OKLAHOMA HEALTH CARE AUTHORITY
SPECIAL BOARD MEETING
March 30, 2020 at 3:30 P.M.
Oklahoma Health Care Authority
Teleconference
OKC, OK

**A G E N D A**

1. Call to Order / Determination of Quorum……Stan Hupfeld, Chair

Teleconference Participants

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| Stanley Hupfeld – Audio | Jean Hausheer, M.D. -- Audio |
| Alex Yaffe – Audio | Philip Kennedy – Audio |
| Robert Boyd – Audio | Marc Nuttle -- Audio |
| Tanya Case – Audio | Laura Shamblin, M.D. – Audio |
| Randy Curry, D. Ph. – Audio | |

2. Public Comment……..……..Stan Hupfeld, Chair

3. Consent Agenda……..Stan Hupfeld, Chair

   a) Approval of the January 22, 2020 OHCA Board Meeting Minutes
   b) Approval of Expenditure of Funds Contracts
      i. Health Information Exchange (HIE)
   c) Approval of State Plan Amendment Rate Committee Rates
   d) Approval of Transfer from Deferral Account

4. Chief Executive Officer's Report…….Kevin Corbett, Chief Executive Officer

5. Chief of Staff's Report…….....Ellen Buettner, Chief of Staff

6. Chief Operating Officer's Report……....Melody Anthony, Chief Operating Officer
   State Medicaid Director

7. Discussion of Report from the……..……..Phil Kennedy
   Compliance Advisory Committee — Chair, Compliance Advisory Committee

8. Discussion of Report from the Legislative……..……Alex Yaffe
   Advisory Committee — Chair, Legislative Advisory Committee

9. Discussion of Report of Administrative……..……..……..Jean Hausheer, MD
   Rules Advisory Committee and Possible Action — Chair, Administrative Rules Advisory Committee
   Regarding Agency Rulemaking (Attachment "A")

   a) Consideration and Vote upon a Declaration of a Compelling Public Interest for the Promulgation of the **Emergency Rules** in Attachment "A" in Accordance with 75 O.S. § 253.

   b) Consideration and Vote of Agency Recommended Rulemaking Pursuant to Article I of the Administrative Procedures Act. OHCA Requests the Adoption of the Following Emergency Rules (see Attachment "A"):

      i. **APA WF # 20-01 High-Investment Drugs Carve-Out —** ADDING agency rules at ***Oklahoma Administrative Code (OAC) 317:30-5-42.20 and 317:30-5-47.6*** and AMENDING ***OAC 317:30-3-31 and 317:30-5-47***

      ii. **APA WF # 20-02 Retroactive Eligibility —** AMENDING agency rules at ***OAC 317:35-6-60*** and ADDING agency rules at ***OAC 317:35-6-60.2***

iii. **APA WF # 20-03 Treatment of Lottery or Gambling Winnings for Income Eligibility —** AMENDING agency rules at ***OAC 317:35-6-51 and 317:35-10-26*** and ADDING agency rules at ***OAC 317:35-6-55***

c) Consideration and Vote of Agency Recommended Rulemaking Pursuant to Article I of the Administrative Procedures Act. OHCA Requests the Adoption of the Following Permanent Rules (see Attachment "A"):

i. **APA WF # 19-03 Applied Behavior Analysis (ABA) Services —** AMENDING agency rules at ***OAC 317:30-5-2, 317:30-5-355.1, 317:30-5-357, 317:30-5-376, 317:30-5-664.1, 317:30-5-1076, 317:30-5-1090, and 317:30-5-1154*** and ADDING agency rules at ***OAC 317:30-3-65.12***

ii. **APA WF # 19-08 Telehealth Services —** AMENDING agency rules at ***OAC 317:30-3-27***

iii. **APA WF # 19-13B Long-Term Care Facilities —** AMENDING agency rules at ***OAC 317:30-5-132 and 317:30-5-136.1*** and ADDING agency rules at ***OAC 317:30-5-132.1 and 317:30-5-132.2***

iv. **APA WF # 19-05 Therapeutic Foster Care Revisions —** AMENDING agency rules at ***OAC 317:30-5-740, 317:30-5-740.1, 317:30-5-740.2, 317:30-5-741, 317:30-5-742, 317:30-5-742.1, 317:30-5-742.2, 317:30-5-743.1, 317:30-5-744, 317:30-5-745, and 317:30-5-746*** and ADDING agency rules at ***OAC 317:30-5-750 through 317:30-5-757***

v. **APA WF # 19-06 Diabetes Self-Management Training (DSMT) Services —** AMENDING agency rules at ***OAC 317:30-5-42.1*** and ADDING agency rules at ***OAC 317:30-5-1080 through 317:30-5-1084***

vi. **APA WF # 19-09 SUPPORT Act —** ADDING agency rules at ***OAC 317:35-6-45***

vii. **APA WF # 19-12 High Risk Obstetrical Services (HROB) —** AMENDING agency rules at ***OAC 317:30-5-22.1 and 317:30-5-42.11***

viii. **APA WF # 19-13A Long-Term Care Facilities —** ADDING agency rules at ***OAC 317:2-1-17***

ix. **APA WF # 19-16 Behavioral Health Targeted Case Management (TCM) Updates —** AMENDING agency rules at ***OAC 317:30-5-241.6***

x. **APA WF # 19-18 Opioid Standards and Drug Utilization Review (DUR) Program —** AMENDING agency rules at ***OAC 317:30-5-86***

xi. **APA WF # 19-19A Step Therapy Exception Process —** AMENDING agency rules at ***OAC 317:2-1-2 and 317:2-1-13*****;** REVOKING agency rules at ***OAC 317:2-1-6*****;** and ADDING agency rules at ***OAC 317:2-1-18***

xii. **APA WF # 19-19B Step Therapy Exception Process —** AMENDING agency rules at ***OAC 317:30-5-77.2 and 317:30-5-77.3*** and ADDING agency rules at ***OAC 317:30-5-77.4***

xiii. **APA WF # 19-20 Pharmacy Revisions and American Indians/Alaska Natives (AI/AN) Cost Sharing Exemptions —** AMENDING agency rules at ***OAC 317:30-3-5, 317:30-5-72, and 317:30-5-77.1***

xiv. **APA WF # 19-10 American Indian/Alaska Native (AI/AN) Cost Sharing Exemptions —** AMENDING agency rules at ***OAC 317:45-9-4 and 317:45-11-24***

