AT:

- (1) Is needed by the member to achieve a specific, identified functional outcome.
 - (A) A functional outcome, in this Section, means the activity is meaningful to the member, occurs on a frequent basis, and would require assistance from others, if the member could not perform the activity independently, such as self-care, assistance with eating, or transfers.
 - (B) Functional outcomes must be reasonable and necessary given a member's age, diagnosis, and abilities; and
- (2) Allows the member receiving services to:
 - (A) Improve or maintain health and safety;
 - (B) Participate in community life;

- (C) Express choices; or
- (D) Participate in vocational training or employment; and
- (3) Is used frequently or in a variety of situations;
- (4) Is easily fit into the member's lifestyle and work place;
- (5) Is specific to the member's unique needs; and
- (6) Is not authorized solely for family or staff convenience.

(g) Requirements and standards for AT devices and service providers.

- (1) Providers guarantee devices, work, and materials for one (1) calendar year, and supply necessary follow-up evaluation to ensure optimum usability.
- (2) Providers ensure a licensed occupational therapist, physical therapist, speech therapist, or rehabilitation engineer evaluates the need for AT, and individually customizes AT devices.

(h) Services not covered through AT devices and services. AT devices and services do not include:

- (1) Trampolines;
- (2) Hot tubs;
- (3) Bean bag chairs;
- (4) Recliners with lift capabilities;
- (5) Computers, except as adapted for individual needs as a primary means of oral communication, and approved, per OAC 317:40-5-100;
- (6) Massage tables;
- (7) Educational games and toys; or
- (8) Generators.

(i) AT approval or denial. DDS approval, conditional approval for pre-determined trial use, or denial of the purchase, rental, or lease or purchase of the AT is determined, per OAC 317:40-5-100.

- (1) The DDS case manager sends the AT request to designated DDS AT-experienced resource development staff. The request must include:
 - (A) The licensed professional's assessment and decision making review;
 - (B) A copy of the Plan of Care;
 - (C) Documentation of the current Team consensus, including consideration of issues, per OAC 317:40-5-100; and
 - (D) All additional documentation to support the AT device or service need.
- (2) The designated AT-experienced resource development staff approves or denies the AT request when the device costs less than \$5000.
- (3) The State Office programs manager for AT approves or denies the AT request when the device has a cost of \$5000 or more. When authorization of an AT device of \$5000 or more is requested:
 - (A) The AT-experienced resource development staff:
 - (i) Solicits three (3) AT bids; and
 - (ii) Submits the AT request, bids, and other relevant information identified in (1) of this

subsection to the State Office DDS AT programs manager or designee within five (5) business days of receipt of the required bids; and

(B) The State Office DDS AT programs manager or designee issues a letter of authorization, a written denial, or a request for additional information within five (5) business days of receipt of all required AT documentation.

(4) Authorization for purchase or a written denial is provided within ten (10) business days of receipt of a complete request.

(A) If the AT is approved, a letter of authorization is issued.

(B) If additional documentation is required by the AT-experienced resource development staff, to authorize the recommended AT, the request packet is returned to the case manager for completion.

(C) When necessary, the case manager contacts the licensed professional to request the additional documentation.

(j) Vehicle approval adaptations. Vehicle adaptations are assessed and approved, per OAC 317:40-5-100. In addition, the requirements in (1) through (3) of this subsection must be met.

(1) The vehicle must be owned or in the process of being purchased by the member receiving services or his or her family in order to be adapted.

(2) The AT request must include a certified mechanic's statement that the vehicle and adaptations are mechanically sound.

(3) Vehicle adaptations are limited to one vehicle in a ten (10) year period per member. Authorization for more than one vehicle adaptation in a ten (10) year period must be approved by the DDS director or designee.

(k) Eye glasses and eye exams. Routine eye examination or the purchase of corrective lenses for members twenty-one (21) years of age and older, not covered by SoonerCare (Medicaid), may be authorized for the purpose of prescribing glasses or visual aids, determination of refractive state, treatment of refractive errors, or purchase of lenses, frames, or visual aids. Payment can be made to a licensed optometrist who has a current contract on file with OHCA for services within the scope of Optometric practice as defined by the appropriate State law; provided, however, that services performed by out-of-state providers are only compensable to the extent that they are covered services.

(l) AT denial. Procedures for denial of an AT device or service are described in (1) through (3) of this subsection.

(1) The person denying the AT request provides a written denial to the case manager citing the reason for denial, per OAC 317:40-5-100.

(2) The case manager sends OKDHS Form 06MP004E, Notice of Action, to the member and his or her family or guardian.

(3) AT service denials may be appealed through the OKDHS hearing process, per OAC 340:2-5.

(m) AT device returns. When, during a trial use period or rental of a device, the therapist or Team including the licensed professional who

recommended the AT and, when available, determines the device is not appropriate, the licensed professional sends a brief report describing the change of device recommendation to the DDS case manager. The DDS case manager forwards the report to the designated resource development staff, who arranges for the equipment return to the vendor or manufacturer.

(n) **AT device rental.** AT devices are rented when the licensed professional or AT-experienced resource development staff determines rental of the device is more cost effective than purchasing the device or the licensed professional recommends a trial period to determine if the device meets the member's needs.

(1) The rental period begins on the date the manufacturer or vendor delivers the equipment to the member, unless otherwise stated in advance by the manufacturer or vendor.

(2) AT-experienced resource development staff monitor use of equipment during the rental agreement for:

(A) Rental time frame cost effectiveness;

(B) Renewal conditions; and

(C) The Team's, including the licensed professional's re-evaluation of the member's need for the device, per OAC 317:40-5-100.

(3) Rental costs are applied toward the purchase price of the device when the option is available from the manufacturer or vendor.

(4) When a device is rented for a trial-use period, the Team including the licensed professional, decides within ninety (90) calendar days whether the device:

(A) Meets the member's needs; and

(B) Needs to be purchased or returned.

(o) **AT committee.** The AT committee reviews equipment requests when deemed necessary by the OKDHS DDS State Office AT programs manager.

(1) The AT committee is comprised of:

(A) DDS professional staff members of the appropriate therapy;

(B) DDS State Office AT programs manager;

(C) The DDS area field administrator or designee; and

(D) An AT expert, not employed by OKDHS.

(2) The AT committee performs a paper review, providing technical guidance, oversight, and consultation.

(3) The AT committee may endorse or recommend denial of a device or service, based on criteria provided in this Section. Any endorsement or denial includes a written rationale for the decision and, when necessary, an alternative solution, directed to the case manager within twenty (20) business days of the receipt of the request. Requests reviewed by the AT committee result in suspension of time frames specified, per OAC 317:40-5-100.

317:40-5-101. Architectural modifications

(a) **Applicability.** The rules in this Section apply to architectural modification (AM) services authorized by the Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD) through Home and Community Based Services (HCBS) Waivers.

(b) **General information.** Architectural Modification services:

(1) are provided by building contractors who have contractual agreements with the Oklahoma Health Care Authority to provide Home and community Based Services. Providers must meet requirements of the International Code Council (ICC), formerly the Building Official and Code Administrators (BOCA), for building, electrical, plumbing and mechanical inspections;

(2) include the installation of ramps, grab-bars, widening of doorways, modification of a bathroom or kitchen facilities, specialized safety adaptations such as scald protection devices, stove guards, and modifications required for the installation of specialized equipment, which are necessary to ensure the health, welfare and safety of the member or that enable the member to function with greater independence in the home;

(3) must be recommended by the member's Team and included in the member's IP. Arrangements for this service must be made through the member's case manager;

(4) are performed on homes of eligible members who have disabilities that limit accessibility or require modifications to ensure health and safety;

(5) are provided based on the:

(A) assessment and Personal Support Team (Team) consideration of the member's unique needs per OAC 317:40-5-101(b);

(B) scope of architectural modifications per OAC 317:40-5-101;

(C) most appropriate and cost effective bid, if applicable, ensuring the quality of materials and workmanship;

(D) lack of a less expensive equivalent, such as assistive technology, that meets the member's needs; and

(E) safety and suitability of the home.

(6) are limited to modifications of two different residences within any seven year period beginning with the member's first request for an approved architectural modification service;

(7) are provided with assurance of plans for the member to remain in the residence for at least five years;

(8) may be denied when DDSD determines the home is unsafe or otherwise unsuitable for architectural modifications.

(A) DDSD area office resource development staff with architectural modification experience screens a home for safety and suitability for architectural modifications prior to home acquisition.

(B) Members needing home modification services and provider agencies assisting members to locate rental

property identify several homes, when possible, for screening in order to select a home with the fewest or most cost effective modifications;

(9) are provided to eligible members with the homeowner's signed permission;

(10) are not authorized to modify homes solely for family or staff convenience or for cosmetic preference;

(11) are provided on finished rooms complete with wiring and plumbing;

(12) services that do not meet the requirements of OAC 317:40-5-101 may be approved by the DDS division administrator or designee in exceptional circumstances; and

(13) are authorized in accordance with requirements of The Oklahoma Central Purchasing Act 74 O.S., § 85.1 et. Seq., Chapter 15 of Title 580 of the Department of Central Services, and other applicable statutory provisions.

(c) Assessment and Team process.

(1) Architectural modification assessments are performed by:

(A) DDS area office resource development staff with architectural modification experience, when the requested architectural modification complies with minimum applicable national standards for persons with physical disabilities as applicable to private homes; or

(B) a licensed occupational therapist or physical therapist, at the request of designated DDS area office resource development staff or area program supervisory staff, when the requested architectural modification exceeds or requires a variance to applicable national standards for persons with physical disabilities, or when such expertise is deemed necessary by DDS area office resource development staff or area program supervisory staff.

(2) The Team considers the most appropriate architectural modifications based on the:

(A) member's needs;

(B) member's ability to access his or her environment; and

(C) possible use of assistive technology instead of architectural modification.

(3) The Team considers architectural modifications that:

(A) are necessary to ensure the health, welfare, and safety of the member; and

(B) provide the member increased access to the home to reduce dependence on others for assistance in daily living activities.

(d) Requirements and standards for architectural modification contractors and construction. All contractors must meet applicable federal, state and local requirements.

(1) Contractors are responsible for:

(A) obtaining all permits required by the municipality where construction is performed;

(B) following all applicable building codes; and

- (C) taking and providing pictures to area office resource development staff of each completed architectural modification project within five working days of project completion and prior to payment of the architectural modification claim. Area office resource development staff may take pictures of the completed architectural modification projects when requested by the contractor.
- (2) Any penalties assessed for failure to comply with requirements of the municipality are the sole responsibility of the contractor.
- (3) New contractors must provide three references of previous work completed.
- (4) Contractors must provide evidence of:
 - (A) liability insurance;
 - (B) vehicle insurance;
 - (C) worker's compensation insurance or affidavit of exemption; and
 - (D) lead paint safety certificate.
- (5) All modifications meet national standards for persons with physical disabilities as applicable to private homes unless a variance is required by the assessment.
- (6) Contractors complete construction in compliance with written assessment recommendations from the:
 - (A) DDS area office resource development staff with architectural modification experience; or
 - (B) a licensed professional.
- (7) All architectural modifications must be completed by using high standard materials and workmanship, in accordance with industry standard.
- (8) Ramps are constructed using the standards in (A) through (G) of this paragraph.
 - (A) All exterior wooden ramps are constructed of number two pressure treated wood.
 - (B) Surface of the ramp has a rough, non-skid texture.
 - (C) Ramps are assembled by the use of deck screws.
 - (D) Hand rails on ramps, if required, are sanded and smooth.
 - (E) Ramps can be constructed of stamped steel.
 - (F) Support legs on ramps are no more than six feet apart.
 - (G) Posts on ramps must be set or anchored in concrete.
- (9) Roll-in showers are constructed to meet standards in (A) through (E) of this paragraph.
 - (A) The roll-in shower includes a new floor that slopes uniformly to the drain at not less than one-fourth nor more than one-half inch per foot.
 - (B) The material around the drain is flush, without an edge on which water can catch before going into the drain.
 - (C) Duro-rock, rather than sheet rock, is installed around the shower area, at least 24 inches up from the floor, with green board above the duro-rock.
 - (D) Tile, shower insert, or other appropriate water resistant material is installed to cover the duro-rock and

green board.

(E) The roll-in shower includes a shower pan, or liner if applicable.

(F) Roll in showers may also be constructed with a one piece pre-formed material.

(10) DDS area office resource development staff inspect any or all architectural modification work, prior to payment of an architectural modifications claim, to ensure:

(A) architectural modifications are completed in accordance with assessments; and

(B) quality of workmanship and materials used comply with requirements of OAC 317:40-5-101.

(e) Architectural modifications when members change residences.

(1) When two or more members share a home that has been modified and the member will no longer be sharing the home, the member whose Plan of Care authorized the modifications is given the first option of remaining in the residence.

(2) Restoration of architectural modifications is performed only for members of the Homeward Bound class when a written agreement between the homeowner and DDS director, negotiated before any architectural modifications begin, describes in full the extent of the restoration. If no written agreement exists between the DDS director and homeowner, OKDHS is not responsible to provide, pay for, or authorize any restorative services.

(f) Services not covered under architectural modifications.

Architectural modifications do not include adaptations or improvements to the home which are of general utility and are not of direct medical or remedial benefit to the member, construction, reconstruction, or remodeling of any existing construction in the home, such as floors, sub-floors, foundation work, roof, or major plumbing.

(1) Square footage is not added to the home as part of an architectural modification.

(2) Architectural modifications are not performed during construction or remodeling of a home.

(3) Modifications not authorized by the OKDHS include, but are not limited to:

(A) roofs;

(B) installation of heating or air conditioning units;

(C) humidifiers;

(D) water softener units;

(E) fences;

(F) sun rooms;

(G) porches;

(H) decks;

(I) canopies;

(J) covered walkways;

(K) driveways;

(L) sewer lateral lines or septic tanks;

(M) foundation work;

(N) room additions;

- (O) carports;
- (P) concrete for any type of ramp, deck, or surface other than a five by five landing pad at the end of a ramp, as described in applicable national standards for persons with physical disabilities as applicable to private homes;
- (Q) non-adapted home appliances;
- (R) carpet or floor covering that is not part of an approved architectural modification that requires and includes a portion of the floor to be re-covered such as a roll in shower, a door widening; or
- (S) a second ramp or roll in shower in a home.

(4) A sidewalk is not authorized unless needed by the member to move between the house and vehicle.

(g) **Approval or denial of architectural modification services.** DDS approval or denial of an architectural modification service is determined in accordance with (1) through (3) of this subsection.

(1) The architectural modification request provided by the DDS case manager to DDS area office resource development staff includes:

- (A) documentation from the member's Team confirming the need and basis for architectural modification, including the architectural modification assessment;
- (B) documentation of current Team consensus, including consideration of issues per OAC 317:40-5-101;
- (C) lease, proof of home ownership, or other evidence that the member is able to live in the modified residence for at least 12 months; and
- (D) an assurance by the member or legal guardian, if applicable, that the member plans to reside in the residence for five years.

(2) The DDS area office:

- (A) authorizes architectural modification services less than \$2500 when the plan of care is less than the state office reviewer limit; and
- (B) provides all required information to the DDS State Office architectural modification programs manager for authorization of services when the plan of care is more than the area office limit or is \$2500 or more.

(3) Architectural modifications may be denied when the requirements of OAC 317:40-5-101 are not met.

(h) **Appeals.** The denial of acquisition of an architectural modification request may be appealed per OAC 340:2-5.

(i) **Resolving problems with services.** If the member, family member, or legal guardian, or Team is dissatisfied with the architectural modification, the problem resolution process per OAC 340:100-3-27 is initiated.

317:40-5-102. Nutrition services

(a) **Applicability.** The rules in this Section apply to nutrition services authorized for members who receive services through Home and Community-Based Services (HCBS) Waivers operated by the Oklahoma Human Services (OKDHS) Developmental Disabilities Services (DDS).

(b) **General information.** Nutrition services include nutritional evaluation and consultation to members and their caregivers, are intended to maximize the member's health and are provided in any community setting as specified in the member's Individual Plan (Plan). Nutrition services must be prior authorized, included in the member's Plan and arrangements for this service must be made through the member's case manager. Nutrition service contract providers must be licensed in the state where they practice and registered as a dietitian with the Commission of Dietetic Registration. Each dietitian must have a current provider agreement with the Oklahoma Health Care Authority to provide HCBS, and a SoonerCare (Medicaid) provider agreement for nutrition services. Nutrition services are provided per Oklahoma Administrative Code (OAC) 340:100-3-33.1. In order for the member to receive Waiver-funded nutrition services, the requirements in this Section must be fulfilled.

(1) The member must be assessed by the case manager to have a possible eating problem or nutritional risk.

(2) The member must have an order for nutrition services current within one (1) year signed by a medical or osteopathic physician, physician assistant, or other licensed health care professional with prescriptive authority.

(3) Per OAC 340:100-5-50 through 58, the Personal Support Team (Team) identifies and addresses member needs.

(4) Nutrition services may include evaluation, planning, consultation, training and monitoring.

(5) A legally competent adult or legal guardian who has been informed of the risks and benefits of the service has the right to refuse nutrition services per OAC 340:100-3-11. Refusal of nutrition services must be documented in the Plan.

(6) A minimum of fifteen (15) minutes for encounter and record documentation is required.

(7) A unit is fifteen (15) minutes.

(8) Nutrition services are limited to one hundred ninety-two (192) units per Plan of Care year.

(c) **Evaluation.** When arranged by the case manager, the nutrition services contract provider evaluates the member's nutritional status and completes the Level of Nutritional Risk Assessment.

(1) The evaluation must include, but is not limited to:

(A) Health, diet, and behavioral history impacting on nutrition;

(B) Clinical measures including body composition and physical assessment;

(C) Dietary assessment, including:

(i) Nutrient needs;

(ii) Eating skills;

- (iii) Nutritional intake; and
- (iv) Drug-nutrient interactions; and
- (D) Recommendations to address nutritional risk needs, including:
 - (i) Outcomes;
 - (ii) Strategies;
 - (iii) Staff training; and
 - (iv) Program monitoring and evaluation.

(2) The nutrition services contract provider and other involved professionals make recommendations for achieving positive nutritional outcomes based on the risks identified on OKDHS Form 06HM040E, Level of Nutritional Risk Assessment.

(3) The nutrition services contract provider sends a copy of the Level of Nutritional Risk Assessment to the case manager within ten (10) days of receipt of the authorization.

(4) If the evaluation shows the member rated as High Nutritional Risk, the nutrition services contract provider sends a copy of the Level of Nutritional Risk Assessment to the DDS area nutrition therapist or DDS area professional support services designee as well as the case manager within ten (10) business days of receipt of the authorization.

(d) **Planning.** The DDS case manager, in conjunction with the Team, reviews the identified nutritional risks that impact the member's life.

(1) Desired nutritional outcomes are developed and integrated into the Plan using the least restrictive, least intrusive, most normalizing measures that can be carried out across environments.

(2) The Team member(s) identified responsible in the Plan develops methods to support the nutritional outcomes, which may include:

- (A) Strategies;
- (B) Staff training; or
- (C) Program monitoring.

(3) When the member has been receiving nutrition services and nutritional status is currently stable and the Team specifies that nutrition services are no longer needed, the Team identifies individual risk factors for the member that would indicate consideration of the resumption of nutrition services and assigns responsibility to a named Team Member(s) for monitoring and reporting the members status regarding these factors.

(4) Any member who receives paid twenty-four (24) hour per day supports and requires constant physical assistance and mealtime intervention to eat safely, or is identified for risk of choking or aspiration must have an individualized mealtime assistance plan developed and reviewed at least annually by the Team member(s) identified responsible in the Plan. Team members may include a nutrition services contract provider and a speech therapy contract provider or occupational therapy contract provider with swallowing expertise. Documentation delineates responsibilities to insure there is no duplication of services. The mealtime assistance plan includes but is not limited to:

- (A) A physician ordered diet;
- (B) Diet instructions;
- (C) Positioning needs;
- (D) Assistive technology needs;
- (E) Communication needs;
- (F) Eating assistance techniques;
- (G) Supervision requirements;
- (H) Documentation requirements;
- (I) Monitoring requirements; and
- (J) Training and assistance.

(5) For those members receiving paid twenty-four (24) hour per day supports and nutrition through a feeding tube, the Team develops and implements strategies for tube feeding administration that enables members to receive nutrition in the safest manner and for oral care that enables optimal oral hygiene and oral-motor integrity as deemed possible per OAC 340:100-5-26. The Team reviews the member's ability to return to oral intake following feeding tube placement and annually thereafter in accordance with the member's needs.

(e) Implementation, Consultation and Training. Strategies are implemented by the assigned person within a designated time frame established by the Team based on individual need(s).

(1) Direct support staff members are trained per the Plan and OAC 340:100-3-38.

(2) All special diets, nutritional supplements, and aids to digestion and elimination must be prescribed and reviewed at least annually by a physician.

(3) Consultation to members and their caregivers is provided as specified in the Plan.

(4) Program documentation is maintained in the member's home record for the purpose of evaluation and monitoring.

(5) The contract professional provider(s) sends documentation regarding the member's program concerns, recommendations for remediation of any problem area and progress notes to the case manager per OAC 340:100-5-52.

(A) The designated professional(s) reviews the program data submitted for:

- (i) completeness;
- (ii) Consistency of implementation; and
- (iii) Positive outcomes.

(B) When a member is identified by the Level of Nutritional Risk Assessment to be at high nutritional risk, he or she receives increased monitoring by the nutrition services contract provider and health care coordinator, as determined necessary by the Team.

(C) Significant changes in nutritional status must be reported to the case manager by the health care coordinator.

(D) The Level of Nutritional Risk Assessment:

- (i) Is used by the nutrition services contract provider to reassess members at high risk on a

quarterly basis; and
(ii) Must be submitted by the nutrition services contract provider to the DDS area nutrition therapist or DDS area professional support services designee within fifteen (15) calendar days following the end of each quarter.

[Source: Reserved at 18 Ok Reg 1168, eff 5-11-01 ; Added at 19 Ok Reg 795, eff 1-25-02 ; Added at 19 Ok Reg 1289, eff 5-28-02 ; Amended at 23 Ok Reg 1396, eff 5-25-06 ; Amended at 27 Ok Reg 1509, eff 6-11-10 ; Amended at 40 Ok Reg 2262, eff 9-11-23]

317:40-5-103. Transportation

(a) **Applicability.** The rules in this Section apply to transportation services provided through Oklahoma Human Services, Developmental Disabilities Services (DDS); Home and Community-Based Services (HCBS) Waivers.

(b) **General Information.** Transportation services include adapted, non-adapted, and public transportation.

(1) Transportation services are provided to promote inclusion in the community, access to programs and services, and participation in activities to enhance community living skills. Members are encouraged to utilize natural supports or community agencies that can provide transportation without charge before accessing transportation services.

(2) Services include, but are not limited to, transportation to and from medical appointments, work or employment services, recreational activities, and other community activities within the number of miles authorized in the Plan of Care (POC).

(A) Adapted or non-adapted transportation may be provided for each eligible person.

(B) Public transportation may be provided up to a maximum of \$15,000 per POC year. The DDS director or designee may approve requests for public transportation services totaling more than \$15,000 per year when public transportation promotes the member's independence, is the most cost-effective option or only service option available for necessary transportation. For the purposes of this Section, public transportation is defined as:

(i) Services, such as an ambulance when medically necessary, a bus, or a taxi; or

(ii) A transportation program operated by the member's employment services or day services provider.

(3) Transportation services must be included in the member's Individual Plan (Plan) and arrangements for this service must be made through the member's case manager.

(4) Authorization of Transportation Services is based on:

(A) Personal Support Team (Team) consideration, per Oklahoma Administrative Code (OAC) 340:100-5-52, of the unique needs of the person and the most cost effective type of transportation services that meets the member's

need, per (d) of this Section; and

(B) The scope of transportation services as explained in this Section.

(c) **Standards for transportation providers.** All drivers employed by contracted transportation providers must have a valid and current Oklahoma driver license, and the vehicle(s) must meet applicable local and state requirements for vehicle licensure, inspection, insurance, and capacity.

(1) The provider must ensure that any vehicle used to transport members:

(A) Meets the member's needs;

(B) Is maintained in a safe condition;

(C) Has a current vehicle tag; and

(D) Is operated per local, state, and federal law, regulation, and ordinance.

(2) The provider maintains liability insurance in an amount sufficient to pay for injuries or loss to persons or property occasioned by negligence or malfeasance by the agency, its agents, or employees.

(3) The provider ensures all members wear safety belts during transport.

(4) Regular vehicle maintenance and repairs are the responsibility of the transportation provider. Providers of adapted transportation services are also responsible for maintenance and repairs of modifications made to vehicles. Providers of non-adapted transportation with a vehicle modification funded through HCBS assistive technology services may have repairs authorized per OAC 317:40-5-100.

(5) Providers must maintain documentation, fully disclosing the extent of services furnished that specifies the:

(A) Service date;

(B) Location and odometer mileage reading at the starting point and destination; or trip mileage calculation from global positioning system software;

(C) Name of the member transported; and

(D) Purpose of the trip.

(6) A family member, including a family member living in the same household of an adult member may establish a contract to provide transportation services to:

(A) Work or employment services;

(B) Medical appointments; and

(C) Other activities identified in the Plan as necessary to meet the needs of the member, per OAC 340:100-3-33.1.

(7) Individual transportation providers must provide verification of vehicle licensure, insurance and capacity to the DDS area office before a contract may be established and updated verification of each upon expiration. Failure to provide updated verification of a current and valid Oklahoma driver license or vehicle licensure may result in cancellation of the contract.

(d) **Services not covered.** Services that cannot be claimed as transportation services include:

- (1) Services not approved by the Team;
- (2) Services not authorized by the POC;
- (3) Trips that have no specified purpose or destination;
- (4) Trips for family, provider, or staff convenience;
- (5) Transportation provided by the member;
- (6) Transportation provided by the member's spouse;
- (7) Transportation provided by the biological, step or adoptive parents of the member or legal guardian, when the member is a minor;
- (8) Trips when the member is not in the vehicle;
- (9) Transportation claimed for more than one (1) member per vehicle at the same time or for the same miles, except public transportation;
- (10) Transportation outside Oklahoma unless:
 - (A) The transportation is provided to access the nearest available medical or therapeutic service; or
 - (B) Advance written approval is given by the DDS area manager or designee;
- (11) Services that are mandated to be provided by the public schools pursuant to the Individuals with Disabilities Education Act;
- (12) Transportation that occurs during the performance of the member's paid employment, even when the employer is a contract provider; or
- (13) Transportation when a closer appropriate location was not selected.

(e) **Assessment and Team process.** At least annually, the Team addresses the member's transportation needs. The Team determines the most appropriate means of transportation based on the:

- (1) Present needs of the member. When addressing the possible need for adapted transportation, the Team only considers the member's needs. The needs of other individuals living in the same household are considered separately;
- (2) Member's ability to access public transportation services; and
- (3) Availability of other transportation resources including natural supports, and community agencies.

(f) **Adapted transportation.** Adapted transportation may be transportation provided in modified vehicles with wheelchair or stretcher-safe travel systems or lifts that meet the member's medical needs that cannot be met with the use of a standard passenger vehicle, including a van when the modification to the vehicle was not funded through HCBS assistive technology service and is owned or leased by the DDS HCBS provider agency, family of an adult member, agency companion provider or specialized foster care provider.

- (1) Adapted transportation is not authorized when a provider agency leases an adapted vehicle from a member or a member's family.
- (2) Exceptions to receive adapted transportation services for modified vehicles other than those with wheelchair or stretcher safe travel systems and lifts may be authorized by the DDS programs manager for transportation services when

documentation supports the need, and there is evidence the modification costs exceeded \$10,000. All other applicable requirements of OAC 317:40-5-103 must be met.

(3) Adapted transportation services do not include vehicles with modifications including, but not limited to:

- (A) Restraint systems;
- (B) Plexi-glass windows;
- (C) Barriers between the driver and the passengers;
- (D) Turney seats; and
- (E) Seat belt extenders.

(4) The Team determines if the member needs adapted transportation according to:

- (A) The member's need for physical support when sitting;
- (B) The member's need for physical assistance during transfers from one surface to another;
- (C) The portability of the member's wheelchair;
- (D) Associated health problems the member may have; and
- (E) Less costly alternatives to meet the need.

(5) The transportation provider and the equipment vendor ensure that the Americans with Disabilities Act requirements are met.

(6) The transportation provider ensures all staff assisting with transportation is trained according to the requirements specified by the Team and the equipment manufacturer.

(g) **Authorization of transportation services.** The limitations in this subsection include the total of all transportation units on the POC, not only the units authorized for the identified residential setting.

(1) Up to 12,000 units of transportation services may be authorized in a member's POC per OAC 340:100-3-33 and OAC 340:100-3-33.1.

(2) When there is a combination of non-adapted transportation and public transportation on a POC, the total cost for transportation cannot exceed the cost for non-adapted transportation services at the current non-adapted transportation reimbursement rate multiplied by 12,000 miles for the POC year.

(3) The DDS area manager or designee may approve:

- (A) Up to 14,400 miles per POC year for people who have extensive needs for transportation services; and
- (B) A combination of non-adapted transportation and public transportation when the total cost for transportation does not exceed the cost for non-adapted transportation services at the current, non-adapted transportation reimbursement rate multiplied by 14,400 miles for the POC year.

(4) The DDS division director or designee may approve:

- (A) Transportation services in excess of 14,400 miles per POC year in extenuating situations when person-centered planning identified specific needs that require additional transportation for a limited period; or
- (B) Any combination of public transportation services with adapted or non-adapted transportation when the total cost for transportation exceeds the cost for non-adapted

transportation services at the current, non-adapted transportation reimbursement rate multiplied by 14,400 miles for the POC year; or
(C) Public transportation services in excess of \$25,000, when it promotes the member's independence, is the most cost effective or only service option available for necessary transportation.

[Source: Reserved at 18 Ok Reg 1168, eff 5-11-01 ; Added at 20 Ok Reg 165, eff 10-8-02 (emergency); Added at 20 Ok Reg 1228, eff 5-27-03 ; Amended at 23 Ok Reg 3192, eff 6-7-06 (emergency); Amended at 24 Ok Reg 958, eff 5-11-07 ; Amended at 28 Ok Reg 1550, eff 6-25-11 ; Amended at 32 Ok Reg 1162, eff 8-27-15 ; Amended at 34 Ok Reg 746, eff 9-1-17 ; Amended at 40 Ok Reg 2262, eff 9-11-23]

317:40-5-104. Medical supplies, equipment, and appliances

(a) **Applicability.** This section applies to medical supplies, equipment, and appliances provided through home and community-based waiver services (HCBS) operated by the Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services (DDS).

(b) **General information.** Medical supplies, equipment, and appliances include supplies specified in the plan of care that enable the member to increase his or her ability to perform activities of daily living. Medical supplies, equipment, and appliances include the purchase of additional supplies not available through SoonerCare.

(1) Medical supplies, equipment, and appliances are included in the member's plan, when prescribed by a physician with a SoonerCare contract, and arrangements for this service must be made through the member's case manager. Items reimbursed with HCBS funds are in addition to supplies furnished by SoonerCare.

(2) Medical supplies, equipment, and appliances meet the criteria for service necessity, per Oklahoma Administrative Code (OAC) 340:100-3-33.1.

(3) All items must meet applicable standards of manufacture, design, and installation.

(4) Medical supplies, equipment, and appliance providers must hold a current SoonerCare Durable Medical Equipment (DME) and/or Medical Supplies Provider Agreement with the Oklahoma Health Care Authority, and be registered to do business in Oklahoma or in the state in which they are domiciled. Providers must enter into the agreement giving assurance of ability to provide products and services and agree to the audit and inspection of all records concerning goods and services provided.

(5) Specialized medical supplies, equipment, and appliances include:

(A) Incontinence supplies, per subsection (b) of this Section;

(B) Nutritional supplements; and

(C) Supplies needed for health conditions.

(6) Items that cannot be purchased as medical supplies, equipment, and appliances include:

(A) Over-the-counter medications(s);

- (B) Personal hygiene items;
 - (C) Medicine cups;
 - (D) Items that are not medically necessary;
 - (E) Prescription medication(s); and
 - (F) Incontinence wipes not used in conjunction with incontinence briefs or incontinence underwear/pull-ons.
- (7) Medical supplies, equipment, and appliances must be:
- (A) Necessary to address a medical condition;
 - (B) Of direct medical or remedial benefit to the member;
 - (C) Medical in nature; and
 - (D) Consistent with accepted health care practice standards and guidelines for the prevention, diagnosis, or treatment of symptoms of illness, disease, or disability.

(c) **Limited coverage.** Items available in limited quantities through medical supplies, equipment, and appliances include:

- (1) Incontinence wipes, three-hundred (300) wipes per month;
- (2) Thirty-six hundred (3,600) individual non-sterile gloves, per plan year;
- (3) Sixty (60) disposable underpads per month;
- (4) One-hundred eighty (180) disposable incontinence briefs per month (Adult disposable incontinence briefs are purchased only in accordance with the implementation of elimination guidelines developed by the team);
- (5) One-hundred fifty (150) disposable incontinence underwear/pull-ons per month (Adult disposable incontinence underwear/pull-ons are purchased only in accordance with the implementation of elimination guidelines developed by the team);
- (6) Any combination of disposable incontinence briefs and disposable incontinence underwear/pull-ons that do not exceed one-hundred fifty (150) per month; and
- (7) One-hundred fifty (150) disposable liner/shield/guard/pads per month.

(d) **Exceptions.** Exceptions to the requirements of this section:

- (1) When a member's Team determines that the member needs medical supplies that:
 - (A) Are not available through SoonerCare and a healthcare common procedure code does not exist, the case manager emails pertinent information regarding the member's medical supply need to the Specialized Medical Supplies programs manager. The email includes all pertinent information that supports the need for the supply including; but not limited to, quantity and purpose; or
 - (B) Exceed the limits stated in subsection(c) of this Section, the case manager documents the need in the individual plan for review and approval, per OAC 340:100-33.
- (2) Approval or denial of exception requests is made on a case-by-case basis and does not override the general applicability of this section.
- (3) Approval of a medical supplies, equipment, and appliances exception does not exceed one (1) plan of care year.

[Source: Reserved at 18 Ok Reg 1168, eff 5-11-01 ; Added at 23 Ok Reg 1396, eff 5-25-06 ; Amended at 27 Ok Reg 1509, eff 6-11-10 ; Amended at 37 Ok Reg 858, eff 8-1-20 ; Amended at 38 Ok Reg 1101, eff 9-1-21]

317:40-5-105. [RESERVED]

[Source: Reserved at 18 Ok Reg 1168, eff 5-11-01]

317:40-5-106. [RESERVED]

[Source: Reserved at 18 Ok Reg 1168, eff 5-11-01]

317:40-5-107. [RESERVED]

[Source: Reserved at 18 Ok Reg 1168, eff 5-11-01]

317:40-5-108. [RESERVED]

[Source: Reserved at 18 Ok Reg 1168, eff 5-11-01]

317:40-5-109. [RESERVED]

[Source: Reserved at 18 Ok Reg 1168, eff 5-11-01]

317:40-5-110. Authorization for Habilitation Training Specialist Services

(a) Habilitation Training Specialist (HTS) Services are:

- (1) authorized as a result of needs identified by the team and informed selection by the SoonerCare member;
- (2) shared among SoonerCare members who are members of the same household or being served in the same community location;
- (3) authorized only during periods when staff are engaged in purposeful activity which directly or indirectly benefits the service recipient. Staff must be physically able and mentally alert to carry out the duties of the job. At no time are HTS services authorized for periods during which the staff are allowed to sleep;
- (4) not authorized to be provided in the home of the HTS unless the SoonerCare member and HTS reside in the same home; and
- (5) directed toward the development or maintenance of a skill in order to achieve a specifically stated outcome. The service provided is not a function which the parent would provide for the individual without charge as a matter of course in the relationship among members of the nuclear family when the member resides in a family home.

