Oklahoma Health Care Authority
MEDICAL ADVISORY COMMITTEE
March 10, 2022
1:00 – 3:30 PM

Charles Ed McFall Board Room

AGENDA

Public access via Zoom:
https://okhca.zoom.us/j/82153410061?pwd=NUV1UkI2cGNKaWlmWm5VQ0Nid1BuZz09
Telephone: 1-346-248-779 **Webinar ID:** 821 5341 0061

***Please note: Since the physical address for the OHCA MAC Meeting has resumed, any livestreaming option provided is provided as a courtesy. Should such livestreaming option fail or have technical issues, the OHCA MAC Meeting will not be suspended or reconvened because of this failure or technical issue.**

I. Welcome, Roll Call, and Public Comment Instructions: **Chairman, Jason Rhynes, O.D.**

II. Action Item: Approval of Minutes of the January 13th, 2021: **Medical Advisory Committee Meeting**

III. Public Comments (2 minute limit)

IV. MAC Member Comments/Discussion

V. Legislative Update**: Katelynn Burns, Legislative Liaison**

VI. CQS Update: **Nathan Valentine, Chief Quality Officer**

VII. SoonerCare Operations: **Traylor Rains, Deputy State Medicaid Director**

VIII. Proposed Rule Changes: Presentation, Discussion, and Vote: **Sandra Puebla, Senior Director of Federal & State Authorities**

- **A. APA WF # 21-17 Dental Revisions**
- **B. APA WF # 21-28 Policy clarification for Qualified Medicare Beneficiary Plus (QMBP)**
- **C. APA WF # 21-29 Partial Hospitalization Program (PHP) Services for Adults**
- **D. APA WF # 21-32 Obstetric (OB) Ultrasound Coverage**
- **E. APA WF # 21-35 Lodging and Meals Revisions**
- **F. APA WF # 21-37 Private Duty Nursing (PDN) Revisions**

G. **APA WF # 21-38A Developmental Disabilities Services (DDS) Updates for Specialized Foster Care, Agency Companion, Employment Services and Self-Directed Services**
H. **APA WF # 21-38B Developmental Disability Services (DDS) Updates for Specialized Foster Care (SFC), Agency Companion, Employment Services and Self-Directed Services**
I. **APA WF # 21-39 Laboratory Services**
J. **APA WF # 21-40 Pregnant Women Copayment Language Cleanup**
K. **APA WF # 21-41A&B Outdated/Obsolete Policy Language Cleanup**
L. **APA WF # 21-42 Rural Health Centers (RHC) and Federally Qualified Health Centers (FQHC) Visit Limitation Revisions**
M. **APA WF # 21-43 Opioid Treatment Provider (OTP) Policy Changes**
N. **APA WF # 21-45 Referrals for Specialty Services Revisions**

IX. New Business: **Chairman, Jason Rhynes, O.D.**

X. Future Meeting: **Chairman, Jason Rhynes, O.D.**
May 12, 2022
July 14, 2022
September 8, 2022
November 10, 2022

XI. Adjourn **Chairman, Jason Rhynes, O.D.**

Oklahoma Health Care Authority
MEDICAL ADVISORY COMMITTEE
MINUTES of the January 13, 2022 Meeting
4345 N. Lincoln Blvd., Oklahoma City, OK 73105

I. Welcome, Roll Call, and Public Comment Instructions:

Chairman, Dr. Jason Rhynes called the meeting to order at 1:00 PM.

Delegates present were: Mr. Nick Barton, Ms. Joni Bruce, Mr. Brett Coble, Dr. Steven Crawford, Ms. Janet Cizek, Ms. Wanda Felty, Dr. Arlen Foulks, Ms. Jennifer King, Ms. Melissa Miller, Dr. Daniel Post, Dr. Jason Rhynes and Dr. Whitney Yeates, providing a quorum.

Alternates present were:

Delegates absent without an alternate were**:** Ms. Tina Johnson, Dr. Raymond Smith, and Dr. Eve Switzer.

II. Approval of the November 4, 2021 Minutes

Medical Advisory Committee

The motion to approve the minutes was by Dr. Steven Crawford and seconded by Dr. Daniel Post and passed unanimously.

III. Public Comments (2 minute limit):

There were no public comments.

IV. MAC Member Comments/Discussion:

There were no MAC member comments.

V. Legislative Update:

Katelynn Burns, Legislative Liaison

Ms. Burns stated that session starts on February 7, 2022. As of now the agency doesn't have any request bills that we have filed for the upcoming session. There is currently over 220 bills that have been pre-filed, which will continue to grow as the deadline approaches. SB1205 makes changes to the MAC, requiring to add at least one pharmacist, and also requires that the committee have at least 2 members from state wide associations representing rural and urban hospitals. SB1158 will make changes to the OHCA board, increasing it from 9 to 11 members, and adds an appointee for the speaker of the house. HB2971 also makes changes to the OHCA board, requiring that 2 of the 5 Governor appointees be medical physicians.

VI. Financial Report:

Tasha Black, Senior Director of Financial Services

Mr. Aaron Morris, CFO, presented the financial report ending in October 2021. OHCA is 5.5% under budget in revenues and 7.2% under budget in expenditures with the result that our budget variance is a positive $25,367,265. The budget variance is primarily attributed to the following: Medicaid Program Variance is a positive 22.8 million state dollars, and administration is a positive 1. million state dollars. For more detailed information, see item 6 in the MAC agenda. For more detailed information, see item 6 in the MAC agenda.

VII. SoonerCare Operations Update:

Traylor Rains, Deputy State Medicaid Director

Mr. Rains presented the SoonerCare Operations update to the committee. Information is based on data for November 2021. Patient Centered Medical Home enrollment is at 757,852 which is up by 19,261. Sooner Care Traditional has a current enrollment of 386,568 which is 2,361 more than the previous month. SoonerPlan has an enrollment of 10,409 and Insure Oklahoma has a total enrollment of 10,409. In total, SoonerCare enrollment is at 1,165,675. For more detailed information, please see item 7 in the MAC agenda.

VIII. Proposed Rule Changes: Presentation, Discussion, and Vote:

Sandra Puebla, Senior Director of Federal & State Authorities

APA WF 21-02A OHS ADvantage Waiver Services and State Plan Personal Care Services – The proposed revisions will align policy with the recently approved 1915c ADvantage waiver renewal and current State Plan Personal Care services authority. Updated policy will provide clarity surrounding eligible provider certification and will also modify procedures to reflect current business practices. Final revisions will correct formatting and grammatical errors.
Budget Impact: Budget neutral
Public comment period: December 15, 2021 – January 18, 2022
Tribal consultation: November 2, 2021
OHCA Board meeting: January 19, 2022
Effective date: September 2022
The rule change motion to approve was by Dr. Arlen Foulks and seconded by Dr. Steven Crawford and passed unanimously.

APA WF 21-02B OHS ADvantage Waiver Services and State Plan Personal Care Services – The proposed revisions will add language to establish guidelines and criteria regarding how an ADvantage member and/or provider are to report critical and non-critical incidents. Additional revisions will align policy with the recently approved 1915c ADvantage waiver renewal and current State Plan Personal Care services authority which will modify procedures to reflect current business practices. Final revisions will correct grammatical errors.
Budget Impact: Budget neutral

Public comment period: December 15, 2021 – January 18, 2022
Tribal consultation: November 2, 2021
OHCA Board meeting: January 19, 2022
Effective date: September 2022
The rule change motion to approve was by Dr. Arlen Foulks and seconded by Dr. Steven Crawford and passed unanimously.

APA WF 21-25 Non-Emergency Transportation (NEMT) Driver Compliance — The proposed revisions will add language to the Agency's non-emergency transportation (NEMT) policy that assure compliance with recent changes made to federal regulations that any NEMT provider or individual driver will meet prescribed minimum requirements.
Budget Impact: Budget neutral
Public comment period: November 2, 2021 - November 17, 2021
Tribal Consultation: November 2, 2021
OHCA Board meeting: January 19, 2022
Effective date: Contingent upon Governor approval; estimated effective date: March 7, 2022
The rule change motion to approve was by Dr. Arlen Foulks and seconded by Dr. Steven Crawford and passed unanimously.

APA WF 21-27 Policy Reference Clean Up - Timely Filing- The proposed revisions will update a section of policy which describes the process when an individual is determined retroactively eligible for Social Security Disability or Supplemental Security Income (SSI). Current policy states that payment will be made for medical services only if the claim is received within twelve (12) months. Updated policy will refer to two relevant sections of policy: "Timely Filing Limitation" (six months) and "Resolution of Claim Payment" (twelve months if claim initially filed timely).
Budget Impact: Budget neutral
Public comment period: December 15, 2021 – January 18, 2022
Tribal consultation: November 2, 2021
OHCA Board meeting: January 19, 2022
Effective date: September 2022
The rule change motion to approve was by Dr. Arlen Foulks and seconded by Dr. Steven Crawford and passed unanimously.

WF 21-30 Eliminate Community Based Extended (CBE) and Community Based Transitional (CBT) Levels of Care - The proposed revisions will eliminate CBE and CBT levels of care. These facilities contract with the OHCA as a type of Psychiatric Residential Treatment Facility (PRTF); however, there is only one contracted CBE facility and zero CBT facilities. The contracted CBE facility will transition to a standard PRTF with the corresponding rate. Other revisions will reorganize policy for clarity and correct grammatical errors.

Budget impact: The standard PRTF per diem is $336.57. The current CBE rate is $319.54, a $17.03 difference. There were 6,090 paid days for the CBE for SFY 2021.The proposed permanent rule changes will result in a budget impact of $103,712.70 with $33,198.4 in state match for SFY2023. ***For the increased rate, the PRTF will be required to provide 2 additional physician visits per month and 4 additional active treatment hours per week.*** **The State match will be paid by the Department of Mental Health and Substance Abuse Services.**
Public comment period: December 15, 2021 – January 18, 2022
Tribal consultation: November 2, 2021
OHCA Board meeting: January 19, 2022
Effective date: September 2022
The rule change motion to approve was by Dr. Steven Crawford and seconded by Dr. Daniel Post and passed unanimously.

APA WF 21-31 Applied Behavior Analysis (ABA) Revisions — The proposed revisions will establish new documentation and signature requirements to ensure accuracy and completeness in clinical documentation as well as better individualized treatment plans for members. Additionally, the proposed changes will clarify the conditions under which concurrent billing codes can be used for the treatment of members.
Budget impact: Budget neutral
Public comment period: December 15, 2021 – January 18, 2022
Tribal consultation: November 2, 2021
OHCA Board meeting: January 19, 2022
Effective date: September 2022
The rule change motion to approve was by Dr. Arlen Foulks and seconded by Dr. Steven Crawford and passed unanimously.

APA WF 21-33 Improve 340B Shared Savings Methodology — The proposed revisions will modify existing rules and the State Plan to improve the identification of 340B drugs and non 340B drug purchases. These revisions will require providers to bill the Agency with a procedure code modifier, on outpatient and hospital claims, that will identify a 340B drug from a non 340B drug. Additional revisions will adjust the methodology by which Medicare crossover claims are included on drug rebate invoices to 340B providers.
Budget impact: The proposed rule changes can potentially result in a reduction to the Agency's overall revenue collections. The combined potential federal and state revenue loss is a total of $3,070,428; $1,002,188 in state share for SFY2023.
Public comment period: December 15, 2021 – January 18, 2022
Tribal consultation: November 2, 2021
OHCA Board meeting: January 19, 2022
Effective date: September 2022

The rule change motion to approve was by Dr. Steven Crawford and seconded by Dr. Daniel Post and passed unanimously.

APA WF 21-34 Reimbursement Methodology for Providers of CCBH Services – The proposed revisions update and clarify language regarding covered CCBH services. The revisions also update language regarding reimbursement of CCBH services in alignment with changes to the Oklahoma Medicaid State Plan. These changes included language related to rebasing frequency and scope updates to the Prospective Payment System (PPS) rates. Other revisions will clarify the definition of "Client Assessment Record (CAR)."
Budget Impact: Budget neutral
Public comment period: December 15, 2021 – January 18, 2022
Tribal consultation: September 7, 2021
OHCA Board meeting: January 19, 2022
Effective date: September 2022
The rule change motion to approve was by Dr. Arlen Foulks and seconded by Dr. Steven Crawford and passed unanimously.

APA WF 21-44 Independent Clinical Psychologist Services for Adults – The proposed revisions update policy to reflect that adults covered by Medicaid can access services provided by licensed clinical psychologists who bill independently and are practicing within state scope of practice. Services provided by independently contracted clinical psychologists were previously a State Plan benefit only available to children.
Budget impact: The proposed permanent rule changes will result in a total budget impact of $1,723,105; with $361,938 in state match for SFY2022. The state match will be paid by the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS).
Public comment period: Dec. 29, 2021- January 13, 2022
Tribal consultation: November 2, 2021
OHCA Board meeting: January 19, 2022
Effective date: Contingent upon Governor's approval; estimated effective date: March 7, 2022
The rule change motion to approve was by Dr. Steven Crawford and seconded by Dr. Arlen Foulks and passed unanimously.

IX. <u>MAC Meeting Dates for Calendar 2022:</u>
Chairman, Jason Rhynes, O.D.

March 10, 2022
May 12, 2022
July 14, 2022
September 8, 2022
November 10, 2022

X. **New Business:**

Chairman, Jason Rhynes, O.D.

Ms. Kara Smith, General Counsel, updated the committee notifying the members that you can attend virtual, and you can participate in the voting while attending the MAC meeting.

XI. Adjourn:

Chairman, Jason Rhynes, O.D.

Chairman Rhynes asked for a motion to adjourn. Motion was provided by Dr. Steven Crawford and seconded by Dr. Arlen Foulks, there was no dissent and the meeting adjourned at 2:01pm.

COMPREHENSIVE QUALITY STRATEGY

Nathan Valentine, MD, CPE, FAAFP

Chief Quality Officer

March 2022 Medical Advisory Committee Meeting

OVERVIEW

- The strategy
- Key tactics we are pursuing
- The Comprehensive Quality Strategy (CQS) process
- Update on feedback sessions

STRATEGY OVERVIEW

STRATEGY OVERVIEW-1

- Key Challenge
  - Quality Assurance → Pop Health Quality Improvement
  - Disease-focus → Wellness focus
  - Current payment model: (FFS → Global w/ cross-sector requirements)
    - Rewards low yield care
    - Upstream, it ties us to disease instead of wellness

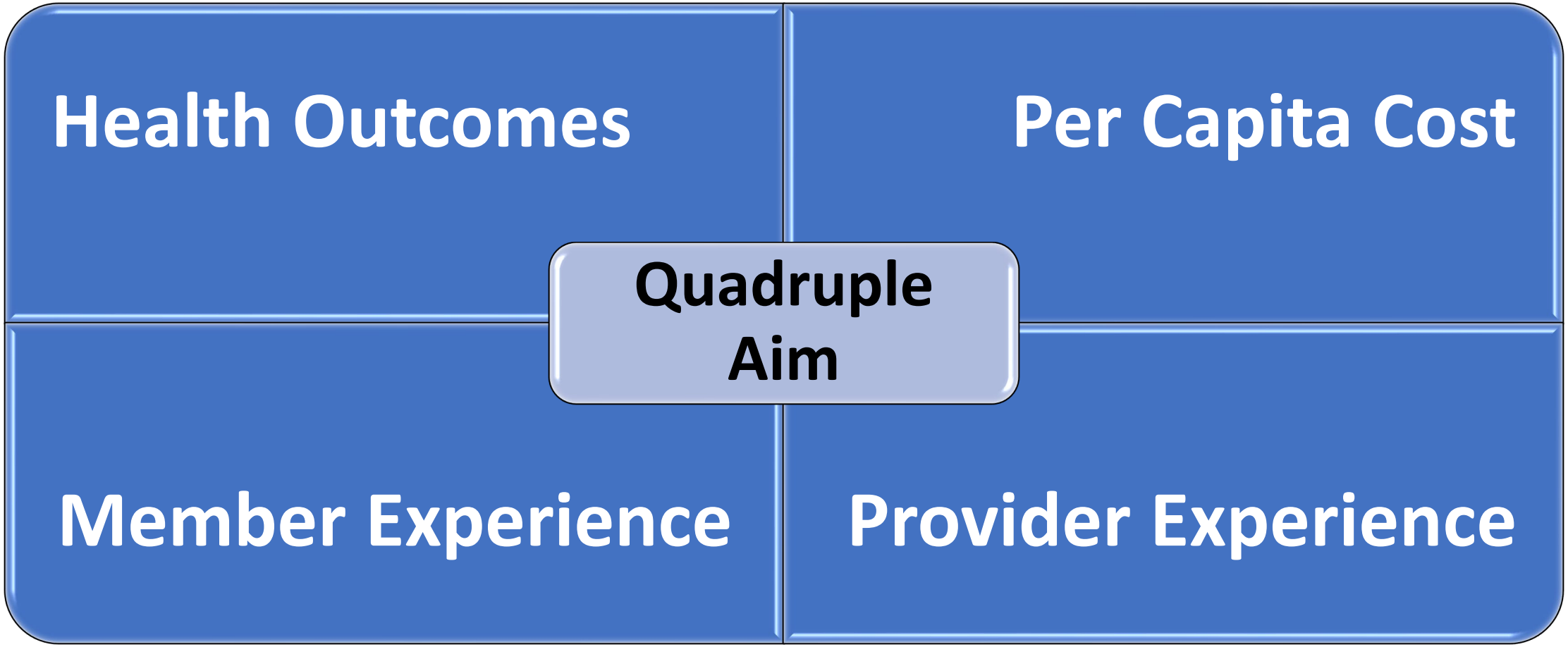
STRATEGY OVERVIEW-2

- Key Tactics:
  - Invest in tools, system updates and staff for more agile data mining, analysis and reporting
    - For Iterative proactive Quality Improvement processes
    - For ongoing identification of rising risk and healthy members
    - For broad engagement of providers and members
  - Engage our healthy members as much as our afflicted members
    - Including both short-term and long-term focused efforts to identify and improve social needs status
  - Payment redesign to drive aligned action for
    - Outcome-linked performance indicator improvement
    - Health equity
    - Social needs