xv. **APA WF # 19-15 Rural Health Clinic (RHC) —** AMENDING agency rules at ***OAC 317:30-5-359.1 and 317:30-5-359.2***

xvi. **APA WF # 19-24 Urine Drug Screening and Laboratory Services Policy —** AMENDING agency rules at ***OAC 317:30-5-20 and 317:30-5-20.1***

xvii. **APA WF # 19-25 Polymerase Chain Reaction (PCR) Testing for Infectious Diseases —** ADDING agency rules at ***OAC 317:30-5-20.2***

xviii. **APA WF # 19-26 Countable Income and Resources for the Aged, Blind and Disabled (ABD) Eligibility Groups and Eligibility as a Qualified Medicare Beneficiary (QMB) Plus Member —** AMENDING agency rules at ***OAC 317:35-5-41.1, 317:35-5-42, and 317:35-7-40***

xix. **APA WF # 19-27 Ground Emergency Medical Transportation (GEMT) Supplemental Payment Program —** ADDING agency rules at ***OAC 317:30-5-344***

xx. **APA WF # 19-29 Reasonable Limits for Necessary Medical and Remedial Care not Covered under the Oklahoma Medicaid State Plan —** AMENDING agency rules at ***OAC 317:35-9-68 and 317:35-19-21***

xxi. **APA WF # 19-32 Inpatient Psychiatric Services and Service Quality Review (SQR) Revisions —** AMENDING agency rules at ***OAC 317:30-5-95, 317:30-5-95.4, 317:30-5-95.14, 317:30-5-95.22, 317:30-5-95.24, 317:30-5-95.29, 317:30-5-95.30, 317:30-5-95.31, 317:30-5-95.33, 317:30-5-95.34, 317:30-5-95.35, 317:30-5-95.37, 317:30-5-95.38, 317:30-5-95.40, 317:30-5-95.41, 317:30-5-95.42, 317:30-5-96.2, and 317:30-5-96.3*** and ADDING agency rules at ***OAC 317:30-5-94***

xxii. **APA WF # 19-34 ADvantage Waiver —** AMENDING agency rules at ***OAC 317:35-17-1 and 317:35-17-3***

xxiii. **APA WF # 19-35 Developmental Disabilities Services (DDS) —** AMENDING agency rules at ***OAC 317:40-9-1***

xxiv. **APA WF # 19-37 Mobile and Portable Dental Treatment Facilities —** ADDING agency rules at ***OAC 317:30-5-706, 317:30-5-707, 317:30-5-708, 317:30-5-709, 317:30-5-710, and 317:30-5-711***

xxv. **APA WF # 19-41A Patient-Centered Medical Homes (PCMH), Health Access Networks (HAN) and Health Management Program (HMP) Updates —** AMENDING agency rules at ***OAC 317:25-7-2, 317:25-7-3, 317:25-7-5, 317:25-7-10, 317:25-7-13, 317:25-7-25, 317:25-7-26, 317:25-7-27, 317:25-7-28, 317:25-7-30, 317:25-7-40, 317:25-9-1, 317:25-9-2, and 317:25-9-3*****;*** ADDING agency rules at ***OAC 317:25-11-1, 317:25-11-2, and 317:25-11-3;*** and REVOKING agency rules at ***OAC 317:25-7-29***

xxvi. **APA WF # 19-41B Insure Oklahoma Individual Plan (IP) and Insure Oklahoma Employer Sponsored Insurance (ESI) —** AMENDING agency rules at ***OAC 317:45-11-2 and 317:45-11-22*** and ADDING agency rules at ***OAC 317:45-9-1.1 and 317:45-11-21.1***

xxvii. **APA WF # 19-42 Adult Inpatient Rehabilitation Days —** AMENDING agency rules at ***OAC 317:30-5-111 and 317:30-5-112***

xxviii. **APA WF # 19-43A Coverage Definitions for Children and Adults —** AMENDING agency rules at ***OAC 317:30-1-3*** and ADDING agency rules at ***OAC 317:30-1-4***

xxix. **APA WF # 19-43B Coverage Definitions for Children and Adults —** AMENDING agency rules at ***OAC 317:35-1-2***

xxx. **APA WF # 19-45 Private Duty Nursing (PDN) Revisions —** AMENDING agency rules at ***OAC 317:30-5-555, 317:30-5-556, and 317:30-5-558***

xxxi. **APA WF # 19-46 School-based/Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Revisions —** AMENDING agency rules at ***OAC 317:30-3-65, 317:30-5-1023, 317:30-5-1026, and 317:30-5-1027,*** and REVOKING agency rules at ***OAC 317:30-5-1022, 317:30-5-1024, and 317:30-5-1025***

xxxii. **APA WF # 19-47 Medically Necessary Extractions Revisions —** AMENDING agency rules at ***OAC 317:30-5-695, 317:30-5-696, 317:30-5-698, 317:30-5-700, 317:30-5-700.1, 317:30-5-704, and 317:30-5-705***

10. Discussion of Report from the Pharmacy Advisory Committee and Possible Action Regarding Drug Utilization Board Recommendations ……Randy Curry Chair, Pharmacy Advisory Committee

    a) Consideration and Vote Regarding Recommendations Made by the Drug Utilization Review Board Pursuant to 63 O.S. § 5030.3 To Add the Following Drugs to the Utilization and Scope Prior Authorization Program under OAC 317:30-5-77.2(e) (Attachment B):

        i. Duaklir® Pressair® (aclidinium bromdide/formoterol fumarate)
        ii. Scensesse® (afamelanotide) and Givlaari™ (givosiran)
        iii. Ultomiris® (ravulizumab-cwvz)
        iv. Korlym® (mifepristone)
        v. Ruzurgi® (Amifampridine)

11. Adjournment……Stan Hupfeld, Chair

NEXT BOARD MEETING
May 20, 2020
TBD

MINUTES OF A SPECIAL BOARD MEETING
OF THE HEALTH CARE AUTHORITY BOARD
January 22, 2020
Oklahoma Health Care Authority Boardroom
Oklahoma City, Oklahoma

Manner and Time of Notice of Meeting: A statutorily required public meeting notice was placed on the front door of the Oklahoma Health Care Authority on January 21, 2020 at 3:00 p.m. Advance public meeting notice was provided to the Oklahoma Secretary of State. In addition to the posting of the statutory public notice, the agency placed its agenda on its website on January 21, 2020 at 8:30 a.m.

Pursuant to a roll call of the members, a quorum was declared to be present, and Chairman Hupfeld called the meeting to order at 3:00 p.m.