(b) HTS Services may be provided in a group home as defined in 317:40-5-152 or community residential service settings defined in OAC 340:100-5-22.1 including:

- (1) agency companion services as described in OAC 317:40-5-1 through 40-5-39;

(2) as provided in accordance with Daily Living Supports policy at OAC 317:40-5-150; and,

(3) as provided in accordance with Specialized Foster Care Policy at OAC 317:40-5-50 through 40-5-76; or

(4) services for people with Prader Willi syndrome.

(c) HTS Services are based on need and limited to no more than 12 hours per day per household in any setting other than settings described in OAC 340:100-5-22.1, Community Residential Supports, except with approval in accordance with OAC 340:100-3-33, Service authorization, that the increased services are necessary to avoid institutional placement due to:

(1) the complexity of the family or caregiver support needs.

Consideration must be given to:

(A) the age and health of the caregiver;

(B) the number of household members requiring the caregiver's time; and

(C) the accessibility of needed resources; and

(2) the resources of the family, caregiver, or household members that are available to the service recipient. Consideration must be given to the number of family members able to assist the caregiver and available community supports; and

(3) the resources of other agencies or programs available to the SoonerCare member or family. Consideration must be given to services available from:

(A) the public schools;

(B) the Oklahoma Health Care Authority;

(C) the Oklahoma Department of Rehabilitative Services;

(D) other OKDHS programs; and

(E) services provided by other local, state, or federal resources.

(d) When it appears that approval of an exception is needed to prevent institutional placement, the case manager submits the request which identifies the circumstances supporting the need for an exception to the area manager.

(e) The DDS area manager or designee must approve, deny, or notify the case manager of issues preventing approval within 10 working days.

(f) HTS providers may not perform any job duties associated with other employment, including on call duties, at the same time they are providing HTS services.

(g) HTS services are limited to no more than 40 hours per week when the HTS resides in the same home as the service recipient. If additional hours of service are needed, they must be provided by someone living outside the home. Exceptions may be authorized when needed for members who receive services through the Homeward Bound Waiver.

(h) When the member is out of the home for school, work, adult day services or other non-HTS supported activities, the total number of hours of HTS and hours away from the home cannot exceed 12 hours per day unless an exception is granted in accordance with subsection c of this policy.

(i) In accordance with OAC 340:100-3-33.1, services must be provided in the most cost effective manner. When the need for HTS services is

expected to continue to exceed 9 hours daily, cost effective community residential services must be considered and requested in accordance with OAC 317:40-1-2. For adults, continuation of non-residential services in excess of 9 hours per day for more than one plan of care year will not be authorized except:

- (1) when needed for members who receive services through the Homeward Bound Waiver;
- (2) when determined by the division administrator or designee to be the most cost effective option; or
- (3) as a transition period of 120 days or less to allow for identification of and transition to a cost effective residential option. Members who do not wish to receive residential services will be assisted to identify options that meet their needs within an average of 9 hours daily.

[Source: Added at 18 Ok Reg 517, eff 1-1-01 (emergency); Added at 18 Ok Reg 1168, eff 5-11-01 ; Amended at 19 Ok Reg 797, eff 1-25-02 (emergency); Amended at 19 Ok Reg 1289, eff 5-28-02 (emergency); Added at 23 Ok Reg 1396, eff 5-25-06 ; Amended at 27 Ok Reg 1509, eff 6-11-10 ; Amended at 29 Ok Reg 1793, eff 7-20-12 (emergency); Amended at 30 Ok Reg 1273, eff 7-1-13]

317:40-5-111. Authorization for Habilitation Training Specialist Services in the Homeward Bound Waiver

(a) Habilitation Training Specialist (HTS) Services are authorized as a result of needs identified by the Personal Support Team and informed service recipient selection.

(b) HTS Services may be provided in the Homeward Bound waiver in service settings including:

- (1) agency companion services as described in OAC 317:40-5-1 through OAC 317:40-5-39;
- (2) daily living supports as described in OAC 317:40-5-153;
- (3) specialized foster care as described in OAC 317:40-5-50 through OAC 317:40-5-76;
- (4) group home services as described in OAC 317:40-5-152; and
- (5) the class member's own home, family's home, or other community residential setting.

(c) HTS services are authorized only during periods when staff are engaged in purposeful activity that directly or indirectly benefits the person receiving services.

- (1) Staff must be physically able and mentally alert to carry out the duties of the job.
- (2) At no time are HTS services authorized for periods during which the staff are allowed to sleep.

[Source: Added at 21 Ok Reg 422, eff 11-21-03 (emergency); Added at 21 Ok Reg 1333, eff 5-27-04 ; Amended at 27 Ok Reg 1509, eff 6-11-10]

317:40-5-112. Dental services

(a) **Applicability.** Coverage applies to members:

- (1) receiving dental services through the Homeward Bound Waiver; and

(2) 21 years of age and older receiving dental services through the Community Waiver or In-Home Supports Waiver for adults.

(b) **Description of services.** Dental services include services per OAC 317:30-5-482. Preventative, restorative, replacement, and repair services to achieve or restore functionality are provided after appropriate review, when required per OAC 317:40-5-112(e).

(c) **Standard of care.** Comprehensive diagnostic and treatment services are authorized for each member eligible to receive such services from qualified personnel including licensed dentists and dental hygienists per applicable Home and Community-Based Services (HCBS) Waiver limits. Part 79 of OAC 317:30-5 and dental guidelines published by the Oklahoma Health Care Authority (OHCA) must be followed.

(d) **Providers.** Providers of dental services must have a non-restrictive license to practice dentistry in Oklahoma or the state where treatment is rendered.

(e) **Treatment plan.** A proposed dental treatment plan must be submitted to the member and Personal Support Team (Team) for review.

(1) All arrangements for services must be made with the Developmental Disabilities Services (DDS) case manager and be specified in the member's Individual Plan (IP).

(2) Requests for pre-authorization must propose services that are the most cost effective to restore dental health per OHCA published dental guidelines.

(f) **Frequency of examination.** The dentist and Team determine frequency of examinations on an individual basis.

(g) **Documentation of dental services.** The dental provider summarizes dental services on the Oklahoma Department of Human Services (DHS) Form 06HM005E, Referral Form for Examination or Treatment, or comparable form for members who receive residential services.

(h) **Prevention.** The member's IP must address the prevention of dental disease and promotion of dental health. Independence in oral hygiene care is promoted. When the member is unable to maintain adequate oral hygiene as determined by the dentist and Team, direct assistance and responsibility must be assigned to appropriate Team members in the IP.

[Source: Added at 21 Ok Reg 512, eff 1-1-04 (emergency); Added at 21 Ok Reg 2276, eff 6-25-04 ; Amended at 25 Ok Reg 2714, eff 7-25-08 ; Amended at 34 Ok Reg 746, eff 9-1-17]

317:40-5-113. Adult Day Services

(a) **Introduction.** Adult Day Services are provided by agencies approved by the Developmental Disabilities Services Division (DDSD) of the Oklahoma Department of Human Services (OKDHS) that have a valid Oklahoma Health Care Authority contract for providing Adult Day Services. This service is available through the Community Waiver, Homeward Bound Waiver and through the In-Home Supports Waiver for Adults. Adult Day Services is a structured, comprehensive program that provides a variety of health, social, and related support services in a protective environment for some portion of a day. Individuals who participate in adult day services receive these services on a planned basis during specified hours. Adult day services are designed to work

toward the goals of:

- (1) promoting the member's maximum level of independence;
- (2) maintaining the member's present level of functioning as long as possible, preventing or delaying further deterioration;
- (3) assisting the member in achieving the highest level of functioning possible;
- (4) providing support, respite, and education for families and other caregivers; and
- (5) fostering socialization and peer interaction.

(b) **Eligibility requirements.** Adult Day Services are provided to eligible members whose teams have determined the service is appropriate to meet their needs. Members must:

- (1) require ongoing support and supervision in a safe environment when away from their own residence;
- (2) be 18 years of age or older; and
- (3) not pose a threat to others.

(c) **Provider requirements.** Provider agencies must:

- (1) meet the licensing requirements set forth by Section 1-873 et seq of Title 63 of the Oklahoma Statutes;
- (2) comply with OAC 310:605, Adult Day Care Centers;
- (3) allow DDS staff to make announced and unannounced visits to the facility during the hours of operation;
- (4) provide the DDS case manager a copy of the individualized plan of care;
- (5) submit incident reports per OAC 340:100-3-34;
- (6) maintain a copy of the member's Individual Plan (Plan);
- (7) submit Oklahoma Department of Human Services (OKDHS), Provider Progress Report for each member receiving services per OAC 340:100-5-52; and
- (8) serve as a member of the Personal Support Team and meet the Personal Support Team requirements per OAC 340:100-5-52.

(d) **Coverage.** The member's Plan contains detailed descriptions of services to be provided and documentation of hours of services. All services must be authorized in the Plan and reflected in the approved plan of care. Arrangements for care must be made with the member's case manager.

[Source: Added at 22 Ok Reg 1029, eff 2-1-05 (emergency); Added at 21 Ok Reg 2531, eff 7-11-05 ; Amended at 27 Ok Reg 1509, eff 6-11-10 ; Amended at 28 Ok Reg 1550, eff 6-25-11 ; Amended at 29 Ok Reg 1199, eff 6-25-12]

PART 11. OTHER COMMUNITY RESIDENTIAL SUPPORTS

317:40-5-150. Daily Living Supports for the Community Waiver

(a) **Introduction.** Daily Living Supports (DLS) are provided by an agency, approved by the Developmental Disabilities Services Division (DDS), that has a valid Oklahoma Health Care Authority contract for the service.

(1) Daily Living Supports require meeting the daily support needs of the members living in the home.

(A) In accordance with the needs of the member, Daily Living Supports include hands-on assistance, supervision, or prompting so that the member performs the task, such as eating, bathing, dressing, toileting, transferring, personal hygiene, light housework, money management, community safety, recreation, social, health, or medication management.

(B) Daily Living Supports also include assistance with cognitive tasks or provision of services, per OAC 340:100-5-57, to prevent a member from harming self or others.

(C) Daily Living Supports also include:

- (i) the provision of staff training per OAC 340:100-3-38, to meet the specific needs of the member;
- (ii) program supervision that includes the 24-hour availability of response staff to meet schedules and unpredictable needs;
- (iii) program oversight;
- (iv) assisting the member in obtaining services and supplies;
- (v) developing and assuring emergency plans are in place; and
- (vi) coordinating overall safety and supports in the home.

(D) Direct support services are coordinated and shared among household members receiving services to meet identified needs and are provided by staff who do not live in the home.

(2) DLS include an average of eight hours daily of direct support services. Members needing direct support services exceeding an average of eight hours per day identify, with case manager assistance, roommates willing to share Daily Living Supports services. Additional direct support services are considered in accordance with subsection (f) of this Section.

(b) **Eligibility.** Daily Living Supports are provided to members who:

- (1) are eighteen years of age or older, unless approved by the Director of OKDHS or designee;
- (2) need an average of at least eight hours of direct support services daily;
- (3) are participants in the DDS Community waiver, per OAC 317:40-1-1;
- (4) need community residential services outside the family home; and
- (5) do not simultaneously receive any other community residential or group home services.

(c) **Service requirements.** Daily Living Supports must be:

- (1) included in the member's Individual Plan per OAC 340:100-5-51, including a description of the type(s) and intensity of supervision and assistance that must be provided to the member;
- (2) authorized in the member's Plan of Care;

- (3) provided by the contracted provider agency chosen by the member or guardian;
- (4) delivered in accordance with DDS Community Residential Supports rules at OAC 340:100-5-22.1; and
- (5) provided directly to the member.

(d) **Home Requirements.** Daily Living Supports are provided to eligible members living outside their family's home in a home that:

- (1) is leased or owned by the member(s) or the member's legal guardian; and
- (2) houses no more than three individuals living together.

Exceptions for homes shared by four members may be granted in writing by the DDS director or designee.

(e) **Responsibilities of provider agencies.** Each provider agency providing Daily Living Supports must:

- (1) ensure ongoing supports as needed when the member is out of the home visiting family and friends, or hospitalized for psychiatric or medical care;
- (2) ensure compliance with all applicable DDS policy found at OAC 340:100; and
- (3) provide for the welfare of all members living in the home.
- (4) ensure that trained staff are available to the member as described in the individual plan.

(f) **Criteria for direct support staff services beyond eight hours per day.** Additional direct support services including Habilitation Training Specialist(HTS), Homemaker, or Intensive Personal Supports, beyond the average of eight hours per day referenced in subsection (a) of this Section must be approved by the DDS area manager or designee.

(1) In order to receive additional direct support staff services, the members living together must have insufficient supports including hourly nursing services to meet their needs for support.

(A) Additional direct support staffing may be authorized if the member is living with two roommates but still has medical or behavior support needs beyond the capacity of staff shared with the other roommates, including participation by staff providing hourly nursing services.

(B) Additional direct support staffing is only provided to a member who has one or no roommates if:

- (i) the area manager or designee documents that behavior support issues make it impossible for the member to have a roommate; or
- (ii) in accordance with paragraph (2) of this subsection.

(C) If a member lives with one or no roommates or requires a second support staff to meet his or her intensive behavior support needs, the Team must provide clear documentation that the member has difficulty establishing compatible relations with others as evidenced by:

- (i) severe and persistent emotional and behavioral disturbances; or

(ii) a history of difficulty sharing a home with others.

(2) The area manager or designee may grant conditional approvals for staff beyond an average of eight hours per day per member:

(A) due to the temporary or permanent departure of a roommate while another roommate is being identified; or

(B) to facilitate emergency residential placement of a person needing services while roommates are being identified.

(3) As part of the annual review, the case manager must:

(A) re-evaluate the member's additional direct support services; and

(B) implement any alternative solutions that would promote independence and reduce intrusion by paid workers as much as possible. Documentation of such evaluations and the implementation of alternative solutions is included in the case manager's record.

(g) Daily Living Supports claims. No more than 365 units of Daily Living Supports may be billed per year, except Leap Year, for each member.

(1) The provider agency claims one unit of service for each day during which the member receives Daily Living Supports. A day is defined as the period between 12:00 a.m. and 11:59 p.m.

(2) Claims must not be based on budgeted amounts.

(3) When a member changes provider agencies, only the outgoing service provider agency claims for the day that the member moves.

(h) Billing for other support services. Additional support services such as HTS, Intensive Personal Supports, or Homemaker Services may be provided to a member receiving Daily Living Supports, if:

(1) the additional support services have been authorized in the member's Plan of Care. Additional support services cannot be authorized unless 56 hours per week of DLS services are scheduled for the member. The direct support staffing is averaged across the week when the needs of the members in the household vary from day to day; and

(2) an average of eight hours of DLS has already been provided to the member each day that week.

(A) The provider cannot bill for additional support services unless 56 hours of DLS have been provided during the week to the member.

(B) If support services are provided to multiple members residing in the same household at the same time, the provider agency cannot count these hours toward each member's 8-hour minimum. For example, three hours of service provided simultaneously by a single direct contact staff to three members in the same household may only be counted as three hours of service for one of the members, not three hours for each member.

(i) **Therapeutic leave.** Therapeutic leave is a SoonerCare payment made to the Daily Living Supports contract provider to enable the member to retain personal care services.

(1) Therapeutic leave is claimed when the member does not receive Daily Living Supports services for 24 consecutive hours from 12:00 a.m. to 11:59 p.m. because of:

(A) a visit with family or friends without direct support staff;

(B) vacation without direct support staff; or

(C) hospitalization, whether direct support staff are present or not. Daily living supports staff may be present with the member in the hospital as approved by the member's Team in the Individual Plan. Staff are present in the role of a visitor and are not responsible for the care of the patient.

(2) A member may receive therapeutic leave for no more than 14 consecutive days per event, not to exceed 60 days per Plan of Care year.

(3) The payment for a day of therapeutic leave is the same amount as the per diem rate for Daily Living Supports.

(4) To promote continuity of direct support staff in the member's absence, the provider pays the staff member the salary that he or she would have earned if the member were not on therapeutic leave if the provider is unable to provide an alternative work opportunity.

[Source: Added at 18 Ok Reg 517, eff 1-1-01 (emergency); Added at 18 Ok Reg 1168, eff 5-11-01 ; Amended at 19 Ok Reg 2179, eff 6-27-02 ; Added at 23 Ok Reg 1396, eff 5-25-06 ; Amended at 27 Ok Reg 1509, eff 6-11-10]

317:40-5-151. Intensive Personal Supports

(a) **Introduction.** Intensive Personal Supports are support services which are provided to eligible persons who need a more enhanced level of direct support in order to successfully reside in a community based setting. Intensive Personal Supports build upon the level of support provided by a Habilitation Training Specialist or Daily Living Supports staff by utilizing a second staff person on duty to provide assistance and training in self-care, daily living, recreational, and habilitation activities.

(b) **Eligibility.** Intensive Personal Supports are provided by OHCA contracted provider agencies to individuals who:

(1) are eighteen years of age of older, unless approved by the Director of DHS or designee;

(2) receive Daily Living Supports and meet the criteria for additional Daily Living Supports given in subsection (f) of OAC 317:40-5-150; and

(3) require a second support staff in order to meet their intensive behavioral or medical support needs, when there is no other resolution.

(c) **Service requirements.** Intensive Personal Supports, which are limited to 24 hours per day must be:

- (1) included in the person's Individual Plan in accordance with OAC 340:100-5-51;
- (2) authorized in the Plan of Care; and
- (3) provided in conjunction with Habilitation Training Services.

(d) **Responsibilities of provider agencies.** Each provider agency providing Intensive Personal Supports must:

- (1) have current, valid contracts with OHCA and DHS/DDSD; and,
- (2) ensure that any staff member providing Intensive Personal Supports has completed the training in accordance with OAC 340:100-3-38.

(e) **Shared staff.** Direct support services are coordinated and shared among household members receiving services to meet identified needs.

[Source: Added at 18 Ok Reg 517, eff 1-1-01 (emergency); Added at 18 Ok Reg 1168, eff 5-11-01 ; Amended at 19 Ok Reg 2179, eff 6-27-02]

317:40-5-152. Group home services for persons with an intellectual disability or certain persons with related conditions

(a) **General Information.** Group homes provide a congregate living arrangement offering up to twenty-four (24) hours per day supervision, supportive assistance, and training in daily living skills to persons who are eligible and eighteen (18) years of age or older. Upon approval of the Oklahoma Department of Human Services OKDHS Developmental Disabilities Services (DDS) director or designee, persons younger than eighteen (18) years of age may be served.

(1) Group homes ensure members reside and participate in the community. Services are provided in homes located in close proximity to generic community services and activities.

(2) Group homes must be licensed by OKDHS per Section 1430.1 et seq. of Title 10 of the Oklahoma Statutes.

(3) Residents of group homes receive no other form of residential supports.

(4) Habilitation training specialist (HTS) services or homemaker services for residents of group homes may only be approved by the DDS director or designee:

(A) For a resident of a group home to resolve a temporary emergency when no other resolution exists; or

(B) For a resident of a community living group home when the resident's needs are so extensive that additional supports are needed for identified specific activities; and

(C) Weekly average of fifty-six (56) hours of direct contact staff must be provided to the resident before HTS services may be approved.

(b) **Minimum provider qualifications.** Approved providers must have a current contract with the Oklahoma Health Care Authority (OHCA) to provide DDS Home and Community-Based Services (HCBS) for persons with an intellectual disability or related conditions.

(1) Group home providers must have a completed and approved application to provide DDS group home services.

(2) Group home staff must:

- (A) Complete the OKDHS DDS-sanctioned training curriculum, per OAC 340:100-3-38; and
- (B) Fulfill requirements for pre-employment screening, per Oklahoma Administrative Code (OAC) 340:100-3-39.

(c) **Description of services.**

(1) Group home services:

- (A) Meet all applicable requirements of OAC 340:100; and
- (B) Are provided in accordance with each member's Individual Plan (IP) developed, per OAC 340:100-5-50 through 340:100-5-58.

- (i) Health care services are secured for each member, per OAC 340:100-5-26.

- (ii) Members are offered recreational and leisure activities maximizing the use of generic programs and resources, including individual and group activities.

(2) Group home providers:

- (A) Follow protective intervention practices, per OAC 340:100-5-57 and 340:100-5-58;

- (B) In addition to the documentation required, per OAC 340:100-3-40, must maintain:

- (i) Staff time sheets that document the hours each staff was present and on duty in the group home; and

- (ii) Documentation of each member's presence or absence on the daily attendance form provided by DDS; and

- (C) Ensure program coordination staff (PCS) meet staff qualifications and supervise, guide, and oversee all aspects of group home services, per OAC 340:100-5-22.6 and 340:100-6, as applicable.

(d) **Coverage limitations.** Group home services are provided up to three-hundred and sixty-six (366) days per year.

(e) **Types of group home services.** Three (3) types of group home services are provided through HCBS Waivers.

(1) **Traditional group homes.** Traditional group homes serve no more than twelve (12) members, per OAC 340:100-6.

(2) **Community living homes.** Community living homes serve no more than twelve (12) members.

(A) Members who receive community living home services:

- (i) Have needs that cannot be met in a less structured setting; and

- (ii) Require regular, frequent, and sometimes constant assistance and support to complete daily living skills, such as bathing, dressing, eating, and toileting; or

- (iii) Require supervision and training in appropriate social and interactive skills, due to on-going behavioral issues to remain included in the community.

(B) Services offered in a community living home include:

- (i) Twenty-four (24) hour awake supervision when a member's IP indicates it is necessary; and
- (ii) Program supervision and oversight including hands-on assistance in performing activities of daily living, transferring, positioning, skill-building, and training.

(C) Services may be approved for individuals in a traditional group home at the community living service rate when the member has had a change in health status or behavior and meets the requirements to receive community living home services.

(3) **Alternative group homes.** Alternative group homes serve no more than four (4) members who have evidence of behavioral or emotional challenges in addition to an intellectual disability and require extensive supervision and assistance in order to remain in the community.

(A) Members who receive alternative group home services must meet criteria, per OAC 340:100-5-22.6.

(B) A determination must be made by the DDS director or designee that alternative group home services are appropriate.

[Source: Added at 20 Ok Reg 1864, eff 4-30-03 (emergency); Added at 21 Ok Reg 1335, eff 5-27-04 ; Added at 23 Ok Reg 1396, eff 5-25-06 ; Amended at 24 Ok Reg 952, eff 5-11-07 ; Amended at 25 Ok Reg 2714, eff 7-25-08 ; Amended at 27 Ok Reg 1509, eff 6-11-10 ; Amended at 29 Ok Reg 1194, eff 6-25-12 ; Amended at 32 Ok Reg 1162, eff 8-27-15 ; Amended at 38 Ok Reg 1081, eff 9-1-21]

317:40-5-153. Daily Living Supports for the Homeward Bound Waiver

(a) **Introduction.** Daily Living Supports are provided by an agency with a valid Oklahoma Health Care Authority (OHCA) contract.

(1) Daily Living Supports require meeting the daily support needs of the member living in the home.

(A) In accordance with the needs of the class member, Daily Living Supports include hands-on assistance, supervision, or prompting so that the member performs the task, such as eating, bathing, dressing, toileting, transferring, personal hygiene, light housework, money management, community safety, recreation, social, health, or medication management.

(B) Daily Living Supports are provided by staff that do not live in the home and include assistance with cognitive tasks or provision of services to prevent a member from harming self or others, in accordance with the needs of the member.

(C) Daily Living Supports also include:

- (i) the provision of staff training per OAC 340:100-3-30 to meet the specific needs of the member;
- (ii) program supervision that includes 24-hour availability of response staff to meet schedules and unpredictable needs;

- (iii) program oversight;
- (iv) assisting the member in obtaining services and supplies;
- (v) developing and assuring emergency plans are in place;
- (vi) coordinating overall safety and supports in the home; and
- (vii) assisting members with personal money management.

(2) Daily Living Supports are used to provide and fund up to eight hours per day of supports for class members receiving supported living services per OAC 340:100-5-22.5.

(b) **Eligibility.** Daily Living Supports, as described in this Section, are provided to members who:

- (1) are members of the class certified in Case Number 85-C-437-E, U.S. District Court for the Northern District of Oklahoma;
- (2) receive community residential services in their own home; and
- (3) do not simultaneously receive any other community residential or group home services.

(c) **Responsibilities of provider agencies.** Each provider agency providing Daily Living Supports must:

- (1) ensure ongoing supports as needed to all members living in the home when one or more members is out of the home visiting family and friends, or hospitalized for psychiatric or medical care;
- (2) ensure compliance with all applicable DDS policy found at OAC 340:100;
- (3) provide for the welfare of all members living in the home ; and
- (4) ensure that trained staff are available as described in the member's individual plan.

(d) **Criteria for direct support staff services in the Homeward Bound Waiver beyond eight hours per day.** Additional direct support services including HTS, Homemaker, or Intensive Personal Supports, beyond the average of eight hours per day referenced in subsection (a) of this Section, are provided based on needs identified by the Personal Support Team and are considered in accordance with subsection (f) of this Section.

(e) **Daily Living Supports claims.** No more than 365 units of Daily Living Supports may be billed per year, except Leap Year, for each member.

- (1) The provider agency claims one unit of service for each day the member receives Daily Living Supports.
- (2) Providers must claim at least monthly for all days that Daily Living Supports were actually provided during the preceding month. Claims must not be based on budgeted amounts.
- (3) When a member changes provider agencies, only the outgoing service provider agency claims for the day that the member moves.

(f) **Billing for other support services.** Additional support services such as HTS, Intensive Personal Supports, or Homemaker Service may be provided to a member receiving Daily Living Supports, if:

- (1) additional support services have been authorized in the member's Plan of Care. Additional support services cannot be authorized unless 56 hours per week of DLS services are scheduled for the member. The direct support staffing is averaged across the week when the needs of the members in the household vary from day to day; and
- (2) an average of eight hours of DLS has already been provided to the member each day that week.

(g) **Therapeutic leave.** Therapeutic leave is a Medicaid payment made to the Daily Living Supports contract provider to enable the member to retain direct support services.

(1) Therapeutic leave is claimed when the member does not receive Daily Living Supports services for 24 consecutive hours because of:

- (A) a visit with family or friends without direct support staff;
- (B) vacation without direct support staff; or
- (C) hospitalization, whether direct support staff are present or not. Daily living supports staff may be present with the member in the hospital as approved by the member's Team in the Individual Plan. Staff are present in the role of a visitor and are not responsible for the care of the patient.

(2) A member may receive therapeutic leave for no more than 14 consecutive days per event, not to exceed 60 days per Plan of Care year.

(3) The payment for a day of therapeutic leave is the same amount as the per diem rate for Daily Living Supports.

(4) If, because of the member's absence, the direct support staff is unable to work, the provider pays the staff the salary that he or she would have earned if the member were not on therapeutic leave.

[Source: Added at 21 Ok Reg 422, eff 11-21-03 (emergency); Added at 21 Ok Reg 1333, eff 5-27-04 ; Amended at 27 Ok Reg 1509, eff 6-11-10]

317:40-5-154. Intensive Personal Supports in the Homeward Bound Waiver

(a) **Introduction.** Intensive Personal Supports are support services provided to class members who need an enhanced level of direct support in order to successfully reside in a community based setting. Intensive Personal Supports build upon the level of support provided by a Habilitation Training Specialist or Daily Living Supports staff by utilizing a second staff person on duty to provide assistance and training in self-care, daily living, recreational, and habilitation activities.

(b) **Eligibility.** Intensive Personal Supports are provided by OHCA contracted provider agencies to class members who:

- (1) are eighteen years of age or older, unless approved by the Director of OKDHS or designee; and
- (2) require a second support staff in order to meet their needs, when there is no other resolution.

(c) **Service requirements.** Intensive Personal Supports are limited to 24 hours per day and must be:

- (1) included in the class member's Individual Plan in accordance with OAC 340:100-5-53;
- (2) authorized in the Plan of Care; and
- (3) provided in conjunction with Habilitation Training Services.

(d) **Responsibilities of provider agencies.** Each provider agency providing Intensive Personal Supports must:

- (1) have current, valid contracts with OHCA and OKDHS/DDSD; and
- (2) ensure that any staff member providing Intensive Personal Supports has completed the training in accordance with OAC 340:100-3-38.

[Source: Added at 21 Ok Reg 422, eff 11-21-03 (emergency); Added at 21 Ok Reg 1333, eff 5-27-04]

SUBCHAPTER 7. EMPLOYMENT SERVICES THROUGH HOME AND COMMUNITY-BASED SERVICES WAIVER

317:40-7-1. Overview of Waiver Employment Services

(a) There are many employment service options available. The options given in (1) through (4) of this subsection are not a continuum, but are prioritized as most desirable by people with and without disabilities. Provider agencies assess each service recipient in maximizing employment options.

(1) The optimum goal is full-time employment at prevailing wage in business or industry at an occupation of the service recipient's choice with natural supports. If prevailing wage is not available, then employment is at minimum wage with or without paid supports.

(2) If a service recipient cannot secure enough work hours through a single job of the service recipient's choice, then two part-time jobs or a job that is not the service recipient's first preference may need to be sought to equal a full time job.

(3) If a fully integrated placement is not currently available, employment of the service recipient's choice in an enclave in a business or industry, with or without paid supports, is an option.

(4) If there are no paid jobs to be found, temporary unpaid training or volunteer service in accordance with Department of Labor regulations, with or without paid supports, may be an option for the purpose of resume building or job exploration, or temporary participation in real work in a center-based setting can be obtained.

(b) There may be instances resulting from a variety of factors when people served have not achieved the goal of full employment. The provider agency makes available those supports needed for the service recipient to achieve full employment.

(c) Employment services are prescribed in accordance with OAC 340:100-17, Part 1, and OAC 340:100-3-33.1.

(d) People receiving services may choose retirement to pursue activities according to each person's interests, including employment or integrated community activities for senior citizens. If the service recipient is age 62 or older, an exception as described in OAC 317:40-7-21 is not required.

[Source: Added at 15 Ok Reg 3873, eff 7-1-98 (emergency); Added at 16 Ok Reg 1445, eff 5-27-99 ; Amended at 21 Ok Reg 1327, eff 5-27-04 ; Amended at 22 Ok Reg 2531, eff 7-11-05]

317:40-7-2. Definitions

The following words and terms, when used in this Subchapter shall have the following meaning, unless the context clearly indicates otherwise.

"Commensurate wage" means wages paid to a worker with a disability based on the worker's productivity in proportion to the wages and productivity of workers without a disability performing essentially the same work in the same geographic area. Commensurate wages must be based on the prevailing wage paid to experienced workers without disabilities doing the same job.

"Competitive integrated employment" means work in the competitive labor market performed on a full-time or part-time basis in integrated community settings. The individual is compensated at or above minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Competitive employment is an individual placement.

"Employment assessment" means the evaluation that identifies the unique preferences, strengths, and needs of members in relation to work. The assessment determines work skills and work behaviors, is supplemented by personal interviews and behavioral observations, and incorporates information that addresses the member's desired medical, physical, psychological, social, cultural, and educational outcomes, as well as present and future employment options. The assessment is updated annually or more frequently as needed, and includes support needs, environmental preferences, and possible accommodations.

"Enhanced rate" means a differential rate established to provide an incentive to provider agencies to provide community employment services to members with significant needs.

"Group placement" means either two (2) to three (3) workers with disabilities making minimum wage or four (4) to five (5) workers with disabilities who may earn less than minimum wage situated close together, who are provided continuous, long-term training and support in an integrated job site. Members may be employed by the company or by the provider agency. The terms "work crew" and "enclave" also describe a group placement.

"Individual placement in community-based services" means the member is provided supports that enable him or her to participate in approved community-based activities per Oklahoma Administrative Code 317:40-7-5, individually and not as part of a group placement.

"Individual placement in job coaching services" means one member receiving job coaching services, who:

- (A) Works in an integrated job setting;
- (B) Receives minimum wage or more;

- (C) Does not receive services from a job coach who is simultaneously responsible for continuous job coaching for a group;
- (D) Is employed by a community employer or the provider agency; and
- (E) Has a job description that is specific to his or her work.

"Integrated employment site" means an activity or job that provides regular interaction with people without disabilities, excluding service providers, to the same extent that a worker without disabilities in a comparable position interacts with others.

"Job coach" means an individual who holds a DDS-approved training job coach certification and provides ongoing support services to eligible persons in supported employment placements. Services directly support the member's work activity including marketing and job development, job and work site assessment, training and worker assessment, job matching procedures, development of co-worker natural and paid supports, and teaching job skills.

"Job sampling" means a paid situational assessment whereby a member performs a job at a prospective employer's integrated job site in order to determine the member's interests and abilities. Situational assessments adhere to the Department of Labor (DOL) regulations regarding wages. The Personal Support Team determines the appropriate type and number of situational assessments for each member.

"On-site supports" means a situation in which the job coach is physically at the job site providing job training to a member.

"Situational assessment" means a comprehensive community-based evaluation of the member's functioning in relation to the supported job including the job site, community through which the member must travel to and from the job, and those at the job site, such as the job coach, co-workers, and supervisors.

"Sub-contract with industry" means the provider agency enters into a sub-contract with an industry or business to pay industry employees to provide supports to members. When the industry agrees, the provider agency may contract directly with an industry employee(s) to provide the services. The state continues to pay the provider agency and the agency provides all pertinent information required for persons served by the agency. The Team determines what, if any, training is required for the employees of the industry providing services.

"Supported employment" means competitive work in an integrated work setting with ongoing support services for members for whom competitive employment has not traditionally occurred or was interrupted or intermittent as a result of the member's disabilities.

"Unpaid training" means unpaid experience in integrated employment sites per Sections 785.27 through 785.32 of Title 29 of the Code of Federal Regulations (29 C.F.R. §§ 785.27 through 785.32). Members do a variety of tasks that do not equal the full job description of a regular worker.

"Volunteer job" means an unpaid activity in which a member freely participates.

[Source: Added at 15 Ok Reg 3873, eff 7-1-98 (emergency); Added at 16 Ok Reg 1445, eff 5-27-99 ; Amended at 18 Ok Reg 2985, eff 5-17-01 (emergency); Amended at 19 Ok Reg 1090, eff 5-13-02 ; Amended at 21 Ok Reg 1327, eff 5-27-04 ; Amended at 22 Ok Reg 2531, eff 7-11-05 ; Amended at 23 Ok Reg 624, eff 12-1-05 (emergency); Amended at 23 Ok Reg 1405, eff 5-25-06 ; Amended at 34 Ok Reg 746, eff 9-1-17 ; Amended at 39 Ok Reg 1595, eff 9-12-22]

317:40-7-3. Eligibility for Waiver Employment Services

- (a) Individuals served through Waiver Employment Services must be:
- (1) 16 years of age and older for persons receiving services through the Community Waiver, In Home Supports Waiver, or the Homeward Bound Waiver; and
 - (2) approved for waiver services, per Oklahoma Administrative Code (OAC) 317:40-1-1.
- (b) Services available to the member through the Oklahoma Department of Rehabilitation Services (DRS) or through the state or local education agency are not funded under Waiver Employment Services.
- (1) Members may utilize waiver employment services during times when school is not in session, and/or the member is not participating in an Individual Education Program that includes extended school year services through the school system.
 - (2) All members seeking competitive, integrated employment make application to DRS. Prior to the authorization of Waiver Employment Services, the case manager documents the application for DRS services. The documentation is permanently maintained in the Client Contact Manager record.
 - (3) Since services provided by DRS are time-limited by federal law, Developmental Disabilities Services provides long-term, on-going supports for individuals who need long-term supports, per OAC 317:40-7-11.