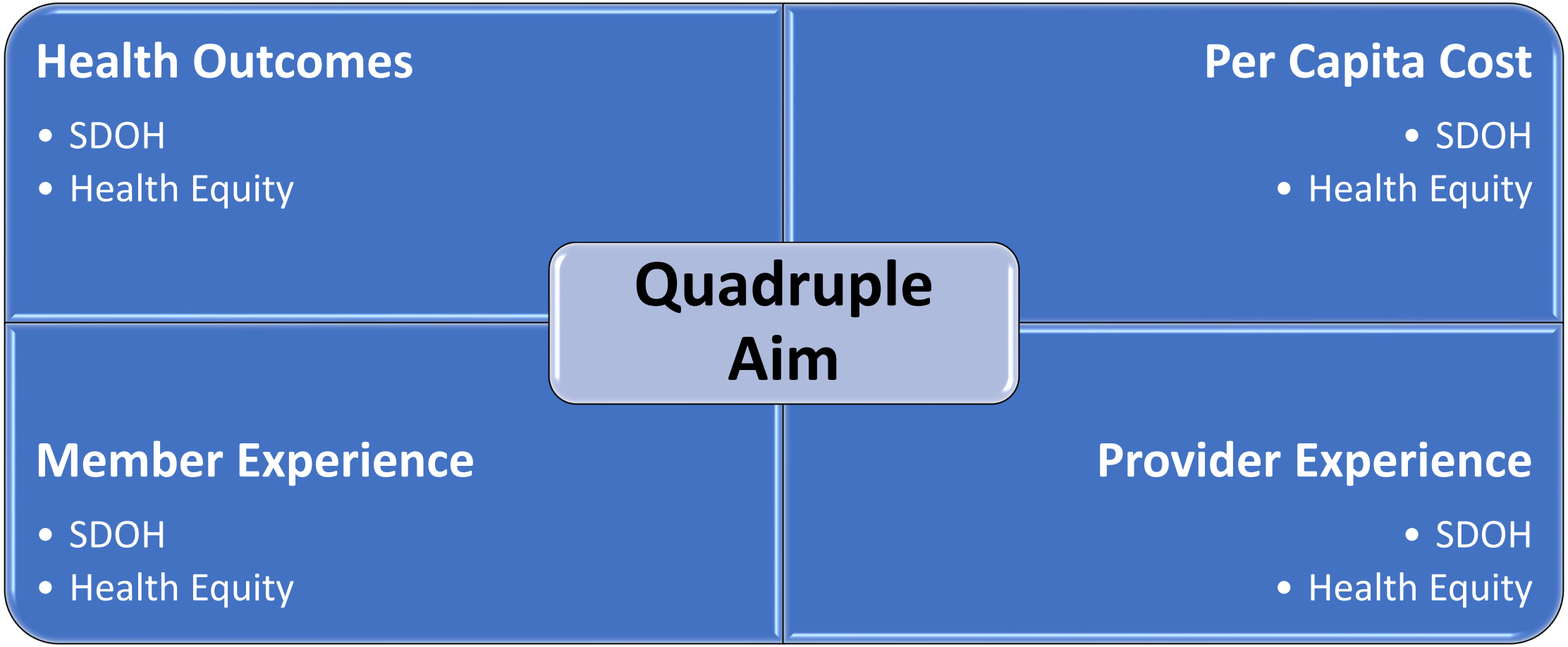
STRATEGY OVERVIEW-3

- 5 Areas of Focus over 4 Domains
  - Obesity: linked to top causes of U.S. mortality, poor mental health outcomes, decreased quality of life.
  - Smoking: leading cause of preventable death
  - Teen Pregnancy: linked to low birth weights and one important engine for generational poverty.
  - SDOH: reinforce current supports and explore new options for sustainable gains.
  - Equity: adding race/ethnicity to all reports, starting PDSA's with equity lens
- 4 Domains: Quadruple Aim
- Measures of Focus
  - Aligned with the CMS Quality Strategy, America's Health Rankings the Governor's Dashboard, and OHCA strategic goals.

CQS DOCUMENT FRAMEWORK



CQS DOCUMENT FRAMEWORK



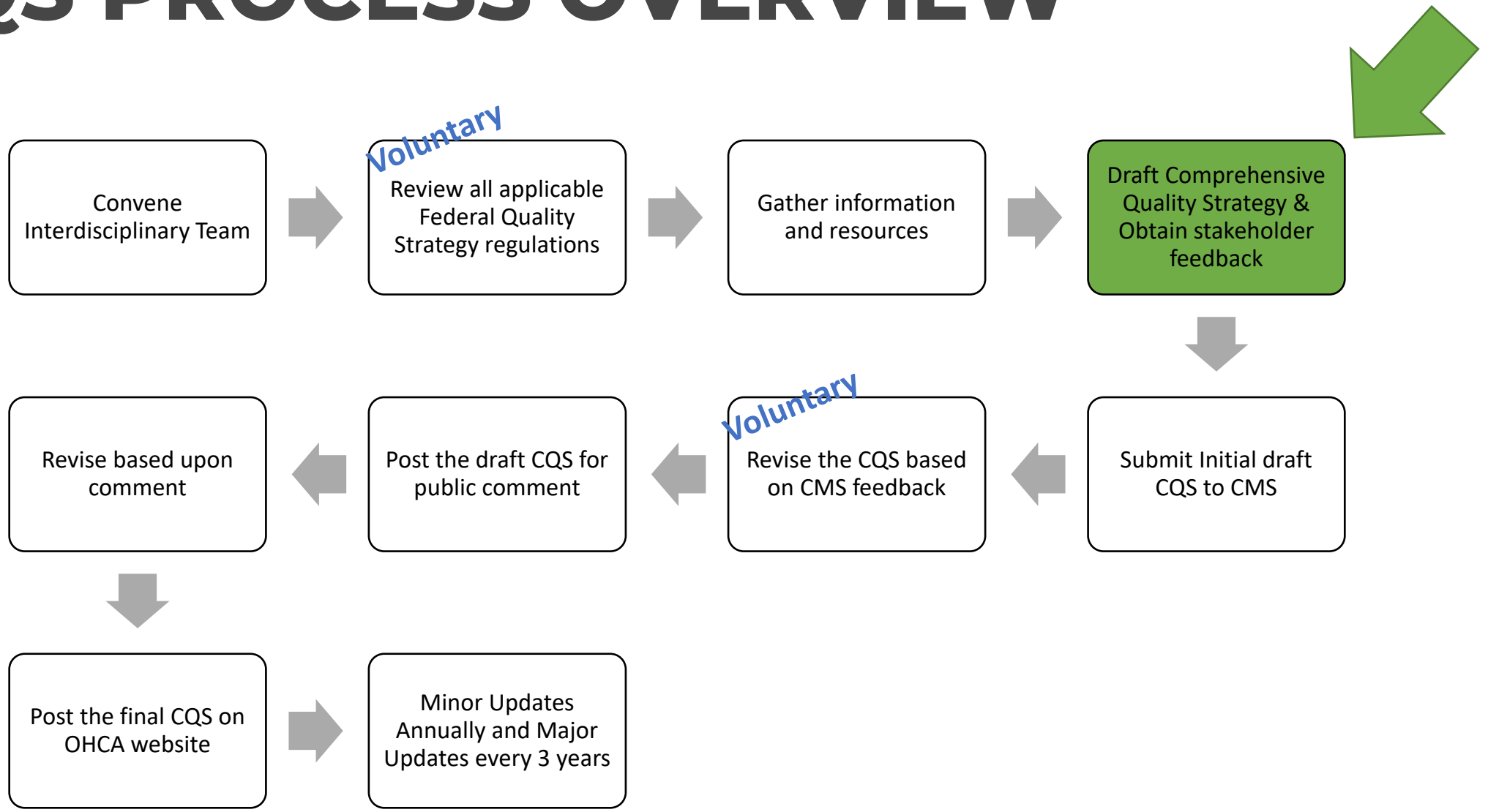
CQS DOCUMENT OVERVIEW

CQS DOCUMENT OVERVIEW

TN Division of TennCare

CQS PROCESS OVERVIEW

CQS PROCESS OVERVIEW



FEEDBACK EVENTS

- 10/30/21: current and former MATF members
- 12/9/21: Tribal Partners
- 12/10/21: Providers
- 12/16/21: State Agency Partners
- 2/18/21: Member TownHall

- Future: 4/14/21 Provider in-person (Tulsa) w/virtual option

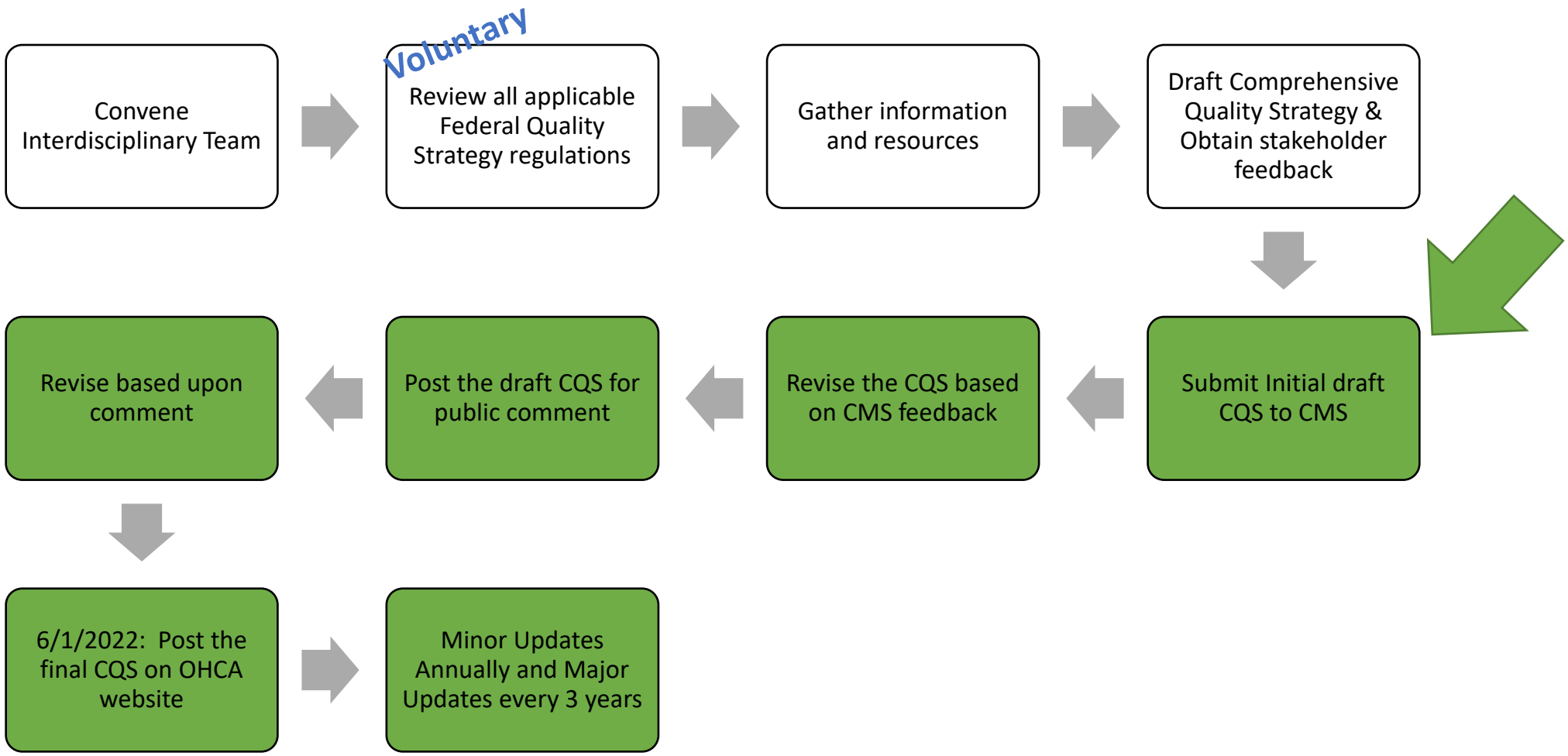
	Members	Tribal Partners	MAC Provider Focus Grp	State Agency Partners
Top SDOH Concern	Housing	Housing		
	Behavioral Health	SUD tx.	Behavioral Health	Suicide
			Transportation	Transportation
NC Tobacco	NC Tobacco		NC Tobacco	
	educate on vaping			educate
Obesity	affordable gyms	gym subsidy		
	affordable health foods	affordable health foods		
	safe outdoor spaces		safe outdoor spaces	
Teen Pregnancy	access to contraceptives	access to contraceptives	access to contraceptives	
	Why-wait and Sex Ed.		evidence-based repro. Ed.	

COMMON CONCERNS/PRIORITIES

	Tribal Partners	MAC Provider Focus Group	State Agency Partners
Health Outcomes	Preventive Visits	Preventive Visits	
	SUD Treatment	SUD Treatment	SUD Treatment
Provider Experience	Provider Relations	Provider Relations	Website/Portal
	Claims Processing	Claims Processing	Provider Relations
	Website/Portal	Website/Portal	Claims Processing
Reduce Per Capita Cost of Care			
	Diabetic Cx Admits	Diabetic Cx Admits	ED Visits
	ED Visits	ED Visits	Diabetic Cx Admits

COMMON CONCERNS/PRIORITIES

NEXT STEPS


Convene Interdisciplinary Team
Voluntary
Review all applicable Federal Quality Strategy regulations
Gather information and resources
Draft Comprehensive Quality Strategy & Obtain stakeholder feedback
Submit Initial draft CQS to CMS
Revise the CQS based on CMS feedback
Post the draft CQS for public comment
Revise based upon comment
6/1/2022: Post the final CQS on OHCA website
Minor Updates Annually and Major Updates every 3 years

OKLAHOMA
Health Care Authority

GET IN TOUCH

4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

oklahoma.gov/ohca
mysoonercare.org

Agency: 405-522-7300
Helpline: 800-987-7767

OHCA Monthly Metrics
January 2022
(November 2021 Data)

SOONERCARE ENROLLMENT/EXPENDITURES

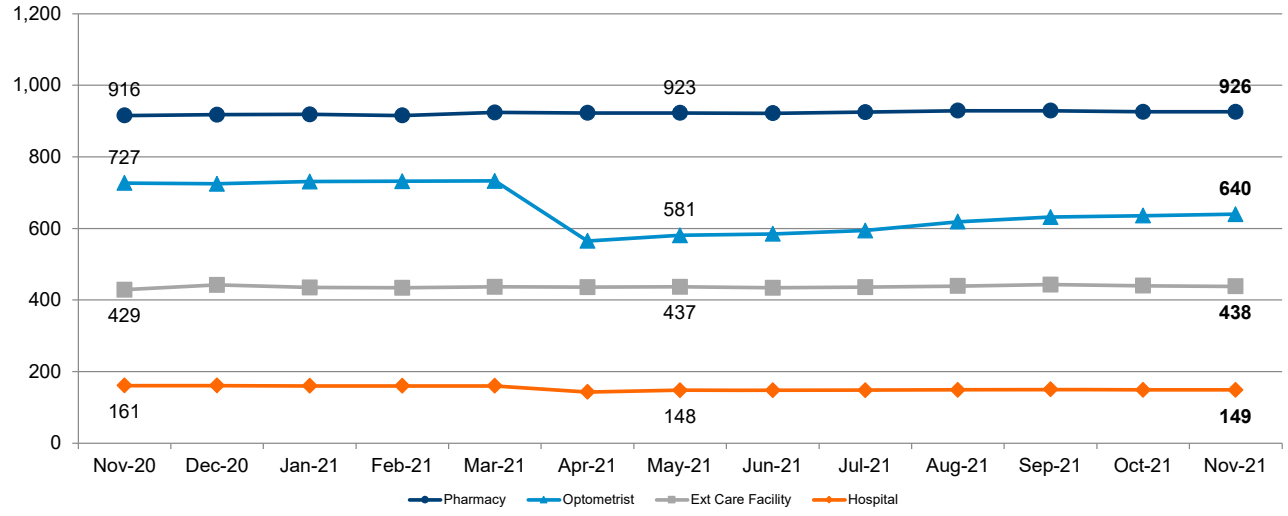
Delivery System		Enrollment November 2021	Children November 2021	Adults November 2021	Enrollment Change	Total Expenditures November	PMPM November 2021
SoonerCare Choice Patient-Centered Medical Home		**757,852**	**544,401**	**213,451**	**19,261**	**$228,677,891**	
	Children/Parents & Expansion	713,550	530,278	183,272	19,429	$178,824,477	$251
	Aged/Blind/Disabled & BCC	44,302	14,123	30,179	-168	$49,853,414	$1,125
SoonerCare Traditional		**386,568**	**117,770**	**268,798**	**2,361**	**$272,719,286**	
	Children/Parents & Expansion	262,268	113,014	149,254	680	$133,093,977	$507
	Aged/Blind/Disabled & BCC	124,300	4,756	119,544	1,681	$139,625,308	$1,123
Insure Oklahoma (ESI)		**10,409**	**421**	**9,988**	**-261**	**$3,404,000**	$327
SoonerPlan		**10,846**	**90**	**10,756**	**-2,200**	**$40,645**	$4
TOTAL (UNDUPLICATED)		**1,165,675**	**662,682**	**502,993**	**19,161**	**$504,841,821**	$433

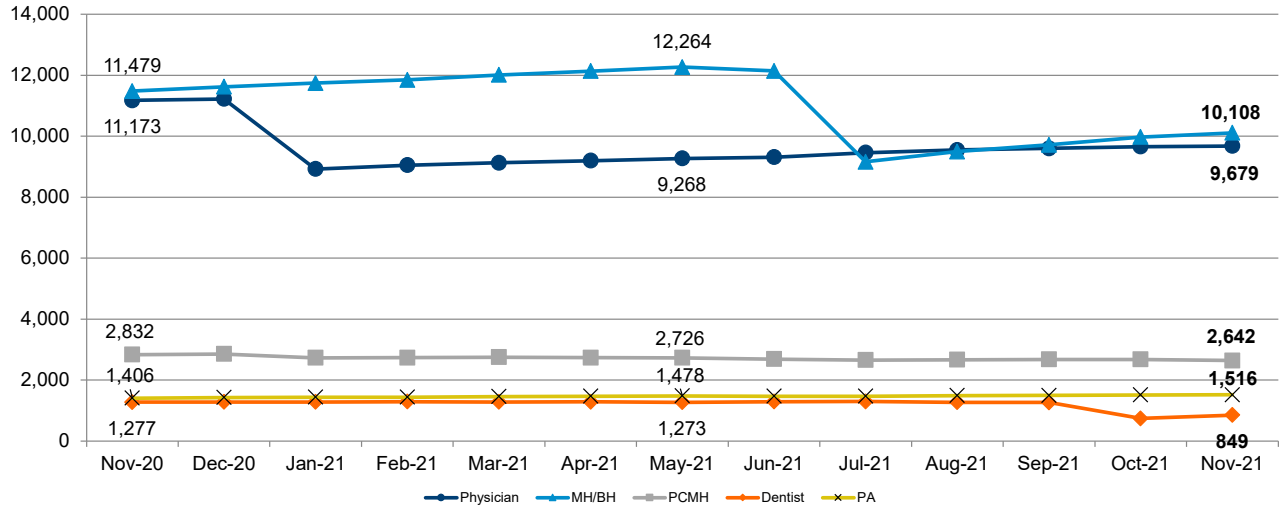
Total Expansion members = 207,606 (52% in PCMH). TEFRA is included with ABD. OTHER is included with Children/Parents. ABD - Traditional includes LTC and HCBS Waiver. Other - Traditional includes Q1 and SLMB.