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| BOARD MEMBERS PRESENT: | Chairman Hupfeld, Vice Chairman Yaffe (arrived at 3:12 p.m.), Member Boyd, Member Curry, Member Hausheer, Member Kennedy, Member Shamblin |
| BOARD MEMBERS ABSENT: | Member Case, Member Nuttle, |

| OTHERS PRESENT: | OTHERS PRESENT: |
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| Aaron Morris, OHCA | Amy Bradt, OHCA |
| Kyle Janzen, OHCA | Tyler Talley, eCap |
| Josh Richards, OHCA | Hank Young, OHCA |
| Jennifer Creecy, OJA | Melissa Miller, ODMHSAS |
| Christina Foss, OHCA | Traylor Rains, ODMHSAS |
| Andrew Cohen, OHCA | Aimee Hoyt |
| Dwyna Vick, OHCA | Brenda Teel, Chickasaw Nation |
| Cassidy Heit, OKPCA | Rick Snyder, OHA |
| Sara Barry, OKPCA | Mary Brinkley, Leading Age Oklahoma |
| Bethany Holderread, PMC | Sandra Puebla, OHCA |
| Nicole Prieto-Johns, OJA | Mike Herndon, OHCA |
| Melody Anthony, OHCA | Ellen Buettner, OHCA |
| Maria Maule, OHCA | Trae Rahill, OHCA |
| Shelley Zumwalt, OHCA | Melinda Thomason, OHCA |
| Jonathan Cannon, OHCA | |

**ITEM 2 / DISCUSSION AND POSSIBLE VOTE ON APPROVAL OF CONSENT AGENDA WHICH INCLUDES:**

a) Approval of the Minutes from September 18, 2019 OHCA board meeting

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| MOTION: | Member Hausheer moved for approval of the items listed in the Consent Agenda, as published. The motion was seconded by Member Boyd. |
| FOR THE MOTION: | Chairman Hupfeld, Member Curry, Member Kennedy, Member Shamblin |
| BOARD MEMBERS ABSENT: | Vice Chairman Yaffe, Member Case, Member Nuttle |

**ITEM 3 / WELCOME AND COMMENTS**
Lou Carmichael, Variety Care Chief Executive Officer

Ms. Carmichael gave a brief overview of Federally Qualified Health Centers throughout Oklahoma, including Variety Care, which included information on patients served in Oklahoma, access, cost effectiveness, primary care, and performance benchmarks.

**ITEM 4 / CHIEF EXECUTIVE OFFICER'S REPORT**
Kevin Corbett, Chief Executive Officer

During the Chief Executive Officer report, Melinda Thomason shared a few words about Trevlyn Cross, retired OHCA employee.

Mr. Corbett presented the 2020 theme: Year of Hope, Compassion and Excellence; as well as measures that currently show where OHCA is currently at and will be used to set targets of where OHCA would like to be. Mr. Corbett also provided brief updates regarding the four focus areas. Dr. Bob Evans and Ms. Marlene Asmussen were honored for their upcoming retirements.

**ITEM 5 / CHIEF OF STAFF'S REPORT**
Ellen Buettner, Chief of Staff

Ms. Buettner stated that OHCA is currently in the data analysis phase with HMA. She added that OHCA leadership has engaged in coaching sessions. Jennifer Lamb-Hornsby will participate in the next step with coaching group to help push down within the agency. "Know your Agency" lunch and learns are being scheduled with Melody's team kicking off with Medicaid Basics and Partnerships. Ms. Buettner concluded her presentation with a reminder for the OHCA Budget Hearing, scheduled Wednesday, January 29, 2020 at 1pm.

**ITEM 6 / CHIEF OPERATING OFFICER'S REPORT**
Melody Anthony, Chief Operating Officer/State Medicaid Director

Ms. Anthony provided a brief overview of the SoonerCare Choice Patient Centered Medical Home (PCMH) Redesign, which included information on SoonerCare Choice today, Current PCMH Program, Redesign Overview, Redesign Considerations and Approach, SoonerCare Choice Next Steps, and Data Sharing. For more detailed information, see item 6 in the board packet.

**ITEM 7 / DISCUSSION OF REPORT FROM THE COMPLIANCE ADVISORY COMMITTEE**
Phil Kennedy, Chair of Compliance Advisory Committee

Member Kennedy gave a brief update regarding the items discussed during the January 8th, 2020 Committee meeting. Items discussed during the committee were the OHCA financials, current Audits, and cyber security. OHCA had a positive $14.5 million state dollar variance through November. Revenues to note: Tobacco tax 1.9 million over budget, Medical Refunds were 3.2 million. Admin is under budget $2.4 million state dollars. No trends to the date suggest any trouble for SFY20. No flu impact at this time. Currently, there are no cash concerns. Medical Fiscal Accountability Rule was discussed, comment period closed last week. CMS is in the evaluation phase and will follow up with states. OHCA Finance team will continue to monitor the situation. OHCA Budget Hearing is scheduled January 29, 2020 at 1pm. There is a one-time payment of $70 million to cover the extra week. A brief audit update was provided at the committee meeting by Mr. Richards. Mr. Janzen provided an update regarding the Microsoft Office 365 migration and cyber security. OHCA Legal recovered over $10 million in third party liabilities.

**ITEM 8 / DISCUSSION OF REPORT FROM THE LEGISLATIVE ADVISORY COMMITTEE**
Alex Yaffe, Chair of the Legislative Advisory Committee

Member Yaffe provided an update regarding the items discussed during the January 15, 2020 Legislative Advisory Committee meeting. Member Yaffe introduced Christina Foss, OHCA Legislative Liaison, to provide an overview of the upcoming session. About 2200 new bills have been filed for this year's session, 4500 when combined with carryover from last session. A couple bills will bring in savings to the agency, two deal with advisory committees, and the CEO appeals process. February 3, 2020 is the State of the State Address. February 27 is the deadline for all measures to be out of committee and March 12 is the deadline for all bills to be out of the chamber or origin.