[Source: Added at 15 Ok Reg 3873, eff 7-1-98 (emergency); Added at 16 Ok Reg 1445, eff 5-27-99 ; Amended at 18 Ok Reg 2985, eff 5-17-01 (emergency); Amended at 19 Ok Reg 1090, eff 5-13-02 ; Amended at 21 Ok Reg 1327, eff 5-27-04 ; Amended at 22 Ok Reg 2531, eff 7-11-05 ; Amended at 35 Ok Reg 1501, eff 9-14-18]

317:40-7-4. Services provided through Waiver Employment Services

- (a) Waiver Employment Services are offered under the Home and Community-Based Waiver for persons with intellectual disabilities at rates prescribed by the Oklahoma Health Care Authority.
- (b) Waiver Employment Services include:
- (1) Vocational Habilitation Training Specialist, Supplemental Support;
 - (2) Employment Training Specialist;
 - (3) Center-Based Services;
 - (4) Community-Based Services;
 - (5) Enhanced Community-Based Services;
 - (6) Job Coaching;
 - (7) Enhanced Job Coaching; and
 - (8) Stabilization Services.

(c) State-funded employment services are available to members of the Homeward Bound class who are not eligible for Developmental Disabilities Services Waiver services.

[Source: Added at 15 Ok Reg 3873, eff 7-1-98 (emergency); Added at 16 Ok Reg 1445, eff 5-27-99 ; Amended at 18 Ok Reg 2985, eff 5-17-01 (emergency); Amended at 19 Ok Reg 1090, eff 5-13-02 ; Amended at 19 Ok Reg 2179, eff 6-27-02 ; Amended at 22 Ok Reg 2531, eff 7-11-05 ; Amended at 29 Ok Reg 1194, eff 6-25-12 ; Amended at 35 Ok Reg 1501, eff 9-14-18]

317:40-7-5. Community-based services

Community-based services are provided in sites and at times typically used by others in the community and promote independence, community inclusion, and the creation of natural supports. Community-based services must reflect the member's choice and values in typical age and cultural situations.

(1) Approved community-based services are individualized work-related supports targeting inclusion into integrated experiences and are pre-planned, documented activities supported by a schedule relating to the member's identified employment outcomes. Approved community-based services activities include:

- (A) active participation in formalized volunteer activities;
- (B) active participation in paid or unpaid work experience sites in community settings;
- (C) training through generic entities such as trade schools, technology centers, community colleges, or other community groups. The provider is paid for the time when direct supports are necessary and provided;
- (D) stamina-enhancing programs in integrated settings;
- (E) transportation to and from employment or community-based activities;
- (F) meals and breaks during the member's employment activities that occur in the community at a location used for the same purpose, with others without disabilities;
- (G) job tours or job shadowing scheduled with and provided by a community-business entity;
- (H) using Workforce OK services; and
- (I) attending job fairs.

(2) Any other work-related, community-based activities must be approved through the exception process, per Oklahoma Administrative Code (OAC) 317:40-7-21.

(3) Community-based services continue when the member goes to a center-based facility for support, such as repositioning or personal care, as long as the member returns immediately to a planned community-based activity. The amount of time for the repositioning and personal care are based upon a Team-approved health care positioning plan.

(4) Community-based services are available for individual and group placements.

- (A) Individual placement means the member is provided supports that enable him or her to participate in individual community-based activities described in this Section and

not as part of a group placement.

(B) Group placement means two-to-five members are provided supports that enable participation in the approved community-based activities described in this Section.

[Source: Added at 15 Ok Reg 3873, eff 7-1-98 (emergency); Added at 16 Ok Reg 1445, eff 5-27-99 ; Amended at 18 Ok Reg 2985, eff 5-17-01 (emergency); Amended at 19 Ok Reg 1090, eff 5-13-02 ; Amended at 21 Ok Reg 1327, eff 5-27-04 ; Amended at 22 Ok Reg 2531, eff 7-11-05 ; Amended at 28 Ok Reg 1550, eff 6-25-11 ; Amended at 36 Ok Reg 962, eff 9-1-19]

317:40-7-6. Center-based services

(a) Center-based services are employment services provided where the majority of the people at the site have disabilities. These settings facilitate opportunities to seek employment in competitive settings and support access to the greater community.

(b) Center-based services are pre-planned, documented activities that relate to the member's identified employment outcomes.

(c) Examples of center-based services are active participation in:

(1) learning and work experiences where the individual can develop general, non-job-task specific strengths and skills that contribute to employability in paid employment in integrated community settings;

(2) team-prescribed therapy programs, such as speech, physical therapy, or a switch activation program implemented by employment provider staff in the workshop or other center-based setting;

(3) computer classes, General Education Development preparation, job club, interviewing skills, or other classes where all participants have disabilities, even when the location is in the community; and

(4) mealtimes where the majority of people with disabilities are employed.

(d) Paid contract work is usually subcontracted, and the member receiving services earns commensurate wage according to Department of Labor regulations.

(e) Participation in center-based services is limited to fifteen (15) hours per week for members receiving services through the Homeward Bound Waiver, unless approved through the exception process, per Oklahoma Administrative Code (OAC) 317:40-7-21.

(f) The provider agency must meet physical plant expectations, per OAC 340:100-17-13.

(g) During periods in which no paid work is available despite the provider's documented good faith efforts to secure work, the employment-provider agency ensures each member participates in training activities that are age appropriate, work related, and consistent with the Individual Plan. Such activities may include, but are not limited to:

(1) resume development and application writing;

(2) work attire selection;

(3) job interview training and practice;

- (4) job safety and evacuation training;
- (5) personal or social skills training; and
- (6) stamina and wellness classes.

[Source: Added at 15 Ok Reg 3873, eff 7-1-98 (emergency); Added at 16 Ok Reg 1445, eff 5-27-99 ; Amended at 18 Ok Reg 2985, eff 5-17-01 (emergency); Amended at 19 Ok Reg 1090, eff 5-13-02 ; Amended at 22 Ok Reg 2531, eff 7-11-05 ; Amended at 26 Ok Reg 2151, eff 6-25-09 ; Amended at 34 Ok Reg 746, eff 9-1-17 ; Amended at 36 Ok Reg 962, eff 9-1-19]

317:40-7-7. Job coaching services

(a) Job coaching services:

- (1) Are pre-planned, documented activities related to the member's identified employment outcomes that include training at the work site and support by provider agency staff who have completed Developmental Disabilities Services (DDS) sanctioned training, per Oklahoma Administrative Code (OAC) 340:100-3-38.2;
- (2) Promote the member's capacity to secure and maintain integrated employment at a job of the member's choice paying at or more than minimum wage, or working to achieve minimum wage;
- (3) Provide active participation in paid work. Efforts are made in cooperation with employers to adapt normal work environments to fit the needs of members through the maintenance of an active relationship with the business;
- (4) Are available for individual and group placements.

(A) Individual placement is:

(i) One (1) member receiving job coaching services who:

- (I) Works in an integrated job setting;
- (II) Is paid at or more than minimum wage;
- (III) Does not receive services from a job coach who is simultaneously responsible for continuous job coaching for a group;
- (IV) Is employed by a community employer or provider agency; and
- (V) Has a job description that is specific to the member's work.

(ii) Authorized when on-site supports by a certified job coach are provided more than twenty percent (20%) of the member's compensable work time. Job coaching services rate continues until a member reaches twenty percent (20%) or less job coach intervention for four (4) consecutive weeks, at which time stabilization services begin and;

(iii) Authorized through remote supports per Health Insurance Portability and Accountability Act (HIPAA) compliant technology, when the Personal Support Team (Team) has an approved remote supports risk assessment.

(B) Small group placement is:

- (i) Two (2) to three (3) members receiving continuous support in an integrated work site who are paid at, or more than, minimum wage; or
 - (ii) Up to four (4) to five (5) members receiving continuous support in an integrated work site, who may earn less than minimum wage.
- (5) Are based on the amount of time for which the member is compensated by the employer, except per OAC 317:40-7-11.
- (b) For members in individual placements, the Team:
 - (1) Evaluates the need for job coaching services at least annually; and
 - (2) Documents a plan for fading job coaching services as the member's independence increases.
- (c) When the member receives commensurate compensation, employment goals include, but are not limited to, increasing:
 - (1) Productivity;
 - (2) Work quality;
 - (3) Independence;
 - (4) Minimum wage opportunities; and
 - (5) Competitive work opportunities.

[Source: Added at 15 Ok Reg 3873, eff 7-1-98 (emergency); Added at 16 Ok Reg 1445, eff 5-27-99 ; Amended at 18 Ok Reg 2985, eff 5-17-01 (emergency); Amended at 19 Ok Reg 1090, eff 5-13-02 ; Amended at 22 Ok Reg 2531, eff 7-11-05 ; Amended at 25 Ok Reg 2714, eff 7-25-08 ; Amended at 28 Ok Reg 1550, eff 6-25-11 ; Amended at 38 Ok Reg 446, eff 1-1-21 (emergency); Amended at 38 Ok Reg 1103, eff 9-1-21]

317:40-7-8. Employment training specialist services

Employment training specialist (ETS) services include evaluation, training, and supportive assistance that allow the member to obtain and engage in remunerative employment. ETS services are:

- (1) provided by a certified job coach;
- (2) not available when subcontracting;
- (3) used to help a member with a new job in a generic employment setting.
 - (A) ETS services are:
 - (i) not available if the member held the same job for the same employer in the past;
 - (ii) available when the member requires 100% on-site intervention for up to the number of hours the member works per week for six weeks per Plan of Care year; and
 - (iii) used in training members employed in individual placements on new jobs when the:
 - (I) member receives at least minimum wage; and
 - (II) employer is not the employment services provider.
 - (B) If the member does not use all of the training units on the first job placement in the Plan of Care year, the balance of training units may be used on a subsequent job placement with the current provider, or with a new

- provider;
- (4) used in assessment and outcome development for members residing in the community who are new to the provider agency, when determined necessary by the Personal Support Team (Team). The provider:
- (A) may claim a documented maximum of 20 hours per member for initial assessment. The projected units for the assessment and outcome development must:
 - (i) be approved in advance by the Team; and
 - (ii) relate to the member's desired outcomes; and
 - (B) cannot claim the same period of time for more than one type of service;
- (5) used in Team meetings, when the case manager has requested participation of direct service employment staff in accordance with OAC 340:100-5-52, up to 20 hours per Plan of Care year;
- (6) used in job development for a member on an individual job site upon the member's completion of three consecutive months on the job.
- (A) Up to 40 hours may be used during a Plan of Care year after documentation of job development activities is submitted to the case manager.
 - (B) The job must:
 - (i) pay at least minimum wage;
 - (ii) employ each member at least 15 hours per week; and
 - (iii) be provided by an employer who is not the member's contract provider;
- (7) used in development of a Plan for Achieving Self-Support (PASS) up to 40 hours per Plan of Care year after documentation of PASS development, if not developed by a Community Work Incentives Coordinator or the Department of Rehabilitation Services, and implementation of an approved PASS after documentation has been submitted to the case manager;
- (8) used in development of an Impairment Related Work Expense (IRWE) up to 20 hours per Plan of Care year after documentation of IRWE development, if not developed by a Community Work Incentives Coordinator or Oklahoma Department of Rehabilitation, and implementation of an approved IRWE after documentation is submitted to the case manager; and
- (9) used in interviewing for a job that is eligible for ETS services.
- (10) If the member needs job coach services after expiration of Stabilization Services, Employment Training Specialist Services may be authorized for the hours necessary to provide direct support to the member or consultation to the employer as described in outcomes and methods in the Individual Plan. The plan should include the process for fading as the member's independence increases and progress documented on OKDHS form 06WP066E.

Amended at 21 Ok Reg 1327, eff 5-27-04 ; Amended at 21 Ok Reg 2531, eff 7-11-05 ; Amended at 24 Ok Reg 952, eff 5-11-07 ; Amended at 26 Ok Reg 2151, eff 6-25-09]

317:40-7-9. Intensive Training Services [REVOKED]

[Source: Added at 15 Ok Reg 3873, eff 7-1-98 (emergency); Added at 16 Ok Reg 1445, eff 5-27-99 ; Revoked at 18 Ok Reg 2985, eff 5-17-01 (emergency); Revoked at 19 Ok Reg 1090, eff 5-13-02]

317:40-7-10. Assessment [REVOKED]

[Source: Added at 15 Ok Reg 3873, eff 7-1-98 (emergency); Added at 16 Ok Reg 1445, eff 5-27-99 ; Revoked at 18 Ok Reg 2985, eff 5-17-01 (emergency); Revoked at 19 Ok Reg 1090, eff 5-13-02]

317:40-7-11. Stabilization Services

Stabilization Services are ongoing support services needed to maintain a member in an integrated competitive employment site. Stabilization Services are provided for up to two (2) years per job. Stabilization Services continue until the next Plan of Care following the end of two (2) years of Stabilization Services.

(1) Stabilization Services are provided when the job coach intervention time required at the job site is twenty percent (20%) or less of the member's total work hours for four (4) consecutive weeks or when the member moved from Department of Rehabilitation Services (DRS) services.

(A) If, after the member moves to Stabilization Services the Team determines that support is needed above twenty percent (20%) for longer than two (2) weeks, the Team may revise the member's Plan of Care to reflect the need for Job Coaching Services.

(B) A member receiving services from DRS moves to services funded by DDS upon completion of the Job Stabilization milestone. The employment provider agency submits the request for transfer of funding during the Job Stabilization milestone as described in the DRS Supported Employment contract.

(2) Stabilization Services must:

(A) Identify the supports needed, including development of natural supports;

(B) Specify, in a measurable manner, the services provided.

(3) Reimbursement for Stabilization Services is based upon the number of hours the member is employed at a rate of minimum wage or above.

(4) Stabilization Services may be authorized through remote supports per a Health Insurance Portability and Accountability Act (HIPAA) compliant technology, when the Team has an approved remote supports risk assessment.

(5) If the member needs job coach services after the expiration of Stabilization Services, Employment Training Specialist Services may be authorized for the hours necessary to provide direct support to the member or consultation to the employer as

described in outcomes and methods in the Individual Plan.

[Source: Added at 15 Ok Reg 3873, eff 7-1-98 (emergency); Added at 16 Ok Reg 1445, eff 5-27-99 ; Amended at 18 Ok Reg 2985, eff 5-17-01 (emergency); Amended at 19 Ok Reg 1090, eff 5-13-02 ; Amended at 21 Ok Reg 1327, eff 5-27-04 ; Amended at 22 Ok Reg 2531, eff 7-11-05 ; Amended at 26 Ok Reg 2151, eff 6-25-09 ; Amended at 38 Ok Reg 1081, eff 9-1-21]

317:40-7-12. Enhanced rates

An enhanced rate is available for both community-based group services and group job-coaching services when necessary to meet a member's intensive personal needs in the employment setting(s). The need for the enhanced rate is identified through the Personal Support Team process and is supported by documentation in the Individual Plan (Plan) with consideration of risk assessment per Oklahoma Administrative Code (OAC) 340:100-5-56 and assessment of medical, nutritional, mobility needs, and the:

- (1) Team assessment of the member's needs per OAC 340:100-5-51, OAC 340:100-5-56, OAC 340:100-5-57, and OAC 340:100-5-26;
- (2) member must:

- (A) have a protective intervention protocol (PIP) that:
 - (i) contains a restrictive or intrusive procedure per OAC 340:100-1-2 implemented in the employment setting; and
 - (ii) is approved by the State Behavior Review Committee (SHRBRC) per OAC 340:100-3-14 or by the Developmental Disabilities Services (DDS) staff per OAC 340:100-5-57;
- (B) have procedures included in the Plan that address dangerous behavior that places the member or others at risk of serious physical harm but are neither restrictive or intrusive procedures per OAC 340:100-1-2. The Team submits documentation of this risk and the procedures to the positive support field specialist to ensure positive approaches are being used to manage dangerous behavior;
- (C) have a visual impairment that requires assistance for mobility or safety;
- (D) have nutritional needs requiring tube feeding or other dependency for food intake that must occur in the employment setting;
- (E) have mobility needs, such that he or she requires two or more people for lifts, transfers, and personal care. Use of a mechanical lift or other assistive technology is evaluated for the current employment program and determined not feasible by the DDS division director or designee; or
- (F) reside in alternative group home per OAC 317:40-5-152; and

(3) enhanced rate can be claimed only when the person providing services fulfills all applicable training criteria specified in OAC 340:100-3-38. There are no exceptions for the enhanced rate

other than as allowed in this Section.

[Source: Added at 15 Ok Reg 3873, eff 7-1-98 (emergency); Added at 16 Ok Reg 1445, eff 5-27-99 ; Amended at 18 Ok Reg 2985, eff 5-17-01 (emergency); Amended at 19 Ok Reg 1090, eff 5-13-02 ; Amended at 21 Ok Reg 1327, eff 5-27-04 ; Amended at 22 Ok Reg 2531, eff 7-11-05 ; Amended at 23 Ok Reg 624, eff 12-1-05 (emergency); Amended at 23 Ok Reg 1405, eff 5-25-06 ; Amended at 27 Ok Reg 1509, eff 6-11-10 ; Amended at 29 Ok Reg 1199, eff 6-25-12 ; Amended at 34 Ok Reg 746, eff 9-1-17]

317:40-7-13. Supplemental supports for center-based services

(a) When a member receiving center-based services needs additional supports, the provider assigns staff in patterns that most effectively meet the needs of each member as indicated by a personal care and/or a risk assessment and defined in the Individual Plan (IP) or Protective Intervention Protocol (PIP).

(b) When re-arranging staff patterns is not sufficient to meet the member's needs, the provider may file a request and plan for Supplemental Supports utilizing Vocational Habilitation Training Specialist Services. Supplemental supports are claimed only when provided by a staff member who completed all specialized training and individual-specific training prescribed by the Team per Oklahoma Administrative Code (OAC) 340:100-3-38.

(c) Supplemental supports for center-based services include two types of services, behavioral continuous support, and personal care intermittent support.

(1) **Continuous supplemental supports.** Continuous supplemental supports cannot exceed 15 hours per week for persons receiving services through the Homeward Bound Waiver unless specifically approved through the exception process per OAC 317:40-7-21.

(A) To be eligible for continuous supplemental supports, the member must have:

(i) a behavioral PIP that:

- (I) contains a restrictive or intrusive procedure per OAC 340:100-1-2 implemented in the employment setting;
- (II) is approved by the State Human Rights and Behavior Review Committee (SHRBRC) per OAC 340:100-3-14 or by the Developmental Disabilities Services (DDS) staff per OAC 340:100-5-57; or

(ii) procedures included in the PIP that address dangerous behavior that places the member or others at risk of serious physical harm. The Team submits documentation of this risk and the procedures to the DDS positive support field specialist to ensure positive approaches are being used to manage dangerous behavior.

(B) The Team documents discussion of the need for continuous supplemental supports.

(2) **Intermittent Supplemental Supports.** To receive personal care intermittent support, a member must have a personal care need that requires staffing of at least one-to-one during the time

frame when the support is needed.

(A) When a member needs intermittent personal care support during center-based services, the Team documents discussion of the:

- (i) specific support need(s) of the member, such as staff-assisted repositioning, lifting, transferring, individualized bathroom assistance, or nutritional support; and
- (ii) calculations that combine the time increments of support to determine the total number of units needed on the Plan of Care.

(B) The case manager sends the documentation to the case management supervisor for approval.

(C) The case management supervisor signs and forwards a copy of the approval, denial, or recommended modifications to the case manager within two business days of receipt of the documentation.

(D) A member may receive center-based services and intermittent supplemental supports at the same time.

(d) Supplemental support for center-based services described in this Section cannot be accessed in community-based services.

(e) Sufficient staff must be available in the center-based facility to provide the supplemental support in order for a provider to claim the units.

[Source: Added at 15 Ok Reg 3873, eff 7-1-98 (emergency); Added at 16 Ok Reg 1445, eff 5-27-99 ; Amended at 18 Ok Reg 2985, eff 5-17-01 (emergency); Amended at 19 Ok Reg 1090, eff 5-13-02 ; Amended at 21 Ok Reg 1327, eff 5-27-04 ; Amended at 22 Ok Reg 2531, eff 7-11-05 ; Amended at 26 Ok Reg 2151, eff 6-25-09 ; Amended at 34 Ok Reg 746, eff 9-1-17]

317:40-7-14. Transportation for Waiver Vocational Services [REVOKED]

[Source: Added at 15 Ok Reg 3873, eff 7-1-98 (emergency); Added at 16 Ok Reg 1445, eff 5-27-99 ; Revoked at 18 Ok Reg 2985, eff 5-17-01 (emergency); Revoked at 19 Ok Reg 1090, eff 5-13-02]

317:40-7-15. Service requirements for employment services through Home and Community-Based Services (HCBS) Waivers

(a) The Oklahoma Human Services (OKDHS) Developmental Disabilities Services (DDS) case manager, the member, the member's family or, when applicable, the member's legal guardian, and the member's provider develop a preliminary plan of services including the:

- (1) Site and amount of the services offered;
- (2) Types of services to be delivered; and
- (3) Expected outcomes.

(b) To promote community integration and inclusion, employment services are delivered in non-residential sites.

- (1) Employment services through HCBS waivers cannot be reimbursed when those services occur in the residence or property of the member or provider-paid staff, including garages and sheds, whether or not the garage or shed is attached to the

home.

(2) No exceptions to Oklahoma Administrative Code (OAC) 317:40-7-15(b) are authorized except when a home-based business is established and supported through Oklahoma Rehabilitation Services (DRS). Once DRS stabilization services end, DDS stabilization services are then utilized.

(c) The service provider is required to notify the DDS case manager in writing when the member:

- (1) Is placed in a new job;
- (2) Loses his or her job. A personal support team (Team) meeting must be held when the member loses the job;
- (3) Experiences significant changes in the community-based or employment schedule; or
- (4) Is involved in critical and non-critical incidents per OAC 340:100-3-34.

(d) The provider submits a DHS Provider Progress Report, per OAC 340:100-5-52, for each member receiving services.

(e) The cost of a member's employment services, excluding transportation and state-funded services cannot exceed limits set forth in OKDHS Appendix D-26, Developmental Disabilities Services Rates Schedule, per Plan of Care (POC) year.

(f) Each member receiving HCBS is supported in opportunities to seek employment and work in competitive integrated settings. When the member is not employed in a competitive integrated job, the Team identifies outcomes, action steps, or both, to create opportunities that move the member toward competitive integrated employment.

(g) Each member receiving residential supports, per OAC 340:100-5-22.1, or group-home services is employed for thirty (30) hours per week or receives a minimum of thirty (30) hours of employment services each week, excluding transportation to and from his or her residence.

(1) Thirty (30) hours of employment service each week may be a combination of community-based services, center-based services, employment training specialist (ETS) intensive training services, stabilization services, or job coaching services. Center-based services cannot exceed fifteen (15) hours per week for members receiving services through the Homeward Bound Waiver.

(2) When the member does not participate in thirty (30) hours per week of employment services, the Team:

- (A) Documents the outcomes and/or action steps to create a pathway that moves toward employment activities;
- (B) Describes a plan to provide a meaningful day in the community; or
- (C) Increases the member's employment activities to thirty (30) hours per week.

(h) Adult members receiving In-Home Supports waiver services can access individual placement in job coaching, stabilization, and employment training specialist services not to exceed limits specified in OKDHS Appendix D-26, per POC year.

Amended at 22 Ok Reg 2531, eff 7-11-05 ; Amended at 25 Ok Reg 2714, eff 7-25-08 ; Amended at 28 Ok Reg 1550, eff 6-25-11 ; Amended at 29 Ok Reg 1199, eff 6-25-12 ; Amended at 32 Ok Reg 1162, eff 8-27-15 ; Amended at 36 Ok Reg 962, eff 9-1-19 ; Amended at 38 Ok Reg 446, eff 1-1-21 (emergency); Amended at 38 Ok Reg 1103, eff 9-1-21]

317:40-7-16. Completion of the Employment Services Plan (ESP) [REVOKED]

[Source: Added at 15 Ok Reg 3873, eff 7-1-98 (emergency); Added at 16 Ok Reg 1445, eff 5-27-99 ; Revoked at 18 Ok Reg 2985, eff 5-17-01 (emergency); Revoked at 19 Ok Reg 1090, eff 5-13-02]

317:40-7-17. Subcontracting with a secondary vocational service provider [REVOKED]

[Source: Added at 15 Ok Reg 3873, eff 7-1-98 (emergency); Added at 16 Ok Reg 1445, eff 5-27-99 ; Revoked at 18 Ok Reg 2985, eff 5-17-01 (emergency); Revoked at 19 Ok Reg 1090, eff 5-13-02]

317:40-7-18. Contracts with industry

(a) The Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD) may contract with an industry to provide job coaching services through a Natural Supports Initiative. The employer:

- (1) designates an existing employee to serve as job coach.
 - (A) The job coach completes training as approved by the DDSD director of Human Resource Development.
 - (B) Training and support are available for members on the job; and
- (2) is reimbursed at the individual placement in job coaching rate based on the hours the member works for the first six months.
 - (A) After the first six months of employment, the employer is reimbursed at the stabilization rate based on the hours the member works.
 - (B) Stabilization services may be provided for up to one year per job.

(b) An employment provider may subcontract with an industry to provide job coaching services to members who are eligible.

- (1) The subcontract with an industry must be reviewed and accepted by the Personal Support Team and member or legal guardian prior to the execution of the subcontract.
- (2) Approval by OKDHS:
 - (A) of any subcontract does not relieve the primary employment provider of any responsibility for performance per OAC 317:40-7; and
 - (B) to subcontract with an industry is given only when it is determined the member's needs can best be met by additional natural supports provided by industry employees.

[Source: Added at 15 Ok Reg 3873, eff 7-1-98 (emergency); Added at 16 Ok Reg 1445, eff 5-27-99 ; Amended at 24 Ok Reg 952, eff 5-11-07]

317:40-7-19. Changing Waiver Employment Services providers [REVOKED]

[Source: Added at 15 Ok Reg 3873, eff 7-1-98 (emergency); Added at 16 Ok Reg 1445, eff 5-27-99 ; Amended at 18 Ok Reg 2985, eff 5-17-01 (emergency); Amended at 19 Ok Reg 1090, eff 5-13-02 ; Revoked at 22 Ok Reg 2531, eff 7-11-05]

317:40-7-20. Waiver Employment Services provider staff qualifications and training

(a) The provider designates a program manager to supply work-site supervision, guidance, and oversight of job coach specialists and paraprofessional staff providing direct services in the waiver employment program. Prior to assuming program management duties, the program manager:

- (1) has completed all required training specified in OAC 340:100-3-38; and
- (2) has a minimum of four years of any combination of college level education and "full time equivalent" experience in serving persons with disabilities.

(b) A job coach addresses the person's needs as identified in the service recipient's chosen employment outcomes under the professional oversight of the program manager.

- (1) The provider designates job coaches whose minimum level of education includes a high school diploma or general equivalency diploma (G.E.D.) and certification through the Division's approved training course.
- (2) Individuals who do not meet the educational requirement but who were certified job coaches prior to July 1, 1995, continue to be approved to provide Job Coaching Services.

(c) The provider agency ensures that all staff comply with DDSD-approved training requirements specified in OAC 340:100-3-38.

[Source: Added at 15 Ok Reg 3873, eff 7-1-98 (emergency); Added at 16 Ok Reg 1445, eff 5-27-99 ; Amended at 18 Ok Reg 2985, eff 5-17-01 (emergency); Amended at 19 Ok Reg 1090, eff 5-13-02 ; Amended at 22 Ok Reg 2531, eff 7-11-05]

317:40-7-21. Exception process for employment services through Home and Community-Based Services Waivers

(a) All exceptions to rules in Oklahoma Administrative Code (OAC) 317:40-7 are:

- (1) approved, per OAC 317:40-7-21 prior to service implementation;
- (2) intended to result in the personal support team (Team) development of an employment plan tailored to meet the member's needs;
- (3) identified in the Individual Plan (Plan) process, per OAC 340:100-5-50 through 340:100-5-58; and
- (4) documented and recorded in the Individual Plan by the Developmental Disabilities Services Division (DDS) case manager after Team approval.

(b) A request for an exception to the maximum limit of fifteen (15) hours per week for center-based services, per OAC 317:40-7-6, or continuous supplemental supports, per OAC 317:40-7-13, for a member receiving services through the Homeward Bound Waiver includes documentation of the Team's:

(1) discussion of:

- (A) a current, specific situation that requires an exception;
- (B) all employment efforts, successful and unsuccessful, made by the member and Team in the past year; and
- (C) progress toward previous exception strategies or plans; and

(2) plan, with specific steps and target dates to address the situation throughout the Plan of Care year, so the exception may be lessened or no longer necessary at the end of the Plan of Care year.

(c) A request for an alternative to required community-based activities per OAC 317:40-7-5 includes documentation of the Team's:

(1) discussion of:

- (A) current specific situation that requires an exception;
- (B) all employment efforts, successful and unsuccessful, made by the member and Team in the past year; and
- (C) progress toward previous exception strategies or plans; and

(2) plan, with specific steps and target dates to address the situation throughout the Plan of Care year, so the exception may be lessened or no longer necessary at the end of the Plan of Care year.

(d) Exception requests, per OAC 340:40-7-21(e), are documented by the DDS case manager after Team consensus, and submitted to the DDS field administrator or designee within ten-business (10-business) days after the annual IP or interim Team meeting. The field administrator approves or denies the request based on the thoroughness of the Team's discussion of possible alternatives and reasons for rejection of the other possible alternatives. A copy of the field administrator's decision is provided to the assigned case manager. A request for any other exception to rules in OAC 317:40-7-21 requires documentation of the Team's discussion of:

- (1) a current, specific situation that requires an exception;
- (2) all employment efforts, successful and unsuccessful, made by the member and Team in the past year; and
- (3) progress toward previous exception strategies or plans.

(e) The DDS director or designee may review exceptions granted per OAC 317:40-7-21, directing the Team to provide additional information, when necessary, to comply with OAC 340:100-3-33.1 and other applicable rules.

[Source: Added at 15 Ok Reg 3873, eff 7-1-98 (emergency); Added at 16 Ok Reg 1445, eff 5-27-99 ; Amended at 18 Ok Reg 2985, eff 5-17-01 (emergency); Amended at 19 Ok Reg 1090, eff 5-13-02 ; Amended at 21 Ok Reg 1327, eff 5-27-04 ; Amended at 22 Ok Reg 2531, eff 7-11-05 ; Amended at 25 Ok Reg 2714, eff 7-25-08 ; Amended at 27 Ok Reg 1509, eff 6-11-10 ; Amended at 28 Ok Reg 1550, eff 6-25-11 ; Amended at 29 Ok Reg 1199, eff 6-25-12 ; Amended at 36 Ok Reg 962, eff 9-1-19]

317:40-7-22. Value-Based Payments (VBP)

(a) **Purpose.** Oklahoma Human Services (OKDHS) Developmental Disabilities Services (DDS) provides incentive payments to support a member as he or she moves toward competitive integrated employment. VBPs are intended to further opportunities for Oklahomans with disabilities to live independently and work in competitive integrated employment. VBPs are included in the member's Individual Plan (Plan) and arrangements for this service are made through the DDS case manager. VBPs support members eighteen (18) years of age and older who receive employment services through the:

- (1) In-Home Supports Waiver;
- (2) Homeward Bound Waiver; or
- (3) Community Waiver.

(b) **Payment criteria.** VBPs support a member as he or she progresses towards competitive employment per the OKDHS Appendix D-26, Developmental Disabilities Services Rates Schedule. VBPs are paid:

- (1) After a member is employed for fifteen (15) business days;
- (2) When the member is employed a minimum of fifteen (15) hours weekly; and
- (3) In accordance with the limits set forth in OKDHS Appendix D-26, Developmental Disabilities Services Rates Schedule.

[Source: Added at 39 Ok Reg 1595, eff 9-12-22]

SUBCHAPTER 9. SELF-DIRECTED SERVICES

317:40-9-1. Self-directed services (SDS)

(a) **Applicability.** This Section applies to SDS provided through Home and Community-Based Services (HCBS) Waivers operated by the Oklahoma Human Services (OKDHS) Developmental Disabilities Services (DDS).

(b) **Member option.** Traditional service delivery methods are available for eligible members who do not elect to self-direct services.

(c) **General information.** SDS are an option for members receiving HCBS through the In-Home Supports Waiver for Adults, In-Home Supports Waiver for Children, and the Community Waiver when the member lives in a non-residential setting. SDS provides members the opportunity to exercise choice and control in identifying, accessing, and managing specific Waiver services and supports in accordance with his or her needs and personal preferences. SDS are Waiver services OKDHS DDS specifies may be directed by the member or representative using employer and budget authority.

- (1) SDS may be directed by:
 - (A) An adult member, when the member has the ability to self-direct;
 - (B) A member's legal representative including a parent, spouse or legal guardian; or
 - (C) A non-legal representative who the member or legal representative freely chooses.
- (2) The person directing services:

- (A) Is eighteen (18) years of age or older;
- (B) Complies with DDS and Oklahoma Health Care Authority (OHCA) rules and regulations;
- (C) Completes required DDS training for self-direction;
- (D) Signs an agreement with DDS;
- (E) Is a member or legal representative approved to act in a representative capacity;
- (F) Demonstrates knowledge and understanding of the member's needs and preferences; and
- (G) Does not serve as the Self-Directed (SD) habilitation training specialist (HTS) for the member when he or she is directing the member's services.

(d) The SDS program includes:

(1) The SDS budget. A Plan of Care (POC) is developed to meet the member's needs without SDS consideration. The member may elect to self-direct part or the entire amount identified for traditional HTS services. This amount is under the member's control and discretion in accordance with this policy and the approved POC, and is the allocated amount that may be used to develop the SDS budget. The SDS budget details the specific spending plan.

(A) The SDS budget is developed annually at the time of the annual plan and updated. Individuals who participate in the budget development include, the member, case manager, parent, legal guardian, and others the member invites to participate.

(B) Payment may only be authorized for goods and services (GS) not covered by SoonerCare, or other generic funding sources, and must meet service necessity criteria, per Oklahoma Administrative Code (OAC) 340:100-3-33.1.

(C) The member's SDS budget includes the actual cost of administrative activities including fees for financial management services (FMS) subagent, background checks, workers' compensation insurance, and the amount identified for SD-HTS, SD Job Coaching, and Self-directed goods and services (SD-GS).

(D) The SDS budget is added to the POC to replace any portion of traditional HTS services to be self-directed.

(E) The member's employment services costs, excluding transportation services, cannot exceed limits set forth in OKDHS Appendix D-26, Developmental Disabilities Services Rates Schedule, per POC year.