Enrollment totals include all members enrolled during the report month. Members may not have expenditure data. Children are members aged 0 - 20 or for Insure Oklahoma enrolled as Students or Dependents. Dual Eligibles (Medicare & Medicaid) are in the Traditional delivery system in both the Low Cost (Q1 & SLMB) and High Cost (ABD) groups. OTHER includes DDSD, PKU, Q1, Refugee, SLMB, STBS and TB.

IN-STATE CONTRACTED PROVIDERS

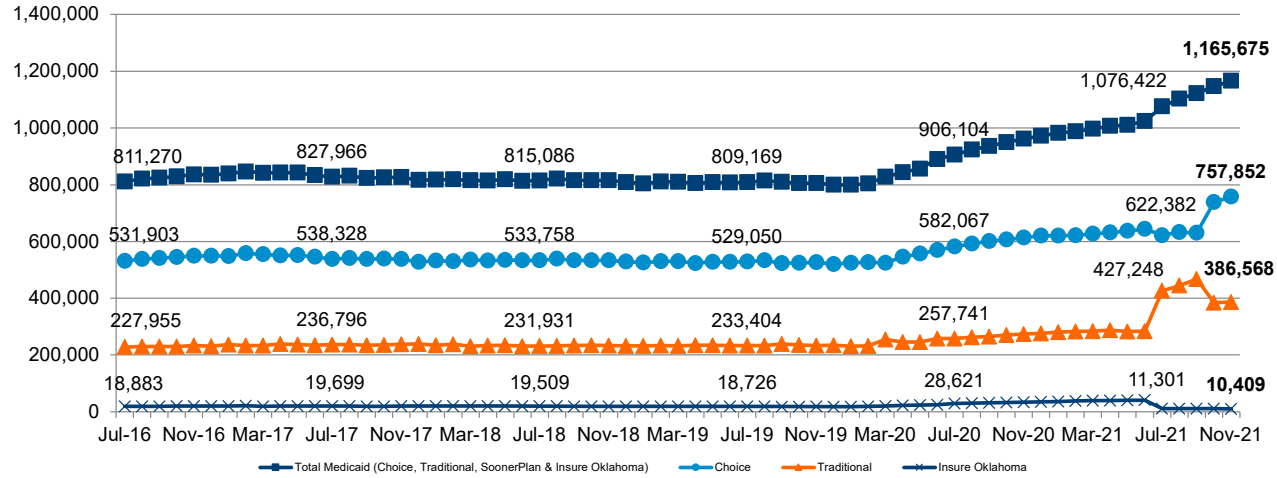
Total In-State Providers: 46,476 (-30) **(In-State Providers counted multiple times due to multiple locations, programs, types, and specialties)**

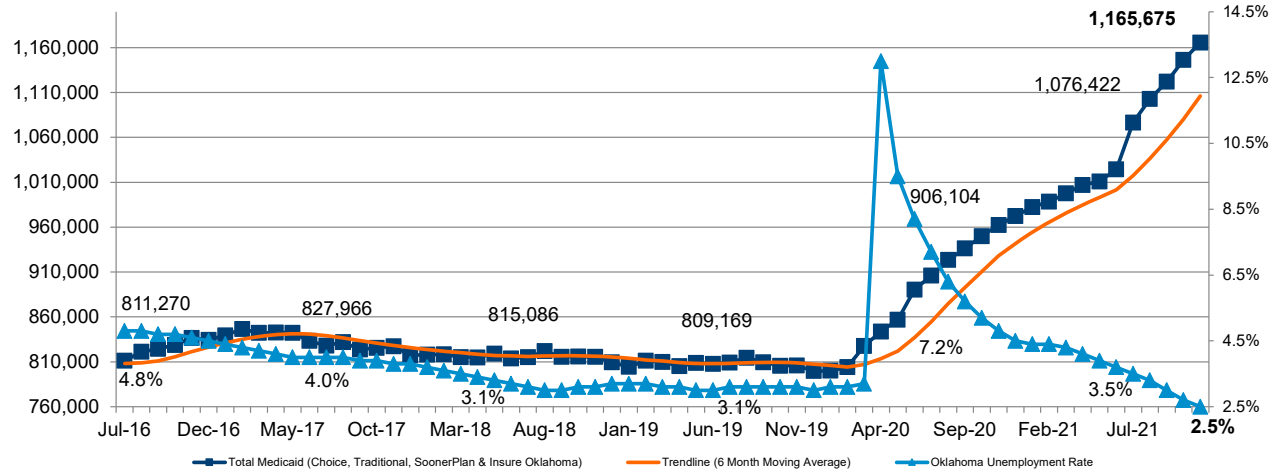




*In general, decreases are due to contract renewal. Decrease during contract renewal period is typical during all renewal periods.
MH/BH is Mental Health and Behavioral Health providers. PCMH is Patient-Centered Medical Home (Choice) providers.

ENROLLMENT BY MONTH





Oklahoma Unemployment Rate is from the Bureau of Labor Statistics 'Local Area Unemployment Statistics' (https://www.bls.gov/lau/) and is seasonally adjusted.

In June 2017 there were changes to the passive renewal system criteria that reduced the number of passively renewed members by 2/3rds. Increase in March 2020 due to COVID-19 economic impact and relief measures (Continuity of care by postponing recertifications). **Expansion was effective in July 2021.**

March MAC
Proposed Rules Amendment Summaries

The following work folders were posted on the Oklahoma Health Care Authority (OHCA) public website for a public comment period.

APA WF # 21-17 Dental Revisions — The proposed revisions will remove the certification requirement for primary care physicians (PCPs) to provide fluoride varnish during the course of a well-child health screening. The proposed revisions will also update the timeframe for dental prophylaxis from once every 184 days to once every six (6) months. Finally, language regarding coverage for periodontal maintenance will be added.

Budget Impact: The estimated budget impact for removing the certification requirements for PCPs to provide fluoride varnish, for SFY2023, will be an increase in the total amount of $97,682; with $26,767 state share. The estimated budget impact, for SFY2024, will be an increase in the total amount of $117,218; with $38,260 state share.

The estimated budget impact for adding coverage for periodontal maintenance, for SFY2023, will be an increase in the total amount of $1,288,682; with $258,104 state share. The estimated budget impact, for SFY2024, will be an increase in the total amount of $1,718,243; with $351,469 state share.

Changing the timeframe for dental prophylaxis is budget neutral.

Proposed Rule Timeline:
Tribal consultation: January 4, 2022
Public comment period: February 1, 2022 – March 3, 2022
Permanent rule public hearing: March 8, 2022
OHCA Board meeting: March 16, 2022
Permanent rule effective date: Contingent upon Legislative and/or Governor approval; estimated effective date: September 2022

APA WF # 21-28 Policy clarification for Qualified Medicare Beneficiary Plus (QMBP) – The proposed revisions clarify policy on how the Agency deems income from an ineligible spouse to an eligible member within the Aged, Blind and Disabled (ABD) eligibility group. The proposed revisions will also clarify that when the eligible member's countable income is over the Social Security Income (SSI) standard, the eligible member must still be evaluated for the Medicare savings program called QMBP.

Budget Impact: Budget neutral

Proposed Rule Timeline:
Tribal consultation: January 4, 2022
Public comment period: February 1, 2022 – March 3, 2022
OHCA Board meeting: March 16, 2022
Permanent rule public hearing: March 8, 2022
Permanent rule effective date: Contingent upon Legislative and/or Governor approval; estimated effective date: September 2022

APA WF # 21-29 Partial Hospitalization Program (PHP) Services for Adults — The proposed revisions add PHP services for individuals ages 21 through 64 with substance use disorder, mental health diagnoses, and/or co-occurring disorders. Currently, PHP services are a benefit offered to children under the age of 21, only. The proposed rulemaking will delineate covered service components, provider qualifications, as well as the reimbursement methodology for these services. Additionally, the proposed revisions will reorganize current policy at OAC 317:30-5-241.2 (Psychotherapy, Multi-systemic therapy, PHP, and day treatment programs) into independent sections for clarity and easier retrieval. Moreover, the proposed revisions will clarify that the clinical team for PHP services for children may include a physician, physician's assistant, or advanced registered nurse practitioner. Finally, the proposed rulemaking will correct minor formatting and grammatical errors.

Budget impact: The proposed permanent rule changes will result in a total budget impact of $771,715; with $160,864 state share for SFY2023 and $1,394,585; with $290,701 state share for SFY 2024. The state match will be paid by the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS).

Proposed Rule Timeline:
Tribal consultation: January 4, 2022
Public comment period: February 1, 2022 – March 3, 2022
OHCA Board meeting: March 16, 2022
Permanent rule public hearing: March 8, 2022
Permanent rule effective date: Contingent upon Legislative and Governor approval; estimated effective date: Sept. 2022

APA WF # 21-32 Obstetric (OB) Ultrasound Coverage – The proposed revisions will amend policy to provide coverage of OB ultrasounds when performed at the emergency room setting when medically necessary without requiring prior authorization.

Budget impact: The proposed permanent rule changes will result in a total budget impact of $166,991.75; with $46,156.52 state share for SFY2023 and $200,390.10; with $65,407.33 state share for SFY2024.

Proposed Rule Timeline:
Tribal consultation: January 4, 2022
Public comment period: February 1, 2022 - March 3, 2022
Board meeting: March 16, 2022
Permanent rule public hearing: March 8, 2022
Permanent rule effective date: Contingent upon Legislative and Governor approval; estimated effective date: Sept. 2022

APA WF # 21-35 Lodging and Meals Revisions — The proposed revisions will outline who can request the lodging and meal services and the timeframe that the request must be submitted. Additionally, a clause addressing emergency situations will be added to override the timeframe. The proposed revisions will also outline the information that must be submitted with each request. Further revisions will define meal requirements and what constitutes a meal. Additional revisions will outline how lodging providers and members authorize the member's length of stay. Authorization for length of stay includes having the lodging provider create a document/attestation that lists all the dates that the member has stayed in the facility and requiring the member’s review and signature of the document/attestation before he/she/they checks out of the lodging provider's

facility. Furthermore, the revisions will specify that it is the responsibility of both, the lodging provider and the member, to ensure that the document/attestation is verified and signed. Additional policy changes will add descriptions and processes for incidental charges and complaints. These changes are necessary to align the policy with current business practices.

Budget Impact: Budget neutral.

Proposed Rule Timeline:
Tribal consultation: January 4, 2022
Public comment period: February 1, 2022 – March 3, 2022
OHCA Board meeting: March 16, 2022
Permanent rule public hearing: March 8, 2022
Permanent rule effective date: Contingent upon Legislative and/or Governor approval; estimated effective date: September 2022

APA WF # 21-37 Private Duty Nursing (PDN) Revisions — The proposed revisions will update how assessments for PDN services are conducted; clarify who can sign the PDN treatment plan; update grammatical and formatting errors; and reorganize policy for better clarity and understanding. These revisions are necessary to align the PDN policy with current business practices.

Budget Impact: The proposed rule changes could create a budget savings for the agency. By allowing the OHCA care management nurses to conduct PDN assessments virtually, the nurses' time will be spent on other priorities for our members instead of traveling to conduct the assessments.

Proposed Rule Timeline:
Tribal consultation: January 4, 2022
Public comment period: February 1, 2022 – March 3, 2022
OHCA Board meeting: March 16, 2022
Permanent rule public hearing: March 8, 2022
Permanent rule effective date: Contingent upon Legislative and/or Governor approval; estimated effective date: September 2022

APA WF # 21-38A Developmental Disabilities Services (DDS) Updates for Specialized Foster Care, Agency Companion, Employment Services and Self-Directed Services – The proposed revisions to the DDS policy will add language to clarify that occupation and physical therapy services can include assistive technology, positioning, and mobility. Additional revisions for speech-language pathology services state that a provider cannot bill or receive reimbursement solely for writing the member's report or recording other documentation. Final revisions will correct formatting and grammatical errors, as well as align policy with current business practices.

Budget Impact: Budget Neutral

Proposed Rule Timeline:
Tribal consultation: January 4, 2022
Public comment period: February 1, 2022 – March 3, 2022
OHCA Board meeting: March 16, 2022
Permanent rule public hearing: March 8, 2022

Permanent rule effective date: Contingent upon Legislative and Governor approval; estimated effective date: Sept. 2022

APA WF # 21-38B Developmental Disability Services (DDS) Updates for Specialized Foster Care (SFC), Agency Companion, Employment Services and Self-Directed Services – The proposed revisions to the DDS policy will add new guidelines to staff that address provisions for the member's safety including: requirements for member's pets; appropriate supervision as it relates to unrelated habilitation training specialist staffing the home; and outlining actions taken by the provider following an injury to the service recipient. Other revisions will add language to clarify home standard exceptions concerning when adult members will be allowed to share bedrooms; the exception for the division director or designee to allow use of non-traditional bedding for temporary respite; and bedding types that are not usually allowed.

Revisions to the specialized foster care (SFC) section outline substitute supervision criteria. Revisions will also update SFC travel requirements to clarify transportation limits for vacation and what are considered non-covered trips. Other revisions will update the minimum contribution fee from $250 to $300 per month for the SFC providers who serve adults. New language will also provide clarification on the case manager's role in reporting issues of concern.

Further revisions will add job coaching as a self-directed service in 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.

Finally, revisions will update and remove outdated language and definitions, remove obsolete references, revoke/combine sections to comply with Executive Order 2020-03, which requires state agencies to reduce unnecessary and outdated rules. Revisions will also correct formatting and grammatical errors, as well as align policy with current business practices.

Budget Impact: Budget Neutral

Proposed Rule Timeline:
Tribal consultation: January 4, 2022
Public comment period: February 1, 2022 – March 3, 2022
OHCA Board meeting: March 16, 2022
Permanent rule public hearing: March 8, 2022
Permanent rule effective date: Contingent upon Legislative and Governor approval; estimated effective date: Sept. 2022

APA WF # 21-39 Laboratory Services - The proposed revisions will remove outdated language referencing "custom panels particular to the ordering provider" from the list of non-compensable laboratory services to reflect current business practices. Further revisions will update policy for better ease and understanding.

Budget Impact: Budget Neutral

Proposed Rule Timeline:
Tribal consultation: January 4, 2022
Public comment period: February 1, 2022 – March 3, 2022
OHCA Board meeting: March 16, 2022
Permanent rule public hearing: March 8, 2022

Permanent rule effective date: Contingent upon Legislative and Governor approval; estimated effective date: Sept. 2022

APA WF # 21-40 Pregnant Women Copayment Language Cleanup — The proposed rule changes will further clarify that no copayment is assessed to pregnant women covered by SoonerCare. The policy changes align Oklahoma's administrative rules regarding copayments for pregnant women and with current business practices.

Budget Impact: Budget neutral.

Proposed Rule Timeline:
Tribal consultation: January 4, 2022
Public comment period: February 1, 2022 – March 3, 2022
OHCA Board meeting: March 16, 2022
Permanent rule effective date: Contingent upon Legislative and/or Governor approval; estimated effective date: September 2022

APA WF # 21-41A&B Outdated/Obsolete Policy Language Cleanup — The proposed rule changes will amend language to remove obsolete references. Additional revisions will combine sections of policy to remove the number of sections that are currently in Title 317. These changes are necessary to comply with Oklahoma Executive Order 2020-03.

Budget Impact: Budget neutral.

Proposed Rule Timeline:
Tribal consultation: January 4, 2022
Public comment period: February 1, 2022 – March 3, 2022
OHCA Board meeting: March 16, 2022
Permanent rule public hearing: March 8, 2022
Permanent rule effective date: Contingent upon Legislative and/or Governor approval; estimated effective date: September 2022

APA WF # 21-42 Rural Health Centers (RHC) and Federally Qualified Health Centers (FQHC) Visit Limitation Revisions — The proposed revisions will add language that allows for a SoonerCare Choice member, who has chosen an RHC/FQHC as his/her/their Patient Centered Medical Home (PCMH)/Primary Care Provider (PCP), to exceed the four (4) visit limitation.

Budget Impact: Budget neutral.

Proposed Rule Timeline:
Tribal consultation: January 4, 2022
Public comment period: February 1, 2022 – March 3, 2022
OHCA Board meeting: March 16, 2022
Permanent rule public hearing: March 8, 2022
Permanent rule effective date: Contingent upon Legislative and/or Governor approval; estimated effective date: September 2022

APA WF # 21-43 Opioid Treatment Provider (OTP) Policy Changes— The proposed revisions will update current OTP service and documentation requirements to align with the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) provider certification standards. The proposed rulemaking will also correct minor formatting and grammatical errors.