**ITEM 9Ai -xiv / DISCUSSION OF REPORT FROM THE ADMINISTRATIVE RULES ADVISORY COMMITTEE AND POSSIBLE ACTION REGARDING AGENCY RULEMAKING**
Jean Hausheer, M.D., Chair of Administrative Rules Advisory Committee

Action Item – a) Consideration and Vote of Agency Recommended Rulemaking Pursuant to Article I of the Administrative Procedures Act. OHCA Requests the Adoption of the Following Permanent Rules:

**The following permanent rule HAS previously been approved by the Board and the Governor under EMERGENCY rulemaking. This rule HAS BEEN revised for PERMANENT rulemaking:**

i. Eligibility Redetermination as Indicated by Returned Mail: AMENDING agency rules at ***OAC 317:35-5-26*** and ADDING agency rules at ***OAC 317:35-5-67***

**The following permanent rules HAVE previously been approved by the Board and the Governor under EMERGENCY rulemaking. They HAVE NOT been revised for PERMANENT rulemaking:**

ii. Certified Community Behavioral Health Clinics (CCBHC) Project: ADDING agency rules at ***OAC 317:30-5-263 through 317:30-5-268***
iii. Board Organization and Policy Revisions: AMENDING agency rules at ***OAC 317:31-1-4, 317:1-1-6, and 317:1-1-7***

**The following PERMANENT rules HAVE NOT previously been approved by the Board:**

iv. Claim Inquiry Procedures: AMENDING agency rules at ***OAC 317:30-3-20***
v. Expedited Appeals: AMENDING agency rules at ***OAC 317:2-1-2.5***
vi. Free-Standing Birthing Centers: REVOKING agency rules at ***OAC 317:30-5-890, 317:30-5-890.1, 317:30-5-891, 317:30-5-892, and 317:30-5-893***
vii. The Oklahoma Office of Juvenile Affairs (OJA) Targeted Case Management (TCM) Services Revisions: ADDING agency rules at ***OAC 317:30-5-971.1*** and AMENDING ***OAC 317:30-5-970 through 317:30-5-974***
viii. Nursing Licensure Revisions: AMENDING agency rules at ***OAC 317:30-5-240.3, 317:30-5-375, 317:30-5-376, 317:30-5-390, 317:30-5-391, 317:30-5-763, and 317:30-5-1043***
ix. Indian Health Services, Tribal Programs, and Urban Indian Clinics (I/T/Us) Obstetrical (OB) Services: AMENDING agency rules at ***OAC 317:30-5-1095 and 317:30-5-1099***
x. Programs of All-Inclusive Care for the Elderly (PACE): AMENDING agency rules at ***OAC 317:35-5-63 and 317:35-18-3***
xi. Title XXI Parity Compliance: AMENDING agency rules at ***OAC 317:35-22-2***
xii. Nursing Home Supplemental Payment Program Revocation: REVOKING agency rules at ***OAC 317:2-1-16***
xiii. Nursing Home Supplemental Payment Program Revocation: REVOKING agency rules at ***OAC 317:30-5-136***
xiv. Defunding Statutory Rape Cover-Up Act: ADDING agency rules at ***OAC 317:30-3-19.6***

MOTION: Member Curry moved for approval of Item 9a.i-xiv as published. The motion was seconded by Member Kennedy.

FOR THE MOTION: Chairman Hupfeld, Vice-Chairman Yaffe, Member Boyd, Member Hausheer, Member Shamblin

BOARD MEMBERS ABSENT: Member Case, Member Nuttle

**ITEM 10i-vii / DISCUSSION OF REPORT FROM THE PHARMACY ADVISORY COMMITTEE AND POSSIBLE ACTION REGARDING DRUG UTILIZATION BOARD RECOMMENDATIONS**

Randy G. Curry, D.Ph., Chair of Pharmacy Advisory Committee

Action Item – a) Consideration and Vote Regarding Recommendations Made by the Drug Utilization Review Board Pursuant to 63 O.S. § 5030.3 to Add the Following Drugs to the Utilization and Scope Prior Authorization Program under OAC 317:30-5-77.2(e).

i. Vyndaqel® (tafamidis meglumine) and Vyndamax™ (tafamidis)
ii. Recarbio™ (imipenem/clastatin/relebactam) and Xenleta™ (Lefamulin)
iii. Turalio™ (Pexidartinib)
iv. Elzonris® (tagraxofusp-erzs) and Inrebic® (Fedratinib)
v. Aemcolo™ (rifamycin), Motegrity™(prucalopride), Zelnorm™ (tegaserod), and Ibsrela®(tenapanor)
vi. Bevyxxa® (betrixaban)
vii. Avaclyr™(acyclovir 3% ophthalmic ointment)

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| MOTION: | Member Hausheer moved for approval of Item 10i-vii as published. The motion was seconded by Member Kennedy. |
| FOR THE MOTION: | Chairman Hupfeld, Vice-Chairman Yaffe, Member Boyd, Member Curry, Member Shamblin |
| BOARD MEMBERS ABSENT: | Member Case, Member Nuttle |

**ITEM 11 / PROPOSED EXECUTIVE SESSION AS RECOMMENDED BY THE CHIEF OF LEGAL SERVICES AND AUTHORIZED BY THE OPEN MEETINGS ACT, 25 OKLAHOMA STATUTES §307(B) (4).**

Stanley Hupfeld, OHCA Board Chairman

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| MOTION: | Member Hausheer moved for approval to move into Executive Session. The motion was seconded by Member Curry. |
| FOR THE MOTION: | Chairman Hupfeld, Vice-Chairman Yaffe, Member Boyd, Member Kennedy, Member Shamblin |
| BOARD MEMBERS ABSENT: | Member Case, Member Nuttle |
| MOTION: | Member Hausheer moved for approval to exit Executive Session. The motion was seconded by Member Kennedy |
| FOR THE MOTION: | Chairman Hupfeld, Vice-Chairman Yaffe, Member Boyd, Member Curry, Member Shamblin |
| BOARD MEMBERS ABSENT: | Member Case, Member Nuttle |

**ITEM 12 / ADJOURNMENT**

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| MOTION: | Member Hausheer moved for approval for adjournment. The motion was seconded by Member Curry. |
| FOR THE MOTION: | Chairman Hupfeld, Vice-Chairman Yaffe, Member Boyd, Member Kennedy, Member Shamblin |
| BOARD MEMBERS ABSENT: | Member Case, Member Nuttle |

Meeting adjourned at 5:11 p.m., 1/22/2020

NEXT BOARD MEETING
March 18, 2020
Oklahoma Health Care Authority
4345 N. Lincoln Blvd
Oklahoma City, OK