(2) The SD-HTS supports the member's self-care and the daily living and leisure skills needed to reside successfully in the community. Services are provided in community-based settings in a manner that contributes to the member's independence, self-sufficiency, community inclusion, and well-being. SD-HTS services must be included in the approved SDS budget. Payment is not made for routine care and supervision that is typically provided by a family member or the member's spouse. SD-HTS services are provided only during periods when staff is engaged in purposeful

activity that directly or indirectly benefits the member. SD-HTS services are limited to a daily average of no more than nine (9) hours per day, per OAC 340:100-5-35. At no time are SD-HTS services authorized for periods when staff is allowed to sleep. Legally responsible persons may not provide services, per OAC 340:100-3-33.2. Other family members providing services must be employed by provider agencies per OAC 340:100-3-33.2. For the purpose of this rule, family members include parents, siblings, step-parents, step siblings, and anyone living in the same home as the member. Payment does not include room and board, maintenance, or upkeep or improvements to the member's or family's residence. An SD-HTS:

- (A) Is eighteen (18) years of age and older;
- (B) Passes a background check, per OAC 340:100-3-39;
- (C) Demonstrates competency to perform required tasks;
- (D) Completes required training, per OAC 340:100-3-38 et seq.;
- (E) Signs an agreement with DDS and the member;
- (F) Is physically able and mentally alert to carry out the job's duties;
- (G) Does not work as an SD-HTS more than forty (40) hours in any week;
- (H) Does not implement prohibited procedures, per OAC 340:100-5-58;
- (I) Provides services to only one (1) member at any given time. This does not preclude providing services in a group setting where services are shared among group members; and
- (J) Does not perform any job duties associated with other employment, including on-call duties, at the same time they are providing SD-HTS services.

(3) SD-Job Coaching services:

- (A) Are pre-planned, documented activities related to the member's identified employment outcomes. This includes training at the work site and support by job coach staff who have completed DDS sanctioned training per OAC 340:100-3-38.2;
- (B) Promote the member's capacity to secure and maintain integrated employment at the member's chosen job, provided the job pays at or more than minimum wage, or the member is working to achieve minimum wage;
- (C) Provide active participation in paid work. Efforts are made in cooperation with employers, and an active relationship with the business is maintained, to adapt normal work environments to fit the member's needs;
- (D) Are available for individual placements. Individual placement is one member receiving job coaching services who:
 - (i) Works in an integrated job setting;
 - (ii) Is paid at or more than minimum wage;

- (iii) Does not receive services from a job coach who is simultaneously responsible for continuous job coaching for a group;
- (iv) Is employed by a community employer; and
- (v) Has a job description that is specific to the member's work; and

(E) Is authorized when on-site supports by a certified job coach are provided more than twenty (20) percent of the member's compensable work time. Job coaching services rate continues until a member reaches twenty (20) percent or less job coach intervention for four (4) consecutive weeks, at which time stabilization services begin.

(F) Are based on the amount of time the member is compensated by the employer, except per OAC 317:40-7-11;

(G) For members in individual placements, the Personal Support Team (Team):

- (i) Evaluates the job coaching services need at least annually; and
- (ii) Documents a plan for fading job coaching services as the member's independence increases.

(H) In order to participate in individual placement, the individual is found ineligible for services funded through the Department of Rehabilitation Services or have a closed case; and

(I) An SD-Job Coach:

- (i) Is eighteen (18) years of age;
- (ii) Passes a background check per OAC 340:100-3-39;
- (iii) Demonstrates competency to perform required tasks;
- (iv) Completes required training per OAC 340:100-3-38 et seq.;
- (v) Signs an agreement with DDS and the member;
- (vi) Is physically able and mentally alert to carry out job duties;
- (vii) Does not work more than forty (40) hours in any week as an SD-Job Coach or SD-HTS;
- (viii) Does not implement restrictive or intrusive procedures per OAC 340:100-5-57;
- (ix) Provides services to only one member at any given time; and
- (x) Does not perform any job duties associated with other employment including on-call duties at the same time he or she is providing SD-Job Coaching services; and

(4) SD-GS are incidental, non-routine, and promote the member's self-care, daily living, adaptive functioning, general household activities, meal preparation, and leisure skills needed to reside successfully in the community. SD-GS do not duplicate other services authorized in the member's POC. These SD-GS must be

included in the Individual Plan (Plan) and approved SDS budget. SD-GS must meet the requirements listed in (A) through (F) of this paragraph.

- (A) The item or service is justified by a licensed professional's recommendation.
- (B) The item or service is not prohibited by federal or state statutes and regulations.
- (C) The item or service meets one (1) or more of the criteria listed in (i) through (iii) of this subparagraph. The item or service:
 - (i) Increases the member's functioning related to the disability;
 - (ii) Increases the member's safety in the home environment; or
 - (iii) Decreases dependence on other SoonerCare funded services.
- (D) SD-GS may include, but are not limited to:
 - (i) Fitness items that can be purchased at retail stores;
 - (ii) Short duration camps lasting fourteen (14) consecutive calendar days or less;
 - (iii) A food catcher;
 - (iv) A specialized swing set;
 - (v) Toothettes or an electric toothbrush;
 - (vi) A seat lift;
 - (vii) Weight loss programs or gym memberships when:
 - (I) There is an identified weight loss or increased physical activity need;
 - (II) Justified by outcomes related to weight loss, increased physical activity or stamina; and
 - (III) In subsequent POC year requests, documentation is provided that supports the member's progress toward weight loss, increased physical activity, or stamina; or
 - (viii) Swimming lessons.
- (E) SD-GS is not used for:
 - (i) Medical services co-payments;
 - (ii) Over-the-counter medications;
 - (iii) Items or treatments not approved by the Food and Drug Administration;
 - (iv) Homeopathic services;
 - (v) Services available through any other funding source, such as SoonerCare, Medicare, private insurance, the public school system, rehabilitation services, or natural supports;
 - (vi) Room and board including deposits, rent, and mortgage payments;
 - (vii) Personal items and services not directly related to the member's disability;

- (viii) Vacation expenses;
- (ix) Insurance;
- (x) Vehicle maintenance or other transportation related expense;
- (xi) Costs related to internet access;
- (xii) Clothing;
- (xiii) Tickets and related costs to attend recreational events;
- (xiv) Services, goods, or supports provided to the member or benefiting persons other than the member;
- (xv) Experimental goods or services;
- (xvi) Personal trainers;
- (xvii) Spa treatments; or
- (xviii) Goods or services with costs that significantly exceed community norms for the same or similar goods or services.

(F) SD-GS are reviewed and approved by the DDS director or designee.

(e) **Member Responsibilities.** When the member chooses the SDS option, the member or member's representative is the employer of record and:

(1) Within forty-five (45) calendar days of enrolling in SDS training, the member or member's representatives completes the DDS-sanctioned self-direction training course. Exceptions to this timeframe may be approved by the DDS director or his/her designee. The training is completed prior to implementing SD.

The training covers:

- (A) Staff recruitment;
- (B) Hiring of staff as an employer of record;
- (C) Staff orientation and instruction;
- (D) Staff supervision including scheduling and service provisions;
- (E) Staff evaluation;
- (F) Staff discharge;
- (G) SD philosophy
- (H) OHCA SD policy;
- (I) Individual budgeting;
- (J) SD support plan development;
- (K) Cultural diversity; and
- (L) Rights, risks, and responsibilities, and

(2) Signs an agreement with DDS;

(3) Agrees to utilize the FMS subagent services;

(4) Agrees to pay administrative costs for background checks, FMS subagent fees, and workers' compensation insurance from his or her SDS budget;

(5) Complies with federal and state employment laws and ensures no employee works more than forty (40) hours per week in an SD-HTS capacity;

(6) Ensures that each employee is qualified to provide the services for which he or she is employed to do and that all billed

- services are actually provided;
- (7) Ensures that each employee complies with all DDS training requirements per OAC 340:100-3-38 et seq.;
 - (8) Recruits, hires, supervises, and discharges all employees providing SDS, when necessary;
 - (9) Verifies employee qualifications;
 - (10) Obtains background screenings on all employees providing SD-HTS services per OAC 340:100-3-39;
 - (11) Sends progress reports per OAC 340:100-5-52.
 - (12) Participates in the Plan and SDS budget process;
 - (13) Notifies the DDS case manager of any emergencies or changes in circumstances that may require modification of the type or amount of services provided for in the member's Plan or SDS budget;
 - (14) Waits for budget modification approval before implementing changes;
 - (15) Complies with DDS and OHCA administrative rules;
 - (16) Cooperates with DDS monitoring requirements per OAC 340:100-3-27;
 - (17) Cooperates with FMS subagent requirements to ensure accurate records and prompt payroll processing including:
 - (A) Reviewing and signing employee time cards;
 - (B) Verifying the accuracy of hours worked; and
 - (C) Ensuring the appropriate fund expenditures; and
 - (18) Completes all required documents within established timeframes;
 - (19) Pays for services incurred in excess of the budget amount;
 - (20) Pays for services not identified and approved in the member's SDS budget;
 - (21) Pays for services provided by an unqualified provider;
 - (22) Determines staff duties and qualifications and specifies service delivery practices consistent with SD-HTS Waiver service specifications;
 - (23) Orients and instructs staff in duties;
 - (24) Evaluates staff performance;
 - (25) Identifies and trains back-up staff, when required;
 - (26) Determines amount paid for services within plan limits;
 - (27) Schedules staff and the services provisions;
 - (28) Ensures SD-HTS do not implement prohibited procedures per OAC 340:100-5-58; and
 - (29) Signs an agreement with the SD-HTS.

(f) **FMS.** The FMS subagent is an entity that DDS designates as an agent to act on a member's behalf who has employer and budget authority. The FMS subagent's purpose is to manage payroll tasks for the member's employee(s) and SD-GS payments as authorized in the member's plan. FMS subagent duties include, but are not limited to:

- (1) Compliance with all DDS and OHCA administrative rules and contract requirements;
- (2) Compliance with DDS or OHCA random and targeted audits;
- (3) Tracking individual expenditures and monitoring SDS budgets;

- (4) Processing the member's employee payroll, withholding, filing and paying of applicable federal, state, and local employment-related taxes and insurance;
- (5) Employee time sheets collection and processing and making payment to member's employees;
- (6) SD-GS invoice collection and processing as authorized in the member's SDS budget;
- (7) Providing each member with information that assists with the SDS budget management;
- (8) Providing reports members and member representatives, as well as providing monthly reports to DDS and to OHCA upon request;
- (9) Providing DDS and OHCA authorities access to individual member's accounts through a web-based program;
- (10) Assisting members in verifying employee citizenship status;
- (11) Maintaining separate accounts for each member's SDS budget;
- (12) Tracking and reporting member funds, balances, and disbursements;
- (13) Receiving and disbursing funds for SDS payment per OHCA agreement; and
- (14) Executing and maintaining a contractual agreement between DDS and the SD-HTS (employee).

(g) **DDS case management responsibilities in support of SDS.**

- (1) The DDS case manager develops the member's plan per OAC 340:100-5-50 through 340:100-5-58.
- (2) The DDS case manager meets with the member or, when applicable, the member's representative or legal guardian to discuss the Waiver service delivery options in (A) and (B) of this paragraph:
 - (A) Traditional Waiver services; and
 - (B) SDS including information regarding scope of choices, options, rights, risks, and responsibilities associated with SDS.
- (3) When the member chooses SDS, the DDS case manager:
 - (A) Discusses the available amount in the budget with the member or the member's representative;
 - (B) Assists the member or representative in developing and modifying the SDS budget;
 - (C) Submits request for SD-GS to the DDS director or designee for review and approval;
 - (D) Assists the member or representative developing or revising an emergency back-up plan;
 - (E) Monitors plan implementation per OAC 340:100-3-27;
 - (F) Ensures services are initiated within required time frames;
 - (G) Conducts ongoing monitoring of plan implementation and of the member's health and welfare; and
 - (H) Ensures the SD-HTS does not implement prohibited procedures, per OAC 340:100-5-58. If the Team determines restrictive or intrusive procedures are

necessary to address behavioral challenges, requirements must be met, per OAC 340:100-5-57.

(h) **Government fiscal/employer agent model.** DDS serves as the Organized Health Care Delivery System (OHCDS) and FMS provider in a Centers for Medicare and Medicaid Services approved government fiscal/employer agent model. DDS has an interagency agreement with OHCA.

(i) **Voluntary termination of self-directed services.** Members may discontinue SDS without disruption at any time, provided traditional Waiver services are in place. Members or representatives may not choose the SDS option again until the next annual planning meeting, with services resuming no earlier than the beginning of the next POC. A member desiring to file a complaint must follow procedures per OAC 340:2-5-61.

(j) **SDS involuntary termination.**

(1) Members may be involuntarily terminated from SDS and offered traditional Waiver services when the DDS director or designee has determined that any of the criteria in (A) through (F) of this paragraph exist:

(A) Immediate health and safety risks associated with self-direction, such as, imminent risk of death or irreversible or serious bodily injury related to Waiver services;

(B) Intentional misuse of funds following notification, assistance and support from DDS;

(C) Failure to follow and implement policies of self-direction after receiving DDS technical assistance and guidance;

(D) Suspected fraud or abuse of funds;

(E) A member no longer receives a minimum of one (1) SDS Waiver service per month and DDS is unable to monitor the member; or

(F) Reliable information shows the employer of record or SD-HTS engaged in illegal activity.

(2) When action is taken to involuntarily terminate the member from SDS, the case manager assists the member in assessing needed and appropriate services through the traditional Waiver services option. The case manager ensures that no lapse in necessary services occurs for which the member is eligible.

(3) The Fair Hearing process, per OAC 340:100-3-13 applies.

(k) **Reporting requirements.** While operating as an OHCDS, DDS provides OHCA reports detailing provider activity in the format and at times OHCA requires.

[Source: Added at 27 Ok Reg 457, eff 12-3-09 (emergency); Added at 27 Ok Reg 983, eff 5-13-10 ; Amended at 28 Ok Reg 1550, eff 6-25-11 ; Amended at 34 Ok Reg 746, eff 9-1-17 ; Amended at 37 Ok Reg 1665, eff 9-14-20 ; Amended at 39 Ok Reg 1595, eff 9-12-22]

CHAPTER 45. INSURE OKLAHOMA

[**Authority:** The Oklahoma Health Care Authority Act; 1115 Demonstration Project No. 11-W00048/6; 63 O.S., §§ 5003 through 5016]
[**Source:** Codified 5-25-06]

SUBCHAPTER 1. GENERAL PROVISIONS

317:45-1-1. Purpose and general program provisions

The purpose of this Chapter is to provide rules, in compliance with all applicable federal and state regulations, for the Insure Oklahoma program that establishes access to affordable health coverage for low-income working adults their dependents, and their spouses; foster parents; and qualified college students.

[**Source:** Added at 23 Ok Reg 278, eff 10-3-05 (emergency); Added at 23 Ok Reg 1407, eff 5-25-06 ; Amended at 26 Ok Reg 621, eff 3-1-09 (emergency); Amended at 26 Ok Reg 2165, eff 6-25-09 ; Amended at 27 Ok Reg 2391, eff 7-1-10 (emergency); Amended at 28 Ok Reg 1574, eff 6-25-11 ; Amended at 38 Ok Reg 831, eff 7-1-21 (emergency); Amended at 39 Ok Reg 1618, eff 9-12-22]

317:45-1-2. Program limitations

(a) The Insure Oklahoma program is contingent upon federal waiver approval and sufficient funding that is collected and dispersed through a revolving fund within the State Treasury designated as the "Health Employee and Economy Improvement Act (HEEIA) Revolving Fund". This fund is a continuing fund, not subject to fiscal year limitations.

(1) All monies accruing to the credit of the fund are budgeted and expended by the Oklahoma Health Care Authority (OHCA) to implement the program.

(2) The program is funded through a portion of monthly proceeds from the Tobacco Tax, Title 68 of the Oklahoma Statutes (O.S.) § 302-5 et seq., collected and dispersed through the HEEIA revolving fund, pursuant to 68 O.S. §§ 302-5 (B)(1) & (C)(1) and 402-3 (B)(1) & (D)(1).

(3) The program is limited in scope such that available funding is not exceeded. Available funding includes the estimated annual deposits from tax collections, accrued interest, federal matching funds and any other revenue source deposited in the HEEIA Revolving Fund for the purpose of this program. If at any time it becomes apparent there is risk the available funding may be exceeded, OHCA must take action to ensure the Insure Oklahoma program continues to operate within its fiscal capacity.

(A) Insure Oklahoma may limit eligibility based on:

- (i) The 1115 Waiver;
- (ii) Tobacco tax collections; and
- (iii) The State Child Health Plan for the State Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act.

(B) The Insure Oklahoma program may limit eligibility when the utilization of services is projected to exceed the spending authority, or, may suspend new eligibility

determinations instead, establishing a waiting list.

(i) Applicants, not previously enrolled and participating in the program, submitting new applications for the Insure Oklahoma program may be placed on a waiting list. Applications, with the exception of college students, are identified by region. Regions are established based on population density statistics as determined through local and national data and may be periodically adjusted to assure statewide availability. Insure Oklahoma program size is determined by OHCA and may be periodically adjusted.

(ii) The waiting list utilizes a "first in - first out" method of selecting eligible applicants by region and program.

(iii) When an applicant is determined eligible and moves from the waiting list to active participation, the applicant must submit a new application.

(iv) Enrolled applicants who are currently participating in the program are not subject to the waiting list.

(v) For approved employers, if the employer hires a new employee after the employer's program eligibility begins, the new employee is allowed to participate.

(vi) For approved employers, if the employer has an employee who has a qualifying event after the employer's program eligibility begins, the employee is allowed to make changes pertaining to the qualifying event.

(b) College student eligibility and participation in the Insure Oklahoma program is contingent upon sufficient funding from the Oklahoma legislature. This funding is separate from the funding described in subsection (a) of this Section.

[Source: Added at 23 Ok Reg 278, eff 10-3-05 (emergency); Added at 23 Ok Reg 819, eff 2-1-06 (emergency); Added at 23 Ok Reg 2590, eff 6-25-06 ; Amended at 24 Ok Reg 101, eff 8-2-06 (emergency); Amended at 24 Ok Reg 963, eff 5-11-07 ; Amended at 26 Ok Reg 621, eff 3-1-09 (emergency); Amended at 26 Ok Reg 2165, eff 6-25-09 ; Amended at 27 Ok Reg 2391, eff 7-1-10 (emergency); Amended at 28 Ok Reg 1574, eff 6-25-11 ; Amended at 30 Ok Reg 1274, eff 7-1-13 ; Amended at 34 Ok Reg 760, eff 9-1-17 ; Amended at 38 Ok Reg 831, eff 7-1-21 (emergency); Amended at 39 Ok Reg 1618, eff 9-12-22]

317:45-1-3. Definitions

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

"Carrier" means:

(A) An insurance company, insurance service, insurance organization, or group health service, which is licensed to engage in the business of insurance in the State of Oklahoma and is subject to State law which regulates insurance, or Health Maintenance Organization (HMO) which provides or arranges for the delivery of basic health

care services to enrollees on a prepaid basis, except for copayments or deductibles for which the enrollee is responsible, or both and is subject to State law which regulates Health Maintenance Organizations (HMOs); (B) A Multiple Employer Welfare Arrangement (MEWA) licensed by the Oklahoma Insurance Department; (C) A domestic MEWA exempt from licensing pursuant to Title 36 of the Oklahoma Statutes (O.S.) § 634(B) that otherwise meets or exceeds all the licensing and financial requirements of MEWAs as set out in Title 36 O.S.; or (D) Any entity organized pursuant to the Interlocal Cooperation Act, 74 O.S. § 1001 et seq. as authorized by 36 O.S. § 607.1 and which is eligible to qualify for and hold a certificate of authority to transact insurance in this State and annually submits on or before March 1st a financial statement to the Oklahoma Insurance Department in a form acceptable to the Insurance Commissioner covering the period ending December 31st of the immediately preceding fiscal year.

"Child care center" means a facility licensed by the Oklahoma Department of Human Services (DHS) which provides care and supervision of children and meets all the requirements in OAC 340:110-3-275 through 340:110-3-311.

"College student" means an Oklahoma resident between the age of nineteen (19) through twenty-two (22) that is a full-time student at an Oklahoma accredited university or college.

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

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

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

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

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

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

"Full-time employer" means the employer who employs an employee per Federal and State regulations, to perform work in exchange for wages or salary.

"Full-time employment" means a normal work week per Federal and State regulations.

"In-network" means providers or health care facilities that are part of a benefit plan's network of providers with which it has negotiated a discount, and services provided by a physician or other health care

provider with a contractual agreement with the insurance company paid at the highest benefit level.

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

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

"Modified Adjusted Gross Income (MAGI)" means the financial eligibility determination methodology established by the Patient Protection and Affordable Care Act (PPACA) in 2009.

"OAC" means the Oklahoma Administrative Code.

"OESC" means the Oklahoma Employment Security Commission.

"OHCA" means the Oklahoma Health Care Authority.

"OKDHS" means the Oklahoma Department of Human Services which is also referenced in rules as Department of Human Services (DHS) and Office of Human Services (OHS).

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

"Primary care provider (PCP)" means a provider under contract with the OHCA to provide primary care services, including all medically necessary referrals.

"Professional employer organization (PEO)" means any person engaged in the business of providing professional employer services shall be subject to registration under the Oklahoma Professional Employer Organization Recognition and Registration Act as provided in 40 O.S. § 600.1 et. seq.

"Qualified benefit plan (QBP)" means a benefit plan that has been approved by the OHCA for participation in the Insure Oklahoma program.

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

"State" means the State of Oklahoma, acting by and through the OHCA.

[Source: Added at 23 Ok Reg 278, eff 10-3-05 (emergency); Added at 23 Ok Reg 1407, eff 5-25-06 ; Amended at 24 Ok Reg 101, eff 8-2-06 (emergency); Amended at 24 Ok Reg 963, eff 5-11-07 ; Amended at 25 Ok Reg 2770, eff 6-1-08 (emergency); Amended at 26 Ok Reg 621, eff 3-1-09 (emergency); Amended at 26 Ok Reg 2165, eff 6-25-09 ; Amended at 27 Ok Reg 2391, eff 7-1-10 (emergency); Amended at 28 Ok Reg 1574, eff 6-25-11 ; Amended at 29 Ok Reg 1210, eff 6-25-12 ; Amended at 31 Ok Reg 1751, eff 9-12-14 ; Amended at 32 Ok Reg 1183, eff 8-27-15 ; Amended at 33 Ok Reg 916, eff 9-1-16 ; Amended at 34 Ok Reg 760, eff 9-1-17 ; Amended at 35 Ok Reg 1503, eff 9-14-18 ; Amended at 38 Ok Reg 831, eff 7-1-21 (emergency); Amended at 39 Ok Reg 1618, eff 9-12-22]

317:45-1-4. Reimbursement for out-of-pocket expenses

(a) Out-of-pocket expenses for all approved and eligible members (and/or their approved and eligible dependents) will be limited to five (5) percent of their annual gross household income. The OHCA will provide reimbursement for out-of-pocket expenses in excess of the five (5) percent annual gross household income. An expense must be for an

allowed and covered service by a QBP to be eligible for reimbursement. For the purpose of this Section, an allowed and covered service is defined as an in-network service covered in accordance with a QBP's benefit summary and policies. For instance, if a QBP has multiple in-network reimbursement percentage methodologies (eighty (80) percent for level 1 provider and seventy (70) percent for level 2 provider) the OHCA will only reimburse expenses related to the highest percentage network. (b) For all eligible expenses as defined above in OAC 317:45-1-4(a), the member must submit the OHCA required form and all OHCA required documentation to support that the member incurred and paid the out-of-pocket expense. The OHCA required documentation must substantiate that the member actually incurred and paid the eligible out-of-pocket expense. The OHCA may request additional documentation at any time to support a member's request for reimbursement of eligible out-of-pocket expenses.

[Source: Added at 24 Ok Reg 101, eff 8-2-06 (emergency); Added at 24 Ok Reg 963, eff 5-11-07 ; Amended at 26 Ok Reg 2169, eff 6-25-09 ; Amended at 27 Ok Reg 2391, eff 7-1-10 (emergency); Amended at 28 Ok Reg 1574, eff 6-25-11 ; Amended at 29 Ok Reg 1210, eff 6-25-12 ; Amended at 33 Ok Reg 916, eff 9-1-16 ; Amended at 35 Ok Reg 1503, eff 9-14-18 ; Amended at 38 Ok Reg 831, eff 7-1-21 (emergency); Amended at 39 Ok Reg 1618, eff 9-12-22]

SUBCHAPTER 3. INSURE OKLAHOMA CARRIERS

317:45-3-1. Carrier eligibility

Carriers must be able to submit all required and requested information and documentation to OHCA for each benefit plan to be considered for qualification. Carriers must be able to supply specific claim payment scenarios as requested by OHCA. Carriers must also provide the name, address, telephone number, and, if available, email address of a contact individual who is able to verify employer enrollment status in a qualified benefit plan.

[Source: Added at 23 Ok Reg 278, eff 10-3-05 (emergency); Added at 23 Ok Reg 819, eff 2-1-06 (emergency); Added at 23 Ok Reg 2590, eff 6-25-06 ; Amended at 26 Ok Reg 2169, eff 6-25-09 ; Amended at 27 Ok Reg 2391, eff 7-1-10 (emergency); Amended at 28 Ok Reg 1574, eff 6-25-11 ; Amended at 33 Ok Reg 916, eff 9-1-16]

317:45-3-2. Reviews

Carriers are subject to reviews related to benefit plan qualifications. These reviews may be conducted periodically to determine if each qualified benefit plan continues to meet all requirements as defined in 317:45-5-1.

[Source: Added at 23 Ok Reg 278, eff 10-3-05 (emergency); Added at 23 Ok Reg 1407, eff 5-25-06 ; Amended at 26 Ok Reg 2169, eff 6-25-09 ; Amended at 27 Ok Reg 2391, eff 7-1-10 (emergency); Amended at 28 Ok Reg 1574, eff 6-25-11 ; Amended at 33 Ok Reg 916, eff 9-1-16]

317:45-3-3. Carrier rate structure requirements [EXPIRED]

[Source: Added at 28 Ok Reg 274, eff 11-15-10 through 7-14-11 (emergency)¹]

Editor's Note: ¹*This emergency action expired without being superseded by a permanent action. Upon expiration of an emergency action enacting a new section, the section is no longer effective. Therefore, on 7-15-11 (after the 7-14-11 expiration of this emergency action), the text of Section 317:45-3-3 was no longer effective. For the official text of the emergency rule that was effective from 11-15-10 through 7-14-11, see 28 Ok Reg 274.*

SUBCHAPTER 5. INSURE OKLAHOMA QUALIFIED BENEFIT PLANS

317:45-5-1. Qualified Benefit Plan requirements

(a) Participating qualified benefit plans must offer, at a minimum, benefits that include:

- (1) hospital services;
- (2) physician services;
- (3) clinical laboratory and radiology;
- (4) pharmacy;
- (5) office visits;
- (6) well baby/well child exams;
- (7) age appropriate immunizations as required by law; and
- (8) emergency services as required by law.

(b) The benefit plan, if required, must be approved by the Oklahoma Insurance Department for participation in the Oklahoma market. All benefit plans must share in the cost of covered services and pharmacy products in addition to any negotiated discounts with network providers, pharmacies, or pharmaceutical manufacturers. If the benefit plan requires co-payments or deductibles, the co-payments or deductibles cannot exceed the limits described in this subsection.

- (1) An annual in-network out-of-pocket maximum cannot exceed \$3,000 per individual, excluding separate pharmacy deductibles.
- (2) Office visits cannot require a co-payment exceeding \$50 per visit.
- (3) Annual in-network pharmacy deductibles cannot exceed \$500 per individual.

(c) Qualified benefit plans will provide an EOB, an expense summary, or required documentation for paid and/or denied claims subject to member co-insurance or member deductible calculations. The required documentation must contain, at a minimum, the:

- (1) provider's name;
- (2) patient's name;
- (3) date(s) of service;

- (4) code(s) and/or description(s) indicating the service(s) rendered, the amount(s) paid or the denied status of the claim(s);
- (5) reason code(s) and description(s) for any denied service(s);
- (6) amount due and/or paid from the patient or responsible party;
- and
- (7) provider network status (in-network or out-of-network provider).

[Source: Added at 23 Ok Reg 278, eff 10-3-05 (emergency); Added at 23 Ok Reg 1407, eff 5-25-06 ; Amended at 24 Ok Reg 101, eff 8-2-06 (emergency); Amended at 24 Ok Reg 963, eff 5-11-07 ; Amended at 26 Ok Reg 2169, eff 6-25-09 ; Amended at 27 Ok Reg 2391, eff 7-1-10 (emergency); Amended at 28 Ok Reg 1574, eff 6-25-11 ; Amended at 33 Ok Reg 916, eff 9-1-16 ; Amended at 35 Ok Reg 1503, eff 9-14-18]

317:45-5-2. Closure criteria for benefit plans

Eligibility for the carrier's benefit plans ends when:

- (1) changes are made to the design of the benefit plan such that it no longer meets the requirements to be considered a qualified benefit plan. Carriers are required to report to OHCA any changes in health plans potentially affecting their qualification for participation in the program not less than 90 days prior to the effective date of such change(s).
- (2) the carrier no longer meets the definition set forth in 317:45-1-3.
- (3) the benefit plan is no longer an available product in the Oklahoma market.
- (4) the benefit plan fails to meet or comply with all requirements for a qualified benefit plan as defined in 317 : 45-5-1.

[Source: Added at 23 Ok Reg 278, eff 10-3-05 (emergency); Added at 23 Ok Reg 1407, eff 5-25-06 ; Amended at 26 Ok Reg 2169, eff 6-25-09 ; Amended at 27 Ok Reg 2391, eff 7-1-10 (emergency); Amended at 28 Ok Reg 1574, eff 6-25-11 ; Amended at 33 Ok Reg 916, eff 9-1-16]

317:45-5-3. Health plan rate structure requirements [EXPIRED]

[Source: Added at 28 Ok Reg 274, eff 11-15-10 through 7-14-11 (emergency)¹]

Editor's Note: ¹*This emergency action expired without being superseded by a permanent action. Upon expiration of an emergency action enacting a new section, the section is no longer effective. Therefore, on 7-15-11 (after the 7-14-11 expiration of this emergency action), the text of Section 317:45-5-3 was no longer effective. For the official text of the emergency rule that was effective from 11-15-10 through 7-14-11, see 28 Ok Reg 274.*

SUBCHAPTER 7. INSURE OKLAHOMA ESI EMPLOYER ELIGIBILITY

317:45-7-1. Employer application and eligibility requirements for Insure Oklahoma ESI

(a) In order for an employer to be eligible to participate in the Insure Oklahoma program the employer must:

- (1) have no more than a total of 250 employees on its payroll if the employer is a for-profit business entity. Not-for-profit businesses may participate if the employer has no more than a total of 500 employees on its payroll. The increase in the number of employees from 250 to 500 will be phased in over time as determined by the Oklahoma Health Care Authority (OHCA). The number of employees is determined based on the third month employee count of the most recently filed OES-3 form with the Oklahoma Employment Security Commission (OESC). Employers may provide additional documentation confirming terminated employees that will be excluded from the OESC employee count. If the employer is exempt from filing an OES-3 form or is contracted with a Professional Employer Organization in accordance with OHCA rules, this determination is based on appropriate supporting documentation to verify employee count. Employers must be in compliance with all OESC requirements to be eligible for the program. As requested by the OHCA, employers that do not file with the OESC must submit documentation that proves compliance with state law;
- (2) have a business that is physically located in Oklahoma;
- (3) be currently offering, or in the contracting stage to offer a qualified benefit plan coverage to employees;
- (4) contribute a minimum twenty-five (25) percent of the eligible employee monthly benefit plan premium or an equivalent forty (40) percent of premiums for dependent children.

(b) An employer who meets all of the requirements listed in OAC 317:45-7-1(a) must complete and submit the OHCA required forms and application to be considered for participation in the program.

(c) The employer must provide its Federal Employee Identification Number (FEIN).

(d) It is the employer's responsibility to notify the OHCA of any changes that might impact eligibility in the program. Employers must notify the OHCA of any participating employee terminations, resignations, or new hires within five (5) working days of the occurrence.

[Source: Added at 23 Ok Reg 278, eff 10-3-05 (emergency); Added at 23 Ok Reg 819, eff 2-1-06 (emergency); Added at 23 Ok Reg 2590, eff 6-25-06 ; Amended at 24 Ok Reg 153, eff 10-8-06 (emergency); Amended at 24 Ok Reg 700, eff 2-1-07 (emergency); Amended at 24 Ok Reg 2159, eff 6-25-07 ; Amended at 26 Ok Reg 621, eff 3-1-09 (emergency); Amended at 26 Ok Reg 2165, eff 6-25-09 ; Amended at 27 Ok Reg 2391, eff 7-1-10 (emergency); Amended at 28 Ok Reg 1574, eff 6-25-11 ; Amended at 33 Ok Reg 916, eff 9-1-16 ; Amended at 35 Ok Reg 1503, eff 9-14-18]

317:45-7-2. Employer eligibility determination

Eligibility for employers is determined using the eligibility requirements listed in 317:45-7-1. Once an employer is determined eligible for Insure Oklahoma, the eligibility period begins on the first day of the month following the date of approval. The eligibility period will renew automatically unless the employer's eligibility has been closed (refer to 317:45-7-8). Employers will be notified of their eligibility decision.

[Source: Added at 23 Ok Reg 278, eff 10-3-05 (emergency); Added at 23 Ok Reg 819, eff 2-1-06 (emergency); Added at 23 Ok Reg 2590, eff 6-25-06 ; Amended at 24 Ok Reg 101, eff 8-2-06 (emergency); Amended at 24 Ok Reg 700, eff 2-1-07 (emergency); Amended at 24 Ok Reg 2159, eff 6-25-07 ; Amended at 26 Ok Reg 2169, eff 6-25-09 ; Amended at 27 Ok Reg 2391, eff 7-1-10 (emergency); Amended at 28 Ok Reg 1574, eff 6-25-11 ; Amended at 34 Ok Reg 760, eff 9-1-17]

317:45-7-3. Employer cost sharing

Employers are responsible for a portion of the eligible employee's monthly benefit plan premium as defined in 317:45-7-1.

[Source: Added at 23 Ok Reg 278, eff 10-3-05 (emergency); Added at 23 Ok Reg 1407, eff 5-25-06 ; Amended at 26 Ok Reg 2169, eff 6-25-09 ; Amended at 27 Ok Reg 2391, eff 7-1-10 (emergency); Amended at 28 Ok Reg 1574, eff 6-25-11 ; Amended at 33 Ok Reg 916, eff 9-1-16]

317:45-7-4. Qualifying Event

Employers must allow an employee to enroll or change coverage following a qualifying event. The employer must submit the required form for each employee experiencing the qualifying event.

[Source: Added at 23 Ok Reg 278, eff 10-3-05 (emergency); Added at 23 Ok Reg 1407, eff 5-25-06 ; Amended at 27 Ok Reg 2391, eff 7-1-10 (emergency); Amended at 28 Ok Reg 1574, eff 6-25-11]

317:45-7-5. Reimbursement

In order to receive a premium subsidy, the employer must submit all pages of the current benefit plan invoice. Due to timely filing requirements, subsidy payments will not be paid on invoices older than six (6) months.