Budget impact: Budget neutral

Proposed Rule Timeline:
Tribal consultation: January 4, 2022
Public comment period: February 1, 2022 - March 3, 2022
OHCA Board meeting: March 16, 2022
Permanent rule public hearing: March 8, 2022
Permanent rule effective date: Contingent upon Legislative and Governor approval; estimated effective date: Sept. 2022

APA WF # 21-45 Referrals for Specialty Services Revisions — The proposed revisions will update retrospective administrative referrals for specialty services within the SoonerCare Choice program. The changes will outline how retrospective administrative referral requests are made and the information that must be provided for the OHCA to process the request. These changes are necessary to align policy with current business practices.

Budget Impact: Budget neutral.

Proposed Rule Timeline:
Tribal consultation: January 4, 2022
Public comment period: February 1, 2022 – March 3, 2022
OHCA Board meeting: March 16, 2022
Permanent rule public hearing: March 8, 2022
Permanent rule effective date: Contingent upon Legislative and/or Governor approval; estimated effective date: September 2022

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 4. EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) PROGRAM/CHILD-HEALTH SERVICES

317:30-3-65.8. Dental services

(a) At a minimum, dental services include relief of pain and infection; limited restoration of teeth and maintenance of dental health; and oral prophylaxis every ~~184 days~~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~~(3)~~(2) for amount, duration and scope~~)~~].

(b) Dental ~~screens~~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 ~~184 days~~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~~ by eligible providers who have attended an OHCA-approved training course related to the application of fluoride varnish~~.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 79. DENTISTS

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 one hundred eighty-four (184) days along with topical application of fluoride.~~Dental prophylaxis is provided once every six (6) months along with topical application of fluoride.

(F) **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).

(G) **Medically necessary extractions.** Medically necessary extractions, as defined in OAC 317:30-5-695. Tooth extraction must have medical need documented.

(H) **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.

(I) **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 ~~one hundred eighty-four (184) days~~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 ~~one hundred eighty-four (184) days~~six (6) months along with topical application of fluoride.
(H) **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.

(I) **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.

(J) **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.

(K) **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.

(L) **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.

(M) **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.

(N) **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.

(O) **Smoking and tobacco use cessation counseling.** Smoking and tobacco use cessation counseling is covered per OAC 317:30-5-2 (DD) (i) through (iv).

(P) **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.

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 sub-gingival 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 sub-gingival 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.

(4) **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.

(e) **Children.** Listed below are examples of services requiring prior authorization for members under twenty-one (21). 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 sub-gingival 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 sub-gingival 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.

(8) **Periodontal Maintenance.** This procedure is provided once every six months for members who have a history of periodontitis and are no longer eligible for oral prophylaxis.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME

PART 5. COUNTABLE INCOME AND RESOURCES

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

(a) **General.** The term income is defined as 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))~~[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 ban 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 ~~VA~~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 ~~FBR~~Federal Benefit Rate (FBR), per OKDHS Appendix C-1, Schedule VIII.C plus the ~~$20~~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 ~~$20~~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 ~~$20~~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 ~~child care~~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 ~~child care~~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.~~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;

~~(i) Is blind or disabled;~~

~~(ii) Is under twenty-two (22) years of age; and~~

~~(iii) Attends a college, university, or a course of vocational or technical training designed to prepare students for gainful employment;~~

(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~~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 ~~$30~~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.

~~(A) Earned or unearned exclusions are never reduced below zero;~~

~~(B) Portions of a monthly exclusion cannot be carried over for use in a subsequent month;~~

~~(C) Earned income exclusions are never applied to unearned income;~~

~~(D) Unearned income exclusions are not applied to earned income except for any remaining portion of the $20 general income exclusion.~~

(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~~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) ~~$30~~Thirty dollars ($30) per calendar quarter of earned income; and

(ii) ~~$60~~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 ~~United States (U.S.)~~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 ~~United States (U.S.)~~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 in less than two (2) pounds ten (10) ounces is considered disabled by the ~~Social Security Administration~~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 ~~Veteran~~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~~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:~~

(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 ~~payments~~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 ~~federal benefit rate (FBR)~~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 ~~$20~~twenty dollars ($20) general exclusion from the couple's unearned income and ~~$65~~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.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 3. HOSPITALS

317:30-5-42.1. 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 of~~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.

PART 21. OUTPATIENT BEHAVIORAL HEALTH AGENCY SERVICES

317:30-5-241.2. Psychotherapy

(a) ~~**Psychotherapy.**~~ **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~~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 ~~a licensed behavioral health professional (LBHP)~~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.

~~(4)~~(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. ~~Psychotherapy for a child younger than three must be medically necessary and meet established Child (0-36 months of Age) criteria as set forth in the Prior~~

~~Authorization Manual.~~ 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~~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~~behavioral health rehabilitation services.

(2) **Group sizes**. Group ~~Psychotherapy~~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 ~~will~~must be provided by an LBHP or licensure candidate. Group ~~Psychotherapy~~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.

~~(5)~~(6) **Limitations**. A maximum of six (6) units per day per member is compensable, not to exceed twelve (12) units per week. Group ~~Psychotherapy~~psychotherapy is not reimbursable for a child younger than the age of ~~three (3)~~thirty-six (36) months. Limitations exclude outpatient behavioral health services provided in a foster care setting.

(c) **Family ~~Psychotherapy~~psychotherapy**.

(1) **Definition**. Family ~~Psychotherapy~~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 titled Family Psychoeducation~~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~~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.

~~(3)~~(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. ~~The practitioner may not bill any time associated with note taking and/or medical record upkeep. The practitioner may only bill the time spent in direct face-to-face contact. Practitioner must comply with documentation requirements listed in OAC 317:30-5-248~~ 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.

~~(d) **Multi-Systemic Therapy (MST)**.~~

~~(1) **Definition**. MST intensive outpatient program services are limited to children within an Office of Juvenile Affairs (OJA) MST treatment program which provides an intensive, family and community-based treatment targeting specific BH disorders in children with SED who exhibit chronic, aggressive, antisocial, and/or substance abusing behaviors, and are at risk for out of home placement. Case loads are kept low due to the intensity of the services provided.~~

~~(2) **Qualified professionals**. Masters level professionals who work with a team that may include bachelor level staff.~~

~~(3) **Documentation requirements**. Providers must comply with documentation requirements in OAC 317:30-5-248.~~

~~(4) **Service limitations**. Partial billing is not allowed, when only one service is provided in a day, providers should not bill for services performed for less than eight (8) minutes.~~

~~(e) **Children/Adolescent Partial Hospitalization Program (PHP).**~~

~~(1) **Definition**. Partial hospitalization services are services that (1) Are reasonable and necessary for the diagnosis or active treatment of the member's condition; (2) Are reasonably expected to improve the member's condition and functional level and to prevent relapse or hospitalization and (3) Include the following:~~

~~(A) Assessment, diagnostic and service plan services for mental illness and/or substance use disorders provided by LBHPs or licensure candidates.~~

~~(B) Individual/Group/Family (primary purpose is treatment of the member's condition) psychotherapies provided by LBHPs or licensure candidates.~~

~~(C) Substance use disorder specific services are provided by LBHPs or licensure candidates qualified to provide these services.~~

~~(D) Drugs and biologicals furnished for therapeutic purposes.~~

~~(E) Family counseling, the primary purpose of which is treatment of the member's condition.~~

~~(F) Behavioral health rehabilitation 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.~~

~~(G) Care Coordination of behavioral health services provided by certified behavioral health case managers.~~

~~(2) **Qualified practitioners**.~~

~~(A) All services in the PHP are provided by a clinical team, consisting of the following required professionals:~~

~~(i) A licensed physician;~~

~~(ii) Registered nurse; and~~

(iii) One or more of the licensed behavioral health professionals (LBHP) or licensure candidates listed in OAC 317:30-5-240.3(a) and (b).

(B) The clinical team may also include a Certified Behavioral Health Case Manager.

(C) The service plan is directed under the supervision of a physician and the number of professionals and paraprofessionals required on the clinical team is dependent on the size of the program.

(3) **Qualified providers**. Provider agencies for PHP must be accredited by one of the national accrediting bodies; The Joint Commission (TJC), Commission on Accreditation of Rehabilitation Facilities (CARF), 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.

(4) **Limitations**. Services are limited to children 0-20 only. 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. Services must be offered at a minimum of three (3) hours per day, five (5) days per week. Therapeutic services are limited to four (4) billable hours per day. PHP services are all inclusive with the exception of physician services and drugs that cannot be self-administered, those services are separately billable. Group size is limited to a maximum of eight (8) individuals as clinically appropriate given diagnostic and developmental functioning. Occupational, Physical and Speech therapy will be provided by the Independent School District (ISD). Academic instruction, meals, and transportation are not covered.

(5) **Service requirements**.

(A) Therapeutic Services are to include the following:

(i) Psychiatrist/physician face-to-face visit two (2) times per month;

(ii) Crisis management services available twenty-four (24) hours a day, seven (7) days a week;

(B) Psychotherapies to be provided a minimum of four (4) hours per week and include the following:

(i) Individual therapy - a minimum of one (1) session per week;

(ii) Family therapy - a minimum of one (1) session per week; and

(iii) Group therapy - a minimum of two (2) sessions per week;

(C) Interchangeable services which include the following:

(i) Behavioral Health Case Management (face-to-face);

(ii) Behavioral health rehabilitation services/alcohol and other drug abuse education except for children under age six (6), unless a prior authorization has been granted for children ages four (4) and five (5);

(iii) Medication Training and Support; and

(iv) Expressive therapy.

(6) **Documentation requirements**. Documentation needs to specify active involvement of the member's family, caretakers, or significant others involved in the individual's treatment. A nursing health assessment must be completed within 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.

(7) **Staffing requirements**. Staffing requirements must consist of the following:

(A) RN trained and competent in the delivery of behavioral health services as evidenced by education and/or experience that is available onsite during program hours to provide necessary nursing care and/or psychiatric nursing care [one (1) RN at a minimum can be backed up by an LPN but an RN must always be onsite]. Nursing staff administers medications, follows up with families on medication compliance, and restraint assessments.
(B) Medical director must be a licensed psychiatrist.
(C) A psychiatrist/physician must be available twenty-four (24) hours a day, seven (7) days a week.

(f) **Children/Adolescent Day Treatment Program**.

(1) **Definition**. Day Treatment Programs are for the stabilization of children and adolescents with severe emotional and/or behavioral disturbances. Treatment is designed for children who have difficulty functioning in mainstream community settings such as classrooms, and who need a higher intensity of services than outpatient counseling provides. Treatment is time limited and includes therapeutically intensive clinical services geared towards reintegration to the home, school, and community.

(2) **Qualified 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 or licensure candidate.

(3) **Qualified providers**. Provider agencies for Day Treatment must be accredited to provide Day Treatment services by one of the national accrediting bodies; The Joint Commission (TJC), Commission on Accreditation of Rehabilitation Facilities (CARF), Accreditation Commission for Health Care (ACHC) or The Council on Accreditation (COA).

(4) **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.

(5) **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 FT 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.~~

~~(6) **Documentation requirements**. Service plans are required every three (3) months.~~

317:30-5-241.2.1 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.

317:30-5-241.2.2 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;
(F) Peer-to-peer services;
(G) Certified Community Behavioral Health (CCBH) services;
(H) Day treatment;
(I) Multi-systemic therapy (MST).

(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).

(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:

(A) Physician services;

(B) Medications;

(C) Psychological testing by a licensed psychologist.

317:30-5-241.2.3 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;
(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.

317:30-5-241.2.4 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.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 1. PHYSICIANS

317:30-5-22. Obstetrical care

(a) Obstetrical (OB) care is billed using the appropriate CPT codes for ~~Maternity Care and Delivery~~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 Assessment 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~~ board eligible/board certified obstetrician-gynecologist (OB-GYN), ~~Radiologist, or a Board Eligible/Board Certified Maternal-Fetal Medicine~~radiologist, or a board eligible/board certified maternal-fetal medicine specialist. In addition, this ultrasound may be performed by a ~~Certified Nurse Midwife, Family Practice Physician or Advance Practice Nurse Practitioner in Obstetrics~~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~~ 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 ~~Certified Nurse Midwife, Family Practice Physician or Advance Practice Nurse Practitioner in Obstetrics~~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~~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)~~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~~fetus(es) are delivered by C-section by the same physician, the ~~higher level~~higher-level procedure is paid. If one (1) fetus is delivered vaginally and additional fetus(es) are delivered by ~~C-Section~~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~~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~~C-sections which include only in-hospital post-operative care. Family practitioners who provide prenatal care and assist at ~~C-Section~~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~~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.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 6. OUT-OF-STATE SERVICES

317:30-3-92. ~~Payment for lodging and meals~~Lodging and meals services

~~(a) Payment for lodging and/or meals assistance for an eligible member and one (1) approved medical escort, if needed, is provided only when medically necessary 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.~~

~~(1) 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 services and up to twenty-four (24) hours after the services end. If travel arrangements cannot meet the aforementioned stipulations, due to travel issues/restrictions and/or medically necessary services, then lodging and/or meals may be provided with approval from the OHCA.~~

~~(2) 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:~~

~~(A) Type of hospital room;~~

~~(B) Availability of "rooming-in";~~

~~(C) Shower facilities available for use by the medical escort; and~~

~~(D) Member's anticipated length of stay.~~

~~(3) The following conditions must be met in order for lodging and/or meals to be reimbursed, unless the lodging and/or meals provision is determined to be the most cost-effective alternative:~~

~~(A) Travel must be to obtain specialty care at the closest appropriate facility and be fifty (50) miles or greater from the member's home;~~

~~(B) The trip cannot be completed during SoonerRide operating hours or the member's medical treatment/condition requires an overnight stay; and~~

~~(C) Medical necessity must be confirmed and the medical escort must be actively engaged and participative in compensable care.~~

~~(4) Meals will be reimbursed if lodging criteria is met. Duration of the trip must be eighteen (18) hours or greater.~~

~~(5) 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. If meals or meal vouchers are provided by either the hospital or the lodging provider, additional reimbursement will not be provided to the member.~~

~~(6) During the first fourteen (14) days of a member's inpatient or outpatient 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.~~

~~(7) 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.~~

~~(b) Criteria for lodging and/or meals reimbursement is as follows:~~

~~(1) Lodging must be with a SoonerCare contracted room and board provider, when available, before direct reimbursement to a member and/or medical escort can be authorized.~~

~~(2) If lodging and/or meals assistance with contracted room and board providers is not available, the member and any medical escort may request reimbursement assistance by submitting the appropriate travel reimbursement forms. The travel reimbursement forms may be obtained by contacting SoonerCare Population Care Management division.~~

~~(3) Any lodging and/or meal expenses claimed on the travel reimbursement forms must be documented with the required receipts. If the compensable service related to lodging/meals is not verifiable, reimbursement will be denied.~~

~~(4) Reimbursement for lodging will not exceed maximum state allowable amounts.~~

~~(5) In order for lodging to be reimbursed for a medical escort of a hospitalized member, the medical escort must be able to assist the member during 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 must comply with them. This includes, but is not limited to, being compliant with the lodging facility's required age to check in.~~

~~(c) If the Oklahoma Department of Human Services (DHS) removes a child from his/her 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. It is the responsibility of the OHCA to determine this necessity. The decision should be based on the following circumstances:~~

~~(1) When the individual's health or disability does not permit traveling alone; and~~

~~(2) When the individual seeking medical services is a minor child.~~

(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 compliant 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.

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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~~, but only when SoonerRide is unavailable, and a lack of PDN services during transportation would require transportation by ambulance pursuant to Oklahoma Administrative Code (OAC) 317:30-5-336~~.

(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)].

317:30-5-557. Coverage by category

(a) **Adults.** SoonerCare does not cover adults ~~(Age 21 or over)~~[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 the age of 21)~~[under twenty-one (21) years of age] if:

(1) ~~the~~The ~~child~~member is eligible for SoonerCare; and

(2) ~~the~~The Oklahoma Health Care Authority (OHCA), in its discretion, deems the services medically necessary. Medical necessity is determined in accordance with ~~OAC~~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.

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 ~~the home health agency~~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) ~~A telephonic interview and/or personal visit by an OHCA care management nurse is required prior to the authorization for services~~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.

317:30-5-559. ~~How services are authorized~~How Private Duty Nursing (PDN) services are authorized

~~An eligible provider may have private duty nursing services authorized by following all the following steps:~~

~~(1) create a treatment plan for the patient as expressed in OAC 317:30-5-560;~~

~~(2) submit the prior authorization request with the appropriate OHCA required forms, the treatment plan, and request the telephonic interview and/or personal visit by an OHCA Care Management Nurse; and~~

~~(3) have an OHCA physician determine medical necessity of the service including scoring the member's needs on the Private Duty Nursing Acuity Grid.~~

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.

317:30-5-560. Treatment ~~Plan~~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~~ medical and social data so that an OHCA physician can appropriately determine medical necessity including use of the Private Duty Nursing Acuity Grid~~:

(1) ~~diagnosis~~Diagnosis;

(2) ~~prognosis~~Prognosis;

(3) ~~anticipated~~Anticipated length of treatment;

(4) ~~number~~Number of ~~hours of private duty nursing~~PDN requested hours ~~requested~~ per day;

(5) ~~assessment~~Assessment needs and frequency (e.g., vital signs, glucose checks, neuro checks, respiratory);

(6) ~~medication~~Medication method of administration and frequency;

(7) ~~age-appropriate~~Age-appropriate feeding requirements (diet, method and frequency);

(8) ~~respiratory~~Respiratory needs;

(9) ~~mobility~~Mobility requirements including need for turning and positioning, and the potential for skin breakdown;

(10) ~~developmental~~Developmental deficits;
(11) ~~casting~~Casting, orthotics, therapies;
(12) ~~age-appropriate~~Age-appropriate elimination needs;
(13) ~~seizure~~Seizure activity and precautions;
(14) ~~age-appropriate~~Age-appropriate sleep patterns;
(15) ~~disorientation~~Disorientation and/or combative issues;
(16) ~~age-appropriate~~Age-appropriate wound care and/or personal care;
(17) ~~communication~~Communication issues;
(18) ~~social~~Social support needs;
(19) ~~name~~Name, skill level, and availability of all caregivers; and
(20) ~~other~~Other pertinent nursing needs such as dialysis, isolation.

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~~A treatment plan for the member;
(2) ~~a telephonic interview and/or personal visit by an OHCA Care Management Nurse~~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~~An OHCA physician to determine medical necessity including use of the ~~Private Duty Nursing Acuity Grid~~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 ~~telephonic interview and/or personal visit by the OHCA Care Management staff~~assessment (telephonic, virtual, or face-to-face) by an OHCA care management nurse.