*Martina Ordonez*
*Board Secretary*

*Minutes Approved:* _____

*Initials:* _____

**SUBMITTED TO THE C.E.O. AND BOARD ON JANUARY 10, 2020**
**AUTHORITY FOR EXPENDITURE OF FUNDS**

## BACKGROUND

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| **Services** | State Wide Health Information Exchange |
| **Purpose and Scope** | Provide a statewide health information exchange (HIE) to be called the Oklahoma Statewide Health Information Network and Exchange (OKSHINE). Oklahoma is looking to achieve statewide health information exchange to allow health information to flow seamlessly to and from authorized organizations and individuals in Oklahoma. OKSHINE is intended to meet the needs of end users, allowing providers and their patients, hospitals and health systems, purchasers and payers, state health agencies and local health departments, health information business associates, and an increasingly inclusive ecosystem of human service organizations to have secure, accurate data available at the right time and place, for the right purposes. |
| **Mandate** | Governors Top 5 Initiative |
| **Procurement Method** | Competitive Bid |
| **Award** | Single Contractor |
| **External Approvals** | OMES and CMS |
| **New Contract Term** | Date of signature thru June 30, 2021 with 10 options to renew. |

## BUDGET

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| **Total Contract Not-to-Exceed Requested for Approval.** | Bids not to exceed $50,564,472.00 and is Pending Award |
| **Not-to-Exceed considerations** | Federal matching considerations will be a blended rate. OHCA expects the first three years to be a matching rate of 90/10. Following years could be 50/50 or 75/25 depending on system certification and CMS Advance Planning Document approvals. |
| **Federal Match Percentage(s) within the Total Contract Not-to-Exceed** | |
| **State Share Costs within the Total Contract Not-to-Exceed** | |

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| **Pricing Methodology** | The request for proposal will be in moving toward Demo's at the time of this Board meeting, OHCA expects a combination of hourly rate, price per service, and system hosting costs. |

**RECOMMENDATION**

Board approval is requested to procure the Health Information Exchange services described above for 11 year, not-to-exceed $50,564,472.00 and is pending award.

**Additional Information**

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| **Contract Term, Including all Optional Renewal Years**<br>Oklahoma law limits State Agencies from encumbering funds for more than a single State Fiscal Year. As a result, all State of Oklahoma contracts are entered into for an initial year period with subsequent optional renewal years. Every OHCA professional services contract includes standard contract termination language, including immediate, 30 day for cause, 60 day without cause, and non-renewal terminations. |
| **Competitive Bid Total Contract Not-to-Exceed Requested for Approval.**<br>Actual not-to-exceed amounts are established by the competitive bid process. If the not-to-exceed amount exceeds the amount previously approved by $125,000.00 or more, the contract increase shall require additional Board approval. |
| **Federal Match Percentage(s)**<br>CMS authorizes Federal Match based upon specific criteria, for example, a single Information Technology contract may qualify for 50% administrative match, 75% operational match, and 90% implementation match. |
| **Pricing Methodologies:**<br>**Hourly Rate:** Hourly Rate contracts authorize payments based on the number of hours required to perform a service within an established not-to-exceed. Hourly rate contractors cannot bill for more hours than worked, and are not guaranteed to be able to bill for the entire not-to-exceed amount.<br>**Fixed Rate:** Fixed rate professional services contracts establish fixed prices based on services performed based on volume estimates, such as completing a prior authorization is valued at X, and costs based on established deliverables. Deliverables may be billed as all-inclusive costs, such as a report, or may include milestones with associated payments, such as a payment for a report for the first draft and another payment upon OHCA approval for the final report. Contractors cannot bill until services are completed. |

# DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES (DMEPOS) RATES

1. **IS THIS A RATE CHANGE OR A METHOD CHANGE?**
   Method Change

2. **IS THIS CHANGE AN INCREASE, DECREASE, OR NO IMPACT?**
   Increase

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   Changes to Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) are needed to comply with the CMS Home Health final rule and the 21st Century CURES Act. Due to the Home Health final rule, Durable Medical Equipment (DME) and Supplies will change from an optional benefit to a mandatory benefit. Prosthetics and Orthotics will continue to be an optional benefit.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current methodology for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) is:
   1. If the item of DMEPOS is covered by Medicare, the Medicaid fee will be equal to or a percentage of the Medicare fee schedule specific to Oklahoma that is available at the time of the fee review, unless there is documentation that the Medicare fee is insufficient for the items covered under the HCPCS code and the item is required by the Medicaid population.
   2. For items of DMEPOS not paid at the Medicare fee or a percentage of the Medicare fee, the provider will be reimbursed either at a fee determined by the OHCA or through manual pricing. The fee established by OHCA will be determined from cost information for providers or manufacturers, surveys of Medicaid fees for other states, survey information from national fee analyzers, or other relevant fee-related information.
   3. Manual pricing is reasonable when one HCPCS code covers a broad range of items with a broad range of costs, since a single fee may not be a reasonable fee for all items covered under the HCPCS code, resulting in access-to-care issues. Examples include: 1) HCPCS codes with a description of not otherwise covered, unclassified, or other miscellaneous items; and 2) HCPCS codes covering customized items. Effective October 1, 2014, if manual pricing is used, the provider is reimbursed the documented

Manufacturer's Suggested Retail Price (MSRP) less 30% or the provider's documented invoice cost plus 30%, whichever is less.

4. Payment for stationary oxygen systems (liquid oxygen systems, gaseous oxygen systems and oxygen concentrators) is based on a continuous rental, i.e., a continuous monthly payment is made as long as it is medically necessary. The rental payment includes all contents and supplies, e.g., regulators, tubing, masks, etc. Portable oxygen systems are considered continuous rental. Separate payment will not be made for maintenance, servicing, delivery, or for the supplier to pickup the equipment when it is no longer necessary. Payment for oxygen and oxygen equipment and supplies will not exceed the Medicare fee for the same HCPCS code. Stationary oxygen system and portable oxygen system rates are reduced by 15 percent for all members residing in nursing facilities (Place of Service 31, skilled nursing facility, & Place of Service 32, nursing facility). For members residing in nursing facilities, oxygen will continue to be reimbursed on a continuous rental basis.
5. The current Medicaid fee schedule is effective for services provided on or after 01/01/10. The fee schedule will be reviewed and changes posted to the Agency's website (www.okhca.org) in relation to the State Fiscal year beginning July 1, 2010, and updated annually.
6. Effective for services provided on or after 04-01-10, the rates in effect on 03-31-10 will be decreased by 3.25%.
7. Effective for services provided on or after 07-01-14, the rates in effect on 06-30-14 will be decreased by 7.75%.
8. Effective for services provided on or after 01-01-16, the rates in effect on 12-31-15 will be decreased by 3%.