[Source: Added at 23 Ok Reg 278, eff 10-3-05 (emergency); Added at 23 Ok Reg 819, eff 2-1-06 (emergency); Added at 23 Ok Reg 2590, eff 6-25-06 ; Amended at 26 Ok Reg 2169, eff 6-25-09 ; Amended at 27 Ok Reg 2391, eff 7-1-10 (emergency); Amended at 28 Ok Reg 1574, eff 6-25-11 ; Amended at 33 Ok Reg 916, eff 9-1-16 ; Amended at 38 Ok Reg 831, eff 7-1-21 (emergency); Amended at 39 Ok Reg 1618, eff 9-12-22]

317:45-7-6. Credits and adjustments

When an overpayment occurs, the employer must immediately report the erroneous payment. When such an overpayment(s) occurs, an automatic recoupment is made to the employer's account against future reimbursements. If the employer is not expecting future reimbursements, either by termination from the program or inactivity, the employer must repay any and all overpayments that are outstanding to the OHCA.

[Source: Added at 23 Ok Reg 278, eff 10-3-05 (emergency); Added at 23 Ok Reg 1407, eff 5-25-06 ; Amended at 27 Ok Reg 2391, eff 7-1-10 (emergency); Amended at 28 Ok Reg 1574, eff 6-25-11]

317:45-7-7. Reviews

Employers are subject to reviews related to program eligibility requirements found at OAC 317:45-7-1 and subsidy payments. Eligibility may be revoked at any time if inconsistencies are found. Any monies paid in error are subject to recoupment.

[Source: Added at 23 Ok Reg 278, eff 10-3-05 (emergency); Added at 23 Ok Reg 1407, eff 5-25-06 ; Amended at 27 Ok Reg 2391, eff 7-1-10 (emergency); Amended at 28 Ok Reg 1574, eff 6-25-11 ; Amended at 33 Ok Reg 916, eff 9-1-16]

317:45-7-8. Closure

Eligibility provided under the Insure Oklahoma ESI program may end during the eligibility period when:

- (1) the employer no longer meets the eligibility requirements in 317:45-7-1;
- (2) the employer fails to pay premiums to the carrier;
- (3) the employer fails to provide an invoice verifying the monthly benefit plan premium has been paid; or
- (4) a review indicates a discrepancy that makes the employer ineligible.

[Source: Added at 23 Ok Reg 278, eff 10-3-05 (emergency); Added at 23 Ok Reg 1407, eff 5-25-06 ; Amended at 24 Ok Reg 101, eff 8-2-06 (emergency); Amended at 24 Ok Reg 700, eff 2-1-07 (emergency); Amended at 24 Ok Reg 2159, eff 6-25-07 ; Amended at 26 Ok Reg 2169, eff 6-25-09 ; Amended at 27 Ok Reg 2391, eff 7-1-10 (emergency); Amended at 28 Ok Reg 1574, eff 6-25-11 ; Amended at 33 Ok Reg 916, eff 9-1-16]

SUBCHAPTER 9. INSURE OKLAHOMA ESI EMPLOYEE ELIGIBILITY

317:45-9-1. Employee eligibility requirements

- (a) Employees must complete and submit the OHCA required forms and application to be considered for participation in the program.
- (b) The eligibility determination will be processed within thirty (30) days from the date the application is received. The employee will be notified in writing of the eligibility decision.
- (c) All eligible employees described in this section must be enrolled in their employer's qualified benefit plan. Eligible employees must:
 - (1) Have countable income at or below the appropriate standard according to the family size on the Insure Oklahoma ESI Income Guidelines form;
 - (A) Financial eligibility for Insure Oklahoma ESI benefits is determined using the MAGI methodology. Unless questionable, the income of applicants does not require verification. See OAC 317:35-6-39 through 317:35-6-55 for the applicable MAGI rules for determining household composition and countable income.
 - (B) Income is evaluated on a monthly basis for all individuals included in the case for Insure Oklahoma ESI Benefits.

- (2) Be a US citizen or alien as described in OAC 317:35-5-25;
- (3) Be Oklahoma residents;
- (4) Furnish, or show documentation of an application for, a Social Security number at the time of application for Insure Oklahoma ESI benefits;
- (5) Not be receiving benefits from SoonerCare or Medicare;
- (6) Be employed with a qualified employer at a business location in Oklahoma;
- (7) Be age nineteen (19) through age sixty-four (64);
- (8) Be eligible for enrollment in the employer's QBP;
- (9) Not have full-time employment with any employer who does not meet the eligible employer guidelines listed in OAC 317:45-7-1(a)(1)-(2);
- (10) Select one of the QBPs the employer is offering; and
- (11) Provide in a timely manner any and all documentation that is requested by the Insure Oklahoma program by the specified due date.

(d) An employee's dependents are eligible when:

- (1) The employer's benefit plan includes coverage for dependents;
- (2) The employee is eligible;
- (3) If employed, the spouse may not have full-time employment with any employer who does not meet the eligible employer guidelines listed in OAC 317:45-7-1 (a) (1)-(2); and
- (4) The dependents are enrolled in the same benefit plan as the employee.

(e) If an employee or their dependents are eligible for multiple QBPs, each may receive a subsidy under only one benefit plan.

(f) College students may enroll in the Insure Oklahoma ESI program as dependents. Financial eligibility for Insure Oklahoma ESI benefits for college students is determined using the MAGI methodology. See OAC 317:35-6-39 through 317:35-6-55 for the applicable MAGI rules for determining household composition and countable income. Dependent college students must enroll under their parents and all annual gross household income (including parent income) must be included in determining eligibility. Independent college students may apply on their own without parent income included in the household. College student status as dependent or independent is determined by the student's current Free Application for Federal Student Aid (FAFSA) or the university's financial aid office. College students must also provide a copy of their current student schedule to prove full-time student status.

(g) Working dependent children must have countable income at the appropriate standard according to the family size on the Insure Oklahoma ESI Income Limits Guidelines form. Financial eligibility for Insure Oklahoma ESI benefits is determined using the MAGI methodology. See OAC 317:35-6-39 through 317:35-6-55 for the applicable MAGI rules for determining household composition and countable income. Children found to be eligible for SoonerCare may not receive coverage through Insure Oklahoma.

(h) ESI approved individuals must notify the OHCA of any changes, including household status and income, that might impact individual and/or dependent eligibility in the program within ten (10) days of the

change.

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

[Source: Added at 23 Ok Reg 278, eff 10-3-05 (emergency); Added at 23 Ok Reg 819, eff 2-1-06 (emergency); Added at 23 Ok Reg 2590, eff 6-25-06 ; Amended at 24 Ok Reg 101, eff 8-2-06 (emergency); Amended at 24 Ok Reg 700, eff 2-1-07 (emergency); Amended at 24 Ok Reg 2160, eff 6-25-07 ; Amended at 25 Ok Reg 169, eff 11-1-07 (emergency); Amended at 25 Ok Reg 1289, eff 5-25-08 ; Amended at 26 Ok Reg 2169, eff 6-25-09 ; Amended at 27 Ok Reg 2391, eff 7-1-10 (emergency); Amended at 28 Ok Reg 1574, eff 6-25-11 ; Amended at 32 Ok Reg 1183, eff 8-27-15 ; Amended at 33 Ok Reg 916, eff 9-1-16 ; Amended at 34 Ok Reg 760, eff 9-1-17 ; Amended at 35 Ok Reg 1503, eff 9-14-18 ; Amended at 38 Ok Reg 831, eff 7-1-21 (emergency); Amended at 39 Ok Reg 1618, eff 9-12-22]

317:45-9-1.1. Certification of newborn child deemed eligible

(a) A newborn child is deemed eligible on the date of birth for SoonerCare benefits when the child is born to a member of Insure Oklahoma Employer Sponsored Insurance (ESI) and the annual gross household income does not exceed SoonerCare requirements. The newborn child is deemed eligible for SoonerCare benefits through the last day of the month the child attains the age of one (1) year.

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

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

- (1) Loses Oklahoma residence; or
- (2) Expires.

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

[Source: Added at 37 Ok Reg 1699, eff 9-14-20]

317:45-9-2. Employee eligibility period

(a) Employee eligibility is contingent upon the employer's program eligibility.

(b) The employee's eligibility is determined using the eligibility requirements listed in OAC 317:45-9-1.

(c) If the employee is determined eligible, he/she is approved for a period not greater than twelve (12) months.

(d) The employee's eligibility period begins on the first day of the month following the date of approval.

[Source: Added at 23 Ok Reg 278, eff 10-3-05 (emergency); Added at 23 Ok Reg 1407, eff 5-25-06 ; Amended at 26 Ok Reg 2169, eff 6-25-09 ; Amended at 27 Ok Reg 2391, eff 7-1-10 (emergency); Amended at 28 Ok Reg 1574, eff 6-25-11 ; Amended at 35 Ok Reg 1503, eff 9-14-18]

317:45-9-3. Qualifying Event

Employees and/or an employee's dependents may apply for the ESI program following a qualifying event.

[Source: Added at 23 Ok Reg 278, eff 10-3-05 (emergency); Added at 23 Ok Reg 1407, eff 5-25-06 ; Amended at 24 Ok Reg 101, eff 8-2-06 (emergency); Amended at 24 Ok Reg 963, eff 5-11-07 ; Amended at 26 Ok Reg 2169, eff 6-25-09 ; Amended at 27 Ok Reg 2391, eff 7-1-10 (emergency); Amended at 28 Ok Reg 1574, eff 6-25-11]

317:45-9-4. Employee cost sharing

Employees are responsible for up to fifteen percent (15%) of their benefit plan premium. The employees are also responsible for up to fifteen percent (15%) of their dependent's benefit plan premium if the dependent is included in the program. The combined portion of the employee's cost sharing for benefit plan premiums cannot exceed three percent of his/her annual gross household income computed monthly. Cost-sharing, including premium payments and copayments, are not required of American Indian and Alaska Native members, as is established in the federally-approved Oklahoma Medicaid State Plan.

[Source: Added at 23 Ok Reg 278, eff 10-3-05 (emergency); Added at 23 Ok Reg 1407, eff 5-25-06 ; Amended at 26 Ok Reg 2169, eff 6-25-09 ; Amended at 27 Ok Reg 2391, eff 7-1-10 (emergency); Amended at 28 Ok Reg 1574, eff 6-25-11 ; Amended at 28 Ok Reg 2335, eff 7-13-11 (emergency); Amended at 29 Ok Reg 484, eff 5-11-12 ; Amended at 33 Ok Reg 916, eff 9-1-16 ; Amended at 37 Ok Reg 1671, eff 9-14-20]

317:45-9-5. Reimbursement for out-of-pocket medical expenses [REVOKED]

[Source: Added at 23 Ok Reg 278, eff 10-3-05 (emergency); Added at 23 Ok Reg 1407, eff 5-25-06 ; Revoked at 24 Ok Reg 101, eff 8-2-06 (emergency); Revoked at 24 Ok Reg 963, eff 5-11-07]

317:45-9-6. Reviews

Individuals participating in the Insure Oklahoma program are subject to reviews related to their eligibility, subsidy payments, and out-of-pocket reimbursements. Eligibility may be reversed at any time if inconsistencies are found. Any monies paid in error will be subject to recoupment.

[Source: Added at 23 Ok Reg 278, eff 10-3-05 (emergency); Added at 23 Ok Reg 1407, eff 5-25-06 ; Amended at 26 Ok Reg 2169, eff 6-25-09 ; Amended at 27 Ok Reg 2391, eff 7-1-10 (emergency); Amended at 28 Ok Reg 1574, eff 6-25-11 ; Amended at 33 Ok Reg 916, eff 9-1-16]

317:45-9-7. Closure

(a) Employer and employee eligibility are tied together. If the employer is no longer eligible, then the associated employees enrolled under that employer are also ineligible. Employees are mailed a notice 10 days prior to closure of eligibility.

(b) The employee's certification period may be terminated when:

- (1) termination of employment, either voluntary or involuntary, occurs;
- (2) the employee moves out-of-state;

- (3) the covered employee dies;
- (4) the employer ends its contract with the qualified benefit plan;
- (5) the employer's eligibility ends;
- (6) a review indicates a discrepancy that makes the employee or employer ineligible;
- (7) the employer is terminated from the program;
- (8) the employer fails to pay the premium;
- (9) the qualified benefit plan or carrier no longer meets the requirements set forth in this Chapter;
- (10) the employee becomes eligible for SoonerCare or Medicare;
- (11) the employee or employer reports any change affecting eligibility;
- (12) the employee is no longer listed as a covered person on the employer's benefit plan invoice;
- (13) the employee requests closure; or
- (14) the employee no longer meets the eligibility criteria set forth in this Chapter.

[Source: Added at 23 Ok Reg 278, eff 10-3-05 (emergency); Added at 23 Ok Reg 1407, eff 5-25-06 ; Amended at 24 Ok Reg 101, eff 8-2-06 (emergency); Amended at 24 Ok Reg 963, eff 5-11-07 ; Amended at 26 Ok Reg 2169, eff 6-25-09 ; Amended at 27 Ok Reg 2391, eff 7-1-10 (emergency); Amended at 28 Ok Reg 1574, eff 6-25-11 ; Amended at 33 Ok Reg 916, eff 9-1-16]

317:45-9-8. Appeals

Employee appeal procedures based on denial of eligibility due to income are described at OAC 317:2-1-2.

[Source: Added at 23 Ok Reg 278, eff 10-3-05 (emergency); Added at 23 Ok Reg 1407, eff 5-25-06 ; Amended at 27 Ok Reg 2391, eff 7-1-10 (emergency); Amended at 28 Ok Reg 1574, eff 6-25-11 ; Amended at 33 Ok Reg 916, eff 9-1-16]

SUBCHAPTER 11. INSURE OKLAHOMA IP [REVOKED]

PART 1. INDIVIDUAL PLAN PROVIDERS [REVOKED]

317:45-11-1. Insure Oklahoma Individual Plan providers [REVOKED]

[Source: Added at 24 Ok Reg 101, eff 8-2-06 (emergency); Added at 24 Ok Reg 963, eff 5-11-07 ; Amended at 25 Ok Reg 439, eff 12-1-07 (emergency); Amended at 25 Ok Reg 1289, eff 5-25-08 ; Amended at 26 Ok Reg 2169, eff 6-25-09 ; Amended at 27 Ok Reg 2391, eff 7-1-10 (emergency); Amended at 28 Ok Reg 1574, eff 6-25-11 ; Revoked at 38 Ok Reg 831, eff 7-1-21 (emergency); Revoked at 39 Ok Reg 1618, eff 9-12-22]

317:45-11-2. Insure Oklahoma Individual Plan (IP) provider payments [REVOKED]

[Source: Added at 24 Ok Reg 101, eff 8-2-06 (emergency); Added at 24 Ok Reg 963, eff 5-11-07 ; Amended at 26 Ok Reg 2169, eff 6-25-09 ; Amended at 27 Ok Reg 2391, eff 7-1-10 (emergency); Amended at 28 Ok Reg 1574, eff 6-25-11 ; Amended at 37 Ok Reg 1669, eff 9-14-20 ; Revoked at 38 Ok Reg 831, eff 7-1-21 (emergency); Revoked at 39 Ok Reg 1618, eff 9-12-22]

PART 3. INSURE OKLAHOMA IP MEMBER BENEFITS [REVOKED]

317:45-11-10. Insure Oklahoma IP adult benefit [REVOKED]

[Source: Added at 24 Ok Reg 101, eff 8-2-06 (emergency); Added at 24 Ok Reg 700, eff 2-1-07 (emergency); Added at 24 Ok Reg 811, eff 4-1-07 (emergency); Added at 24 Ok Reg 2162, eff 6-25-07 ; Amended at 26 Ok Reg 409, eff 1-1-09 (emergency); Amended at 26 Ok Reg 2175, eff 6-25-09 ; Amended at 27 Ok Reg 2391, eff 7-1-10 (emergency); Amended at 28 Ok Reg 1574, eff 6-25-11 ; Amended at 28 Ok Reg 2335, eff 7-13-11 (emergency); Amended at 29 Ok Reg 484, eff 5-11-12 ; Amended at 30 Ok Reg 1274, eff 7-1-13 ; Amended at 31 Ok Reg 147, eff 10-15-13 (emergency); Amended at 31 Ok Reg 1751, eff 9-12-14 ; Amended at 34 Ok Reg 760, eff 9-1-17 ; Amended at 35 Ok Reg 1503, eff 9-14-18 ; Revoked at 38 Ok Reg 831, eff 7-1-21 (emergency); Revoked at 39 Ok Reg 1618, eff 9-12-22]

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

[Source: Added at 24 Ok Reg 101, eff 8-2-06 (emergency); Added at 24 Ok Reg 700, eff 2-1-07 (emergency); Added at 24 Ok Reg 811, eff 4-1-07 (emergency); Added at 24 Ok Reg 2162, eff 6-25-07 ; Amended at 25 Ok Reg 1289, eff 5-25-08 ; Amended at 26 Ok Reg 409, eff 1-1-09 (emergency); Amended at 26 Ok Reg 2175, eff 6-25-09 ; Amended at 26 Ok Reg 3035, eff 9-1-09 (emergency); Amended at 27 Ok Reg 987, eff 5-13-10 ; Amended at 27 Ok Reg 2391, eff 7-1-10 (emergency); Amended at 28 Ok Reg 1574, eff 6-25-11 ; Amended at 31 Ok Reg 147, eff 10-15-13 (emergency); Amended at 31 Ok Reg 1751, eff 9-12-14 ; Amended at 33 Ok Reg 916, eff 9-1-16 ; Amended at 34 Ok Reg 760, eff 9-1-17 ; Amended at 35 Ok Reg 1503, eff 9-14-18 ; Revoked at 38 Ok Reg 831, eff 7-1-21 (emergency); Revoked at 39 Ok Reg 1618, eff 9-12-22]

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

[Source: Added at 27 Ok Reg 2391, eff 7-1-10 (emergency); Added at 28 Ok Reg 1574, eff 6-25-11 ; Amended at 28 Ok Reg 2335, eff 7-13-11 (emergency); Amended at 29 Ok Reg 484, eff 5-11-12 ; Revoked at 31 Ok Reg 147, eff 10-15-13 (emergency); Revoked at 31 Ok Reg 1751, eff 9-12-14]

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

[Source: Added at 27 Ok Reg 2391, eff 7-1-10 (emergency); Added at 28 Ok Reg 1574, eff 6-25-11 ; Revoked at 31 Ok Reg 147, eff 10-15-13 (emergency); Revoked at 31 Ok Reg 1751, eff 9-12-14]

PART 5. INSURE OKLAHOMA IP MEMBER ELIGIBILITY [REVOKED]

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

[Source: Added at 24 Ok Reg 101, eff 8-2-06 (emergency); Added at 24 Ok Reg 700, eff 2-1-07 (emergency); Added at 24 Ok Reg 2160, eff 6-25-07 ; Amended at 25 Ok Reg 169, eff 11-1-07 (emergency); Amended at 25 Ok Reg 1289, eff 5-25-08 ; Amended at 26 Ok Reg 2169, eff 6-25-09 ; Amended at 26 Ok Reg 1784, eff 7-1-09 (emergency); Amended at 27 Ok Reg 727, eff 2-4-10 (emergency); Amended at 27 Ok Reg 1528, eff 6-11-10 ; Amended at 27 Ok Reg 2391, eff 7-1-10 (emergency); Amended at 28 Ok Reg 1574, eff 6-25-11 ; Amended at 31 Ok Reg 147, eff 10-15-13 (emergency); Amended at 31 Ok Reg 1751, eff 9-12-14 ; Amended at 32 Ok Reg 1183, eff 8-27-15 ; Amended at 33 Ok Reg 916, eff 9-1-16 ; Amended at 34 Ok Reg 760, eff 9-1-17 ; Amended at 35 Ok Reg 205, eff 11-7-17 (emergency); Amended at 35 Ok Reg 1503, eff 9-14-18 ; Revoked at 38 Ok Reg 831, eff

7-1-21 (emergency); Revoked at 39 Ok Reg 1618, eff 9-12-22]

317:45-11-21. Dependent eligibility [REVOKED]

[Source: Added at 24 Ok Reg 101, eff 8-2-06 (emergency); Added at 24 Ok Reg 963, eff 5-11-07 ; Amended at 26 Ok Reg 2169, eff 6-25-09 ; Amended at 27 Ok Reg 2391, eff 7-1-10 (emergency); Amended at 28 Ok Reg 1574, eff 6-25-11 ; Amended at 31 Ok Reg 147, eff 10-15-13 (emergency); Amended at 31 Ok Reg 1751, eff 9-12-14 ; Amended at 32 Ok Reg 1183, eff 8-27-15 ; Amended at 33 Ok Reg 916, eff 9-1-16 ; Revoked at 38 Ok Reg 831, eff 7-1-21 (emergency); Revoked at 39 Ok Reg 1618, eff 9-12-22]

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

[Source: Added ; Added at 25 Ok Reg 171, eff 8-1-07 (emergency); Added at 25 Ok Reg 1289, eff 5-25-08 ; Amended at 26 Ok Reg 2169, eff 6-25-09 ; Amended at 27 Ok Reg 2391, eff 7-1-10 (emergency); Amended at 28 Ok Reg 1574, eff 6-25-11 ; Revoked at 31 Ok Reg 147, eff 10-15-13 (emergency); Revoked at 31 Ok Reg 1751, eff 9-12-14 ; Added at 37 Ok Reg 1699, eff 9-14-20 ; Revoked at 38 Ok Reg 831, eff 7-1-21 (emergency); Revoked at 39 Ok Reg 1618, eff 9-12-22]

317:45-11-22. Primary Care Physician (PCP) choices [REVOKED]

[Source: Added at 24 Ok Reg 101, eff 8-2-06 (emergency); Added at 24 Ok Reg 963, eff 5-11-07 ; Amended at 26 Ok Reg 2169, eff 6-25-09 ; Amended at 27 Ok Reg 2391, eff 7-1-10 (emergency); Amended at 28 Ok Reg 1574, eff 6-25-11 ; Amended at 37 Ok Reg 1669, eff 9-14-20 ; Revoked at 38 Ok Reg 831, eff 7-1-21 (emergency); Revoked at 39 Ok Reg 1618, eff 9-12-22]

317:45-11-23. Member eligibility period [REVOKED]

[Source: Added at 24 Ok Reg 101, eff 8-2-06 (emergency); Added at 24 Ok Reg 963, eff 5-11-07 ; Amended at 26 Ok Reg 2169, eff 6-25-09 ; Amended at 27 Ok Reg 2391, eff 7-1-10 (emergency); Amended at 28 Ok Reg 1574, eff 6-25-11 ; Amended at 33 Ok Reg 916, eff 9-1-16 ; Amended at 34 Ok Reg 760, eff 9-1-17 ; Amended at 35 Ok Reg 1503, eff 9-14-18 ; Revoked at 38 Ok Reg 831, eff 7-1-21 (emergency); Revoked at 39 Ok Reg 1618, eff 9-12-22]

317:45-11-24. Member cost sharing [REVOKED]

[Source: Added at 24 Ok Reg 101, eff 8-2-06 (emergency); Added at 24 Ok Reg 963, eff 5-11-07 ; Amended at 26 Ok Reg 2169, eff 6-25-09 ; Amended at 27 Ok Reg 2391, eff 7-1-10 (emergency); Amended at 28 Ok Reg 1574, eff 6-25-11 ; Amended at 29 Ok Reg 484, eff 5-11-12 ; Amended at 31 Ok Reg 147, eff 10-15-13 (emergency); Amended at 31 Ok Reg 1751, eff 9-12-14 ; Amended at 33 Ok Reg 916, eff 9-1-16 ; Amended at 37 Ok Reg 1671, eff 9-14-20 ; Revoked at 38 Ok Reg 831, eff 7-1-21 (emergency); Revoked at 39 Ok Reg 1618, eff 9-12-22]

317:45-11-25. Premium payment [REVOKED]

[Source: Added at 24 Ok Reg 101, eff 8-2-06 (emergency); Added at 24 Ok Reg 963, eff 5-11-07 ; Amended at 26 Ok Reg 621, eff 3-1-09 (emergency); Amended at 26 Ok Reg 2165, eff 6-25-09 ; Amended at 27 Ok Reg 2391, eff 7-1-10 (emergency); Amended at 28 Ok Reg 1574, eff 6-25-11 ; Revoked at 35 Ok Reg 1503, eff 9-14-18]

317:45-11-26. Reviews [REVOKED]

[Source: Added at 24 Ok Reg 101, eff 8-2-06 (emergency); Added at 24 Ok Reg 963, eff 5-11-07 ; Amended at 26 Ok Reg 2169, eff 6-25-09 ; Amended at 27 Ok Reg 2391, eff 7-1-10 (emergency); Amended at 28 Ok Reg 1574, eff 6-25-11 ; Amended at 33 Ok Reg 916, eff 9-1-16 ; Revoked at 38 Ok Reg 831, eff 7-1-21 (emergency); Revoked at 39 Ok Reg 1618, eff 9-12-22]

317:45-11-27. Closure [REVOKED]

[Source: Added at 24 Ok Reg 101, eff 8-2-06 (emergency); Added at 24 Ok Reg 963, eff 5-11-07 ; Amended at 26 Ok Reg 2169, eff 6-25-09 ; Amended at 27 Ok Reg 727, eff 2-4-10 (emergency); Amended at 27 Ok Reg 1528, eff 6-11-10 ; Amended at 27 Ok Reg 2391, eff 7-1-10 (emergency); Amended at 28 Ok Reg 1574, eff 6-25-11 ; Amended at 33 Ok Reg 916, eff 9-1-16 ; Revoked at 38 Ok Reg 831, eff 7-1-21 (emergency); Revoked at 39 Ok Reg 1618, eff 9-12-22]

317:45-11-28. Appeals [REVOKED]

[Source: Added at 24 Ok Reg 101, eff 8-2-06 (emergency); Added at 24 Ok Reg 963, eff 5-11-07 ; Amended at 27 Ok Reg 2391, eff 7-1-10 (emergency); Amended at 28 Ok Reg 1574, eff 6-25-11 ; Amended at 33 Ok Reg 916, eff 9-1-16 ; Revoked at 38 Ok Reg 831, eff 7-1-21 (emergency); Revoked at 39 Ok Reg 1618, eff 9-12-22]

SUBCHAPTER 13. INSURE OKLAHOMA DENTAL SERVICES

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

[Source: Added at 28 Ok Reg 126, eff 10-14-10 (emergency); Added at 28 Ok Reg 1588, eff 6-25-11 ; Amended at 28 Ok Reg 2335, eff 7-13-11 (emergency); Amended at 29 Ok Reg 484, eff 5-11-12 ; Revoked at 31 Ok Reg 147, eff 10-15-13 (emergency); Revoked at 31 Ok Reg 1751, eff 9-12-14]

CHAPTER 50. HOME AND COMMUNITY-BASED WAIVER SERVICES

[**Authority:** Federal Social Security Act; Oklahoma Health Care Authority Act, Title 66 O.S., 5003 through 5016]
[**Source:** Codified 6-25-11]

SUBCHAPTER 1. MEDICALLY FRAGILE WAIVER SERVICES

317:50-1-1. Purpose

The Medically Fragile Waiver Program is a Medicaid Home and Community Based Services (HCBS) Waiver used to finance non-institutional long-term care services through Oklahoma's SoonerCare program for medically fragile individuals. To receive Medically Fragile Program services, individuals must be at least 19 years of age, be SoonerCare eligible, and meet the OHCA skilled nursing facility (SNF) or hospital level of care (LOC) criteria. Eligibility does not guarantee placement in the program as Waiver membership is limited.

[**Source:** Added at 27 Ok Reg 2769, eff 8-1-10 (emergency); Added at 28 Ok Reg 1589, eff 6-25-11]

317:50-1-2. Definitions

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

"**ADL**" means the activities of daily living. Activities of daily living are activities that reflect the member's ability to perform self-care tasks essential for sustaining health and safety such as:

- (A) bathing,
- (B) eating,
- (C) dressing,
- (D) grooming,
- (E) transferring (includes getting in and out of a tub, bed to chair, etc.),
- (F) mobility,
- (G) toileting, and
- (H) bowel/bladder control.

"**Cognitive Impairment**" means that the person, as determined by the clinical judgment of the Long Term Care Nurse or the information obtained in the Uniform Comprehensive Assessment Test Tool (UCAT) assessment does not have the capability to think, reason, remember or learn required task for self-care, communicating needs, directing care givers and/or using appropriate judgment for maintenance of their own health or safety. The clinical judgment of cognitive impairment is based on mental status questionnaire performance in combination with a more general evaluation of cognitive function from interaction with the person during the UCAT assessment.

"**Developmental Disability**" means a severe, chronic disability of an individual that:

(A) is attributable to a mental or physical impairment or combination of mental and physical impairments;
(B) is manifested before the individual attains age 22;
(C) is likely to continue indefinitely;
(D) results in substantial functional limitations in three or more of the following areas of major life activity:

- (i) self-care;
- (ii) receptive and expressive language;
- (iii) learning;
- (iv) mobility;
- (v) self-direction;
- (vi) capacity for independent living; and
- (vii) economic self-sufficiency; and

(E) reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, supports, or other assistance that is of lifelong or extended duration and is individually planned and coordinated.

"IADL" means the instrumental activities of daily living.

"Instrumental activities of daily living" means those activities that reflect the member's ability to perform household chores and tasks within the community essential for sustaining health and safety such as:

- (A) shopping,
- (B) cooking,
- (C) cleaning,
- (D) managing money,
- (E) using a telephone,
- (F) doing laundry,
- (G) taking medication, and
- (H) accessing transportation.

"Intellectual Disability" means that the person has, as determined by a Preadmission Screening Resident Review level II evaluation, substantial limitations in functional ability due to significantly sub-average intellectual functioning related to an event occurring before the age of eighteen (18).

"Level of Care Services" To be eligible for level of care services, meeting the minimum Uniform Comprehensive Assessment Test criteria established for skilled nursing facility or hospital level of care demonstrates the individual must:

- (A) require a treatment plan involving the planning and administration of services that require the skills of licensed or otherwise certified technical or professional personnel, and are provided directly or under the supervision of such personnel;
- (B) have a physical impairment or combination of physical, mental and/or functional impairments;
- (C) require professional nursing supervision (medication, hygiene and/or dietary assistance);
- (D) lack the ability to adequately and appropriately care for self or communicate needs to others;
- (E) require medical care and treatment in order to minimize physical health regression or deterioration;

(F) require care that is not available through family and friends, Medicare, Veterans Administration, or other federal entitlement program with the exception of Indian Health Services; and

(G) require care that cannot be met through Medicaid state plan Services, including Personal Care, if financially eligible.

"MSQ" means the mental status questionnaire.

"Progressive degenerative disease process that responds to treatment" means a process such as, but not limited to, Multiple Sclerosis (MS), Parkinson's Disease, Human Immunodeficiency Virus (HIV), or Acquired Immunodeficiency Syndrome (AIDS), that, untreated, systematically impairs normal body function which leads to acute illness and/or disability but that reacts positively to a medically prescribed treatment intervention (usually medication) which arrests or significantly delays the destructive action of the process.

[Source: Added at 27 Ok Reg 2769, eff 8-1-10 (emergency); Added at 28 Ok Reg 1589, eff 6-25-11 ; Amended at 29 Ok Reg 1212, eff 6-25-12 ; Amended at 35 Ok Reg 1511, eff 9-14-18]

317:50-1-3. Medically Fragile Program overview

(a) The Medically Fragile Waiver program is a Medicaid Home and Community Based Services Waiver used to finance non-institutional long-term care services for a targeted group of physically disabled adults when there is a reasonable expectation that the person's health, due to disease process or disability, would, without appropriate services, deteriorate and require skilled nursing facility or hospital level of care to arrest the deterioration. Medically Fragile Waiver program members must be SoonerCare eligible and must not reside in an institution; room and board licensed residential care facility. The number of members who may receive Medically Fragile Waiver services is limited.

(1) To receive Medically Fragile Waiver services, individuals must meet the following criteria:

(A) be nineteen (19) years of age or older;

(B) have a chronic medical condition which results in prolonged dependency on medical care for which daily skilled intervention is necessary and is characterized by one or more of the following:

(i) a life threatening condition characterized by reasonably frequent periods of acute exacerbation which requires frequent medical supervision and/or physician consultation and which, in the absence of such supervision or consultation, would require hospitalization;

(ii) require frequent time consuming administration of specialized treatments which are medically necessary;

(iii) be dependent on medical technology such that without the technology, a reasonable level of health could not be maintained.

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

(A) meet service eligibility criteria [see OAC 317:50-1-3(d)]; and

(B) meet program eligibility criteria [see OAC 317:50-1-3(e)].

(b) Home and Community Based Waiver Services are outside the scope of state plan Medicaid services. The Medicaid waiver allows the Oklahoma Health Care Authority to offer certain Home and Community Based services to an annually capped number of persons who are categorically needy (refer to Department of Human Services form 08AX001E, Schedule VIII. B. 1) and without such services would be institutionalized. Services provided through the Medically Fragile Waiver are approved based on medical necessity.

(c) Services provided through the Medically Fragile Waiver are:

- (1) case management;
- (2) institutional transition case management;
- (3) respite;
- (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;
- (8) skilled nursing;
- (9) home delivered meals;
- (10) hospice care;
- (11) medically necessary prescription drugs within the limits of the waiver;
- (12) personal care;
- (13) personal emergency response system (PERS);
- (14) self-directed personal care, respite and advanced supportive/restorative assistance;
- (15) self-directed goods and services (SD-GS);
- (16) transitional case management; and
- (17) SoonerCare medical services within the scope of the state plan.

(d) A service eligibility determination is made using the following criteria:

- (1) an open Medically Fragile Waiver 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 member. If it is determined that all Medically Fragile Waiver slots are filled, the member cannot be certified as eligible for Medically Fragile Waiver services and the member's name is placed on a waiting list for entry as an open slot becomes available. Medically Fragile Waiver slots and corresponding waiting lists, if necessary, are maintained.
- (2) the member is in the Medically Fragile Waiver targeted service group. The target group is an individual who is age nineteen (19) or older with a physical disability and may be technology dependent.

(3) the 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 individual or other household visitors.

(e) The Medically Fragile Waiver program eligibility determination is made through the service plan approval process. The following criteria are used to make the determination that an individual is not eligible:

(1) if the individual's needs as identified by Uniform Comprehensive Assessment Test assessment and other professional assessments cannot be met through Medically Fragile Waiver program services, SoonerCare state plan services and other formal or informal services. The State, as part of the waiver program approval authorization, assures CMS that each waiver member's health, safety, or welfare can be maintained in their home. If an individual's identified needs cannot be met through provision of Medically Fragile Waiver program or SoonerCare state plan services and other formal or informal services are not in place or immediately available to meet those needs, the individual's health, safety or welfare in their home cannot be assured.

(2) if the 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 individual or other household visitors.

(4) if the individual's needs are being met, or do not require Medically Fragile Waiver services to be met, or if the individual would not require institutionalization if needs are not met.

(5) if, after the service and care plan is developed, the risk to individual health and safety is not acceptable to the individual, or to the interdisciplinary service plan team, or to the OHCA.

(f) Professional documentation is provided 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 member is removed from the Medically Fragile Waiver program. As a part of the procedures requesting redetermination of program eligibility, the OHCA will provide technical assistance to the provider for transitioning the member to other services.

(g) Redetermination of program eligibility can be requested for the following reasons:

(1) if the member fails to comply with the community service plan;

(2) if the member's health and safety cannot be assured;

(3) as deemed necessary by waiver review staff or the member's case manager.

(h) Individuals determined ineligible for Medically Fragile Waiver program services are notified in writing of the determination and of his or her right to appeal the decision.