317:30-5-560.2. Record documentation

~~The treatment plan must be updated and signed by the attending physician at least annually. Copies of the attending physician's orders and, at a minimum, the last 30 days of medical records for the actual care provided must be maintained in the home. Medical records must include the beginning and ending time of the care and must be signed by the person providing care. The nurse's credentials must also be included. 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 in the record. All records must meet the requirements set forth in OAC 317:30-3-15.~~
(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.

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PART 51. HABILITATION SERVICES

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) ~~An oral examination;~~Oral examinations;

(ii) ~~Bite-wing X-rays;~~Medically necessary images;

(iii) ~~Dental cleaning;~~Prophylaxis;

(iv) ~~Topical fluoride treatment;~~Flouride application;

(v) Development of a sequenced treatment plan that prioritizes:

(I) ~~Elimination of pain;~~Pain elimination;

(II) Adequate oral hygiene; and

(III) ~~Restoration or an improved~~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.** ~~Coverage of dental services~~Dental service coverage is specified in the member's Individual Plan (IP) in accordance with applicable Waiver limits. ~~Dental~~Cosmetic dental services are not authorized~~ when recommended for cosmetic purposes~~.

(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 ~~must~~ have current, non-restrictive licensure by the Oklahoma Board of Medical Licensure and Supervision. Occupational therapy assistants ~~must be~~are supervised by occupational therapists, per OAC 317:30-5-295 (b) (1).

(B) ~~**Description of services.**~~**Service description.** Occupational therapy services include evaluation, treatment, and consultation in leisure management, daily living skills, sensory motor, perceptual motor, ~~and~~ mealtime assistance~~.~~, assistive technology, positioning, and mobility. Occupational therapy services may include ~~the use of~~ 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 ~~must include~~includes a practitioner's prescription.

(ii) For this Section's purposes ~~of this Section~~, a practitioner ~~is defined as~~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) ~~The~~Service provision ~~of services~~ includes a written report or record documentation in the member's record, as required.

(C) **Coverage limitations.** ~~Payment~~For compensable services, payment is made ~~for compensable services~~ 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 ~~15-minute~~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 ~~must supervise~~supervises the physical therapist assistant, per OAC 317:30-5-290.1 (b) (1).

(B) ~~**Description of services.**~~**Service description.** Physical therapy services include evaluation, treatment, and consultation in locomotion or mobility ~~and~~ skeletal and muscular conditioning, assistive technology, and positioning to maximize the member's mobility and skeletal/muscular well-being. Physical therapy services may include ~~the use of~~ 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 ~~must include~~includes a practitioner's prescription. For this Section's purposes ~~of this Section~~, 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) ~~The provision of services~~Service provision includes a written report or record documentation in the member's record, as required.

(C) **Coverage limitations.** ~~Payment~~For compensable services, payment is ~~made for compensable services~~ 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 ~~15-minute~~fifteen-minute (15-minute) units with a limit of four hundred and eighty (480) units per ~~Plan of Care year.~~POC. Payment is not allowed solely for written reports or record documentation.

(5) **Psychological services.**

(A) **Minimum qualifications.** Qualification ~~as a provider of~~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 ~~in which~~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) **~~Description of services.~~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 ~~must develop, implement, evaluate and revise~~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) ~~Approval of services~~Service approval is based ~~upon~~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 ~~must~~does not exceed one hundred and ninety-two (192) units, forty-eight (48) service hours ~~of service~~.

(II) Authorizations may not exceed two hundred and eighty-eight (288) units per ~~plan of care~~POC year unless the DDS Behavior Support Services director or designee makes an exception ~~is made by the DDS director of Behavior Support Services or his or her designee~~.

(III) No more than twelve (12) hours of services, forty-eight (48) units, may be billed for PIP preparation. Any clinical document ~~must be~~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 ~~must be~~is clearly documented and ~~must~~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) **~~Description of services.~~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 ~~Plan of Care~~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) ~~**Description of services.**~~**Service description.** Speech therapy includes evaluation, treatment, and consultation in communication, ~~and~~ 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 ~~must include~~includes a practitioner's prescription. For this Section's purposes ~~of this Section~~, practitioners are defined as licensed medical and osteopathic physicians, physician assistants, and other licensed professionals with prescriptive authority to order speech ~~and/or~~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 ~~Plan of Care year.~~POC. Payment is not allowed solely for written reports or record documentation.

(8) **Habilitation training specialist (HTS) services.**

(A) **Minimum qualifications.** Providers ~~must~~ complete ~~the~~ Oklahoma ~~Department of~~ Human Services ~~(DHS)~~(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) ~~Were~~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 ~~(O.S.);~~(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) ~~**Description of services.**~~**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 ~~provided by family;~~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 ~~must~~ 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 ~~requiring~~who require HTS services for more than forty (40) hours per week ~~of HTS services, must~~ 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 ~~must~~ clearly ~~specify~~specifies the role of the HTS and person providing IPS to ensure there is no service duplication ~~of services~~.

(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) ~~Must be~~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 ~~services~~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) ~~A~~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 ~~of the group~~.

(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.

~~(9)~~(10) **Self Directed HTS (SD HTS).** SD HTS are provided per OAC 317:40-9-1.

~~(10)~~(11) **Self Directed Goods and Services (SD GS).** SD GS are provided per OAC 317:40-9-1.

~~(11)~~(12) **Audiology services.**

(A) **Minimum qualifications.** Audiologists ~~must~~ 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) ~~**Description of services.**~~**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 ~~must include~~includes a practitioner's prescription. For this Section's purposes ~~of this Section~~, practitioners are defined as licensed medical and

osteopathic physicians, and physician assistants in accordance with ~~rules and regulations~~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.

~~(12)~~(13) **Prevocational services.**

(A) **Minimum qualifications.** Prevocational services providers:

(i) ~~Are at least eighteen (18) years of age;~~Are eighteen (18) years of age or older;

(ii) Complete ~~the DHS~~OKDHS DDS-sanctioned training curriculum;

(iii) ~~Were~~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 ~~by~~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) ~~**Description of services.**~~**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 ~~individual~~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 ~~for the purpose of furthering~~to further habilitation goals that lead to greater opportunities for competitive, integrated employment. All prevocational services are reflected in the member's IP. Documentation ~~must be~~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 ~~$27,000, per Plan of Care year.~~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) ~~Intensive Personal Supports;~~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.

~~(13)~~(13) **Supported employment.**

(A) **Minimum qualifications.** Supported employment providers:
(i) Are ~~at least~~ eighteen (18) years of age~~;~~or older;
(ii) Complete the ~~DHS~~OKDHS DDS-sanctioned training curriculum;
(iii) ~~Were~~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 ~~by~~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) ~~**Description of services.**~~**Services description.** ~~Supported~~For members receiving HCBS Waiver services, supported employment is conducted in ~~a variety of~~various settings, particularly worksites ~~in which~~where persons without disabilities are employed, and includes activities that are outcome based and needed to sustain paid work ~~by members receiving services through HCBS Waivers~~, including supervision and training. The supported employment outcome ~~of supported employment~~ is sustained paid employment at or above minimum wage, but not less than the customary wage and benefit level ~~paid by~~ the employer pays for the same or similar work ~~performed by~~ 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 ~~in which~~where persons without disabilities are employed, payment:
(I) Is made for the adaptations, supervision, and training ~~required by~~ 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 ~~Individuals with Disabilities Education Act (IDEA).~~IDEA.
(iv) Documentation that the service is not otherwise available under a program funded by the Rehabilitation Act of 1973 or IDEA ~~must be~~is maintained in ~~the~~each member's record ~~of each member receiving the service~~.

(v) Federal financial participation ~~(FFP)~~ 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 ~~Plan of Care~~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) ~~Intensive Personal Supports;~~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.

~~(14)~~(15) ~~**Intensive personal supports (IPS).**~~**IPS.**

(A) **Minimum qualifications.** IPS provider agencies must have a current provider agreement with OHCA and ~~DHS~~OKDHS DDS. Providers:

(i) Are ~~at least~~ eighteen (18) years of age~~;~~ or older;

(ii) Complete ~~the DHS~~OKDHS DDS-sanctioned training curriculum;

(iii) ~~Were~~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 ~~by~~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) ~~**Description of services.**~~**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 ~~upon~~on the support level ~~of support provided by a~~ HTS or ~~daily living supports (DLS)~~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 ~~Individual Plan (IP) must~~IP clearly ~~specifys~~specifies the role of HTS and the person providing IPS to ensure there is no service duplication ~~of services~~.

(iii) ~~Review and approval by the DDS plan of care reviewer is required.~~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 ~~must be~~are included in the member's IP, per OAC 317:40-5-151 and 317:40-5-153.

~~(15)~~(16) **Adult day services.**

(A) **Minimum qualifications.** Adult day ~~services~~service provider agencies ~~must~~:

(i) Meet ~~the~~ licensing requirements, per 63 O.S. § 1-873 *et seq*. and comply with OAC 310:605; and

(ii) ~~Be~~Are approved by the ~~DHS~~OKDHS DDS director and have a valid OHCA contract for adult day services.

(B) ~~**Description of services.**~~**Service description.** Adult day services provide assistance with ~~the retention~~retaining or ~~improvement of~~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 ~~must be~~are authorized in the member's IP.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 40. DEVELOPMENTAL DISABILITIES SERVICES

SUBCHAPTER 5. MEMBER SERVICES

PART 1. AGENCY COMPANION SERVICES

317:40-5-5. Agency companion services (ACS) provider requirements and responsibilities

(a) ~~Companions are required to meet all applicable standards outlined in this subchapter and competency-based training per Oklahoma Administrative Code (OAC) 340:100-3-38. The provider agency ensures all companions meet the criteria in this Section.~~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) ~~Failure to follow any rules or standards, failure to promote the independence of the member, or failure to follow recommendation(s) of the personal support team (Team) results in problem resolution, per OAC 340:100-3-27, for the companion, and when warranted, revocation of approval of the companion.~~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) The companion:~~

~~(1) Ensures no other adult or child is cared for in the home on a regular or part-time basis, including other Oklahoma Department of Human Services (OKDHS) placements, family members, or friends without prior written authorization from the Developmental Disabilities Services (DDS) area residential services programs manager or state office residential services programs manager;~~

~~(2) Meets the requirements of OAC 317:40-5-103. Neither the companion nor the provider agency may claim transportation reimbursement for vacation travel;~~

~~(3) Transports or arranges transportation for the member 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 as a member of the member's Team and assists in the development of the member's Individual Plan(Plan) for service provision;~~

~~(6) Develops, implements, evaluates, and revises the training strategies corresponding to the relevant outcomes for which the companion is responsible, as identified in the Plan. The~~

~~companion may request assistance from the case manager or program coordinator. The companion documents and provides monthly data and health care summaries 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 mandated to be provided by the public school district pursuant to the Individuals with Disabilities Education Act (IDEA);~~
~~(9) Is sensitive to and assists the member in participating in the member's chosen religious faith. 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 visitation is desired by the member;~~
~~(11) Obtains permission from the member's legal guardian, a guardian is assigned, 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) Involvement of the member in any publicity;~~
~~(12) Serves as the member's health care coordinator, per OAC 340:100-5-26;~~
~~(13) Ensures the monthly room and board contribution received from the member is used toward the cost of operating the household;~~
~~(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 the member's maximum level of independence;~~
~~(17) Submits, in a timely manner, to the provider agency program coordination staff all necessary information regarding the member;~~
~~(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 representative payee for the member 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 properly 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, using (OKDHS) Form 06AC020E, Evacuation/Escape~~

~~Plan, for the home and conducts training with the member;~~
~~(26) Conducts fire and weather drills at least quarterly and documents the fire and weather drills 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) Assisting the member to wear appropriate work attire; and~~
~~(B) Contacting the member's employer as outlined by the Team and in the Plan;~~
~~(29) Is responsible for the cost of the member's meals and entertainment during recreational and leisure activities. Activities must be affordable to the member. Concerns about affordability are presented to the Team for resolution;~~
~~(30) For adults, reports suspected maltreatment including abuse, verbal abuse, sexual abuse, neglect, financial neglect, or exploitation of a vulnerable adult per Section 10-104 of Title 43A of the Oklahoma Statutes, to the OKDHS Office of Client Advocacy (OCA);~~
~~(31) For children, reports abuse, neglect, sexual abuse, or sexual exploitation per Section 1-2-101 of Title 10A of the Oklahoma Statutes to the Child Abuse and Neglect Hotline at 1-800-522-3511;~~
~~(32) Follows all applicable rules promulgated by the Oklahoma Health Care Authority and DDS, 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 servicing as companion must meet all requirements listed in this Subchapter; and~~
~~(34) Is not the Chief Executive Officer of a provider agency.~~

(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.

317:40-5-6. Agency Companion contractor requirements [REVOKED]

~~(a) The service recipient or legal guardian, the provider agency, or the Oklahoma Department of Human Services Developmental Disabilities Services (DDS) case manager may identify an applicant to be screened for approval to serve as companion.~~

~~(b) Approval by DDS for a person to provide contracted Agency Companion Services (ACS) requires the applicant:~~

~~(1) is 21 years of age or older;~~
~~(2) has attended the DDS or provider agency ACS orientation;~~
~~(3) contracts with a provider agency having a current contract with the Oklahoma Health Care Authority to provide ACS;~~
~~(4) submits the completed DDS application packet per Oklahoma Administrative Code (OAC) 317:40-5-40 within the required time period to designated DDS staff or the provider agency staff;~~
~~(5) cooperates 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) has completed all training required by OAC 340:100-3-38, including medication administration training, and all provider agency pre-employment training per OAC 317:40-5-40.~~

SUBCHAPTER 3. GUIDELINES TO STAFF

317:40-5-40. Home profile process ~~1 & 2~~

(a) **Applicability.** This Section establishes procedures for ~~the~~ Developmental Disabilities Services (DDS) home profile process. A home profile is required for:

(1) Agency companion services (ACS);
(2) Specialized ~~foster care~~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 ~~to~~that include, but are not limited to:

(1) Facts description~~, and guiding principles of the Home and Community-Based Services (HCBS) program~~;
(2) An explanation of:
(A) Home and Community-Based Services (HCBS) program's guiding principles;
~~(A)~~(B) The home profile process;
~~(B)~~(C) Basic provider qualifications;
~~(C)~~(D) Health, safety, and environmental issues; and
~~(D)~~(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, ~~and~~ contact information, and motivation to provide services; and
(4) An explanation of ~~a~~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 ~~(DPS)~~, Sex Offender Registry, Mary Rippy 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 ~~of the applicant~~ and any adult ~~members of the~~

~~household;~~household member's fingerprints; except when an exception is necessary as outlined ~~below.~~in (I) through (II) of this subsection.

(I) When fingerprints are low quality, ~~(as determined by OSBI, FBI, or both)~~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)~~ state, national, or both, may be authorized.

(II) When the DDS State Office residential staff ~~request~~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)~~state, national, or both may be authorized.

(iii) ~~Search~~A search of any involvement as a party in a court action;

(iv) ~~Search~~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 ~~of the out-of-state child abuse and neglect registry checks, when a registry is maintained in the applicable state,~~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, ~~a~~an information request ~~for information~~ is made to the applicable state; and

(vi) ~~Search~~A search of Juvenile Justice Information System ~~(JOLTS)~~ 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-year~~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 ~~of the prescreening~~, the initial home profile process described in (1) through (8) of this subsection is initiated.

(1) The applicant provides required information for ~~the~~home profile completion ~~of the home profile~~.

(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 ~~provided by~~ the applicant~~,~~ provides, designated DDS staff documents the completed reference check results ~~of each completed reference check~~.

(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 ~~of responsibilities~~ with the applicant and ~~acknowledgment is made in writing by the applicant and designated DDS staff.~~DDS staff and the applicant acknowledge the review in writing.

(7) The DDS ~~area residential services~~area residential services programs manager sends ~~to~~ 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 completion~~ 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 ~~must be~~are comfortable, clean, and in good repair, and the grounds ~~must be~~are maintained. There ~~must be~~is no ~~accumulation of~~accumulating garbage, debris, ~~or~~ 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; ~~and~~

(iii) Provide space for the member's personal possessions and privacy; and

(iv) Allow adequate space for the occupants' recreational and social needs ~~of the occupants~~.

(C) Provisions for the member's safety ~~must be~~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;

~~(v)~~(vii) Adequate lighting;

~~(vi)~~(viii) Anti-scald devices; and

~~(vii)~~(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 ~~must be~~are equipped with sufficient safety barriers or devices designed to prevent accidental injury or unsupervised access.

(E) The household ~~must be~~is covered by homeowner's or renter's insurance including personal liability insurance.

(2) **Sanitation.**

(A) Sanitary facilities ~~must be~~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 ~~must be~~is in good working order.

(C) Garbage and refuse ~~must be~~is stored in readily cleanable containers, pending weekly removal.

~~(D) Sanitation for household pets and other domestic animals must be adequate to prevent health hazards.~~

~~(i) Proof of rabies or other vaccinations as required by a licensed veterinarian for household pets must be maintained on the premises.~~

~~(ii) Pets not confined in enclosures must be under control and not present a danger to members or guests.~~

~~(E)~~(D) There ~~must be~~is adequate control of insects and rodents, including doors and windows with ventilation screens ~~used for ventilation~~ in good repair ~~on doors and windows~~.

~~(F)~~(E) Universal precautions for infection control ~~must be~~are followed in ~~care to the member.~~the member's care. Hands and other skin surfaces ~~must be~~are washed immediately and thoroughly when contaminated with blood or other body fluids.

~~(G)~~(F) Laundry equipment, if in the home, ~~must be~~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 ~~must be~~is located near each toilet.

(ii) ~~A~~For members who are non-ambulatory or who have limited mobility, a toilet, shower and sink ~~must be~~are provided on each floor where their rooms ~~of members who are non-ambulatory or with limited mobility~~ 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 ~~must~~:

(A) ~~Have~~Has been constructed ~~as such~~for that purpose when the home was built or remodeled under permit;

(B) ~~Be~~Is provided for each member.