**5. NEW METHODOLOGY OR RATE STRUCTURE.**

All services will now be tied to the Medicare fee schedule and will be updated annually. The Medicare fee schedule lists 4 rate types: non-rural, rural, a Tulsa competitive bid area, and an Oklahoma City competitive bid area. Durable Medical Equipment will be reimbursed at 100% of the lowest of the 4 Medicare fee schedule rates. Prosthetics, Orthotics, and parenteral food and supplies will be reimbursed at 70% of the lowest of the 4 Medicare fee schedule rates. Medical supplies will be reimbursed at 80% of the lowest of the 4 Medicare fee schedule rates. Enteral supplies will be reimbursed at 150% of the lowest of the 4 Medicare fee schedule rates. For products that do not have a rate published on the Medicare fee schedule, one of the following manual pricing methods will be used:

Manufacturer's suggested retail price (MSRP) less 30 percent or the provider's documented invoice cost plus 30 percent, whichever is lesser of the two; or a Fair Market Value fee will be established through claims review and analysis, from cost information from providers or manufacturers, surveys of rates from other Medicaid states, or other reliable pricing data. For durable medical equipment, supplies, and appliances purchased at the pharmacy point of sale, providers will be reimbursed the equivalent of Medicare Part B, ASP + 6%. When ASP is not available, an equivalent price is calculated using Wholesale Acquisition Cost (WAC). If no Medicare, ASP, or WAC pricing is available, then the price will be calculated based on invoice cost. Durable Medical Equipment and Supplies will no longer be reimbursed separately for residents in a nursing facility.

6. **BUDGET ESTIMATE.**
The estimated budget impact for SFY2021 and SFY2022 will be an increase in the total amount of $2,615,007; with $912,376 state share.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
The Oklahoma Health Care Authority does not anticipate any negative impact on access to care.

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the following for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies:
   - Durable Medical Equipment will be reimbursed at 100% of the lowest of the 4 Medicare fee schedule rates.
   - Prosthetics, Orthotics, and parenteral food and supplies will be reimbursed at 70% of the lowest of the 4 Medicare fee schedule rates.
   - Medical supplies will be reimbursed at 80% of the lowest of the 4 Medicare fee schedule rates.
   - Enteral supplies will be reimbursed at 150% of the lowest of the 4 Medicare fee schedule rates.
   - For products that do not have a rate published on the Medicare fee schedule, a manual pricing method will be used.
   - For items purchased at a pharmacy, pharmacy point-of-sale pricing may be used.

9. **EFFECTIVE DATE OF CHANGE.**

July 1, 2020, pending CMS approval.

# ADD SMA TEST TO NEWBORN SCREENING PANEL

1. **IS THIS A RATE CHANGE OR A METHOD CHANGE?**
   Rate Change

2. **IS THIS CHANGE AN INCREASE, DECREASE, OR NO IMPACT?**
   Increase

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The Oklahoma state department of health (OSDH) public health laboratory (PHL) and newborn screening follow-up program are proposing to expand the newborn screening panel to include spinal muscular atrophy (SMA).

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   Currently the newborn screening panel does not include the SMA test.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   This test will be added to the Severe Combined Immunodeficiency (SCID) testing at the rate of $4.81 per specimen bringing total cost for SCID/SMA to $10.81 per specimen.

6. **BUDGET ESTIMATE.**
   The estimated budget impact for the remainder of SFY2020 will be an increase of $31,025; with state share of $10,542. The estimated budget impact for SFY 2021 will be an increase in the total amount of $ 124,098; with $40,332 in state share. The state share will be paid by the Oklahoma Department of Health.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
   The Oklahoma State Department of Health does not anticipate any negative impact on access to care.

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
   The Oklahoma State Department of Health requests the State Plan Amendment Rate Committee to approve the increase of $4.81 to the Newborn Screening Panel for the addition of SMA testing.

9. **EFFECTIVE DATE OF CHANGE.**
   May 1, 2020

# DEVELOPMENTAL DISABILITIES SERVICES INCREASES

1. **IS THIS A RATE CHANGE OR A METHOD CHANGE?**
   Rate Change

2. **IS THIS CHANGE AN INCREASE, DECREASE, OR NO IMPACT?**
   Increase

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   This request was made by Centers for Medicare and Medicaid (CMS) to increase the rate paid for **Waiver Services, Respite, In Own Home – Maximum** to match the Waiver Services, Respite, Out of Home rate less room and board**.** The services are available to service recipients on the Homeward Bound Waiver and Community Based Waiver.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current rate structure for services for which a rate increase is being implemented is a fixed and uniform rate configuration established through the State Plan Amendment Rate Committee process. The services and current service codes and rates are as follows:

| Description | Service Code | Current Rate |
|---|---|---|
| Respite, In Own Home-Maximum | S9125 | $38.00 a day |

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   The rate established for Respite, out of home less the room and board adjustment.

| Description | Service Code | Proposed Rate |
|---|---|---|
| Respite, In Own Home-Maximum | S9125 | $57.04 a day |

6. **BUDGET ESTIMATE.**
   The estimated budget impact for SFY2021 is an increase in the amount of $461 total dollars or $147 state share. The estimated budget impact for SFY2022 is an increase in the amount of $553 total dollars or $177 state share. The Department of Human Services attests that it has adequate funds to cover the state share of the projected cost of services per fiscal year.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
   A rate increase will bring the Respite, In Own Home - Maximum rate up to the same level as the Respite, Out Of Home rate less the daily room and board adjustment as request by CMS. This will not have a negative impact on access to care.

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
   The Department of Human Services requests the State Plan Amendment Rate Committee approve the $57.04 per day rate on Respite, In Own Home-Maximum.

9. **EFFECTIVE DATE OF CHANGE.**
   September 1, 2020, Pending CMS Approval

# PHYSICAL THERAPY ASSISTANTS, OCCUPATIONAL THERAPY ASSISTANTS, SPEECH-LANGUAGE PATHOLOGY ASSISTANTS AND CLINICAL FELLOWS

1. **IS THIS A RATE CHANGE OR A METHOD CHANGE?**
   Rate Change

2. **IS THIS CHANGE AN INCREASE, DECREASE, OR NO IMPACT?**
   Increase

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The Oklahoma Health Care Authority (OHCA) recommends a revision to the current methodology of Physical Therapy Assistants, Occupational Therapy Assistants, and Speech-Language Pathology Assistants and Clinical Fellows.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   Currently Physical Therapy Assistants and Occupational Therapy Assistants are paid the same as Physical Therapists and Occupational Therapists 93.63% of the Medicare Physician Fee Schedule. Speech-Language Pathology Assistants and Clinical Fellows are not currently contracted with or reimbursed.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   The proposed methodology is to pay Physical Therapy Assistants, Occupational Therapy Assistants, and Speech-Language Pathology Assistants and Clinical Fellows 85% of Physical Therapists, Occupational Therapists, and Speech-Language Pathologists, respectively.