[Source: Added at 27 Ok Reg 2769, eff 8-1-10 (emergency); Added at 28 Ok Reg 1589, eff 6-25-11 ; Amended at 29 Ok Reg 1212, eff 6-25-12 ; Amended at 30 Ok Reg 1277, eff 7-1-13 ; Amended at 33 Ok Reg 924, eff 9-1-16 ; Amended at 35 Ok Reg 1511, eff 9-14-18]

317:50-1-4. Application for Medically Fragile Waiver services

(a) The application process is initiated by the receipt of a UCAT, Part I or by receipt of the initial waiver referral form. A written financial application is not required for an individual who is a SoonerCare member at the time of application. A financial application for Medically Fragile Waiver services consists of the Medical Assistance Application form. The form is signed by the applicant, parent, spouse, guardian or someone else acting on the applicant's behalf.

(1) All conditions of financial eligibility must be verified and documented in the case record. When current information is already available that establishes financial eligibility, such information may be used by recording source and date of information. If the applicant also wishes to apply for a State Supplemental Payment, either the applicant or his/her guardian must sign the application form.

(2) An individual residing in a NF or requesting waiver services, or the individual's community spouse may request an assessment of resources available to each spouse by using DHS form 08MA011E, Assessment of Assets, when SoonerCare application is not being made. The individual and/or spouse must provide documentation of resources. The assessment reflects all countable resources of the couple (owned individually or as a couple) and establishes the spousal share to be protected when subsequent determination of SoonerCare long-term care eligibility is made.

(3) When SoonerCare application is being made, an assessment of resources must be completed if it was not completed when the individual entered the NF or began receiving waiver services. For applicants of the Medically Fragile waiver, those resources owned by the couple the month the application was made determines the spousal share of resources. If the individual applies for SoonerCare at the time of entry into the Medically Fragile Waiver, Form 08MA011E is not appropriate. However, the spousal share must be determined using the resource information provided on the SoonerCare application form and computed using DHS form 08MA12E, Title XIX Worksheet.

(b) **Date of application.** The date of application is the date the signed application is received or the date when the request for SoonerCare is made orally and the financial application form is signed later. The date of the oral request is noted above the date the form is signed.

(c) **Medically Fragile Waiver waiting list procedures.** Medically Fragile Waiver Program capacity is the number of members that may be enrolled in the Program without exceeding, on an annualized basis, the maximum number authorized by the waiver to be served in the waiver year. If available waiver capacity has been realized, requests for services are not processed as applications, but placed on a waiting list. As

available capacity permits, the OHCA selects in chronological order (first on, first off) requests for services from the waiting list to forward for application processing. When waiver capacity exceeds the number on the waiting list and after all persons on the waiting list have been processed, waiting list procedures are suspended.

[Source: Added at 27 Ok Reg 2769, eff 8-1-10 (emergency); Added at 28 Ok Reg 1589, eff 6-25-11 ; Amended at 29 Ok Reg 1218, eff 6-25-12 ; Amended at 33 Ok Reg 924, eff 9-1-16]

317:50-1-5. Medically Fragile Waiver program medical eligibility determination

A medical eligibility determination is made for Medically Fragile Waiver program services based on the Uniform Comprehensive Assessment Tool (UCAT) assessment, professional judgment and the determination that the member has unmet care needs that require Medically Fragile Waiver Program, skilled nursing facility (SNF) or hospital services to assure member health and safety. Medically Fragile Waiver services are initiated to support the informal care that is being provided in the member's home, or, that based on the UCAT, can be expected to be provided in the member's home upon discharge of the member from a SNF or hospital. These services are not intended to take the place of regular care provided by family members and/or by significant others. When there is an informal (not paid) system of care available in the home, Medically Fragile Waiver service provision will supplement the system within the limitations of Medically Fragile Waiver program policy.

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

(2) Community agencies complete the UCAT, Part I and forward the form to the Oklahoma Health Care Authority. If the UCAT, Part I indicates that the applicant does not qualify for SoonerCare long-term care services, the applicant is referred to appropriate community resources.

(3) The member and family are informed of agencies certified to deliver Medically Fragile Waiver case management and in-home care services in the local area to obtain the member's primary and secondary informed choices.

(A) If the member and/or family declines to make a provider choice, that decision is documented on the member choice form.

(B) A rotating system is used to select an agency for the member from a list of all local certified case management and in-home care agencies.

(4) The names of the chosen agencies and the agreement (by dated signature) of the member to receive services provided by

the agencies are documented.

(5) If the needs of the member require an immediate interdisciplinary team (IDT) meeting with home health agency nurse participation to develop a care plan and service plan, the need is documented.

(6) If, based upon the information obtained during the assessment, the nurse determines that the member's health and safety may be at risk, Department of Human Services Adult Protective Services (APS) staff are notified immediately and the referral is documented on the UCAT.

(7) Within ten (10) working days of receipt of a complete UCAT, medical eligibility is determined using level of care criteria and service eligibility criteria.

(8) Once eligibility has been established, notification is given to the member and the case management provider so that care plan and service plan development may begin. The member's case management provider is notified of the member's name, address and case number.

(9) If the member has a current certification and requests a change to Medically Fragile Waiver services, a new UCAT is required. The UCAT is updated when a member requests a change from Medically Fragile Waiver services to Personal Care services. If a member is receiving Medically Fragile Waiver services and requests to go to a nursing facility, a new medical level of care decision is not needed.

(10) When a UCAT assessment has been completed more than sixty (60) days prior to submission for determination of a medical decision, the UCAT must be updated to reflect changes in the medical condition; if submitted after ninety (90) days, a new assessment is required.

[Source: Added at 27 Ok Reg 2769, eff 8-1-10 (emergency); Added at 28 Ok Reg 1589, eff 6-25-11 ; Amended at 33 Ok Reg 924, eff 9-1-16 ; Amended at 35 Ok Reg 1511, eff 9-14-18]

317:50-1-6. Determining financial eligibility for the Medically Fragile Waiver program

Financial eligibility for Medically Fragile Waiver services is determined using the rules on income and resources according to the category to which the individual is related. Only individuals who are categorically related to Aged Blind and Disabled (ABD) may be served through the Medically Fragile Waiver. Income, resources and expenses are evaluated on a monthly basis for all individuals requesting payment for the Medically Fragile Waiver Program. In determining income and resources for the individual categorically related to ABD, the family includes the individual and spouse, if any. However, consideration is not given to the income and resources of a spouse included in a Temporary Assistance for Needy Families case. If an individual and spouse cease to live together for reasons other than institutionalization, income and resources are considered available to each other through the month in which they are separated. Mutual consideration ceases with the month after the month in which the separation occurs. Any amounts which are

actually contributed to the spouse after the mutual consideration has ended are considered. Financial eligibility for individuals in Medically Fragile Waiver program services is as follows:

(1) **Individual without a spouse.** For an individual without a spouse, the following rules are used to determine financial eligibility.

(A) **Income eligibility.** To determine the income of the individual, the rules in (i) through (iii) of this subparagraph apply.

(i) If payment of income is made to the individual and another person(s), the income is considered in proportion to the individual's interest.

(ii) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

(iii) After determination of income, the gross income of the individual cannot exceed the categorically needy standard in DHS form 08AX001E, Schedule VIII. B. 1., to be eligible for Medically Fragile Waiver services. If the individual's gross income exceeds that standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC 317:35-5-41.6(6)(B)].

(B) **Resource eligibility.** In order for an individual without a spouse to be eligible for Medically Fragile Waiver services, his/her countable resources cannot exceed the maximum resource standard for an individual listed in DHS form 08AX001E, Schedule VIII. D.

(C) **Equity in capital resources.** If the equity in the individual's capital resources is in excess of the maximum resource standards, certification is delayed up to thirty (30) days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources cannot reasonably be expected to come within standards in one month, the application is denied.

(2) **Individual with a spouse who receives Home and Community-Based Services (HCBS), or is institutionalized in a Nursing Facility (NF) or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), or is sixty-five (65) or over and in a mental health hospital.** For an individual with a spouse who receives HCBS, or is institutionalized in a NF or ICF/IID, or is sixty-five (65) or over and in a mental health hospital, resources are determined for each individual as the amount owned by each individual plus one-half of the jointly owned resources of the couple. Once this separation of assets is made, a resource of either spouse is not

considered available to the other during the receipt of HCBS program services.

(A) **Income eligibility.** Income is determined separately for an individual and his/her spouse if the spouse is in a HCBS program, or is institutionalized in a NF or ICF/IID, or is sixty-five (65) or older and in a mental health hospital. The income of either spouse is not considered as available to the other during the receipt of Medically Fragile Waiver services. The rules in (i) - (v) of this subparagraph apply in this situation:

(i) If payment of income is made solely to one or the other, the income is considered available only to that individual.

(ii) If payment of income is made to both, one-half is considered for each individual.

(iii) If payment of income is made to either one or both and another person(s), the income is considered in proportion to either spouse's interest (if payment is to that spouse) or one-half of the joint interest if no interest is specified.

(iv) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

(v) After determination of income, the gross income of the individual cannot exceed the categorically needy standard in DHS form 08AX001E, Schedule VIII. B. 1., to be eligible for Medically Fragile Waiver services. If the individual's gross income exceeds this standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust OAC 317:35-5-41.6(6)(B)].

(B) **Resource eligibility.** In order for an individual with a spouse who receives HCBS, or is institutionalized in a NF or ICF/IID or is sixty-five (65) or older and in a mental health hospital to be eligible for the Medically Fragile Waiver services, his/her countable resources cannot exceed the maximum resource standard for an individual listed in DHS form 08AX001E, Schedule VIII. D.

(C) **Equity in capital resources.** If the equity in the individual's capital resources is in excess of the maximum resource standards, certification is delayed up to thirty (30) days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources cannot reasonably be expected to come within standards in one month, the application is denied.

(3) **Individual with a spouse in the home who is not in a Home and Community Based Services program.** When only

one individual of a couple in their own home is in a HCBS Program, income and resources are determined separately. However, the income and resources of the individual who is not in the HCBS program (community spouse) must be included on the application form. At redetermination of eligibility, the community spouse's income must be included in the review process. During any month that the individual is receiving Medically Fragile Waiver program services, the income of the community spouse is not considered available to that individual. The following rules are used to determine the income and resources of each:

(A) **Income eligibility.** To determine the income of both spouses, the rules in (i) - (v) of this subparagraph apply.

(i) If payment of income is made solely to one or the other, the income is considered available only to that individual.

(ii) If payment of income is made to both, one-half is considered for each individual.

(iii) If payment of income is made to either one or both and another person(s), the income is considered in proportion to either spouse's interest (if payment is to that spouse) or one-half of the joint interest if no interest is specified.

(iv) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

(v) After determination of income, the gross income of the individual in the Medically Fragile Waiver program cannot exceed the categorically needy standard in DHS form 08AX001E, Schedule VIII. B. 1., to be eligible for care. If the individual's gross income exceeds this standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC 317:35-5-41.6(6)(B)].

(B) **Resource eligibility.** To determine resource eligibility, it is necessary to determine the amount of resources for both spouses for the month of the individual's application for the Medically Fragile Waiver program. Of the resources available to the couple (both individual and joint ownership) an amount will be protected for the community spouse which will not be considered available to the spouse receiving Medically Fragile Waiver program services. The amount determined as the spousal share is used for all subsequent applications for SoonerCare, regardless of changes in the couple's resources. The protected spousal share cannot be changed for any reason. When application for SoonerCare is made at the same time the individual begins receiving Medically Fragile program services, DHS Form 08MA012E, Title XIX Worksheet, is used.

(i) The first step in the assessment process is to establish the total amount of resources for the

couple during the month of application of the spouse into the Medically Fragile Waiver program (regardless of payment source).

(ii) The community spouse's share is equal to one-half of the total resources of the couple not to exceed the maximum amount of resource value that can be protected for the community spouse, as shown on DHS form 08AX001E, Schedule XI.

(iii) The minimum resource standard for the community spouse, as established by the OHCA, is found on DHS form 08AX001E, Schedule XI. When the community spouse's share is less than the minimum standard, an amount may be deemed from the other spouse's share to ensure the minimum resource standard for the community spouse. If the community spouse's share equals or exceeds the minimum resource standard, deeming cannot be done.

(iv) If deeming is necessary to meet the minimum resource standard for the community spouse, the amount that is deemed must be legally transferred to the community spouse within one year of the effective date of certification for SoonerCare. At the first redetermination of eligibility, the worker must document that the resources have been transferred. After the first year of SoonerCare eligibility, resources of the community spouse will not be available to the other spouse and resources cannot be deemed to the community spouse.

(v) After the month in which the institutionalized spouse and community spouse have met the resource standard and the institutionalized spouse is determined eligible for benefits, no resources of the community spouse, regardless of value, will be considered available to the institutionalized spouse. If the resources of the community spouse grow to exceed the original deemed amount, the State cannot require the community spouse to apply any of these excess resources toward the cost of the care of the institutionalized spouse.

(vi) When determining eligibility for SoonerCare, the community spouse's share of resources is protected and the remainder considered available to the spouse receiving Medically Fragile Waiver program services.

(vii) The resources determined in (i) - (vi) of this subparagraph for the individual receiving Medically Fragile Waiver program services cannot exceed the maximum resource standard for an individual as shown in DHS form 08AX001E, Schedule VIII. D.

(viii) Once the dollar value of the community spouse's share of resources is established for the month of the other spouse's entry into the Medically Fragile Waiver program, that amount is used when determining resource eligibility for a subsequent SoonerCare application for long-term care for either spouse.

(ix) Once a determination of eligibility for SoonerCare is made, either spouse is entitled to a fair hearing. A fair hearing regarding the determination of the community spouse's resource allowance is held within thirty (30) days of the date of the request for the hearing. Either spouse is entitled to a fair hearing if dissatisfied with a determination of:

(I) the community spouse's monthly income allowance;

(II) the amount of monthly income otherwise available to the community spouse;

(III) determination of the spousal share of resource;

(IV) the attribution of resources (amount deemed); or

(V) the determination of the community spouse's resource allowance.

(x) The rules on determination of income and resources are applicable only when an individual receiving Medically Fragile Waiver program services is likely to remain under care for thirty (30) consecutive days. The thirty (30) day requirement is considered to have been met even if a hospital stay interrupts it or the individual is deceased before the thirty (30) day period ends.

(C) **Excess resources.** If the equity in the individual's capital resources is in excess of the maximum resource standards, certification is delayed up to thirty (30) days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources cannot reasonably be expected to come within standards in one month, the application is denied.

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

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

(A) For an institutionalized individual, the look-back date is thirty-six (36) months before the first day the individual is both institutionalized and has applied for SoonerCare.

However, in the case of payments from a trust or portions of a trust that are treated as transfers of assets, the look back date is sixty (60) months.

(B) For purposes of this paragraph, an institutionalized individual is one who is receiving HCBS program services.

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

(D) The penalty period consists of a period of ineligibility (whole number of months) determined by dividing the total uncompensated value of the asset by the average monthly cost (\$2,000) to a private patient in an skilled nursing facility or hospital level of care in Oklahoma. In this calculation, any partial month is dropped. There is no limit to the length of the penalty period for these transfers. Uncompensated value is defined as the difference between the fair market value at the time of transfer less encumbrances and the amount received for the resource.

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

- (i) by the individual or such individual's spouse;
- (ii) by a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or such individual's spouse;
- or
- (iii) by any person, including any court or administrative body acting at the direction or upon the request of the individual or such individual's spouse.

(F) A penalty would not apply if:

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

- (I) the spouse;
- (II) the individual's child who is under age twenty-one (21) or is blind or totally disabled as determined by the Social Security Administration;
- (III) a sibling who has equity interest in the home and resided in the home for at least one (1) year immediately prior to the

institutionalization of the individual; or
(IV) the individual's son or daughter who
resided in the home and provided care for
at least two (2) years immediately prior to
the individual's institutionalization.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(B) For purposes of this paragraph, an institutionalized individual is one who is receiving Medically Fragile program services.

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

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

(ii) the date on which the individual is:

(I) eligible for medical assistance; and

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

(D) The penalty period:

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

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

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

(E) The penalty period consists of a period of ineligibility determined by dividing the total uncompensated value of the asset by the average monthly cost to a private patient in a nursing facility in Oklahoma shown on DHS form 08AX001E. In this calculation, the penalty must include a partial month disqualification based upon the relationship between that fractional amount and the average monthly cost to a private patient in a nursing facility in Oklahoma. There is no limit to the length of the penalty period for these transfers. Uncompensated value is defined as the difference between the fair market value at the time of transfer less encumbrances and the amount received for the resource.

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

- (i) by the individual or such individual's spouse;
- (ii) by a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or such individual's spouse;
- or
- (iii) by any person, including any court or administrative body acting at the direction or upon the request of the individual or such individual's spouse.

(G) Special situations that would apply:

(i) Separate Maintenance or Divorce.

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

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

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

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

eligibility.

(ii) Inheritance from a spouse.

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

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

(H) A penalty would not apply if:

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

(I) the spouse; or

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

(III) a sibling who has equity interest in the home and resided in the home for at least one (1) year immediately prior to the institutionalization of the individual; or

(IV) the individual's son or daughter who resided in the home and provided care for at least two (2) years immediately prior to the individual's institutionalization.

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

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

means that the amount transferred will be used for the benefit of the community spouse during his or her expected life.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(N) When a transfer of assets by the spouse of an individual results in a period of ineligibility and the spouse who made such transfer subsequently becomes institutionalized, the period of ineligibility will be apportioned between the two (2) institutionalized spouses.

(6) **Commensurate return.** Commensurate return for purposes of this Section is defined as actual money payment or documentation of money spent on the member's behalf; i.e., property taxes, medical debts, nursing care expenses, etc., corresponding to the market value of the transferred property. The definition does not include personal services, labor or provision of rent-free shelter. It also does not include a monetary value assigned and projected for future payment either by cash or provision of services. Any transfer of property within the five (5) years prior to application or during receipt of assistance must be analyzed in regard to commensurate return as well as determination of intent.

[Source: Added at 27 Ok Reg 2769, eff 8-1-10 (emergency); Added at 28 Ok Reg 1589, eff 6-25-11 ; Amended at 30 Ok Reg 1277, eff 7-1-13 ; Amended at 35 Ok Reg 1511, eff 9-14-18]

317:50-1-7. Certification for Medically Fragile Waiver program services

(a) **Financial certification period for Medically Fragile Waiver program services.** The financial certification period for the Medically Fragile Waiver program is 12 months.

(b) **Medical Certification period for Medically Fragile Waiver program services.** The medical certification period for Medically Fragile

Waiver program services is 12 months. Reassessment and redetermination of medical eligibility is completed in coordination with the annual recertification of the member's service plan. If documentation supports a reasonable expectation that the member will not continue to meet medical eligibility criteria or have a need for long term care services for more than 12 months, an independent evaluation of medical eligibility is completed before the end of the current medical certification period.

[Source: Added at 27 Ok Reg 2769, eff 8-1-10 (emergency); Added at 28 Ok Reg 1589, eff 6-25-11]

317:50-1-8. Redetermination of eligibility for Medically Fragile Waiver services

A redetermination of medical and financial eligibility must be completed prior to the end of the certification period.

[Source: Added at 27 Ok Reg 2769, eff 8-1-10 (emergency); Added at 28 Ok Reg 1589, eff 6-25-11]

317:50-1-9. Member annual level of care re-evaluation and annual re-authorization of service plan

(a) Annually, the case manager reassesses the member's needs and the service plan, especially with respect to progress of the member toward service plan goals and objectives. Based on the reassessment, the case manager develops a new service plan with the member and service providers, as appropriate, and submits the new service plan for certification along with the supporting documentation and the assessment of the existing service plan. The case manager initiates the fourth quarter monitoring to allow sufficient time for certification of a new service plan prior to the expiration date on the existing service plan.

(b) At a maximum of every eleven (11) months, the case manager makes a home visit to evaluate the Medically Fragile Waiver member using the Uniform Comprehensive Assessment Tool (UCAT), Parts I and III and other information as necessary as part of the annual service plan development process.

(1) The case manager's assessment of a member done within a 60-day period prior to the existing service plan end date is the basis for medical eligibility redetermination.

(2) As part of the service plan recertification process, the member is evaluated for the continued need for skilled nursing facility or hospital level of care.

(3) Based on evaluation of the UCAT, a determination of continued medical eligibility is made and recertification of medical eligibility is done prior to the expiration date of current medical eligibility certification. If medical eligibility recertification is not made prior to current medical eligibility expiration, the existing medical eligibility certification is automatically extended until recertification is determined or for sixty (60) days, whichever is less. If the member no longer meets medical eligibility, upon making the level of care determination, the member's medical eligibility end date is updated in the system. The member's case

manager is notified that the member has been determined to no longer meet medical eligibility for Medically Fragile Waiver services as of the effective date of the eligibility determination. The member is notified and if the member requests, the case manager helps the member arrange alternate services in place of Medically Fragile Waiver services.

[Source: Added at 27 Ok Reg 2769, eff 8-1-10 (emergency); Added at 28 Ok Reg 1589, eff 6-25-11 ; Amended at 35 Ok Reg 1511, eff 9-14-18]

317:50-1-10. Medically Fragile Waiver services during hospitalization or NF placement

If a member requires hospital or nursing facility services, the case manager assists the member in accessing institutional care, periodically monitors the member's progress during the institutional stay and, as appropriate, updates the service plan and prepares services to start on the date the member is discharged from the institution and returns home.

(1) **Hospital discharge.** When the member returns home from a hospital or when notified of the member's anticipated discharge date, the case manager notifies relevant providers and coordinates the resumption of services.

(2) **NF placement of less than 30 days.** When the member returns home from a NF stay of 30 days or less or when notified of the member's anticipated discharge date the case manager notifies relevant providers and coordinates the resumption of Medically Fragile Waiver services in the home.

(3) **NF placement greater than 30 days.** When the member is scheduled to be discharged and return home from a NF stay that is greater than 30 days, the member's case manager expedites the restart of Medically Fragile Waiver services for the member.

[Source: Added at 27 Ok Reg 2769, eff 8-1-10 (emergency); Added at 28 Ok Reg 1589, eff 6-25-11 ; Amended at 33 Ok Reg 924, eff 9-1-16]

317:50-1-11. Closure or termination of Medically Fragile Waiver services

(a) **Voluntary closure of Medically Fragile Waiver services.** If the member requests a lower level of care than Medically Fragile Waiver services or if the member agrees that Medically Fragile Waiver services are no longer needed to meet his/her needs, a medical decision is not needed. The closure request is completed and signed by the member and the case manager and placed in the member's case record. Documentation is made of all circumstances involving the reasons for the voluntary termination of services and alternatives for services if written request for closure cannot be secured.

(b) **Closure due to financial or medical ineligibility.** The process for closure due to financial or medical ineligibility is described in this subsection.

(1) **Financial ineligibility.** Anytime it is determined that a member does not meet the financial eligibility criteria, the

member and provider are notified of financial ineligibility. A medical eligibility redetermination is not required when a financial ineligibility period does not exceed the medical certification period.

(2) **Medical ineligibility.** When the member is found to no longer be medically eligible for Medically Fragile Waiver services, the individual and provider are notified of the decision.

(c) **Closure due to other reasons.** Refer to OAC 317:50-1-3(e) - (f).

(d) **Resumption of Medically Fragile Waiver services.** If a member approved for Medically Fragile Waiver services has been without services for less than ninety (90) days and has a current medical and financial eligibility determination, services may be resumed using the previously approved service plan. If a member decides he/she desires to have his/her services restarted after ninety (90) days, the member must request the services.

[Source: Added at 27 Ok Reg 2769, eff 8-1-10 (emergency); Added at 28 Ok Reg 1589, eff 6-25-11 ; Amended at 35 Ok Reg 1511, eff 9-14-18]

317:50-1-12. Eligible providers

Medically Fragile Program service providers, must be certified by the Oklahoma Health Care Authority (OHCA) and all providers must have a current signed SoonerCare contract on file with the Medicaid Agency (Oklahoma Health Care Authority).

(1) The provider programmatic certification process verifies that the provider meets licensure, certification and training standards as specified in the Waiver document and agrees to Medically Fragile program Conditions of Participation. Providers must obtain programmatic certification to be Medically Fragile program certified.

(2) The provider financial certification process verifies that the provider uses sound business management practices and has a financially stable business.

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

(4) At a minimum, provider financial certification is reevaluated annually.

(5) Providers of medical equipment and supplies environmental modifications, personal emergency response systems, hospice, and skilled nursing facility respite services do not have a programmatic evaluation after the initial certification.

(6) OHCA may authorize a legally responsible family member (spouse or legal guardian) of an adult member to be SoonerCare reimbursed under the 1915(c) Medically Fragile program as a service provider, if the provider meets all of the following authorization criteria and monitoring provisions:

(A) Authorization for a legally responsible family member to be the care provider for a member may occur only if the member is offered a choice of providers and documentation demonstrates that:

- (i) either no other provider is available; or
- (ii) available providers are unable to provide necessary care to the member; or
- (iii) the needs of the member are so extensive that the spouse or legal guardian who provides the care is prohibited from working outside the home due to the member's need for care.

(B) The service must:

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

(I) spouse or guardian has resigned from full-time/part-time employment to provide care for the member; or

(II) spouse or guardian has reduced employment from full-time to part-time to provide care for the member; or

(III) spouse or guardian has taken a leave of absence without pay to provide care for the member; or

(IV) spouse or guardian provides assistance/care for the member thirty-five (35) or more hours per week without pay and the member has remaining unmet needs because no other provider is available due to the nature of the assistance/care, special language or communication, or intermittent hours of care requirements of the member.

(C) The spouse or legal guardian who is a service provider will comply with the following:

- (i) not provide more than forty (40) hours of services in a seven (7) day period;
- (ii) planned work schedules must be available in advance to the member's case manager, and variations to the schedule must be noted and supplied two (2) weeks in advance to the case manager, unless change is due to an emergency;
- (iii) maintain and submit time sheets and other required documentation for hours paid; and
- (iv) be documented in the service plan as the member's care provider.

(D) In addition to case management, monitoring, and reporting activities required for all waiver services, the state is obligated to additional monitoring requirements when members elect to use a spouse or legal guardian as a paid service provider. The OHCA will monitor through documentation submitted by the case manager the following:

- (i) at least quarterly reviews by the case manager of expenditures and the health, safety and welfare status of the individual member; and
- (ii) face-to-face visits with the member by the case manager on at least a semi annual basis.

(7) The OHCA periodically performs a programmatic audit of Case Management, Home Care (providers of Skilled Nursing, State Plan Personal Care, In-Home Respite, Advanced Supportive/Restorative Assistance and Therapy Services), and Self-Directed service providers. If due to a programmatic audit, a provider plan of correction is required, the OHCA stops new case referrals to the provider until the plan of correction has been approved and implemented. Depending on the nature and severity of problems discovered during a programmatic audit, at the discretion of the OHCA, members determined to be at risk for health or safety may be transferred from a provider requiring a plan of correction to another provider.

(8) As additional providers are certified or if a provider loses certification, the OHCA provides notice to appropriate personnel in counties affected by the certification changes.

[Source: Added at 27 Ok Reg 2769, eff 8-1-10 (emergency); Added at 28 Ok Reg 1589, eff 6-25-11 ; Amended at 35 Ok Reg 1511, eff 9-14-18]

317:50-1-13. Coverage

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

(1) Case Managers within the Self-Directed Services approved area will provide information and materials that explain the service option to the members. The OHCA provides information and material on Self-Direction to Case Managers for distribution to members.

(2) The member may request to Self-Direct their services from their Case Manager or call the Medically Fragile Program toll-free number to request the Self-Directed Services option.

[Source: Added at 27 Ok Reg 2769, eff 8-1-10 (emergency); Added at 28 Ok Reg 1589, eff 6-25-11 ; Amended at 33 Ok Reg 924, eff 9-1-16]

317:50-1-14. Description of services

Services included in the Medically Fragile waiver program are as follows:

(1) Case Management.

(A) Case management services are services that assist a member in gaining access to medical, social, educational or other services, regardless of payment source of services, that may benefit the member in maintaining health and safety. Case managers initiate and oversee necessary assessments and reassessments to establish or reestablish waiver program eligibility. Case managers develop the member's comprehensive service plan, listing only services which are necessary to prevent institutionalization of the member, as determined through assessments. Case managers initiate the addition of necessary services or deletion of unnecessary services, as dictated by the member's condition and available support. Case managers monitor the member's condition to ensure delivery and appropriateness of services and initiate service plan reviews. If a member requires hospital or skilled nursing facility (NF) services, the case manager assists the member in accessing institutional care and, as appropriate, periodically monitors the member's progress during the institutional stay and helps the member transition from institution to home by updating the service plan and preparing services to start on the date the member is discharged from the institution. Case managers must meet Medically Fragile waiver program minimum requirements for qualification and training prior to providing services to members. Prior to providing services to members choosing to self-direct their services, case managers are required to receive training and demonstrate knowledge regarding the self-directed service delivery model.

(B) Providers may only claim time for billable case management activities described as follows:

(i) A billable case management activity is any task or function defined under Oklahoma Administrative Code (OAC) 317:50-1-15(1)(A), that only a

Medically Fragile case manager because of skill, training, or authority, can perform on behalf of a member;

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

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

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

(ii) Case management services are billed using a very rural/outside providers' service rate for billable service activities provided to a member who resides in a county with population density equal to or less than twenty-five (25) persons per square mile. An exception would be services to members that reside in OHCA-identified zip codes in Osage county adjacent to metropolitan areas of Tulsa and Washington counties. Services to these members are prior authorized and billed using the standard rate.

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

(D) Case managers providing case management services to Medically Fragile waiver members must submit monthly monitoring case notes on a monthly basis to the OHCA Medically Fragile waiver staff.

(E) Providers of Home and Community-Based waiver services (HCBS) for the member, or those who have an interest in or are employed by a provider of HCBS for the member, must not provide case management or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered

service plans in a geographic area also provides HCBS.

(2) **Institutional transitional case management.**

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

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

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

(3) **Respite.**

(A) Respite services are provided to members who are unable to care for themselves. They are provided on a short-term basis because of the absence or need for relief of the primary caregiver. Payment for respite care does not include room and board costs unless more than seven (7) hours are provided in a nursing facility (NF). Respite care will only be utilized when other sources of care and support have been exhausted. Respite care will only be listed on the service plan when it is necessary to prevent institutionalization of the member. Units of services are limited to the number of units approved on the service plan.

(B) In-home respite services are billed per fifteen (15) minute unit service. Within any one (1) day period, a minimum of eight (8) units must be provided with a maximum of twenty-eight (28) units provided. The service is provided in the member's home.

(C) Facility-based extended respite is filed for a per diem rate, if provided in a NF. Extended respite must be at least eight (8) hours in duration.

(D) In-Home Extended respite is filed for a per diem rate. A minimum of eight (8) hours must be provided in the member's home.

(4) **Environmental modifications.**

(A) Environmental modifications are physical adaptations to the home, required by the member's service plan, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function

with greater independence in the home and without which, the member would require institutionalization. Adaptations or improvements to the home which are not of direct medical or remedial benefit to the waiver member are excluded.

(B) All services require prior authorization.

(C) All services shall be provided in accordance with applicable state and local building codes and conform to the Americans with Disabilities Act Accessibility Guidelines, Title 28 of the Code of Federal Regulations Part 36 Appendix A.

(D) Payment for these services is made on an individual basis following a uniform process approved by the Medicaid agency.

(5) Medical Supplies, Equipment, and Appliances.

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

(B) Medical supplies, equipment, and supplies are billed using the appropriate healthcare common procedure code (HCPC). Reoccurring supplies which are shipped to the member are compensable only when the member remains eligible for waiver services, continues to reside in the home and is not institutionalized in a hospital, skilled (NF) or nursing home. It is the provider's responsibility to verify the member's status prior to shipping these items. Payment for medical supplies, equipment, and supplies is limited to the Medicare rate, or the SoonerCare rate, or is determined through manual pricing. If manual pricing is used, the provider is reimbursed at the provider's documented manufacturer's suggested retail price (MSRP) minus thirty (30) percent or invoice cost plus thirty (30) percent, whichever is the lesser of the two (2). OHCA may establish a fair market price through claims review and analysis.

(6) Advanced supportive/restorative assistance.

(A) Advanced supportive/restorative assistance services are maintenance services to assist a member who has a chronic, yet stable, condition. These services assist with activities of daily living which require devices and procedures related to altered body functions. This service

is for maintenance only and is not utilized as a treatment service.

(B) Advanced supportive/restorative assistance service is billed per fifteen (15) minute unit of service. The number of units of this service a member may receive is limited to the number of units approved on the service plan.

(7) Nursing.

(A) Nursing services are services listed in the service plan which are within the scope of the Oklahoma Nursing Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State. Nursing services includes skilled nursing and/or private duty nursing. Skilled nursing is provided on an intermittent or part-time basis. Private duty nursing is individual and continuous care provided to a participant at home by licensed nurses. The provision of the nursing service will work to prevent or postpone the institutionalization of the member.

(B) Nursing services are services of a maintenance or preventive nature provided to members with stable, chronic conditions. These services are not intended to treat an acute health condition and may not include services which would be reimbursable under either Medicaid or Medicare's Home Health program. This service primarily provides nurse supervision to the Personal Care Assistant or to the Advanced Supportive/Restorative Assistance Aide and assesses the member's health and prescribed medical services to ensure that they meet the member's needs as specified in the service plan. A skilled nursing assessment/evaluation on-site visit is made to each member for whom Advanced Supportive/Restorative Assistance services are authorized to evaluate the condition of the member and medical appropriateness of services. An assessment/evaluation visit report will be made to the Medically Fragile Waiver case manager in accordance with review schedule determined in consultation between the Case Manager and the Skilled Nurse, to report the member's condition or other significant information concerning each advanced supportive/restorative care member.

(i) The case manager may recommend authorization of Skilled Nursing services as part of the interdisciplinary team planning for the member's service plan and/or assessment/evaluation of:

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

(II) the adequacy of personal care and/or advanced supportive/restorative assistance services to meet the member's needs

including providing on-the-job training and competency testing for personal care or advanced supportive/restorative care aides in accordance with rules and regulations for delegation of nursing tasks as established by the Oklahoma Board of Nursing.

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

(I) preparing a one (1) week supply of insulin syringes for a blind diabetic, who can safely self-inject the medication but cannot fill his/her own syringe. This service would include monitoring the member's continued ability to self-administer the insulin;

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

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

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

(V) providing consultation and education to the member, member's family and/or other informal caregivers identified in the service plan, regarding the nature of the member's chronic condition. Provide skills training (including return skills demonstration to establish competency) to the member, family and/or other informal caregivers as specified in the service plan for preventive and rehabilitative care procedures.

(C) Nursing service can be billed for service plan development and/or assessment/evaluation services or, for other services within the scope of the Oklahoma Nursing Practice Act including private duty nursing. Nursing services are billed per fifteen (15) minute unit of service. A specific procedure code is used to bill for assessment/evaluation/service plan development skilled nursing services and other procedure codes are used to bill for all other authorized nursing services. A maximum of eight (8) units per day of skilled nursing for assessment/evaluation and/or service plan development

are allowed. An agreement by a provider to perform a nurse evaluation is also an agreement, to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted. Reimbursement for a nurse evaluation is denied if the provider that produced the nurse evaluation fails to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted.

(8) Home Delivered Meals.

(A) Home Delivered Meals provide one (1) meal per day. A home delivered meal is a meal prepared in advance and brought to the member's home. Each meal must have a nutritional content equal to at least one third (1/3) of the recommended daily allowance as established by the Food and Nutrition Board of the National Academy of Sciences. Meals are only provided to members who are unable to prepare meals and lack an informal provider to do meal preparation.