(i)~~Exception~~The DDS are residential services program manager may make exceptions to allow members to share a bedroom ~~may be made by DDS area residential program manager,~~ when DDS determines sharing a bedroom is in the members' best ~~interest of the member.~~interests.

(ii) A member must not share a bedroom with more than one (1) other ~~person;~~member;

(iii) Minor members must not share bedrooms with ~~adults.~~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) ~~Have~~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 ~~and two (2) means of egress~~. The home's provider, family members, or other occupants ~~of the home~~ 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 not the non-member are eighteen (18) years are 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) ~~Be~~Is finished with standard construction walls or partitions ~~of standard construction~~ that go from floor to ceiling;

(E) ~~Be~~Is adequately ventilated, heated, cooled, and lighted;

(F) ~~Include~~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, ~~rollaways,~~rollaway beds, couches, futons, air mattresses, and folding beds ~~must not be~~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 ~~must have~~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 ~~must be~~are laundered at least weekly or more often if necessary.

(iii) Waterproof mattress covers ~~must be~~are used for members who are incontinent;

(G) ~~Have~~Has sufficient space for each member's clothing and personal effects, including hygiene and grooming supplies.

(i) Members ~~must be~~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 ~~must be~~are in good condition and allow privacy for members;

(H) ~~Be~~Is on ground level for members with impaired mobility or who are non-ambulatory; and

(I) ~~Be~~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 ~~must be~~is available to maintain food at the proper temperature, including a properly working refrigerator~~. Food storage must be~~ such that, and to keep food ~~is~~ protected from dirt and contamination ~~and maintained at proper temperatures~~ to prevent spoilage.

(B) Utensils, dishes, glassware, and food supplies ~~must not be~~not stored in bedrooms, bathrooms, or living areas.

(C) Utensils, dishes, and glassware ~~must be~~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) ~~A~~There is a working phone ~~must be provided~~ in the home that is available and accessible for the member's use, ~~for incoming and outgoing calls.~~including during periods of time when the member is home alone.

(B) Phone numbers to the home and providers ~~must be~~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, ~~must be~~are installed in accordance with all applicable fire and life safety codes. Such equipment ~~must be~~is used and maintained properly and kept in good repair.

(i) ~~Protective~~Fireplaces are required to have protective glass screens or metal mesh curtains attached at top and bottom ~~are required on fireplaces~~.

(ii) Unvented portable oil, gas, or kerosene heaters are prohibited.

(C) Extension cord wiring ~~must not be~~is not used in place of permanent wiring.

(D) Hardware for all exit and interior doors must have an obvious operation method ~~of operation~~ that cannot be locked against egress.

(8) **Emergencies.**

(A) Working smoke detectors ~~must be~~are provided in each bedroom, adjacent hallways, and in two (2) story homes, at the top of each stairway. Alarms ~~must be~~are equipped with a device that ~~warns of low battery condition,~~has a low battery warning when battery operated.

(B) At least one (1) working fire extinguisher ~~must be~~is in a readily accessible location.

(C) A working flashlight ~~must be~~is available for emergency lighting on each floor of the home.

(D) The provider:

(i) ~~Mainstays~~Maintains a working carbon monoxide detector in the home;

(ii) ~~Mainstays a~~Maintains the home's written evacuation plan ~~for the home and conducts~~evacuation training ~~for evacuation~~ 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 ~~by DDS~~;

(v) Has a written back-up plan for temporary housing in the event of an emergency; and

(vi) Is responsible ~~to re-establish~~for re-establishing a residence~~,~~ if the home

becomes uninhabitable.

(E) A first aid kit ~~must be~~is available in the home.

(F) The home's address ~~of the home must be~~is clearly visible from the street.

(9) **Special hazards.**

(A) Firearms and other dangerous weapons ~~must be~~are stored in a locked permanent enclosure. Ammunition ~~must be~~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 ~~must be~~are safely and properly stored in original, properly labeled containers.

(C) Cleaning supplies, medical sharps containers, poisons, and insecticides ~~must be~~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 ~~must~~ meet local and state requirements for accessibility ~~and~~, safe transit, licensing, inspection, insurance, and capacity.

(B) Drivers ~~of vehicles must~~ 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 ~~of relief~~; and

(2) Assessment and recommendation. DDS staff:

(A) Evaluates the applicant's ability ~~of the applicant~~ to provide services;

(B) Assesses the applicant's overall compatibility ~~of the applicant and~~with the service recipient, ensuring the lifestyles and personalities of each are compatible for the shared living arrangement. The applicant ~~must~~:

(i) ~~Express~~Expresses a long term commitment to the service member unless the applicant will only be providing respite services;

(ii) ~~Demonstrate~~Demonstrates the skills to meet the ~~individual~~member's needs ~~of the member~~;

(iii) ~~Express~~Expresses an understanding of the commitment required as a service provider ~~of services~~;

(iv) ~~Express~~Expresses an understanding of the impact the arrangement will have on personal and family life;

(v) ~~Demonstrate~~Demonstrates the ability to establish and maintain positive relationships, especially during stressful situations; and

(vi) ~~Demonstrates~~Demonstrates the ability to work collaboratively and cooperatively with others in a team process;

(C) ~~Approves only~~Only approves applicants who can fulfill ~~the~~service provider expectations ~~of the role of service provider~~; and

(D) ~~When~~Ensures that when the applicant does not meet standards, per OAC 317:40-5-40, ~~ensures~~ the final recommendation includes:

(i) A basis for the denial decision; ~~and~~

(ii) An effective date for determining the applicant does not meet standards. ~~Reasons for denying a request to be a provider may include, but are not limited to:~~; 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 ~~of the applicant~~ that impedes ~~the applicant's~~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) References who are guarded or have reservations in recommending the applicant;~~

~~(VII) The applicant failed to complete the application, required training, or verifications in a timely manner as requested or provided incomplete, inconsistent, or untruthful information;~~

(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;

~~(VIII)~~(VII) The home is determined unsuitable for the member requiring

placement;
~~(IX)~~(VIII) Confirmed abuse, neglect, or exploitation of any person;
~~(X) Breach of confidentiality;~~(IX) Confidentiality breach;
~~(XI) Involvement of the applicant~~(X) Applicant or provider involvement in criminal activity or criminal activity in the home;
~~(XII)~~(XI) Failures to complete training, per OAC 340:100-3-38;
~~(XIII) Failures of the home~~(XII) Home's failure to meet standards per subsection (d) of this Section; ~~and~~
~~(XIV) Failures~~(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 ~~of the home profile~~; and

(F) ~~When an application is canceled or withdrawn prior to completion of the home profile, completes a final written assessment that includes the:~~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's~~staff impression of the applicant based on information obtained; and
(iii) Effective ~~date of~~ cancellation or withdrawal. date. Written notice is sent to the applicant to confirm application cancellation or withdrawal ~~of the application~~, 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.

~~(f) **Frequency of evaluation.**~~(g) **Evaluation frequency.** Home profile evaluations are completed for an applicant's initial approval or denial ~~of an applicant~~. After an initial approval, a home profile review is conducted annually and as needed for compliance and continued approval. DDS area residential services staff ~~conduct~~conducts at least biannual home visits to ~~specialized foster care~~SFC providers. The annual home profile review is a comprehensive review of the living arrangement, the provider's continued ability to meet standards, ~~the needs of the member and the~~

~~home~~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 provider of agency companion or SFC services,~~ 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 ~~areas of~~ service areas where improvement is needed;

(6) Includes ~~areas of~~ 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) ~~Ensures~~When applicable, ensures written notification of continued provider approval to providers and agencies~~, when applicable, of the continued approval of the provider.~~; 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 ~~correction of~~ the identified standards.

~~(g)~~(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) Lack of stable, adequate income to meet the provider's own or total family needs or poor management of available income;~~

~~(2) A physical facility that is inadequate to accommodate the addition of a member to the home or presents health or safety concerns;~~

~~(3) The age, health, or any other condition of the provider that impedes the provider's ability to provide appropriate care for a member;~~

~~(4) Relationships in the provider's household that are unstable and unsatisfactory;~~

~~(5) The mental health of the provider or other family or household member impedes the provider's ability to provide appropriate care for a member;~~

~~(6) The provider fails to complete required training, or verifications in a timely manner as requested or provides incomplete, inconsistent, or untruthful information;~~

~~(7) The home is determined unsuitable for the member;~~

~~(8) Failure of the provider~~(1) Provider's failure to complete tasks related to problem resolution, as agreed, per OAC 340:100-3-27;

~~(9) Failure of the provider~~(2) Provider's failure to complete ~~a plan of action,~~an action plan, as agreed, per OAC 317:40-5-63;

~~(10) Confirmed abuse, neglect, or exploitation of any person;~~

~~(11) Breach of confidentiality;~~

~~(12) Involvement of the applicant or provider involvement in the criminal activity or criminal activity in the home;~~

~~(13)~~(3) Failure to provide for the service member's care and well-being~~ of the service member~~;

~~(14)~~(4) Failure or continued failure to implement the ~~individual~~member's Individual Plan, per OAC 340:100-5-50 through 100-5-58;

~~(15) Failure to complete and maintain training, per OAC 340:100-3-38;~~

~~(16)~~(5) Failure to report changes in the household;

~~(17) Failure to meet standards of the home per subsection (d) of this Section;~~

~~(18) Failure or continued failure to follow applicable OKDHS or OHCA rules;~~

~~(19)~~(6) Decline ~~of~~in the provider's health to the point he or she can no longer meet the service member's needs~~ of the service member~~;

~~(20) Employment by the provider~~(7) Provider employment without prior ~~approval of the DDS area programs manager for residential services;~~DDS area residential services programs manager approval; or

~~(21)~~(8) Domestic disputes that cause emotional distress to the member.

~~(h) **Termination of placement.**~~(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 ~~of the member and state is~~are removed promptly and appropriately by the member or his or her designee.

SUBCHAPTER 5. SPECIALIZED FOSTER CARE

317:40-5-50. ~~Purpose of~~ Specialized Foster Care Scope

(a) Specialized Foster Care (SFC) provides up to ~~24~~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 ~~ages~~ three (3) years of age and older. SFC provides an individualized living arrangement in a family setting including up to ~~24~~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~~ of the service recipient~~.

(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 member is a child; or

(B) Required by the adult member’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 intent is to allow the member's family relief 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 (maintenance). HCBS services do not pay for room and board (maintenance).

(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 in accordance with 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 his or her Individual 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.

317:40-5-51. Scope of Specialized Foster Care [REVOKED]

~~(a) **Children in OKDHS custody.** A child in the custody of the Oklahoma Department of Human Services (OKDHS) who is determined eligible for HCBS Waiver services in accordance with OAC 317:40-1-1 is eligible to receive Specialized Foster Care (SFC) services if the special needs of the child cannot be met in a Division of Children and Family Services (DCFS) foster home.~~

~~(1) SFC provides a temporary, stable, nurturing, and safe home environment for the child while the 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.~~

~~(b) **Non-custody children.** SFC is a temporary service provided to children who are not in the custody of OKDHS when needed to prevent institutionalization.~~

~~(1) The intent of SFC is to allow the service recipient's family relief that cannot be satisfied by the provision of respite services or other in-home supports.~~
~~(2) SFC provides a nurturing, substitute home environment for the service recipient while plans are made to reunify the family.~~
~~(3) Parents of a child receiving SFC services must comply with requirements of OAC 317:40-5-56.~~

(c) **Adults.** SFC is an appropriate living arrangement for many adults. The decision to use SFC for an adult is based on the service recipient's need for residential support as described in his or her Plan.

(1) In general, SFC is appropriate for service recipients who have not experienced family life. A child served in SFC may continue to receive services in the home indefinitely after turning 18 years of age.

(2) The service recipient who receives SFC services lives in the provider's home.

317:40-5-52. Visitation and reunification in Specialized Foster Care [REVOKED]

Service recipients in Specialized Foster Care (SFC) have a written plan that addresses visitation, reunification, or permanency planning, and which may also address guardianship as the service recipient approaches age 18.

(1) **Custody children.** When the Court has established a specific visitation plan, the Division of Children and Family Services (DCFS) specialist informs the SFC provider, the service recipient, the Developmental Disabilities Services Division (DDSD) 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 service recipient's Team.

(B) The reunification effort is a joint responsibility of:

(i) the DCFS worker;

(ii) the DDSD case manager;

(iii) the natural family; and

(iv) the SFC family.

(C) For children in the custody of the Oklahoma Department of Human Services (OKDHS) who are attaining the age of 18, DCFS and DDSD 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 divisions work together to locate a guardian.

(2) **Non-custody children.** Visitation with the family is a part of the reunification efforts for non-custody children. Visitation must not be intrusive to the SFC home.

(3) **Adults.** Visitation with the adult service recipient's family is encouraged and arranged according to the preference of the service recipient. Visitation must not be intrusive to the SFC home.

317:40-5-54. Selection of Specialized Foster Care provider [REVOKED]

Providers of Specialized Foster Care (SFC) must meet the requirements of this Section.

(1) Each provider is approved through the home profile process described in OAC 317:40-5-40.

(2) The individual provider of Specialized Foster Care is required to have a current Home and Community Based Waiver (HCBW) services contract with the Oklahoma Health Care Authority.

(3) The provider is required to have a current Fixed Rate Contract for room and board reimbursement with Developmental Disabilities Services Division (DDSD) when:

(A) the SFC service recipient is a child; or

(B) required by the adult SFC recipient's Team.

(4) OKDHS Form DCW-SH-2, Claim for Foster and Adoptive Home Purchase of Care, if required in accordance with paragraph (3) of this subsection, is completed and submitted

~~monthly to OKDHS Finance by staff as designated by the DDSD area manager.~~

317:40-5-55. Specialized Foster Care (SFC) provider responsibilities

(a) **General responsibilities.** ~~The responsibilities of all Specialized Foster Care (SFC) providers~~The SFC providers responsibilities are listed in (a) through (c) of this Section. Each provider:

(1) ~~Providers of SFC are required~~Is required to meet all applicable standards per OAC 317:40-5-40~~.~~;

(2) ~~Providers of SFC are required~~Is required to receive ~~competency based~~competency-based training per OAC 340:100-3-38. The provider keeps all required training ~~up to date~~current and submits documentation to the SFC specialist at the time training is completed~~.~~;

(3) ~~The provider is an~~Is an active participant of the member's Personal Support Team (Team) and assists in ~~the development of~~developing the member's Individual Plan (Plan), per OAC 340:100-5-50 through 100-5-58~~.~~;

(4) ~~The provider documents~~Documents and notifies the case manager of any changes in ~~behaviors~~the member's behavior or medical conditions ~~of the member~~ within one working day. ~~Incident reports are completed by the SFC provider and submitted~~The SFC provider completes incident reports and submits them to the Developmental Disabilities Services ~~Division (DDSD)~~(DDS) case manager per OAC 340:100-3-34~~.~~;

(5) ~~The SFC provider is~~Is available to the member at any time~~.~~;

(6) ~~The~~Has primary responsibility ~~of the SFC provider is~~ to provide SFC services to the member. The SFC provider does not have employment unless the employment ~~has been~~is pre-approved by the ~~residential programs supervisor for DDSD.~~DDS area residential services programs manager or the State Office residential services programs manager;

(A) ~~Generally, providers are not approved for employment because the~~The provider must be available before and after school or vocational programs and ~~often~~as needed during the day due to holidays or illnesses~~.~~;

(B) ~~If, after~~After receiving employment approval ~~for employment~~, ~~it is found that~~if the ~~SFC~~ provider's employment interferes with the member's care, training, or supervision ~~needed by the member~~, the provider must determine if he or she wants to terminate the employment or have the member moved from the home~~.~~; and

(C) ~~DDSD~~DDS does not authorize ~~Homemaker, Habilitation Training Specialist,~~homemaker, habilitation training specialist, or respite services in order for the SFC provider to perform employment.