6. **BUDGET ESTIMATE.**
   The estimated budget impact for SFY2021 will be an increase in the total amount of $2,297,680; with $856,116 state share. The estimated budget impact for SFY2022 will be an increase in the total amount of $4,595,360; with $1,493,492 state share.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
   The Oklahoma Health Care Authority does not anticipate any negative impact on access to care.

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
   The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee approve the proposed methodology to pay Physical Therapy Assistants, Occupational Therapy Assistants, and Speech-Language Pathology Assistants and Clinical Fellows 85% of Physical Therapists, Occupational Therapists, and Speech-Language Pathologists, respectively.

9. **EFFECTIVE DATE OF CHANGE.**
   January 1, 2021, Pending CMS Approval

**March Board**
**Proposed Rule Changes**

Face-to-face tribal consultations regarding the following proposed changes were held on Tuesday, May 7, 2019, Tuesday, July 2, 2019, Tuesday, September 3, 2019, Tuesday, November 5, 2019, and Tuesday, January 7, 2020 in the Charles Ed McFall Boardroom of the Oklahoma Health Care Authority (OHCA). The proposed rules were presented to the Medical Advisory Committee (MAC) on Thursday, July 18, 2019, Thursday, September 5, 2019, Thursday, November 7, 2019, and Thursday, March 12, 2020. Additionally, the proposed ***PERMANENT*** rules were presented at a public hearing on Wednesday, February 19, 2020 at 1 p.m. in the OHCA Boardroom. Finally, all APA work folders were posted on the public website for a public comment period.

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

**A.** **APA WF # 20-01 High-Investment Drugs Carve-Out —** ADDING agency rules at ***Oklahoma Administrative Code (OAC) 317:30-5-42.20 and 317:30-5-47.6*** and AMENDING ***OAC 317:30-3-31 and 317:30-5-47*** will allow certain high-investment drugs to be reimbursed outside of the inpatient and outpatient hospital payment methodologies. Additionally, the proposed rule changes will require inpatient and outpatient hospitals to seek prior authorization of high-investment drugs and follow applicable requirements and conditions of payment. Lastly, revisions will align policy with current practice and correct grammatical errors.
**Budget Impact: Budget neutral**

**B.** **APA WF # 20-02 Retroactive Eligibility —** AMENDING agency rules at ***OAC 317:35-6-60*** and ADDING agency rules at ***OAC 317:35-6-60.2*** will allow for a retroactive period of eligibility. Revisions provide that, in addition to certifying an applicant for coverage from the date of certification forward, the applicant may also be certified for coverage for a retroactive period of three months directly prior to the date of application. If the applicant received reimbursable SoonerCare services at any time during the prior three months and if the applicant would have been eligible for SoonerCare at the time he or she received the services, the member may be eligible for retroactive eligibility coverage. Revisions also specify the requirements that must be met to be eligible for retroactive coverage. Oklahoma had been granted a waiver exemption for retroactive eligibility for children and pregnant women through the 1115(a) waiver; however, in the latest renewal of the waiver, this exemption was removed by the Centers for Medicaid and Medicare Services (CMS), thus mandating the Oklahoma Health Care Authority to extend retroactive eligibility for pregnant women and children. The proposed revisions apply to children and pregnant women and do not apply to adult parents/caretaker relatives. Additionally, the responsibility will be upon the applicant to apply for the retroactive coverage, provide any needed documentation to verify eligibility, and to inform the provider that he/she has SoonerCare eligibility. The timely filing deadline in OAC 317:30-3-11 will still apply to the filing of any claims.
**Budget Impact: Although it is expected that implementing retroactive eligibility will have a budget impact to the agency, it is not possible at this time to predict how many applicants will be eligible for and receive a retroactive coverage option.**

**C**. **APA WF # 20-03 Treatment of Lottery or Gambling Winnings for Income Eligibility —** AMENDING agency rules at ***OAC 317:35-6-51 and 317:35-10-26*** and ADDING agency rules at ***OAC 317:35-6-55*** will bring the agency into compliance with the

Advancing Chronic Care, Extenders and Social Services Act, referred to as the ACCESS Act and included in Public Law No. 115-123 § 53103. The ACCESS Act changed the way qualified lottery winnings or qualified gambling winnings of $80,000 and above, which are paid out in a single payout option, are treated when determining MAGI-based income eligibility. Previous federal regulations and OHCA rules required that all lump sum income, including lottery and gambling winnings, be counted as income only in the month received. Winnings will still be counted as income against the SoonerCare household in the month received; however, winnings of $80,000 and above which are paid out in a single payout option will be counted in multiple months and in equal monthly installments against the individual household member receiving the winnings. Lottery winnings that are paid out in installments over a period of time would be treated as recurring income. The formula for counting winnings of $80,000 and above is set forth in the new OHCA policy at OAC 317:35-6-55(b) and (c).

**Budget Impact: Agency staff has determined that the impact of the proposed rule changes on the budget is unknown as the number of SoonerCare members who will have lottery or gambling winnings is unknown; however, savings could potentially be realized if a member lost eligibility for multiple months due to receipt of lottery or gambling winnings above $80,000 paid out in a single payout.**

***The following permanent rules HAVE previously been approved by the Board and the Governor under EMERGENCY rulemaking. These rules HAVE been revised for PERMANENT rulemaking.***

**D.** **APA WF # 19-03 Applied Behavior Analysis (ABA) Services —** AMENDING agency rules at ***OAC 317:30-5-2, 317:30-5-355.1, 317:30-5-357, 317:30-5-376, 317:30-5-664.1, 317:30-5-1076, 317:30-5-1090, and 317:30-5-1154*** and ADDING agency rules at ***OAC 317:30-3-65.12*** to establish coverage and reimbursement for ABA services as an Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. The proposed language will define scope of service, medical necessity, prior authorization and extension requests for continued services. The proposed rule changes will define provider criteria and credentialing requirements for Board Certified Behavior Analyst® (BCBA®), Board Certified Assistant Behavior Analyst® (BCaBA®), Registered Behavior Technician™ (RBT®) and human services professionals. Additionally, SoonerCare will set prior authorization limits for ABA treatment. Authorizations will be granted for up to thirty (30) hours per week within a six (6) month period. SoonerCare recognizes that in some cases additional hours may be medically necessary; therefore, providers must submit a prior authorization request with supporting documentation for a secondary medical review. Other revisions will involve limited rewriting aimed at clarifying medical necessity criteria and updating outdated policy sections. These rules are currently in place as emergency rules.