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

(9) Occupational Therapy services.

(A) Occupational Therapy services are those services that increase functional independence by enhancing the development of adaptive skills and performance capacities of members with physical disabilities and related psychological and cognitive impairments. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Treatment involves the therapeutic use of self-care, work and play activities and may include modification of the tasks or environment to enable the member to achieve maximum independence, prevent further disability, and maintain health. Under a physician's order, a licensed occupational therapist evaluates the member's rehabilitation potential and develops an appropriate written therapeutic regimen. The regimen utilizes paraprofessional occupational therapy assistant services, within the limits of their practice, working under the supervision of the licensed occupational therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will

ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential. (B) Occupational Therapy services are billed per fifteen (15) minute unit of service. Payment is not allowed solely for written reports or record documentation.

(10) Physical Therapy services.

(A) Physical Therapy services are those services that prevent physical disability through the evaluation and rehabilitation of members disabled by pain, disease or injury. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Treatment involves use of physical therapeutic means such as massage, manipulation, therapeutic exercise, cold or heat therapy, hydrotherapy, electrical stimulation and light therapy. Under a physician's order, a licensed physical therapist evaluates the member's rehabilitation potential and develops an appropriate, written therapeutic regimen. The regimen utilizes paraprofessional physical therapy assistant services, within the limits of their practice, working under the supervision of the licensed physical therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential. (B) Physical Therapy services are billed per fifteen (15) minute units of service. Payment is not allowed solely for written reports or record documentation.

(11) Speech and Language Therapy services.

(A) Speech/Language Therapy services are those that prevent speech and language communication disability through the evaluation and rehabilitation of members disabled by pain, disease or injury. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Services involve use of therapeutic means such as evaluation, specialized treatment, and/or development and oversight of a therapeutic maintenance program. Under a physician's order, a licensed Speech/Language Pathologist evaluates the member's rehabilitation potential and develops an appropriate, written therapeutic regimen. The regimen utilizes paraprofessional therapy assistant services within the limits of their practice, working under the supervision

of the licensed Speech/Language Pathologist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The Pathologist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

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

(12) Respiratory Therapy Services.

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

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

(13) Hospice Services.

(A) Hospice is palliative and/or comfort care provided to the member and his/her family when a physician certifies that the member has a terminal illness and has six (6) months or less to live and orders hospice care. Medically Fragile Waiver hospice care is authorized for a six (6) month period and requires a physician certification of a terminal illness and orders of hospice care. If the member requires more than six months of hospice care, a physician or nurse practitioner must have a face-to-face visit with the member thirty (30) days prior to the initial hospice authorization end date and re-certify that the member has a terminal illness and has six months or less to live and

orders additional hospice care. After the initial authorization period, additional periods of hospice may be authorized for a maximum of sixty (60) days increments with physician certification that the member has a terminal illness and has six months or less to live. A member's service plan that includes hospice care must comply with waiver requirements to be within total service plan cost limits.

(B) A hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional and spiritual stresses which are experienced during the final stages of illness and during dying and bereavement. The member signs a statement choosing hospice care instead of routine medical care that has the objective to treat and cure the member's illness. Once the member has elected hospice care, the hospice medical team assumes responsibility for the member's medical care for the terminal illness in the home environment. Hospice care services include nursing care, physician services, medical equipment and supplies, drugs for symptom control and pain relief, home health aide and personal care services, physical, occupational and/or speech therapy, medical social services, dietary counseling and grief and bereavement counseling to the member and/or family. A hospice plan of care must be developed by the hospice team in conjunction with the member's case manager before hospice services are provided. The hospice services must be related to the palliation or management of the member's terminal illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills. Hospice may be provided to the member in a Nursing Facility (NF) only when the member is placed in the NF for Medically Fragile Facility Based Extended Respite. Hospice provided as part of Facility Based Extended Respite may not be reimbursed for more than five days during any thirty (30) day period. A member that is eligible for Medicare Hospice provided as a Medicare Part A benefit, is not eligible to receive Medically Fragile hospice services.

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

(14) Personal Care.

(A) Personal Care is assistance to a member in carrying out activities of daily living such as bathing, grooming and toileting, or in carrying out instrumental activities of daily living, such as preparing meals and doing laundry, to assure personal health and safety of the individual or to prevent or minimize physical health regression or deterioration. Personal Care services do not include

service provision of a technical nature, i.e. tracheal suctioning, bladder catheterization, colostomy irrigation, and operation/maintenance of equipment of a technical nature.

(B) Medically Fragile Home Care Agency Skilled Nursing staff working in coordination with a case manager are responsible for development and monitoring of the member's Personal Care plan.

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

(15) Personal Emergency Response System.

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

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

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

(16) Prescription drugs. Members are eligible for a maximum of six (6) prescriptions per month with a limit of three (3) brand-name prescriptions. Seven (7) additional generic prescriptions per month are allowed if medically necessary. Medically necessary

prescriptions beyond the three (3) brand-name or thirteen (13) total prescriptions will be covered with prior authorization. More information on prescription drugs is provided at OAC 317:30-5-72.

(17) Self-Direction.

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

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

(i) Have an existing need for Self-Directed services to prevent institutionalization;

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

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

(II) The member is not willing to assume responsibility, or to enlist an authorized representative to assume responsibility, in one (1) or more areas of Self-Direction such as in service planning, or in assuming the role of employer of the Personal Care Assistant (PCA) or Advanced Supportive/Restorative (ASR) service provider, or in monitoring and managing health or in preparation for emergency backup; or

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

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

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

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

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

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

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

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

(vi) The member, even with case manager and financial management services assistance, is unable to operate successfully within their Individual Budget Allocation (IBA); or

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

(E) The member may designate a family member or friend as an "authorized representative" to assist in the service planning process and in executing member employer responsibilities. If the member chooses to designate an "authorized representative", the designation and agreement identifying the "willing adult" to assume this

role and responsibility is documented with dated signatures of the member, the designee and the member's case manager or the OHCA staff.

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

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

(F) Self-Directed Services are delivered as authorized on the service plan and are limited to Personal Care, Respite and Advanced Supportive/Restorative Care. The member employs the respite or PCA and/or the ASR provider and is responsible, with assistance from the Administrative Financial Management Services (FMS), for ensuring that the employment complies with state and federal labor law requirements. The member:

(i) Recruits, hires and, as necessary, discharges the PCA and ASR;

(ii) Provides instruction and training to the PCA or ASR on tasks to be done and works with the case manager to obtain skilled nursing services assistance with training when necessary. Prior to performing an ASR provider task for the first time, the ASR must demonstrate competency in the tasks in an on-the-job training session conducted by the member and the member must document the attendant's competency in performing each task in the ASR provider personnel file;

(iii) Determines where and how the PCA or ASR works, hours of work, what is to be accomplished and, within IBA limits, wages to be paid for the work;

(iv) Supervises and documents employee work time; and

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

(G) FMS are program administrative services provided to participating Self-Directed Service employer/members by agencies contracted with the OHCA. FMS are employer related assistance that provides Internal Revenue Service (IRS) fiscal reporting agent and other financial management tasks and functions including, but not limited to:

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

(ii) Other employer related payment disbursements as agreed to with the member and in accordance with the member's IBA;

(iii) Responsibility for obtaining criminal and abuse registry background checks, on behalf of the member, on prospective hires for PCA or ASR provider;

(iv) Providing to the member, as needed, assistance with employer related cognitive tasks, decision-making and specialized skills that may include assistance with IBA planning and support for making decisions including training and providing reference material and consultation regarding employee management tasks such as recruiting, hiring, training and supervising the member's respite or PCA or ASR provider; and

(H) The service of respite or PCA is billed per fifteen (15) minute unit of service. The number of units of PCA a member may receive is limited to the number of units approved on the Service Plan.

(I) ASR services are billed per fifteen (15) minute unit of service. The number of units of ASR a member may receive is limited to the number of units approved on the Service Plan.

(J) Self-Directed Services rates are determined using the IBA expenditure accounts determination process for each member. The IBA expenditure accounts determination process includes consideration and decisions about the following:

(i) The IBA expenditure accounts determination constrains total SoonerCare reimbursement for Self-Directed services to be less than expenditures for equivalent services using agency providers.

(ii) The PCA and ASR service unit rates are calculated by the OHCA during the Self-Directed service eligibility determination process. The allocation of portions of the PCA and/or ASR rate to cover salary, mandatory taxes, and optional benefits (including worker's compensation insurance, if available) is determined individually for each member using the Self-Directed services IBA expenditure accounts determination process.

(iii) The IBA Expenditure Accounts Determination process defines the level of program financial resources required to meet the member's need for Self-Directed services. If the member's need for services changes due to a change in health/disability status and/or a change in the level of support available from other sources, the case manager, based upon an updated assessment, amends the service plan to increase Self-Directed

service units appropriate to meet additional member need. The OHCA, upon favorable review, authorizes the amended plan and updates the member's IBA. Service amendments based on changes in member need for services do not change an existing PCA or ASR rate. The member, with assistance from the FMS, reviews and revises the IBA expenditure accounts calculation annually or more often to the extent appropriate and necessary.

(18) Self-Directed Goods and Services (SD-GS).

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

(B) These goods and services are purchased from the self-directed budget. All goods and services must be approved by the Medically Fragile waiver staff. Documentation must be available upon request.

(19) Transitional case management.

(A) Transitional case management are one-time billable expenses for members who transition from within the community to the Medically Fragile waiver.

(B) Transitional case management must be reasonable and necessary as determined through the transition plan development process and must be clearly identified in the plan.

(C) Transitional case management assist members that are eligible to receive waiver services in gaining access to needed waiver and other state plan services, as well as needed medical, social, educational, and other services to assist the transition, regardless of the funding source for the services which access is gained.

(D) Transitional case management may be authorized for assisting the member transition to the Medically Fragile Waiver by updating the service plan, including preparing for necessary services and supports to be in place or to start on the date the member is effective with the waiver.

[Source: Added at 27 Ok Reg 2769, eff 8-1-10 (emergency); Added at 28 Ok Reg 1589, eff 6-25-11 ; Amended at 30 Ok Reg 1277, eff 7-1-13 ; Amended at 32 Ok Reg 240, eff 11-3-14 ; Amended at 32 Ok Reg 1187, eff 8-27-15 ; Amended at 33 Ok Reg 924, eff 9-1-16 ; Amended at 35 Ok Reg 1511, eff 9-14-18 ; Amended at 37 Ok Reg 860, eff 8-1-20 (emergency); Amended at 38 Ok Reg 1105, eff 9-1-21]

317:50-1-15. Reimbursement

(a) Rate methodologies for Waiver services are set in accordance with the rate setting process by the State Plan Amendment Rate Committee (SPARC) and approved by the Oklahoma Health Care Authority Board.

- (1) The rate for SNF Respite is set equivalent to the rate for skilled nursing facility services that require providers having equivalent qualifications;
- (2) The rate for units of Home-Delivered Meals are set equivalent to the rate established by the Oklahoma Department of Human Services for the equivalent services provided for the Home-Delivered Meals Program that require providers having equivalent qualifications;
- (3) The rates for units of Personal Care and In-Home Respite are set equivalent to State Plan Agency Personal Care unit rate which require providers having equivalent qualifications;
- (4) The rates for Advanced Supportive/Restorative Assistance is set equivalent to 1.077 of the State Plan Agency Personal Care unit rate;
- (5) Self-Directed rates are determined using the Individual Budget Allocation (IBA) Expenditure Accounts Determination process for each member.

[Source: Added at 27 Ok Reg 2769, eff 8-1-10 (emergency); Added at 28 Ok Reg 1589, eff 6-25-11]

317:50-1-16. Billing procedures for Medically Fragile Waiver services

- (a) Billing procedures for long-term care medical services are contained in the OKMMIS Billing and Procedure Manual. Questions regarding billing procedures which cannot be resolved through a study of the manual should be referred to the OHCA.
- (b) The approved Medically Fragile Waiver service plan is the basis for the MMIS service prior authorization, specifying:
 - (1) service;
 - (2) service provider;
 - (3) units authorized; and
 - (4) begin and end dates of service authorization.
- (c) As part of Medically Fragile Waiver quality assurance, provider audits are used to evaluate whether paid claims are consistent with service plan authorizations and documentation of service provision. Evidence of paid claims that are not supported by service plan authorization and/or documentation of service provision will be turned over to the OHCA Provider Audit Unit for follow-up investigation.

[Source: Added at 27 Ok Reg 2769, eff 8-1-10 (emergency); Added at 28 Ok Reg 1589, eff 6-25-11 ; Amended at 33 Ok Reg 924, eff 9-1-16]

SUBCHAPTER 3. MY LIFE, MY CHOICE [REVOKED]

317:50-3-1. Purpose [REVOKED]

[Source: Added at 28 Ok Reg 127, eff 10-14-10 (emergency); Added at 28 Ok Reg 1608, eff 6-25-11 ; Revoked at 32 Ok Reg 1195, eff 8-27-15]

317:50-3-2. Definitions [REVOKED]

[Source: Added at 28 Ok Reg 127, eff 10-14-10 (emergency); Added at 28 Ok Reg 1608, eff 6-25-11 ; Amended at 29 Ok Reg 1212, eff 6-25-12 ; Revoked at 32 Ok Reg 1195, eff 8-27-15]

317:50-3-3. My Life, My Choice program overview [REVOKED]

[Source: Added at 28 Ok Reg 127, eff 10-14-10 (emergency); Added at 28 Ok Reg 1608, eff 6-25-11 ; Amended at 30 Ok Reg 1291, eff 7-1-13 ; Revoked at 32 Ok Reg 1195, eff 8-27-15]

317:50-3-4. Application for My Life, My Choice Waiver services [REVOKED]

[Source: Added at 28 Ok Reg 127, eff 10-14-10 (emergency); Added at 28 Ok Reg 1608, eff 6-25-11 ; Amended at 29 Ok Reg 1219, eff 6-25-12 ; Revoked at 32 Ok Reg 1195, eff 8-27-15]

317:50-3-5. My Life, My Choice Waiver program medical eligibility determination [REVOKED]

[Source: Added at 28 Ok Reg 127, eff 10-14-10 (emergency); Added at 28 Ok Reg 1608, eff 6-25-11 ; Revoked at 32 Ok Reg 1195, eff 8-27-15]

317:50-3-6. Determining financial eligibility for the My Life, My Choice Waiver program [REVOKED]

[Source: Added at 28 Ok Reg 127, eff 10-14-10 (emergency); Added at 28 Ok Reg 1608, eff 6-25-11 ; Amended at 30 Ok Reg 1291, eff 7-1-13 ; Revoked at 32 Ok Reg 1195, eff 8-27-15]

317:50-3-7. Certification for My Life, My Choice Waiver program services [REVOKED]

[Source: Added at 28 Ok Reg 127, eff 10-14-10 (emergency); Added at 28 Ok Reg 1608, eff 6-25-11 ; Revoked at 32 Ok Reg 1195, eff 8-27-15]

317:50-3-8. Redetermination of eligibility for My Life, My Choice Waiver services [REVOKED]

[Source: Added at 28 Ok Reg 127, eff 10-14-10 (emergency); Added at 28 Ok Reg 1608, eff 6-25-11 ; Revoked at 32 Ok Reg 1195, eff 8-27-15]

317:50-3-9. Member annual level of care re-evaluation and annual re-authorization of service plan [REVOKED]

[Source: Added at 28 Ok Reg 127, eff 10-14-10 (emergency); Added at 28 Ok Reg 1608, eff 6-25-11 ; Revoked at 32 Ok Reg 1195, eff 8-27-15]

317:50-3-10. My Life, My Choice Waiver services during hospitalization or nursing facility placement [REVOKED]

[Source: Added at 28 Ok Reg 127, eff 10-14-10 (emergency); Added at 28 Ok Reg 1608, eff 6-25-11 ; Revoked at 32 Ok Reg 1195, eff 8-27-15]

317:50-3-11. Closure or termination of My Life, My Choice Waiver services [REVOKED]

[Source: Added at 28 Ok Reg 127, eff 10-14-10 (emergency); Added at 28 Ok Reg 1608, eff 6-25-11 ; Revoked at 32 Ok Reg 1195, eff 8-27-15]

317:50-3-12. Eligible providers [REVOKED]

[Source: Added at 28 Ok Reg 127, eff 10-14-10 (emergency); Added at 28 Ok Reg 1608, eff 6-25-11 ; Revoked at 32 Ok Reg 1195, eff 8-27-15]

317:50-3-13. Coverage [REVOKED]

[Source: Added at 28 Ok Reg 127, eff 10-14-10 (emergency); Added at 28 Ok Reg 1608, eff 6-25-11 ; Revoked at 32 Ok Reg 1195, eff 8-27-15]

317:50-3-14. Description of services [REVOKED]

[Source: Added at 28 Ok Reg 127, eff 10-14-10 (emergency); Added at 28 Ok Reg 1608, eff 6-25-11 ; Amended at 30 Ok Reg 1291, eff 7-1-13 ; Amended at 31 Ok Reg 1759, eff 9-12-14 ; Amended at 32 Ok Reg 240, eff 11-3-14 (emergency); Revoked at 32 Ok Reg 1195, eff 8-27-15]

317:50-3-15. Reimbursement [REVOKED]

[Source: Added at 28 Ok Reg 127, eff 10-14-10 (emergency); Added at 28 Ok Reg 1608, eff 6-25-11 ; Revoked at 32 Ok Reg 1195, eff 8-27-15]

317:50-3-16. Billing procedures for My Life, My Choice Waiver services [REVOKED]

[Source: Added at 28 Ok Reg 127, eff 10-14-10 (emergency); Added at 28 Ok Reg 1608, eff 6-25-11 ; Revoked at 32 Ok Reg 1195, eff 8-27-15]

SUBCHAPTER 5. SOONER SENIORS [REVOKED]

317:50-5-1. Purpose [REVOKED]

[Source: Added at 28 Ok Reg 148, eff 10-14-10 (emergency); Added at 28 Ok Reg 1630, eff 6-25-11 ; Revoked at 32 Ok Reg 1195, eff 8-27-15]

317:50-5-2. Definitions [REVOKED]

[Source: Added at 28 Ok Reg 148, eff 10-14-10 (emergency); Added at 28 Ok Reg 1630, eff 6-25-11 ; Amended at 29 Ok Reg 1212, eff 6-25-12 ; Revoked at 32 Ok Reg 1195, eff 8-27-15]

317:50-5-3. Sooner Seniors program overview [REVOKED]

[Source: Added at 28 Ok Reg 148, eff 10-14-10 (emergency); Added at 28 Ok Reg 1630, eff 6-25-11 ; Amended at 30 Ok Reg 1307, eff 7-1-13 ; Revoked at 32 Ok Reg 1195, eff 8-27-15]

317:50-5-4. Application for Sooner Seniors Waiver services [REVOKED]

[Source: Added at 28 Ok Reg 148, eff 10-14-10 (emergency); Added at 28 Ok Reg 1630, eff 6-25-11 ; Amended at 29 Ok Reg 1220, eff 6-25-12 ; Revoked at 32 Ok Reg 1195, eff 8-27-15]

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

[Source: Added at 28 Ok Reg 148, eff 10-14-10 (emergency); Added at 28 Ok Reg 1630, eff 6-25-11 ; Amended at 31 Ok Reg 1759, eff 9-12-14 ; Revoked at 32 Ok Reg 1195, eff 8-27-15]

317:50-5-6. Determining financial eligibility for the Sooner Seniors Waiver program [REVOKED]

[Source: Added at 28 Ok Reg 148, eff 10-14-10 (emergency); Added at 28 Ok Reg 1630, eff 6-25-11 ; Amended at 30 Ok Reg 1307, eff 7-1-13 ; Revoked at 32 Ok Reg 1195, eff 8-27-15]

317:50-5-7. Certification for Sooner Seniors Waiver program services [REVOKED]

[Source: Added at 28 Ok Reg 148, eff 10-14-10 (emergency); Added at 28 Ok Reg 1630, eff 6-25-11 ; Revoked at 32 Ok Reg 1195, eff 8-27-15]

317:50-5-8. Redetermination of eligibility for Sooner Seniors Waiver services [REVOKED]

[Source: Added at 28 Ok Reg 148, eff 10-14-10 (emergency); Added at 28 Ok Reg 1630, eff 6-25-11 ; Revoked at 32 Ok Reg 1195, eff 8-27-15]

317:50-5-9. Member annual level of care re-evaluation and annual re-authorization of service plan [REVOKED]

[Source: Added at 28 Ok Reg 148, eff 10-14-10 (emergency); Added at 28 Ok Reg 1630, eff 6-25-11 ; Revoked at 32 Ok Reg 1195, eff 8-27-15]

317:50-5-10. Sooner Seniors Waiver services during hospitalization or nursing facility placement [REVOKED]

[Source: Added at 28 Ok Reg 148, eff 10-14-10 (emergency); Added at 28 Ok Reg 1630, eff 6-25-11 ; Revoked at 32 Ok Reg 1195, eff 8-27-15]

317:50-5-11. Closure or termination of Sooner Seniors Waiver services [REVOKED]

[Source: Added at 28 Ok Reg 148, eff 10-14-10 (emergency); Added at 28 Ok Reg 1630, eff 6-25-11 ; Revoked at 32 Ok Reg 1195, eff 8-27-15]

317:50-5-12. Eligible providers [REVOKED]

[Source: Added at 28 Ok Reg 148, eff 10-14-10 (emergency); Added at 28 Ok Reg 1630, eff 6-25-11 ; Revoked at 32 Ok Reg 1195, eff 8-27-15]

317:50-5-13. Coverage [REVOKED]

[Source: Added at 28 Ok Reg 148, eff 10-14-10 (emergency); Added at 28 Ok Reg 1630, eff 6-25-11 ; Revoked at 32 Ok Reg 1195, eff 8-27-15]

317:50-5-14. Description of services [REVOKED]

[Source: Added at 28 Ok Reg 148, eff 10-14-10 (emergency); Added at 28 Ok Reg 1630, eff 6-25-11 ; Amended at 30 Ok Reg 1307, eff 7-1-13 ; Amended at 31 Ok Reg 1759, eff 9-12-14 ; Amended at 32 Ok Reg 240, eff 11-3-14 (emergency); Revoked at 32 Ok Reg 1195, eff 8-27-15]

317:50-5-15. Reimbursement [REVOKED]

[Source: Added at 28 Ok Reg 148, eff 10-14-10 (emergency); Added at 28 Ok Reg 1630, eff 6-25-11 ; Revoked at 32 Ok Reg 1195, eff 8-27-15]

317:50-5-16. Billing procedures for Sooner Seniors Waiver services [REVOKED]

[Source: Added at 28 Ok Reg 148, eff 10-14-10 (emergency); Added at 28 Ok Reg 1630, eff 6-25-11 ; Revoked at 32 Ok Reg 1195, eff 8-27-15]

CHAPTER 55. MANAGED CARE

[Source: Codified 9-12-22]

SUBCHAPTER 1. GENERAL PROVISIONS

317:55-1-1. Purpose; use of manuals

The purpose of this Chapter is to provide detailed rules which govern the delivery of health care services provided by managed care organizations or dental benefits managers as required by the "Ensuring Access to Medicaid Act", 2021 Okla. Sess. Law Serv. Ch. 542 (S.B. 131), Title 56 of the Oklahoma Statutes, Sections 4002-4004 and 42 Code of Federal Regulations (C.F.R.), Part 438. The Oklahoma Health Care Authority may also develop manuals and medical guidelines that formalize terms, conditions, and applicable policy of awarded contracts.

[Source: Added at 39 Ok Reg 450, eff 12-21-21 (emergency); Added at 39 Ok Reg 1628, eff 9-12-22]

317:55-1-2. Monitoring system for all managed care programs

In accordance with 42 C.F.R. § 438.66, the Oklahoma Health Care Authority will monitor each managed care organization or dental benefits manager to assess its ability and capacity to comply with program- and contract-specific requirements and to assess its ability to perform satisfactorily in all major operational areas.

[Source: Added at 39 Ok Reg 450, eff 12-21-21 (emergency); Added at 39 Ok Reg 1628, eff 9-12-22]

317:55-1-3. Definitions

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

"1115 waiver" means the demonstration waiver, as amended and including all active special terms and conditions (STCs) at a specific point in time, that authorizes Oklahoma Health Care Authority (OHCA) to operate a program in which one or more requirements of Title XIX of the Social Security Act (Act) are waived based on the waiver authority of section 1115 of the Act.

"1915(c) waiver" means any waiver, authorized by section 1915(c) of the Act, that allows specific coverage of home- and community-based services to a limited group of Medicaid-eligible individuals as an alternative to institutional care.

"Accountable care organization" or **"ACO"** means a group of clinicians, hospitals, or other health care providers who come together voluntarily to give coordinated high-quality care to a designated group of patients.

"Act" means the Social Security Act.

"Adult" means an individual twenty-one (21) years of age or older, unless otherwise specified by statute, regulation, and/or policy adopted by the OHCA. For eligibility criteria policy for children and adults, please refer to Oklahoma Administrative Code (OAC) 317:35-5-2.

"Adverse determination" means a determination by a health carrier, including an managed care organization (MCO) or dental benefits manager (DBM), or its designee that an admission, availability of care, continued stay or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service or payment for services is therefore denied, reduced or terminated.

"Alternative benefit plan" means the benefit package delivered to expansion adults which is developed by OHCA and approved by the Centers for Medicare and Medicaid Services (CMS) in accordance with the requirements of Subpart C of 42 C.F.R. Part 440.

"American Indian/Alaska Native" or **"AI/AN"** means any individual as defined in 25 U.S.C. §§ 1603(13), 1603(28) or 1679(a) or who has been determined eligible as an Indian under 42 C.F.R. § 136.12.

"Appeal" means a review by an MCO or DBM of an adverse benefit determination.

"Authorized representative" means a competent adult who has the managed care enrollee's signed, written authorization to act on the managed care enrollee's behalf during the grievance, appeal, and State fair hearing process. The written authority to act will specify any limits of the representation.

"Capitation payment" means a payment, based on an actuarially sound capitation rate for the provision of Oklahoma Medicaid State Plan services under a managed care contract, that OHCA makes periodically to the MCO or DBM behalf of each enrollee enrolled in that MCO or DBM, regardless of whether the enrollee actually receives services during the period covered by the payment.

"Capitation rate" means the actuarially sound per-enrollee, per-month amount, including any adjustments, that OHCA agrees to pay an MCO or DBM for the provision of State Plan services.

"Child" means an individual under twenty-one (21) years of age, unless otherwise specified by statute, regulation, and/or policy adopted by the OHCA. For eligibility criteria policy for children and adults, please refer to OAC 317:35-5-2.

"Children's Health Insurance Program" or **"CHIP"** means a federal Medicaid program authorized under Title XXI of the Social Security Act.

"Choice counseling" means the provision of information and services designed to assist eligibles in making enrollment decisions related to the managed care program. Choice counseling includes answering questions and identifying factors to consider when choosing among MCOs or DBMs, as well as when choosing a patient-centered medical home provider or dental home provider. Choice counseling does not include making recommendations for or against enrollment into a specific MCO or DBM.

"Chronic condition" means a condition that is expected to last one (1) year or more and requires ongoing medical attention and/or limits activities of daily living (ADL).

"Civil monetary damage" means a damage imposed by OHCA which the MCO must pay for acting or failing to act in accordance with 42 C.F.R. § 438.700 et seq. Amounts may not exceed those specified in 42 C.F.R. § 438.704.

"Claims denial error rate" means the rate of claims denials that are overturned on appeal.

"Clean claim" means a properly completed billing form with coding based on Current Procedural Terminology (CPT), 4th Edition or a more recent edition, the Tenth Revision of the International Classification of Diseases or a more recent revision, or Healthcare Common Procedure Coding System (HCPCS), where applicable, to provide information specifically required in the OHCA Provider Billing and Procedure Manual.

"C.F.R." means the Code of Federal Regulations.

"Contract" means the risk contract or the written and executed agreement between OHCA and a health plan or managed care organization or dental benefit manager for health plan or managed care services and includes the solicitation, the bid, the contract addenda, appendices, attachments, and amendments, and any documents incorporated into the contract by reference or otherwise, as well as any document or information subject to the rules on legally binding procurement in Chapter 10 of these rules.

"Copayment" means a fixed amount that an enrollee pays for a covered health care service when the enrollee receives the service.

"Cost sharing" means the State's requirement that an enrollee bear some of the cost of their care through mechanisms such as copayments, deductibles, and other similar charges.

"Deemed newborn" means children born to SoonerCare enrolled mothers and determined eligible under 42 C.F.R. § 435.117.

"Dental benefits manager" or **"DBM"** means a health plan under contract with the OHCA to manage and deliver dental benefits and services to enrollees and designated as a pre-paid ambulatory health plan (PAHP) under 42 C.F.R. Part 438.

"Dental home" or **"DH"** means the care coordinated delivery system as defined within the contract between OHCA and a DBM.

"Disenrollment" means OHCA's removal of an enrollee from participation in a specific MCO or DBM or from participation in the managed care program.

"Dual eligible individuals" means individuals eligible for both Medicaid and Medicare.

"Eligible" means an individual who has been deemed eligible for Medicaid in the State of Oklahoma and is eligible for participation in the managed care program but who is not yet enrolled in an MCO or DBM.

"Emergency services" means medical services provided for a medical condition, including injury, manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the individual's health, or the health of an unborn child, in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organs or parts.

"Enrollee" means an individual who has been deemed eligible for Medicaid in the State of Oklahoma, who has been deemed eligible for enrollment in a managed care program, and who is currently enrolled in a managed care program.

"Enrollee handbook" means a guidebook prepared as a model by OHCA and modified and distributed by the MCO or DBM to its enrollees. The enrollee handbook is designed to help the enrollee understand the MCO or DBM, the managed care program, and the rights and responsibilities that come with enrollment in the program.

"Enrollment" means the OHCA process by which an eligible becomes an enrollee with an MCO or DBM.

"Enrollment activities" means activities that OHCA performs or conducts related to distributing, collecting, or processing enrollment materials, taking enrollments by technological device or in person, or enrolling or disenrolling eligibles into any MCO or DBM.

"Essential community provider" means a provider defined by 45 C.F.R. § 156.235.

"Essential hospital services" means tertiary care hospital services to which the MCO must provide access, including but not limited to neonatal, perinatal, pediatric, trauma and burn services.

"Expansion adult" means an individual nineteen (19) or older and under age sixty-five (65), with income at or below one hundred thirty-eight percent (138%) of the federal poverty level (FPL) determined eligible in accordance with 42 C.F.R. § 435.119), and who are not categorically related to the aged, blind, and disabled.

"Former foster children" or **"FFC"** means individuals under age twenty-six (26) determined eligible in accordance with 42 C.F.R. § 435.150 who were in foster care under the responsibility of the State or an Indian Tribe within Oklahoma and enrolled in SoonerCare on the date of attaining age eighteen (18) or aging out of foster care.

"Foster children (FC)" means children in foster care under the responsibility of the State, including children and youth who are in State custody due to abuse or neglect.

"Fraud" means intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or State law.

"Grievance" means an enrollee's expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee or failure to respect the enrollee's rights regardless of whether remedial action is requested. A grievance includes an enrollee's right to dispute an extension of time to make an authorization decision when proposed by the MCO or DBM.

"Grievance and appeal system" means the processes the MCO or DBM must implement in accordance with 42 C.F.R. Part 438, Subpart F, to handle enrollee grievances and appeals, as well as the processes to collect and track information about them.

"Health care services" means all Medicaid State Plan services provided, according to contract, by the MCO or DBM in any setting.

Health care services may include but are not limited to medical care, behavioral health care, dental care, and pharmacy services.

"Health plan" means the same in these rules as at 36 O.S. § 4405.1.

"Implementation" means the process by which OHCA and the MCO or DBM performs actions and responsibilities to actively implement a managed care program or contract for the first time. Implementation also means, depending on its use, the moment in time that such actions and responsibilities are fully completed.

"Implementation period" means the period of time, as defined in contract, during which implementation occurs.

"Indian health care provider" or **"IHCP"** means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1603).

"Initial enrollment" means an eligible's enrollment in an MCO or DBM during the initial enrollment period.

"Initial enrollment period" means the first period of time, as defined in contract, prior to or immediately following managed care program or contract implementation, when eligibles can first enroll in an MCO or DBM for the managed care program.

"Managed care organization" or **"MCO"** means a health plan designated as a managed care organization pursuant to 42 C.F.R. 438.2 and under contract with OHCA to participate in the managed care program and to deliver health care services to enrollees.

"Managed care program" or **"managed care"** or **"MCP"** means a health care delivery system organized to manage cost, utilization, and quality that is operated by a state as authorized under sections 1915(a), 1915(b), 1932(a), or 1115(a) of the Social Security Act and relevant state law.

"Manual" or **"guide"** means any document, outside of the Medicaid State Plan, any Medicaid waiver, and the rules, that is created by or for OHCA for use in interpreting or implementing contractual terms. "Manual" is synonymous with guide, guidebook, companion guide, manual, reference book, dictionary, handbook, model, instructions, primer, workbook, or any other words denoting a document that is handled as a matter of convenience.

"Material change" means, but not limited to, any change in the overall business operations such as policy, process or protocol which affects, or can reasonably be expected to affect, more than five percent (5%) of enrollees or participating providers of the MCO or DBM.

"Medical necessity" means a standard for evaluating the appropriateness of services as established under OAC 317:30-3-1.

"National Provider Identifier (NPI)" means a unique identification number for covered health care providers. Covered health care providers and all MCOs, DBMs, and health care clearinghouses must use an NPI in the administrative and financial transactions adopted under the Health Insurance Portability and Accountability Act (HIPAA). The NPI is a ten-position, intelligence-free numeric identifier (ten-digit number). This means that the numbers do not carry other information

about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.

"Non-participating provider" means a physician or other provider who has not contracted with or is not employed by the MCO or DBM to deliver services under the managed care program.

"Non-urgent sick visit" means medical care given for an acute onset of symptoms which is not emergent or urgent in nature but which requires face-to-face medical attention within seventy-two (72) hours of enrollee notification of a non-urgent condition, as clinically indicated. Examples of non-urgent sick visits include cold symptoms, sore throat, and nasal congestion.

"Open enrollment" means an eligible's selection of and enrollment in an MCO or DBM during the open enrollment period.

"Open enrollment period" means the annual period of time, as defined by contract, when managed care enrollees and eligibles can enroll in and select an MCO or DBM for the managed care program.

"Parent and caretaker relative" means an individual determined eligible under 42 C.F.R. § 435.110.

"Participating provider" means a physician or other provider who has a contract with or is employed by an MCO or DBM to provide health care services to enrollees under the capitated managed care delivery model of the managed care program.

"Patient-centered medical home" or **"PCMH"** means, in this chapter, the care coordinated delivery system as defined within the contract between OHCA and an MCO.

"Pregnant women" means women determined eligible for SoonerCare under 42 C.F.R. § 435.116.

"Presumptive eligibility" means limited period of managed care program eligibility for individuals who are categorically related to certain eligibility groups listed in OAC 317:35-6-38(a)(1)(A)(i) through (vi) and are also determined by a qualified hospital, on the basis of preliminary information provided by the applicant on a completed HPE application, to be eligible for managed care program services.

"Primary care dentist" or **"PCD"** means a provider under contract with a DBM to provide primary health care services, as contracted, and case management, including all medically necessary referrals for specialty services and prior authorizations. In these rules, "dental home provider" or "DH provider" bears the same meaning as "primary care dentist" or "PCD".