(7) ~~The provider does~~Does not deliver services that duplicate ~~the~~public school district mandated services ~~mandated to be~~that are provided ~~by the public school district~~ pursuant to the Individuals ~~With~~with Disabilities Education Act (IDEA-B)~~.~~;

(8) ~~The provider allows~~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) ~~The provider ensures~~Ensures confidentiality is maintained regarding the member per OAC 340:100-3-2~~.~~;

(10) ~~The provider is~~Is sensitive to, and assists the member in participating in, the member's ~~choice of~~ religious faith. No member is expected to attend any religious service against his or her wishes~~.~~;

(11) ~~The provider arranges,~~Arranges for, and ensures ~~that~~ the member obtains, a dental examination at least annually, and is responsible for obtaining regular and emergency medical services as needed~~.~~;
(12) ~~The provider has~~Has a valid Oklahoma driver license~~, and~~ maintains a motor vehicle in working order, ~~and complies with requirements of~~perOAC 317:40-5-103~~, Transportation.~~;
(13) ~~The provider transports~~Transports, or arranges transportation~~, using adapted transportation when appropriate,~~ for the member, ~~to and from school, employment, church, recreational activities, and medical or therapy appointments.~~using adapted transportation when appropriate, per OAC 317:40-5-103, the SFC provider:

(A) ~~SFC providers may~~May enter into a transportation contract~~.~~;

(B) ~~The provider must assure~~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) ~~The provider assures~~Assures the member is clean, appropriately dressed, and on time for activities and appointments~~.~~;
(15) ~~The provider ensures~~Ensures no other adult or child is cared for or resides in the home on a regular or part-time basis ~~that was~~who is not approved through the home profile review process or without prior approval from the ~~DDSD~~DDS area residential services programs manager~~ or designee~~;
(16) ~~The provider does~~Does not provide services to more than three (3) individuals regardless of ~~the type of service provided,~~service type provided, including SFC, ~~Children and Family Services Division~~Welfare Services foster care, respite, baby-sitting, or other such services. Any exception to this paragraph must be approved in writing by the ~~director of DDSD~~DDS director or designee prior to authorization or service delivery~~.~~;
(17) ~~The provider permits visitation and monitoring of the home by authorized DDSD staff.~~ Permits DDS staff to conduct monitoring and home visits. In order to assure ~~maintenance of~~ 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~~ of the member.~~;
(18) ~~The provider encourages~~Encourages and cooperates in planning visits in the SFC home by the member's relatives, guardians, or friends~~ of the member~~. ~~Visits by the member to the home of friends or relatives~~Member visits to his or her friends' or relative's homes must be approved by the member's legally authorized representative~~.~~;
(19) ~~The provider abides by the policies of DDSD per OAC 340:100-3-12, Prohibition of client abuse, and OAC 340:100-5-58, Prohibited procedures. The provider is~~Is prohibited from signing an authorization for school personnel to use physical discipline or corporal punishment~~.~~;
(20) ~~The provider notifies~~Notifies the ~~DDSD case manager~~DDS social services specialist (SSS) when the need arises for substitute supervision in ~~the event of~~ an emergency, ~~in accordance with the Backup Plan,~~ per OAC 317:40-5-59. ~~If~~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 ~~that~~who resides in the home~~.~~;

(B) The Team approves the natural support and defines when this support may be accessed~~.~~;

(C) Persons ~~who are~~ 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) ~~The provider provides written 30-day~~Provides written thirty (30) calendar day notice to the member and ~~DDSD~~DDS case manager when it is necessary for a member to be moved from the home~~.~~;

(22) ~~The SFC provider does~~Does not serve as the member's representative ~~payee for the member.~~;

(23) ~~The provider ensures~~Ensures the member's funds are properly safeguarded~~.~~;

(24) ~~The provider assists~~Assists the member in accessing and using entitlement programs for which the member may be eligible~~.~~;

(25) ~~The provider must~~Must use the room and board reimbursement payment to meet the member's needs, ~~as specified in~~per the ~~room and board contract.~~Fixed Rate Foster Home Contract;

(A) The provider retains a copy of the current ~~room and board contract~~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;~~Housing;

(ii) ~~food;~~Food;

(iii) ~~clothing;~~Clothing;

(iv) ~~care;~~Care;

(v) ~~incidental~~Incidental expenses such as:

(I) ~~birthday~~Birthday and Christmas gifts;

(II) ~~haircuts;~~Haircuts;

(III) ~~personal~~Personal grooming equipment;

(IV) ~~allowances;~~Allowances;

(V) ~~toys;~~Toys;

(VI) ~~school~~School supplies and lunches;

(VII) ~~school~~School pictures;

(VIII) ~~costs~~Costs of recreational activities;

(IX) ~~special~~Special clothing items required for dress occasions and school classes such as gym shorts and shirts;

(X) ~~extracurricular~~Extracurricular athletic and other equipment, including uniforms, needed for the member to pursue his or her particular interests or job;

(XI) ~~prom~~Prom and graduation expenses including caps, gowns, rings, pictures, and announcements;

(XII) ~~routine~~Routine transportation expenses involved in meeting the member's medical, educational, or recreational needs, unless the provider has a transportation contract;

(XIII) ~~non-prescription~~Non-prescription medication; and

(XIV) ~~other~~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 ~~of the member~~. Purchased items are documented on OKDHS Form 06AC022E, Personal Possession Inventory, and are ~~given by the provider~~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) ~~The provider maintains a~~Maintains Form 06AC022, Personal Possession Inventory, ~~Form 06AC022E (DDS-22)~~ for each member living in the home~~.~~;

(27) ~~The provider maintains~~Maintains the member's home record, per OAC 340:100-3-40~~.~~;

(28) ~~The provider immediately~~Immediately reports to the ~~DDSD SFC staff~~DDS SSS all changes in the household including, but not limited to:

(A) ~~telephone~~Phone number;

(B) ~~address;~~Address;

(C) ~~marriage~~Marriage or divorce;

(D) ~~persons~~Persons moving into or out of the home;
(E) ~~provider's~~Provider's health status;
(F) ~~provider's~~Provider's employment; and
(G) ~~provider's~~Provider's income.

(29) ~~The provider maintains~~Maintains home owner's or renter's insurance, including applicable liability coverages, and provides a copy to the ~~SFC Specialist.~~DDS SSS;

(30) ~~The provider serves~~Serves as the ~~Health Care Coordinator~~health care coordinator, and follows the ~~Health Care Coordinator policy~~rules per OAC 340:100-5-26~~.~~; and

(31) ~~Each SFC provider follows~~Follows all applicable OKDHS and Oklahoma Health Care Authority rules, ~~of the Oklahoma Department of Human Services and the Oklahoma Health Care Authority, promotes the independence of the member, and follows recommendations of the member's Team.~~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 ~~has to exercise~~. 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) ~~The provider works~~Works with the ~~DDSD~~DDS case manager and ~~CFSD~~CWS staff when the provider needs respite for a child in OKDHS or tribal custody~~.~~;

(2) ~~The provider participates~~Participates in ~~the development of~~developing the Individual Education Plan (IEP) and may serve as surrogate parent when appropriate~~.~~;

(3) ~~The provider obtains~~Obtains permission and legal consent from the child's custodial parent or guardian and ~~DDSD~~DDS case manager prior to traveling ~~out of state~~out-of-state for an overnight visit. If the child is in ~~the~~OKDHS or tribal custody, ~~of the OKDHS, the~~CWS permission ~~of the CFSD specialist~~ is also secured~~.~~;

(4) ~~The provider obtains~~Obtains permission and legal consent from the child's custodial parent or guardian and ~~DDSD~~DDS case manager prior to the child's involvement ~~of the child~~ in any publicity. If the child is in OKDHS or tribal custody, ~~the~~CWS permission ~~of the CFSD specialist~~ is also secured~~.~~; and

(5) The provider reports any suspected abuse, neglect, sexual abuse, or sexual exploitation of children ~~per Section 1-2-101 of Title 10A of the Oklahoma Statutes to the Abuse Hotline at 1-800-522-3511.~~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 ~~DDSD~~DDS case manager, prior to:

(A) ~~traveling out of state~~Traveling out-of-state for an overnight visit~~.~~; or

(B) The member's involvement ~~of the member~~ 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, ~~for services~~ 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 $~~250.00~~$300.00 per month.

(B) Changes in the member's monthly contribution are ~~developed~~made on an

individualized basis by the member's Team.

(3) ~~Reports~~The SFC provider reports any suspected ~~maltreatment including~~ abuse, verbal abuse, sexual abuse, neglect, financial neglect~~, and/or~~ or exploitation ~~of a vulnerable adult per Section 10-104 of Title 43A of the Oklahoma Statutes to the Office of Client Advocacy (OCA).~~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.

317:40-5-56. Responsibilities of the parents of individuals in voluntary specialized foster care [REVOKED]

~~(a) Natural or adoptive parents retain the responsibility for on going involvement and support of their child while the child is in specialized foster care (SFC).~~

~~(1) The parents are required to sign a written agreement allowing the Oklahoma Department of Human Services (OKDHS) to serve as the representative payee for the child's Social Security, other government benefits, and court-authorized child support.~~

~~(2) Social Security, other government benefits, and child support are used to pay for room and board (maintenance). Home and Community Based Services (HCBS) services do not pay for room and board (maintenance).~~

~~(b) Responsibilities of the parents of a child receiving voluntary SFC are:~~

~~(1) to provide respite to the foster SFC provider;~~

~~(2) to provide transportation to and from parental visitation;~~

~~(3) to provide a financial contribution toward the support of their child;~~

~~(4) to provide in kind supports such as disposable undergarments if needed, clothing, recreation, birthday and holiday presents, school supplies, and allowances or personal spending money;~~

~~(5) to follow the visitation plan as outlined by the service recipient's Team; (see OAC 317:40-5-52);~~

~~(6) to maintain ongoing communication with the service recipient and SFC provider by letters and telephone calls;~~

~~(7) to be available in the event of an emergency;~~

~~(8) to work toward reunification when appropriate;~~

~~(9) to provide written consent for medical treatments as appropriate;~~

~~(10) to attend medical appointments, when possible, and keep informed of the service recipient's health status;~~

~~(11) to participate in the service recipient's education plan in accordance with the Department of Education regulations; and~~

~~(12) to be present for all Team meetings.~~

~~(c) When moving out of Oklahoma, parents of a child receiving voluntary SFC are responsible to take their minor child with them, since the child is no longer eligible for services because he or she is no longer a resident of the State of Oklahoma.~~

~~(d) For children under age 18, the case manager reports to DCFS if the family moves out of Oklahoma without taking their child with them or cannot be located.~~

317:40-5-57. Developmental Disabilities Services ~~Division~~DDS Specialized Foster Care (SFC) case ~~manager~~management roles and responsibilities ~~regarding Specialized Foster Care~~

In addition to other identified roles and responsibilities, the ~~Developmental Disabilities Services Division (DDSD)~~DDS case manager is responsible for:

(1) ~~reporting~~Reporting any significant changes with the member or the SFC household to the ~~SFC specialist;~~DDS social service specialist (SSS);

(2) ~~assessing~~The member's guardianship needs;

(3) ~~facilitating pre-placement~~Pre-placement visits when approved by the ~~SFC specialist;~~DDS SSS;

(4) ~~monitoring for current~~Reviewing the member's backup plan, ~~as described in OAC~~per Oklahoma Administrative Code (OAC) 317:40-5-59;

(5) ~~monitoring the service recipient's personal inventory, Form DDS-22;~~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) ~~monitoring the service recipient's funds and resources monthly;~~Ensuring the SFC provider documents the member's personal belongings on Oklahoma Human Services (OKDHS) Form 06AC022, Personal Possession Inventory, including adaptive equipment;

(7) ~~reporting any potential violations of policy and standards to the SFC specialist in accordance with OAC 317:40-5-63 and assisting with the development of the provider's plan of action, if appropriate;~~Attending court hearings for children in OKDHS and tribal custody;

(8) ~~assisting in the inventory of any necessary adaptive equipment, Form DDS-22;~~Forwarding quarterly progress reports to the OKDHS Child Welfare Services (CWS) specialist for children in OKDHS custody;

(9) ~~attending Court hearings for custody children;~~Notifying the CWS or legally authorized representative of needed medical consents for pre-planned or emergency services; and

(10) ~~forwarding copies of monthly contact reports on custody children to the DCFS specialist;~~Completing the appropriate section of OKDHS Form 06AC024E, SFC/Agency Companion Services (ACS) Annual Review, and providing the information to the DDS SSS.

~~(11) notifying the DCFS specialist or legally authorized representative of needed medical consents for pre-planned or emergency services; and~~

~~(12) completing appropriate section of Form DDS-24, Annual Review, and providing the information to the SFC specialist.~~

317:40-5-58. Developmental Disabilities Services ~~Division~~(DDS) ~~Specialized Foster Care (SFC) staff~~Social Services Specialist (SSS) roles and responsibilities

~~Developmental Disabilities Services Division (DDSD) SFC~~DDS SSS staff have the responsibility for:

(1) SFC applicant orientation and prescreening ~~of SFC applicants~~;

(2) ~~making~~Making contact with the potential SFC provider within five (5) working days of ~~receipt of~~receiving a completed application to schedule interviews and start the ~~Home Profile Process, described in~~home profile process, per OAC 317:40-5-40;

(3) ~~completing the Home Profile~~Completing the home profile within ~~90 working~~ninety (90) calendar days after application assignment ~~of the application~~. The ~~SFC specialist~~DDS SSS documents the reason for any delay beyond ~~90~~ninety (90) calendar days;

(4) ~~maintaining~~Maintaining regular contact with the SFC provider by making a monitoring

visit every six (6) months ~~with a minimum of one telephone contact in all other months.~~and completing OKDHS Form 06AC023E, Monitoring Report;

~~(A) The SFC specialist completes the Monitoring Report (DDS-23) for each monitoring review.~~

~~(B) Items to be discussed during the telephone contacts are detailed in the Monthly Contact Monitoring Guide.~~

(5) ~~completing a~~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~~Attending member's Personal Support Team meetings ~~for service recipients in SFC~~ as necessary;

(7) ~~responding to requests for~~Responding to SFC and respite care~~;~~ requests;

(8) ~~providing~~Providing technical assistance and training to SFC providers regarding claims and ~~resolution of problems,~~problem resolutions, such as:

(A) ~~payments;~~Payments;

(B) ~~family~~Family dynamics;

(C) ~~DDSD~~DDS policy;

(D) ~~setting~~Setting up the in-home record ~~as described in~~per OAC 340:100-3-40;

(E) ~~setting~~Setting up the SFC provider record; and

(F) SFC provider training~~;~~.

(9) ~~making~~Making unannounced home visits to ensure homes and providers are in compliance with ~~DDSD standards and~~DDS policy;

(10) ~~reporting to DDSD State Office Training Staff as the provider's training occurs and is updated:~~

~~(A) the provider's name;~~

~~(B) the provider's Social Security Number; and~~

~~(C) dates and places of specific provider training;~~Providing SFC providers with technical assistance and training regarding room and board responsibilities.

(11) ~~facilitating a written agreement for room and board contributions on behalf of the service recipient, if the Oklahoma Department of Human Services is not the representative payee for the service recipient;~~Completing or obtaining the authorization for SFC services on OKDHS From 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 medial care and provides insurance information.

~~(12) completing or obtaining the:~~

~~(A) Room and Board Reimbursement for Foster Care (DCW-FH-2);~~

~~(B) Authorization for SFC Services (DDS-SFC-1), that:~~

~~(i) is signed by the parent or legal guardian for service recipients not in custody who are requesting SFC services; and~~

~~(ii) allows for authorization of routine or emergency medical care and provides insurance information.~~

317:40-5-59. Back-up Plan for ~~persons~~members receiving Specialized Foster Care (SFC)

Prior to a member moving into ~~Specialized Foster Care (SFC),~~SFC, the SFC provider and the ~~SFC specialist~~Developmental Disabilities Services (DDS) social services specialist (SSS) develop a Back-up Plan. The ~~SFC specialist~~DDS SSS communicates the Back-Up Plan in writing to the ~~DDSD~~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 ~~OKDHS,~~Oklahoma Human Services (OKDHS), unless the member is in ~~the~~OKDHS or tribal custody ~~of the Oklahoma Department of Human Services~~.

(3) The Back-up Plan contains the name(s) and current ~~telephone~~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~~, a Home Profile must be completed for the back-up staff per OAC 317:40-5-40.~~:

(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~~An Oklahoma State Bureau of Investigation (OSBI) name and criminal history records ~~history~~ search, including the Department of Public Safety ~~(DPS)~~, Sex Offender, and Mary Rippy Violent Offender ~~Registries;~~registries;

(ii) ~~a~~A Federal Bureau of Investigation ~~(FBI)~~ national criminal history search, based on the substitute applicant's fingerprints ~~of the applicant~~;

(iii) ~~a~~A search of any involvement as a party in a court ~~action that~~action that may impact the member's safety or stability ~~of the member~~ that includes:

(I) ~~victims~~Victims protective order; or

(II) ~~bankruptcy;~~Bankruptcy;

(iv) ~~a~~A search of all ~~Oklahoma Department of Human Services (OKDHS)~~OKDHS records, including ~~child welfare (CW)~~Child Welfare Services' records;

(v) ~~a~~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~~Completion of required ~~DDSD~~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 ~~is paid by the provider~~ and is not reimbursed by ~~DDSD.~~DDS.

(5) The Back-up Plan is jointly reviewed at least monthly by the ~~SFC specialist~~DDS SSS and the SFC provider to ensure the Back-up Plan continues to be appropriate and current.

(6) The SFC provider is responsible ~~to report~~for reporting any needed changes in the Back-up Plan to the ~~SFC specialist.~~DDS SSS.

(7) The ~~SFC specialist will report~~DDS SSS reports any changes in the Back-up Plan to the DDS case manager.

317:40-5-62. ~~Evaluation of~~Specialized Foster Care (SFC) policy ~~violation~~violations or program ~~concern in a specialized foster care home~~concerns

(a) Developmental Disabilities Services ~~Division (DDSD)~~DDS ~~Specialized Foster Care (SFC)~~SFC staff begin an evaluation ~~process~~ upon receipt of a complaint or observation of ~~program concern(s) or policy violation(s) by the provider.~~SFC provider policy violations or concerns.

(b) Concerns may include~~:~~ the SFC provider's:

(1) ~~provider's use~~Use of judgment;

(2) ~~provision~~Provision of program supervision;

(3) ~~non-compliance~~Non-compliance with ~~DDSD~~Oklahoma Human Services or Oklahoma Health Care Authority policy or contract; or

(4) ~~other~~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~~The service recipient;

(2) ~~the~~The DDSD case manager;

(3) ~~the~~The provider;

(4) ~~any~~Any other person(s) living in the home; and

(5) ~~any~~Any other person(s) who may have relevant information.

(e) When the evaluation findings indicate ~~programming concern(s) or violation(s) of policy or contract, the DDSD SFC staff,~~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 ~~concern(s) or violation(s).~~concerns or violations. The ~~SFC staff~~DDS SSS notifies the ~~DDSD~~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. ~~The case manager monitors to ensure the Plan 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.

SUBCHAPTER 7. STANDARDS FOR SPECIALIZED FOSTER CARE AND RESPITE HOMES

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 ~~two-to-eight~~either two (2) to three (3) workers with disabilities ~~abilities~~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~~Works in an integrated job setting;

(B) ~~receives~~Receives minimum wage or more;

(C) ~~does~~Does not receive services from a job coach who is simultaneously responsible for continuous job coaching for a group;

(D) ~~is~~Is employed by a community employer or the provider agency; and

(E) ~~has~~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 ~~with DOL regulations.~~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.

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.

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 ~~Department of~~ Human Services ~~OKDHS~~(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 ~~(IHSW-A)~~, In-Home Supports Waiver for Children ~~(IHSW-C)~~, and the Community Waiver when the member lives in a non-residential setting. SDS provides ~~a member~~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 ~~chosen by the member or his or her legal representative.~~chooses.

(2) The person directing services ~~must~~:

(A) ~~Be~~Is eighteen (18) years of age or older;

(B) ~~Comply~~Complies with DDS and Oklahoma Health Care Authority (OHCA) rules and regulations;

(C) ~~Complete~~Completes required DDS training for self-direction;

(D) ~~Sign~~Signs an agreement with DDS;

(E) ~~Be~~Is a member or legal representative approved ~~by the member or his or her legal representative~~ to act in ~~the capacity of a representative;~~a representative capacity;

(F) ~~Demonstrate~~Demonstrates knowledge and understanding of the member's needs and preferences; and

(G) ~~Not~~Does not serve as the Self-Directed (SD) ~~Habilitation Training Specialist~~habilitation training specialist (HTS) for the member ~~whom~~when he or she is directing the member's services.