"Primary care provider" or **"PCP"** means a provider under contract with an MCO to provide primary health care services, as contracted, and case management, including securing all medically necessary referrals for specialty services and prior authorizations. In these rules, "patient-centered medical home provider" or "PCMH provider" bears the same meaning as "primary care provider" or "PCP".

"Prior authorization" or **"PA"** means a requirement that an enrollee, through the enrollee's provider, obtain the MCO's or DBM's approval before a requested medical service is provided or before services by a non-participating provider are received. Prior authorization is not a guarantee of claims payment; however, failure to obtain prior

authorization may result in denial of the claim or reduction in payment of the claim.

"Provider" means a health care services provider licensed or certified in this State.

"Provider agreement" means an agreement between the MCO or DBM and a participating provider that describes the conditions under which the participating provider agrees to furnish covered health care services to enrollees.

"Risk contract" means a contract between OHCA and an MCO, prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP), as those terms are defined at 42 C.F.R. § 438.2, under which the contractor assumes risk for the cost of the services covered under the contract and incurs loss if the cost of furnishing the services exceeds the payments under the contract.

"SoonerCare" means the Oklahoma Medicaid program.

"Soon-To-Be-Sooner" means Oklahoma's separate CHIP providing coverage to unborn children of families earning up to and including one hundred eighty-five percent (185%) of the FPL.

"Specialty Children's Plan" means the single statewide managed care plan, as contracted with a single MCO, that will coordinate and deliver health care services, as defined by contract, in a highly coordinated manner to the specialty population. The specialty population includes Medicaid eligibles who are FFC, select juvenile justice involved Office of Juvenile Affairs (OJA), in foster care (FC), children with an open prevention services case (PSC) through case workers or receiving adoption assistance (AA).

"State Plan" means an agreement between OHCA and CMS describing how Oklahoma administers its Medicaid and CHIP programs.

"Steady state enrollment" means the period of time, as defined by contract, when an individual, who first became an eligible during steady state operations or who became eligible again during steady state operations after more than two (2) months lapse of eligibility, can first enroll in and select an MCO or DBM for the managed care program.

"Steady state operations" or **"steady state"** means the period of time, as defined by contract, after initial implementation and prior to contract termination, during which all managed care program elements are expected to be operational.

"Third party liability" or **"TPL"** means all or part of the expenditures for a managed care enrollee's medical assistance furnished under the Oklahoma Medicaid State Plan that may be the liability of a third-party individual, entity or program.

"Value-added benefit" means any benefit or service offered by an MCO or DBM when that benefit or service is not a covered benefit per the State Plan. These benefits are subject to change annually as determined by the MCO or DBM and OHCA.

"Value-based payment arrangement" means a payment arrangement between an MCO or DBM and its participating providers when payment is intentionally aligned with quality measures OHCA applies to the MCO or DBM.

"Value-based purchasing" means the provisions of a contract for managed care services when those provisions intentionally align OHCA

payments to the MCO or DBM under contract with quality measures or other performance factors OHCA may apply to the MCO or DBM.

[Source: Added at 39 Ok Reg 450, eff 12-21-21 (emergency); Added at 39 Ok Reg 1628, eff 9-12-22]

SUBCHAPTER 3. GENERAL PROGRAM INFORMATION

PART 1. ELIGIBILITY

317:55-3-1. Mandatory populations

(a) **Mandatory MCO enrollment.** Per 56 O.S. § 4002.3, eligibles in the following categories will be mandatorily enrolled in the MCP and with an MCO:

- (1) Expansion adults;
- (2) Parents and caretaker relatives;
- (3) Pregnant women;
- (4) Deemed newborns;
- (5) Children; and
- (6) All other populations requiring mandatory coverage pursuant to in 42 C.F.R. Part 435, Subpart B (§§ 435.100 435.172), unless otherwise covered by SoonerCare.

(b) **Mandatory Specialty Children's Plan enrollment.** Per 56 O.S. § 4002.3, eligibles in the following categories, upon entering custody of the State, will be mandatorily enrolled in the MCP and with the MCO under contract to provide the Specialty Children's Plan:

- (1) Foster children (FC); and
- (2) Certain children in the custody of OJA.

(c) **Mandatory Specialty Children's Plan enrollment, opt out.** Per 56 O.S. § 4002.3, eligibles in the following categories will be mandatorily enrolled in the MCP and with the MCO under contract to provide the Specialty Children's Plan, if they do not select a different MCO during initial enrollment, open enrollment, or steady state enrollment:

- (1) Former foster care (FFC); and
- (2) Children receiving adoption assistance (AA).

(d) **Mandatory DBM enrollment.** Per 56 O.S. § 4002.3, the following eligibles will be mandatorily enrolled in the MCP and with a DBM:

- (1) Expansion adults;
- (2) Parents and caretaker relatives;
- (3) Pregnant women;
- (4) Deemed newborns;
- (5) Former foster children;
- (6) Certain children in the custody of OJA;
- (7) Foster care children;
- (8) Children receiving adoption assistance; and
- (9) Children.

[Source: Added at 39 Ok Reg 450, eff 12-21-21 (emergency); Added at 39 Ok Reg 1628, eff 9-12-22]

317:55-3-2. Excluded populations

(a) Per 56 O.S. § 4002.3, individuals in the following categories will be excluded from enrollment in a MCP contracted with one (1) or more MCOs:

- (1) Dual eligible individuals;
- (2) Individuals enrolled in the Medicare Savings Program, including Qualified Medicare Beneficiaries (QMB), Specified Low Income Medicare Beneficiaries (SLMB), Qualified Disabled Workers (QDW) and Qualified Individuals (QI);
- (3) Persons with a nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF/IID) level of care, except that enrollees who are transitioning into long-term care will remain enrolled in any MCO for up to sixty (60) days while the enrollee's level of care determination is pending. Prior to disenrollment from an MCO, such excepted enrollees will receive a facility's pre-admission screening and resident review (PASRR) process. If OHCA approves the PASRR and designates the nursing facility or ICF/IID level of care, reimbursement will be made to the facility and the enrollee will be disenrolled from their MCO;
- (4) Individuals during a period of presumptive eligibility;
- (5) Individuals infected with tuberculosis eligible for tuberculosis-related services under 42 C.F.R. § 435.215;
- (6) Individuals determined eligible for SoonerCare on the basis of needing treatment for breast or cervical cancer under 42 C.F.R. § 435.213;
- (7) Individuals enrolled in a 1915(c) waiver;
- (8) Undocumented persons eligible for emergency services only in accordance with 42 C.F.R. § 435.139;
- (9) Insure Oklahoma employee sponsored insurance (ESI) dependent children in accordance with the Oklahoma Title XXI State Plan;
- (10) Coverage of pregnancy-related services under Title XXI for the benefit of unborn children (Soon- to-be-Sooners), as allowed by 42 C.F.R. § 457.10; and
- (11) Individuals determined eligible for Medicaid on the basis of age, blindness or disability.

(b) Per 56 O.S. § 4002.3, eligibles in the following categories will be excluded from enrollment in a MCP contracted with one (1) or more DBMs:

- (1) Dual eligible individuals;
- (2) Individuals enrolled in the Medicare Savings Program, including QMB, SLMB, QDW and QI;
- (3) Persons with a nursing facility or ICF-IID level of care, except that enrollees who are transitioning into long-term care will remain enrolled in any DBM for up to sixty (60) days while the enrollee's level of care determination is pending. Prior to disenrollment from a DBM, such excepted enrollees will receive a facility's PASRR process. If OHCA approves the PASRR and designates the nursing facility or ICF/IID level of care, reimbursement will be made to the facility and the enrollee will

be disenrolled from the DBM.

- (4) Individuals during a period of presumptive eligibility;
- (5) Individuals infected with tuberculosis eligible for tuberculosis-related services under 42 C.F.R. § 435.215;
- (6) Individuals determined eligible for SoonerCare on the basis of needing treatment for breast or cervical cancer under 42 C.F.R. § 435.213;
- (7) Individuals enrolled in a §1915(c) waiver;
- (8) Undocumented persons eligible only for emergency services in accordance with 42 C.F.R. § 435.139;
- (9) Insure Oklahoma Employee Sponsored Insurance (ESI) dependent children in accordance with the Oklahoma Title XXI State Plan;
- (10) Coverage of Pregnancy-related services under Title XXI for the benefit of unborn children (Soon-to-be-Sooners), as allowed by 42 C.F.R. § 457.10; and
- (11) Individuals determined eligible for Medicaid on the basis of age, blindness or disability.

[Source: Added at 39 Ok Reg 450, eff 12-21-21 (emergency); Added at 39 Ok Reg 1628, eff 9-12-22]

317:55-3-3. Voluntary enrollment and disenrollment

(a) Per 56 O.S. § 4002.3, AI/AN populations that are eligible for SoonerCare will have the option to:

- (1) Voluntarily enroll in the MCP through an opt-in process;
- (2) Enroll in an MCO or DBM at each open enrollment period, regardless of initial selection or past disenrollment from the MCP;
- (3) Receive services from an IHCP;
- (4) Choose the IHCP as the enrollee's PCMH provider or DH provider, if the provider has the capacity to provide such services;
- (5) Obtain services covered under the contract from out-of-network IHCPs when the enrollee is otherwise eligible to receive the IHCP's services;
- (6) Self-refer for services provided by IHCPs to AI/AN enrollees;
- (7) Obtain services covered under the contract from out-of-network IHCPs when the AI/AN enrollee is otherwise eligible to receive the IHCP's services; and
- (8) Disenroll from any MCO or DBM at any time without cause.

(b) Children receiving prevention services from child welfare services have the option to enroll in the MCO contract to provide health care services under the Specialty Children's Plan.

[Source: Added at 39 Ok Reg 450, eff 12-21-21 (emergency); Added at 39 Ok Reg 1628, eff 9-12-22]

PART 3. SCOPE AND ADMINISTRATION

317:55-3-10. Grievances and appeals

(a) **Filing.** Grievances and appeals are to be initially filed with each enrollee's MCO or DBM. Grievances may be filed with the enrollee's

MCO or DBM at any time, either orally or in writing. A provider or an authorized representative may file an appeal, grievance, or request for a State fair hearing on behalf of an enrollee, provided that the provider or authorized representative has obtained the enrollee's written consent.

(b) **Levels of appeal.** Pursuant to 42 C.F.R. § 438.402, MCOs and DBMs will only have one (1) level of appeal. Enrollees and providers may file an appeal to OHCA seeking the review of a final adverse benefit determination rendered by an MCO or DBM.

(c) **Governing rules.** The provisions at OAC 317:2-1-1 et seq. will govern any enrollee or provider right to file a grievance, complaint, appeal or request for a State fair hearing pursuant to 56 O.S. § 4002-4004, 42 C.F.R. Parts 431 or 438, or the managed care contract.

[Source: Added at 39 Ok Reg 450, eff 12-21-21 (emergency); Added at 39 Ok Reg 1628, eff 9-12-22]

317:55-3-11. Intermediate sanctions

(a) **Intermediate sanctions obligation.** OHCA will establish intermediate sanctions that it may impose on an MCO if OHCA makes any of the determinations specified in 42 C.F.R. § 438.700(b)-(d).

(b) **Adoption of intermediate sanctions.** OHCA adopts the intermediate sanctions as provided at 42 C.F.R. § 438.702.

(c) **Imposition of sanctions.** If OHCA makes a determination per 42 C.F.R. §§ 438.700 or 438.706 and thereby imposes intermediate sanctions as listed at 42 C.F.R. §§ 438.702 or 438.706, OHCA will consider the totality of and follow all relevant regulations at 42 C.F.R. Part 438, Subpart I.

(d) **Required imposition of temporary management.** In accordance with 42 C.F.R. § 438.706(b), OHCA will impose the intermediate sanction of temporary management, regardless of any other sanction that may be imposed, if OHCA finds that an MCO has repeatedly failed to meet substantive requirements in sections 1903(m) or 1932 of the Act or 42 C.F.R. Part 438. In this situation, OHCA will also grant enrollees the right to terminate enrollment without cause, as described in 42 C.F.R. § 438.702(a)(3), and must notify the affected enrollees of their right to terminate enrollment. Notwithstanding any other Section of these rules, OHCA will not delay imposition of temporary management to provide a hearing before imposing this sanction. OHCA will continue this sanction until the MCO can ensure that the sanctioned behavior will not recur.

(e) **Retained authority.** OHCA retains authority to impose additional sanctions under State statutes or State regulations that address areas of noncompliance specified in 42 C.F.R. § 438.700, as well as additional areas of noncompliance. Nothing in 42 C.F.R. Part 438, Subpart I, prevents OHCA from exercising that authority.

(f) **Notice.** Before imposing an intermediate sanction, OHCA will give the affected MCO timely written notice that explains the basis and nature of the sanction and any other appeal rights that OHCA elects to provide.

(g) **Right to request fair hearing.** Though not required under federal regulation, OHCA provides each MCO the right, upon notice of a sanction other than optional or required temporary management, to request a fair hearing before an administrative law judge (ALJ) retained by OHCA. The

cost of actions necessary to process an MCO's request will be paid by OHCA.

- (1) An MCO must file any request for fair hearing within thirty (30) days after receiving the notice.
- (2) The ALJ has jurisdiction to hear any request under this section. The ALJ will review the appeal for legal authority and jurisdiction. If legal authority and jurisdictional requirements are met, the ALJ will conduct an administrative hearing according to the hearing practices of OAC 317:2-1-5, provide proposed findings of fact and conclusions of law to the parties, and send written notice to the parties of the final order sustaining or denying imposition of the sanction.
- (3) At the ALJ's discretion, the ALJ will:
 - (A) Establish a scheduling order;
 - (B) Establish reasonable procedures such as authorizing pleadings to be filed by facsimile or electronic mail;
 - (C) Rule on all interlocutory motions;
 - (D) Require briefing of any or all issues;
 - (E) Conduct hearings in a forum and manner as determined by the ALJ;
 - (F) Rule on the admissibility of all evidence;
 - (G) Question witnesses;
 - (H) Impose appropriate sanctions against any person failing to obey an order of the ALJ or authorized under the rules in this section which will include:
 - (i) Refusing to allow the person to assert or oppose designated claims or defenses, or prohibiting that person from introducing designated matters in evidence;
 - (ii) Excluding all testimony of an unresponsive or evasive witness; or
 - (iii) Expelling the person from further participation in the hearing;
 - (I) Take official notice of any material fact not appearing as evidence in the record, if the fact is among traditional matters of judicial notice;
 - (J) Administer oaths or affirmations;
 - (K) Determine the location of the hearing and manner in which it will be conducted;
 - (L) Allow either party to request that the hearing be recorded by a court reporter with costs to be borne by the requesting party. The original of such transcription, if ordered, will be given to the ALJ with a copy to be given to the requesting party;
 - (M) Recess and reconvene the hearing;
 - (N) Set and/or limit the time frame of the hearing;
 - (O) Make proposed findings of facts and conclusions of law; and
 - (P) Sustain or deny OHCA's imposition of the sanction(s).

317:55-3-12. Non-compliance damages and remedies

If OHCA finds an MCO or DBM to be in violation of the provisions of 56 O.S. §§ 4002-4004, rules promulgated thereto, or the terms and conditions of the contract, OHCA may enforce any damages or remedies for non-compliance as required by CMS, as provided for in the contract, or as permitted by State or Federal law.

[Source: Added at 39 Ok Reg 450, eff 12-21-21 (emergency); Added at 39 Ok Reg 1628, eff 9-12-22]

317:55-3-13. Termination of managed care contract

(a) Termination of an MCO, permitted by 42 C. F.R. § 438.708.

Members impacted by the contract termination of an MCO will be enrolled with a different MCO or be provided Medicaid benefits through options as prescribed in the Oklahoma Medicaid State Plan. OHCA may terminate a contract with an MCO if OHCA determines that the MCO:

- (1) Failed to carry out the substantive terms of the contract; or
- (2) Failed to meet applicable requirements of sections 1903(m), 1905(t), or 1932 of the Act.

(b) Termination permitted by contract, MCO or DBM. Grounds for termination include:

(1) **Mutual consent.** OHCA and the MCO or DBM may terminate the contract by a mutually written agreement. The MCO or DBM does not have the right to appeal the termination. Enrollees impacted by the contract termination will be enrolled with a different MCO or DBM of their choosing or, if no choice is made, a default MCO or DBM.

(2) **Termination for convenience.** OHCA may terminate a contract for convenience, in whole or part, with a sixty (60) day written notice to the MCO or DBM if the State determines that termination is in the State's best interest. Any partial termination of the contract will not be construed as a waiver of, and will not affect, the rights and obligations of any party regarding portions of the contract that remain in effect. Upon receipt of notice of such termination, the MCO or DBM will immediately comply with the notice terms and take all necessary steps to minimize the incurrence of costs allocable to the work affected by the notice.

(3) **Termination for unavailability of funds.** OHCA may terminate a contract for lack of the availability of funds with written notice to the managed care. OHCA will give written notice to the MCO or DBM, effective the close of business on the day specified. OHCA is the final authority on the availability of funds, and the MCO or DBM does not have the right to appeal this termination.

(4) **Termination for lack of authority.** In the event that the State is determined, in whole or part, to lack Federal or State approval or authority to contract with an MCO or DBM, OHCA may terminate the contract immediately, effective on the close of business on the day specified. The MCO or DBM does not have the right to appeal this termination.

(5) **Termination for default.** OHCA may terminate the contract, in whole or in part, whenever the MCO has failed to carry out the terms of the contract or meet the applicable readiness requirements of §§ 1932, 1903(m) or 1905(t) of the Act.

(6) **Termination for financial instability.** In the event that OHCA, in its sole discretion, deems an MCO or DBM to be financially unstable to the point of threatening the ability of OHCA to obtain the services provided for under this contract, or to conduct business in the normal course, makes a general assignment for the benefit of creditors or suffers or permits the appointment of a receiver for its business or its assets, then OHCA may, at its option, immediately terminate the contract effective on the close of business on the date specified. In the event OHCA elects to terminate the contract under this provision, the MCO or DBM will be notified in writing specifying the date of termination. In the event of the filing of a petition in bankruptcy court by or against a principal subcontractor, the MCO or DBM will immediately advise OHCA. The MCO or DBM will ensure that all tasks related to the subcontract are performed in accordance with the terms of the contract.

(7) **Termination for debarment.** Section 1932(d)(1) of the Act prohibits affiliations with individuals debarred by federal agencies. The MCO will not knowingly have an individual or affiliate, as defined in Section 1932(d)(1)(C), who has been debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

(c) **Notice and pre-termination hearing.** Prior to terminating an MCO's contract for default, financial instability, or debarment, OHCA will provide the MCO a pre-termination hearing. OHCA will:

(1) Give the MCO written notice of the intent to terminate, the reason for termination, and the time and place of the hearing. The notice will detail how the MCO has failed to carry out the terms of the contract and/or failed to comply with the requirements of 1932, 1903(m) and 1905(t) of the Act. A time period will be provided, if applicable, in which the MCO is allowed to cure the default prior to the pre-termination hearing. If the MCO cures the default within the specified timeframe, no further action is required;

(2) After the hearing, the MCO will receive written notice of the decision affirming or reversing the proposed termination of the contract. In the event the decision is affirmed the notice is to include the effective date of the termination; and

(3) Upon affirmation of a decision, OHCA will give enrollees of the MCO written notice, comporting with the content requirements of 42 C.F.R § 438.10, of the termination and information identifying options for receiving Medicaid services following the effective date of termination. This notice will be provided within five (5) business days of the affirming decision.

(d) **Hearing timing.** Though not required under federal regulation, OHCA provides each MCO the right, upon notice of a termination, to request a fair hearing before an administrative law judge (ALJ) retained by OHCA. The cost of actions necessary to process an MCO's request will be paid by OHCA.

(1) An MCO will file any request for fair hearing within thirty (30) days after receiving the notice.

(2) The ALJ has jurisdiction to hear any request under this section. The ALJ will review the appeal for legal authority and jurisdiction. If legal authority and jurisdictional requirements are met, the ALJ will conduct an administrative hearing according to the hearing practices of OAC 317:2-1-5, provide proposed findings of fact and conclusions of law to the parties, and send written notice to the parties of the final order sustaining or denying imposition of the sanction.

(3) At the ALJ's discretion, the ALJ will:

(A) Establish a scheduling order;

(B) Establish reasonable procedures such as authorizing pleadings to be filed by facsimile or electronic mail;

(C) Rule on all interlocutory motions;

(D) Require briefing of any or all issues;

(E) Conduct hearings in a forum and manner as determined by the ALJ;

(F) Rule on the admissibility of all evidence;

(G) Question witnesses;

(H) Impose appropriate sanctions against any person failing to obey an order of the ALJ or authorized under the rules in this section which will include:

(i) Refusing to allow the person to assert or oppose designated claims or defenses, or prohibiting that person from introducing designated matters in evidence;

(ii) Excluding all testimony of an unresponsive or evasive witness; or

(iii) Expelling the person from further participation in the hearing;

(I) Take official notice of any material fact not appearing as evidence in the record, if the fact is among traditional matters of judicial notice;

(J) Administer oaths or affirmations;

(K) Determine the location of the hearing and manner in which it will be conducted;

(L) Allow either party to request that the hearing be recorded by a court reporter with costs to be borne by the requesting party. The original of such transcription, if ordered, will be given to the ALJ with a copy to be given to the requesting party;

(M) Recess and reconvene the hearing;

(N) Set and/or limit the time frame of the hearing;

(O) Make proposed findings of facts and conclusions of law; and

(P) Sustain or deny OHCA's imposition of the termination(s).

[Source: Added at 39 Ok Reg 450, eff 12-21-21 (emergency); Added at 39 Ok Reg 1628, eff 9-12-22]

317:55-3-14. Record retention

In addition to the requirements found at OAC 317:30-3-15 and 317:30-5-70.2, the MCO or DBM and its affiliates, subcontractors, and employees must retain records in compliance with the provisions and spirit of 42 C.F.R. §§ 438.3(h) and (u), to the extent applicable.

[Source: Added at 39 Ok Reg 450, eff 12-21-21 (emergency); Added at 39 Ok Reg 1628, eff 9-12-22]

PART 5. REQUIRED FEDERAL AUTHORIZATIONS

317:55-3-20. Authorizations

Prior to the implementation of any MCP authorized under 42 C.F.R. Part 438, OHCA will receive the following authorizations:

- (1) Federal authority through a State Plan Amendment or waiver of the Act;
- (2) CMS approval of each contract in relation to the MCP;
- (3) CMS approval of all contract rates authorized under the MCP; and
- (4) CMS approval of direct payment arrangements authorized under the MCP.

[Source: Added at 39 Ok Reg 450, eff 12-21-21 (emergency); Added at 39 Ok Reg 1628, eff 9-12-22]

317:55-3-21. Timing

OHCA may only execute transition to a managed care delivery system ninety (90) days after CMS has approved all contracts entered into between OHCA and all MCOs or DBMs following OHCA's submission of readiness review results to CMS, pursuant to 42 C.F.R. § 438.66.

[Source: Added at 39 Ok Reg 450, eff 12-21-21 (emergency); Added at 39 Ok Reg 1628, eff 9-12-22]

SUBCHAPTER 5. REQUIREMENTS FOR MANAGED CARE ORGANIZATIONS AND DENTAL BENEFITS MANAGERS

PART 1. ACCREDITATION AND READINESS

317:55-5-1. MCO or DBM accreditation

All MCOs and DBMs will be accredited in accordance with 45 C.F.R. § 165.275 by an accrediting entity recognized by the United States Department of Health and Human Services.

[Source: Added at 39 Ok Reg 450, eff 12-21-21 (emergency); Added at 39 Ok Reg 1628, eff 9-12-22]

317:55-5-2. MCO or DBM readiness

(a) According to 42 C.F.R. § 438.66, during implementation and prior to enrollment effective dates, the MCO or DBM will participate in a readiness review process. To be deemed eligible to effect enrollments, the MCO or DBM will complete all readiness review activities to the satisfaction of OHCA and CMS. The readiness reviews will be conducted through one (1) or more desk reviews and one or more on-site reviews. The MCO or DBM must satisfactorily demonstrate readiness for MCP operations, including but not limited to focus areas identified at 42 C.F.R. § 438.66(b). At any stage(s) of the readiness review process, OHCA may but is not required to provide an MCO or DBM with notice(s) of deficiency and reasonable opportunity(ies) to cure the deficiency. As between the parties to the managed care contract, OHCA has sole authority to determine the readiness of any MCO or DBM.

(b) As a part of any readiness review, OHCA will ensure the MCO or DBM meets the requirements at 56 O.S. § 4002.10.

[Source: Added at 39 Ok Reg 450, eff 12-21-21 (emergency); Added at 39 Ok Reg 1628, eff 9-12-22]

PART 3. PROVIDER REQUIREMENTS

317:55-5-10. Provider contracts and credentialing standards

(a) All MCOs and DBMs will formally credential and recredential network providers at a frequency required by a single, consolidated provider enrollment and credentialing process established by OHCA in accordance with 42 C.F.R. § 438.214 and in coordination with MCOs and DBMs.

(b) All MCOs and DBMs will contract to the extent possible and practicable with all essential community providers who receive directed payments in accordance with 42 C.F.R. Part 438 and any other providers as specified by OHCA through contract.

(c) Every MCO and DBM will contract with every participating provider through a written provider agreement that:

(1) Identifies the contractual obligations between the MCO or DBM and the participating provider; and

(2) Incorporates any provision required by the contract between OHCA and the MCO or DBM for inclusion in the provider agreement.

(d) An MCO or DBM or any subcontractor thereof will not enforce with any provider a policy or contract term that requires the provider to contract for all products currently offered or that may be offered in the future by the MCO, DBM, or subcontractor.

[Source: Added at 39 Ok Reg 450, eff 12-21-21 (emergency); Added at 39 Ok Reg 1628, eff 9-12-22]

317:55-5-11. Network adequacy standards

In accordance with 42 C.F.R. § 438.604, the MCO or DBM will submit documentation for which OHCA will base its certification to CMS that the MCO or DBM has complied with requirements for availability and accessibility of services, including health professional shortage areas and adequacy of the MCO's or DBM's network, as set forth in 42 C.F.R. §§ 438.206, 438.14 and 438.68.

[Source: Added at 39 Ok Reg 450, eff 12-21-21 (emergency); Added at 39 Ok Reg 1628, eff 9-12-22]

317:55-5-12. Prior authorization requirements, generally

The OHCA will establish prior authorization requirements that are consistent with 56 O.S. §§ 4002-4004. MCOs and DBMs may establish prior authorization of benefits to the extent these are consistent with OHCA's policies and rules. The MCO or DBM may propose to impose additional prior authorization requirements, subject to OHCA's review and approval, except for those benefits identified in the Oklahoma Medicaid State Plan, rules, or practices as exempt from prior authorization. The MCO or DBM may be less restrictive on the requirements of a prior authorization than OHCA but may not impose greater restrictions.

[Source: Added at 39 Ok Reg 450, eff 12-21-21 (emergency); Added at 39 Ok Reg 1628, eff 9-12-22]

317:55-5-13. Notification of material change

An MCO or DBM will promptly, within one (1) business day, notify OHCA of all changes materially affecting the delivery of care or the administration of the MCP.

[Source: Added at 39 Ok Reg 450, eff 12-21-21 (emergency); Added at 39 Ok Reg 1628, eff 9-12-22]

317:55-5-14. Patient data

An MCO or DBM will provide patient data to a provider upon request to the extent allowed under federal or State laws, rules, or regulations, including but not limited to the Health Insurance Portability and Accountability Act of 1996.

[Source: Added at 39 Ok Reg 450, eff 12-21-21 (emergency); Added at 39 Ok Reg 1628, eff 9-12-22]

PART 5. FINANCE

317:55-5-20. Capitation rates

OHCA will contract with an actuary, as defined at 42 C.F.R. § 438.2, to establish actuarially sound capitation rates, as described at 42 C.F.R. §§ 438.3(c), 438.4, and 438.5, for OHCA to pay to MCOs and DBMs.

[Source: Added at 39 Ok Reg 450, eff 12-21-21 (emergency); Added at 39 Ok Reg 1628, eff 9-12-22]

317:55-5-21. Medical loss ratio

An MCO or DBM will have a medical loss ratio that, at minimum, meets the standards provided by 42 C.F.R. § 438.8.

[Source: Added at 39 Ok Reg 450, eff 12-21-21 (emergency); Added at 39 Ok Reg 1628, eff 9-12-22]

317:55-5-22. Value-based purchasing

In any contract for managed care services, OHCA may include provisions in which payments OHCA makes to an MCO or DBM are based in whole or in part on quality measures and/or any other performance metric as defined in the contract.

[Source: Added at 39 Ok Reg 450, eff 12-21-21 (emergency); Added at 39 Ok Reg 1628, eff 9-12-22]

317:55-5-23. Special contract provisions related to payment

(a) **Federal regulation.** Any special contract provision related to payment, as described at 42 C.F.R. § 438.6, will meet all related standards within the federal regulation.

(b) **Provider payments.**

(1) OHCA will establish minimum rates of reimbursement paid by MCOs and DBPs to providers who choose not to enter into value-based payment arrangements for health care items and services furnished by such providers to enrollees.

(A) For participating providers, the reimbursement rate until July 1, 2026, will be equal to or greater than one

hundred percent (100%) of the reimbursement rate for the applicable item or service per the applicable OHCA fee schedule.

(B) For non-participating providers and subject to CMS approval as a directed payment or otherwise, the reimbursement rate, until July 1, 2026, will be equal to or greater than ninety percent (90%) of the reimbursement rate for the applicable item or service provided by a non-participating provider per the applicable OHCA fee schedule as of January 1, 2021.

(2) Notwithstanding any other provision of this section, OHCA will comply with payment methodologies required by federal law or regulation for specific types of providers including, but not limited to, Federally Qualified Health Centers (FQHCs), rural health clinics (RHCs), pharmacies, Indian Health Care Providers (IHCPs), and emergency services.

(c) **Optional value-based payments.** The MCO or DBM will offer optional value-based payment arrangements to all providers. Reimbursement amounts to providers in value-based payment arrangements align with the quality measures OHCA applies to MCOs or DBMs, respectively.

[Source: Added at 39 Ok Reg 450, eff 12-21-21 (emergency); Added at 39 Ok Reg 1628, eff 9-12-22]

317:55-5-24. Hospital readmission damages

The OHCA will establish a hospital readmission damage program to reduce potentially preventable readmissions. The program will use a nationally recognized tool to establish a base measurement year and a performance year and will provide for risk-adjustment based on the population of the state Medicaid program covered by the MCOs or DBMs. The program will be fully described in the managed care contract so that the program will be founded on contract-current tools, populations, and other factors.

[Source: Added at 39 Ok Reg 450, eff 12-21-21 (emergency); Added at 39 Ok Reg 1628, eff 9-12-22]

317:55-5-25. Claims processing and methodology; post payment audits

(a) **Claims payment systems.** The MCO or DBM will maintain a claims payment system capable of processing and adjudicating claims for payment in an accurate and timely manner and in full compliance with all State and Federal laws.

(b) **Claim filing.** A claim that is filed by a provider within six (6) months of the date the item or service was furnished will be considered timely, per Oklahoma Administrative Code (OAC) 317:30-3-11.

(c) **Clean claims.** The MCO or DBM will process a clean claim within the time frame outlined in 36 O.S. § 1219.

(1) The MCO or DBM will ensure that at least ninety percent (90%) of clean claims received from all providers are paid within fourteen (14) days of receipt.

(2) A clean claim that is not processed within the time frame will bear simple interest at the monthly rate of one and one-half percent (1.5%), which is payable to the provider.

(d) **Additional documentation.** After a claim has been paid but not prior to payment, the MCO or DBM may request medical records, if additional documentation is needed to review the claim for medical necessity.

(e) **Claim denials.**

(1) A claim denial will include the following information:

- (A) Detailed explanation of the basis for the denial; and
- (B) Detailed description of the additional information necessary to substantiate the claim.

(2) The MCO or DBM will establish a process for all claim denials by which the provider may identify and provide additional information to substantiate the claim.

(3) A provider will have six (6) months from the receipt of a claim denial to file an appeal per OAC 317:2-3-10.

(f) **Post payment audits.**

(1) In accordance with OAC 317:30-5-70.2, the MCO or DBM will comply with the post payment audit process established by OHCA.

(2) The MCO or DBM will adhere to limits set forth by OHCA regarding the percentage of claims that can be subjected to post payment audits.

(3) An MCO or DBM who has a claims denial error rate of greater than five percent (5%) will be subject to damages as set forth by OHCA in the managed care contract.

[Source: Added at 39 Ok Reg 450, eff 12-21-21 (emergency); Added at 39 Ok Reg 1628, eff 9-12-22]

PART 7. THE MANAGED CARE QUALITY ADVISORY COMMITTEE

317:55-5-30. Managed care quality advisory committee

(a) The Chief Executive Officer (CEO) of OHCA will establish and appoint members to the MC Quality Advisory Committee (Committee). Committee members serve without compensation and at the pleasure of the CEO.

The Committee will consist of:

- (1) Participating providers as a majority of the Committee members;
- (2) Representatives of hospitals and health systems;
- (3) Members of the health care community; and
- (4) Members of the academic community with an expertise in health care or other applicable field.

(b) The primary power and duty of the Committee is set forth at 56 O.S. § 4002.13.

(c) Committee meetings will be subject to the Oklahoma Open Meeting Act.

(d) The Committee will select from among its membership a chair and vice chair.

(e) The Committee may meet as often as may be required in order to perform the duties imposed on it.

(f) A quorum of the Committee will be required to approve any final action of the Committee. A majority of the members of the Committee will constitute a quorum.

[Source: Added at 39 Ok Reg 450, eff 12-21-21 (emergency); Added at 39 Ok Reg 1628, eff 9-12-22]

317:55-5-31. Quality scorecard

(a) Within one (1) year of beginning steady state operations of any MCP, OHCA will create a quality scorecard, in accordance with 56 O.S. § 4002.11, that compares MCOs to one another and DBMs to one another.

(b) OHCA will provide the most recent quarterly scorecard for initial enrollees during choice counseling.

(c) OHCA will provide the most recent quarterly scorecard to all enrollees at the beginning of each open enrollment period.

(d) OHCA will publish each quarterly scorecard on its website.

[Source: Added at 39 Ok Reg 450, eff 12-21-21 (emergency); Added at 39 Ok Reg 1628, eff 9-12-22]

PART 9. ACCOUNTABLE CARE ORGANIZATIONS

317:55-5-40. Accountable care organization, no prohibition

OHCA will not contract with or otherwise prohibit an MCO or DBM from contracting with a statewide or regional ACO to implement the capitated managed care delivery model of the State Medicaid program.

[Source: Added at 39 Ok Reg 450, eff 12-21-21 (emergency); Added at 39 Ok Reg 1628, eff 9-12-22]

317:55-5-41. Accountable care organization, duties

(a) Any MCO or DBM that contracts with an ACO will retain full responsibility as to all terms of the MCO's or DBM's managed care contract with OHCA.

(b) The MCO or DBM will track and report quality metrics of any contracted ACO in accordance with the terms of the MCO's or DBM's managed care contract with OHCA.

(c) The MCO or DBM will timely and accurately collect and analyze data related to patient utilization and costs. All such data and analysis will be shared with OHCA.

(d) The MCO or DBM in coordination with the ACO must use collected data to improve quality and target patients for care management interventions and program.

[Source: Added at 39 Ok Reg 450, eff 12-21-21 (emergency); Added at 39 Ok Reg 1628, eff 9-12-22]