(d) **The SDS program includes:**

(1) The SDS budget. A ~~plan of care~~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 ~~of the member~~ in accordance with this policy and the approved ~~plan of care,~~ POC, and is the allocated amount that may be used to develop the SDS budget. The SDS budget details the specific spending plan ~~for spending~~.

(A) The SDS budget is developed annually at the time of the annual plan ~~development~~ and updated. ~~as necessary by~~Individuals who participate in the budget development include, the member, case manager, parent, legal guardian, and others the member invites to participate ~~in the development of the budget~~.

(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 ~~of service necessity~~, 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) ~~performed by a 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 ~~plan of care~~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 ~~normally~~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 ~~during which~~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. ~~A~~An SD-HTS ~~must~~:

(A) ~~Be~~Is eighteen (18) years of age~~;~~ and older;

(B) ~~Pass~~Passes a background check, per OAC 340:100-3-39;

(C) ~~Demonstrate~~Demonstrates competency to perform required tasks;

(D) ~~Complete~~Completes required training, per OAC 340:100-3-38 et seq.;

(E) ~~Sign~~Signs an agreement with DDS and the member;

(F) ~~Be~~Is physically able and mentally alert to carry out the job's duties ~~of the job~~;

(G) ~~Not~~Does not work as an SD-HTS more than forty (40) hours in any week ~~in the capacity of a SD-HTS~~;

(H) ~~Not~~Does not implement prohibited procedures, per OAC 340:100-5-58;

(I) ~~Provide~~Provides services to only one (1) member at any given time. This does not preclude providing services ~~from being provided~~ in a group setting where services are shared among group members ~~of the group~~; and

(J) ~~Not~~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

~~(3)~~(4) SD-GS are incidental, non-routine ~~goods and services that~~, 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 ~~and~~. SD-GS do not duplicate other services authorized in the member's ~~plan of care.~~POC. These SD-GS must be included in the ~~individual plan~~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 ~~from a licensed professional~~.

(B) The item or service is not prohibited by federal or state statutes and regulations.

(C) ~~One (1)~~The item or service meets one (1) or more of the ~~following additional~~ criteria ~~are met.~~listed in (i) through (iii) of this subparagraph. The item or service ~~would~~:

(i) ~~Increase~~Increases the member's functioning related to the disability;
(ii) ~~Increase~~Increases the member's safety in the home environment; or
(iii) ~~Decrease~~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 ~~need for~~ weight loss or increased physical activity~~;~~ need;
(II) Justified by outcomes related to weight loss, increased physical activity or stamina; and
(III) In subsequent ~~plan of care~~POC year requests, documentation is provided that supports the member's progress toward weight loss ~~or~~, increased physical activity, or stamina; or
(viii) Swimming lessons.

(E) SD-GS ~~may~~is not ~~be~~ used for:
(i) ~~Co-payments for medical services;~~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 ~~must~~:

(1) ~~Enroll and complete~~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~~ within forty-five (45) calendar days of SDS training enrollment~~. Exceptions to this timeframe may be approved by the DDS director or his/her designee. The training ~~must be~~is completed prior to ~~the implementation of self-direction and covers:~~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) ~~Philosophy of self-direction;~~SD philosophy
(H) OHCA SD policy~~ on self-direction~~;
(I) Individual budgeting;
(J) ~~Development of a self-directed~~SD support plan~~;~~ development;
(K) Cultural diversity; and
(L) Rights, risks, and responsibilities~~.~~, and

(2) ~~Sign~~Signs an agreement with DDS;
(3) ~~Agree~~Agrees to utilize the ~~services of a~~ FMS subagent~~;~~ services;
(4) ~~Agree~~Agrees to pay administrative costs for background checks, FMS subagent ~~fee,~~fees, and workers' compensation insurance from his or her SDS budget;
(5) ~~Comply~~Complies with federal and state employment laws and ~~ensure~~ensures no employee works more than forty (40) hours per week in ~~the capacity of~~ an SD-HTS~~;~~ capacity;
(6) ~~Ensure~~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) ~~Ensure~~Ensures that each employee complies with all DDS training requirements per OAC 340:100-3-38 et seq.;
(8) ~~Recruit, hire, supervise, and discharge~~Recruits, hires, supervises, and discharges all employees providing ~~self-directed services,~~SDS, when necessary;
(9) ~~Verify~~Verifies employee qualifications;
(10) ~~Obtain~~Obtains background screenings on all employees providing SD-HTS services per OAC 340:100-3-39;
(11) ~~Send~~Sends progress reports per OAC 340:100-5-52.
(12) ~~Participate~~Participates in the ~~Individual~~ Plan and SDS budget process;
(13) ~~Immediately notify~~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 ~~Individual~~ Plan or SDS budget;
(14) ~~Wait~~Waits for budget modification approval ~~of budget modifications~~ before implementing changes;
(15) ~~Comply~~Complies with DDS and OHCA administrative rules;
(16) ~~Cooperate~~Cooperates with DDS monitoring requirements per OAC 340:100-3-27;
(17) ~~Cooperate~~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 ~~expenditure of funds;~~fund expenditures; and

(18) ~~Complete~~Completes all required documents within established timeframes;

(19) ~~Pay~~Pays for services incurred in excess of the budget amount;

(20) ~~Pay~~Pays for services not identified and approved in the member's SDS budget;

(21) ~~Pay~~Pays for services provided by an unqualified provider;

(22) ~~Determine~~Determines staff duties~~, qualifications, and specify~~ and qualifications and specifies service delivery practices consistent with SD-HTS Waiver service specifications;

(23) ~~Orient and instruct~~Orients and instructs staff in duties;

(24) ~~Evaluate~~Evaluates staff performance;

(25) ~~Identify and train~~Identifies and trains back-up staff, when required;

(26) ~~Determine~~Determines amount paid for services within plan limits;

(27) ~~Schedule~~Schedules staff and ~~the provision of services;~~the services provisions;

(28) ~~Ensure~~Ensures SD-HTS do not implement prohibited procedures per OAC 340:100-5-58; and

(29) ~~Sign~~Signs an agreement with the SD-HTS.

(f) **FMS.** The FMS subagent is an entity ~~designated~~that DDS designates as an agent ~~by DDS~~ to act on ~~behalf of members who have~~a member's behalf who has employer and budget authority. ~~for the~~The FMS subagent's purpose ~~of managing~~is to manage payroll tasks for the member's employee(s) and ~~for making payment of~~ 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) ~~Collection and process of employee's~~Employee time sheets collection and processing and making payment to member's employees;

(6) ~~Processing and payment of invoices for~~ 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 ~~to members/representatives,~~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~~, when applicable,~~ to discuss the Waiver service delivery options in (A) and (B) of this paragraph:

(A) Traditional Waiver services; and

(B) ~~Self-directed services~~SDS including information regarding scope of choices, options, rights, risks, and responsibilities associated with ~~self-direction.~~SDS.

(3) When the member chooses ~~self-direction,~~SDS, the DDS case manager:

(A) Discusses ~~with member or representative~~ the available amount in the budget~~;~~ with the member or the member's representative;

(B) Assists the member or representative ~~with the development~~in developing and ~~modification of~~modifying the SDS budget;

(C) Submits request for SD-GS to the DDS director or designee for review and approval;

~~(D) Develops the SDS budget and modifications;~~

~~(E)~~(D) Assists the member or representative ~~develop or revise~~developing or revising an emergency back-up plan;

~~(F)~~(E) Monitors plan implementation ~~of the plan~~ per OAC 340:100-3-27;

~~(G)~~(F) Ensures services are initiated within required time frames;

~~(H)~~(G) Conducts ongoing monitoring of plan implementation and of the member's health and welfare; and

~~(I)~~(H) Ensures the SD-HTS does not implement prohibited procedures, per OAC 340:100-5-58~~ are not implemented by the SD-HTS~~. 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 ~~(CMS)~~ approved government fiscal/employer agent model. DDS has an interagency agreement with OHCA.

(i) **Voluntary termination of self-directed services.** Members may discontinue ~~self-directing services~~SDS without disruption at any time, provided traditional Waiver services are in place. Members or representatives may not choose the ~~self-directed~~SDS option again until the next annual planning meeting, with services resuming no earlier than the beginning of the next ~~plan of care.~~POC. A member desiring to file a complaint must follow procedures per OAC 340:2-5-61.

(j) **~~Involuntary termination of self-directed services.~~SDS involuntary termination.**

(1) Members may be involuntarily terminated from ~~self-direction~~SDS and offered traditional Waiver services when ~~it has been determined by the DDS director or designee that any of the following exist:~~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) ~~Fraud;~~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 ~~self-directed services,~~SDS, the case manager assists the member ~~access~~in assessing needed and appropriate services through the traditional Waiver services option~~,~~. ~~ensuring~~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.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 1. PHYSICIANS

317:30-5-20. Laboratory services

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

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

(A) Reimbursement for lab services is made in accordance with the Clinical Laboratory Improvement Amendment of 1988 (CLIA). These regulations provide that payment may be made only for services furnished by a laboratory that meets CLIA conditions, including those furnished in physicians' offices. Eligible providers must be certified under the CLIA program and have obtained a CLIA ID number from Centers for Medicare and Medicaid Services and have a current contract on file with the Oklahoma Health Care Authority (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 patient-specific indications in the medical record.

(ii) Testing is only compensable if the results will affect patient 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 patient and the patient'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).

(2) **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~~, custom panels particular to the ordering provider,~~ or lab panels which have no impact on the patient's plan of care are not covered.

(C) Split billing, or dividing the billed services for the same patient 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 laboratory. These services are considered part of the laboratory analysis.~~Separate payment is not made for blood specimens obtained by venipuncture, arterial puncture, 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.

(3) **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.

(4) **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.

317:30-5-20.1. 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 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 317:30-5-20(1)(A).

(c) **Compensable services**. Drug testing must be ordered by the physician or non-physician provider and must be individualized to the patient and the patient's medical history or assessment indicators as evidenced in the medical documentation.

(1) Compensable testing must be medically indicated as evidenced by patient specific indications in the medical record.

(A) Testing is only compensable if the results will affect patient 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 patient's history, patient'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 patient'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 patient sample sources of saliva, oral fluids, or hair;

(3) Testing of two different specimen types (urine and blood) from the same patient 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, ~~custom panels specific for the ordering provider,~~ 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 patient'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) Patient 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 patient'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.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-5. 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.

~~(2)~~(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.

~~(3) **"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.~~

(b) **Assignment in ~~fee-for-service~~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 ~~fee-for-service~~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 ~~fee-for-service~~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 ~~fee-for-service~~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~~, if those services relate to the pregnancy or to any other medical condition which may complicate the pregnancy, including prenatal vitamins~~.

(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.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 1. ADMINISTRATIVE OPERATIONS

SUBCHAPTER 1. ORGANIZATION AND ADMINISTRATION

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.

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

~~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.~~

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 1. GENERAL PROVISIONS

317:30-1-1. Purpose~~; use of manuals~~

~~The purpose of this Chapter is to detail rules applicable to providers of medical services purchased by the Oklahoma Health Care Authority. 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. As a convenience to providers, the Authority compiles applicable Subchapters and Sections into manuals which are available to providers at no cost.~~

(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.

317:30-1-3. Description of rules [REVOKED]

~~How to use this Chapter. 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 coverageand reimbursement of SoonerCare servicesand the Agency's expectations of providers. As users of the rules in this Chapter, OHCA also solicits suggestions and comments from providers.~~

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 3. HOSPITALS

317:30-5-40.2. Definitions [REVOKED]

~~The following words and terms, when used in this Part, shall have the following meaning, unless the context clearly indicates otherwise.~~

~~**"CMS"** means the Center for Medicare and Medicaid Services~~

~~**"Diagnosis Related Group"** means a patient classification system that relates types of patients treated to the resources they consume.~~

PART 27. INDEPENDENT PHYSICAL THERAPISTS AND PHYSICAL THERAPIST ASSISTANTS

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.

317:30-5-291.1. Payment rates [REVOKED]

~~All physical therapy services are reimbursed per the methodology described in the Oklahoma Medicaid State Plan.~~

317:30-5-291.2. Procedure codes [REVOKED]

~~The appropriate procedure codes used for billing physical therapy services are found in the Physicians' Current Procedural Terminology (CPT) Coding Manual.~~

PART 28. OCCUPATIONAL THERAPISTS AND OCCUPATIONAL THERAPY ASSISTANTS

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.

317:30-5-297. Payment rates [REVOKED]

~~All occupational therapy services are reimbursed per the methodology described in the Oklahoma Medicaid State Plan.~~

317:30-5-298. Procedure codes [REVOKED]

~~The appropriate procedure codes used for billing occupational therapy services are found in the Physicians' Current Procedural Terminology (CPT) Coding Manual.~~

PART 73. EARLY INTERVENTION SERVICES

317:30-5-640.1. Periodicity schedule

(a) The Oklahoma Health Care Authority requires that all physicians providing reimbursable Early and Periodic Screening, ~~Diagnosis~~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.

317:30-5-641.1. Periodic and interperiodic screening examination [REVOKED]

~~Refer to Oklahoma Administrative Code 317:30-3-65 through 317:30-3-65.12.~~

PART 77. SPEECH-LANGUAGE PATHOLOGISTS, SPEECH-LANGUAGE PATHOLOGY ASSISTANTS, CLINICAL FELLOWS AND AUDIOLOGISTS

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~~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.

317:30-5-677. Payment rates [REVOKED]

~~All speech-language pathology and hearing services are reimbursed per the methodology described in the Oklahoma Medicaid State Plan.~~

317:30-5-678. Procedure codes [REVOKED]

~~The appropriate procedure codes used for billing speech and hearing services are found in the Physicians' Current Procedural Terminology (CPT) Coding Manual.~~

PART 103. QUALIFIED SCHOOLS AS PROVIDERS OF HEALTH RELATED SERVICES

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 program~~Early And Periodic Screening, Diagnostic and Treatment **(EPSDT)** Program/Child-Health Services, of Oklahoma Administrative Code (OAC) at 317:30-3-65 through ~~317:30-3-63.12~~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~~registered nurse (RN) or ~~Licensed Practical Nurse~~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~~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~~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 ~~CPR~~Cardiopulmonary resuscitation (CPR) and ~~First Aid~~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.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 35. RURAL HEALTH CLINICS

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.)

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.

PART 75. FEDERALLY QUALIFIED HEALTH CENTERS

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. <u>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.</u>

(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.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 21. OUTPATIENT BEHAVIORAL HEALTH AGENCY SERVICES

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 a minimum ninety (90) day period in which the member attends the opioid treatment program for observation of medication assisted treatment daily or at least six (6) days a week.

(6) **"Phase II"** means the phase of treatment for members who have been admitted for more than ninety (90) days and who have successfully completed Phase I.

(7) **"Phase III"** means the phase of treatment for members who have been admitted for more than six (6) months and who have successfully completed Phase II.

(8) **"Phase IV"** means the phase of treatment for members who have been admitted for more than nine (9) months and who have successfully completed Phase III.

(9) **"Phase V"** means the phase of treatment for members who have been admitted for more than one (1) year.

(10) **"Phase VI"** means the phase of treatment for members who voluntarily seek medically supervised withdrawal and abstinence from all drugs, including methadone as prescribed. A member may enter this phase at any time in the treatment and rehabilitation process.

(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)(17).

(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**~~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**~~isOTP 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) sessions of therapy or rehabilitation services per month with at least one (1) session being individual therapy, rehabilitation, or case management.~~

~~(2) During phase II the member shall participate in at least two (2) therapy or rehabilitation service sessions per month during the first ninety (90) days, with at least one (1) of the sessions being individual therapy, rehabilitation, or case management. After the initial ninety (90) days in Phase II, the member shall participate in at least one (1) session of individual therapy or rehabilitation service per month.~~

~~(3) During phase III, phase IV and phase V, the member shall participate in at least one (1) session of individual therapy, rehabilitation, or case management per month.~~

(1) During phase I, the member shall participate in a minimum of four (4) treatment sessions per month, including, but not exclusive 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 during the first ninety (90) days, including, but not exclusive to, therapy, rehabilitation, case management, and peer recovery support services. After the initial ninety (90) days in Phase II, the member shall participate in at least one (1) treatment session per month.

(3) During phase III, phase IV and phase V, the member shall participate in at least one (1) treatment session per month, including, but not exclusive 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 completed by a licensure candidate must be co-signed and dated by a fully-licensed LBHP.

(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) During phase I, the service plan shall be reviewed and updated a minimum of once monthly.~~

~~(B) During phase II, the service plan shall be reviewed and updated a minimum of once every three (3) months.~~

~~(C) A service plan review shall be completed for the following situations:~~

~~(i) Change in goals and objectives based upon member's documented progress, or identification of any new problem(s);~~

~~(ii) Change in primary therapist or rehabilitation service provider assignment;~~

~~(iii) Change in frequency and types of services provided;~~

~~(iv) Critical incident reports;~~

~~(v) Sentinel events; or~~

~~(vi) Phase change.~~

(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 ~~therapy or rehabilitation service~~ 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; ~~and~~

(k) **Reimbursement.** ~~In order to~~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.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 25. SOONERCARE CHOICE

SUBCHAPTER 7. SOONERCARE

PART 1. GENERAL PROVISIONS

317:25-7-7. Referrals for specialty services

(a) ~~PCPs~~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 ~~OAC~~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 ~~OHCA~~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~~The specialty services are referred from an IHS, tribal, or urban Indian clinic;

(2) ~~the~~The specialty services are referred as the result of an emergency room visit or emergency room follow-up visit; or

~~(3) the specialty services are referred for pre-operative facility services prior to a dental procedure; or~~

~~(4) the retrospective administrative referral request for specialty services is requested from the OHCA within 30 calendar days of the specialty care date of service. If the retrospective administrative referral is requested within the 30 calendar days, the request must include appropriate documentation for the OHCA to approve the request. Appropriate documentation must include:~~

~~(A) proof that the specialist has attempted to collect a PCP referral from the member's assigned PCP; and~~

~~(B) medical documentation to substantiate that the specialty services are medically necessary pursuant to OAC 317:30-3-1(f).~~

(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.