Further rule changes will clarify how Indian Health Services, Tribal Programs, and Urban Indian Clinics (I/T/Us) obstetrical (OB) providers should bill for OB care. I/T/Us have the option of either billing for OB encounters or a bundled rate for total OB care. The clarification will require I/T/Us to be specific when choosing a billing method as they are only allowed to choose one of the billing methods. The proposed rule change related to I/T/Us OB providers included in this work folder is part of WF 19-33 I/T/U OB Care which was approved by the Board on January 22, 2020.

**Budget Impact: The proposed rule change will not result in any additional costs and/or savings to the agency. Budget allocation to establish coverage of and reimbursement for ABA services, including services rendered by RBTs, was**

**approved during promulgation of the emergency rule on July 1, 2019.**

**The proposed rule changes to clarify how I/T/U OB providers should bill for OB care will not result in any cost and/or savings to the agency.**

**E.** **APA WF # 19-08 Telehealth Services —** AMENDING agency rules at ***OAC 317:30-3-27*** to comply with Oklahoma Senate Bill (SB) No. 575, which amended 25 Oklahoma Statutes (O.S.), Section 2004 and 2005. Revisions outline and further define the following requirements: parental consent for telehealth services; confidentiality and security of protected health information in order to comply with state and federal law; that services provided or received outside of Oklahoma may require prior authorization; and that services provided must be within the scope of the practitioner's license or certification. Revisions also define that program restrictions and coverage for telehealth services mirror those which exist for the same services when not provided through telehealth, provided, however, that only certain telehealth codes are reimbursable by SoonerCare. These rules are currently in place as emergency rules.
**Budget Impact: Agency staff has determined that the proposed rule changes will result in a budget impact of $332,330 of which $115,950 is the state share.**

**F.** **APA WF # 19-13B Long-Term Care Facilities —** AMENDING agency rules at ***OAC 317:30-5-132 and 317:30-5-136.1*** and ADDING agency rules at ***OAC 317:30-5-132.1 and 317:30-5-132.2*** to comply with Senate Bill (SB) 280. Revisions provide the OHCA's website for cost report instructions, establishes procedures for annual cost report submission extension requests for long-term care facilities, outline the processes when, based on onsite audit findings, the cost report may be adjusted, and define allowable and unallowable costs for long-term care facilities. Finally, the proposed policy changes will establish new quality measures and criteria, as well as, recalculate the incentive reimbursement rate plan for nursing facilities participating in the pay-for-performance program. These rules are currently in place as emergency rules.
**Budget Impact: The estimated budget impact for the remainder of SFY2020 will be an increase in the total amount of $95,819,280; with $32,559,391 in state share [$4,400,309 of the state share is from Quality of Care (QOC) fees paid by providers]. The estimated budget impact for SFY21 will be an increase in the total amount of $127,759,040; with $43,412,522 in state share ($6,286,156 of the state share is from QOC fees paid by providers).**

***The following permanent rules HAVE previously been approved by the Board and the Governor under EMERGENCY rulemaking. These rules HAVE NOT been revised for PERMANENT rulemaking.***

**G.** **APA WF # 19-05 Therapeutic Foster Care Revisions —** AMENDING agency rules at ***OAC 317:30-5-740, 317:30-5-740.1, 317:30-5-740.2, 317:30-5-741, 317:30-5-742, 317:30-5-742.1, 317:30-5-742.2, 317:30-5-743.1, 317:30-5-744, 317:30-5-745, and 317:30-5-746*** and ADDING agency rules at ***OAC 317:30-5-750 through 317:30-5-757*** will align therapeutic foster care (TFC) policy with current business practice. Revisions will also add new language establishing a more intensive treatment program for children in Oklahoma Department of Human Services (OKDHS) and Office of Juvenile Affairs (OJA) custody known as Intensive Treatment Family Care (ITFC). ITFC is a TFC model that addresses children's complex/severe behavioral and emotional health needs and/or disorders. ITFC utilizes a team approach of professionals including therapists, care coordinators, and foster parents to provide the intensive treatment services in a family

care setting. The proposed revisions will define ITFC, member criteria for the provision of ITFC services, provider participation and credentialing requirements, program coverage, and program limitations. Lastly, the proposed revisions will establish reimbursement methodology and applicable rates for ITFC services. These rules are currently in place as emergency rules.

**Budget Impact: The proposed rule changes will not result in any additional costs and/or savings to the agency. Budget allocation for implementation and enforcement of the proposed rules, was approved during promulgation of the emergency rule on August 21, 2019. The state share is the responsibility of the Oklahoma Department of Human Services with the current therapeutic foster care budget.**

**H.** **APA WF # 19-06 Diabetes Self-Management Training (DSMT) Services —** AMENDING agency rules at ***OAC 317:30-5-42.1*** and ADDING agency rules at ***OAC 317:30-5-1080 through 317:30-5-1084*** to establish diabetes self-management training (DSMT) as a new benefit in the SoonerCare program for members with diabetes. DSMT is an educational disease management benefit designed to teach members how to successfully manage and control his/her diabetes. The proposed revisions will outline member eligibility, program coverage and limitations, provider requirements, and reimbursement. These rules are currently in place as emergency rules.

**Budget Impact: The proposed rule changes will not result in any additional costs and/or savings to the agency. Budget allocation for implementation and enforcement of the proposed rule, was approved during promulgation of the emergency rule on November 20, 2019.**

**I.** **APA WF # 19-09 SUPPORT Act —** ADDING agency rules at ***OAC 317:35-6-45*** to comply with recent changes in federal law, which provides that individuals under the age of twenty-one, or individuals under the age of twenty-six in the former foster care eligibility group, who become incarcerated, shall not have their eligibility terminated. Eligibility, for the aforementioned populations, will instead be suspended for the duration of the incarceration. Additionally, revisions outline that a redetermination of eligibility, based on information known to the OHCA, will be conducted prior to the inmate's release without requiring a new application. Eligibility will be restored to the date the inmate is released from custody, if the individual meets all other eligibility requirements. The process of restoring SoonerCare eligibility to the date the individual is released from incarceration will involve collaboration between the OHCA, Oklahoma Department of Human Services (DHS), Oklahoma Office of Juvenile Affairs (OJA), and the Oklahoma Department of Corrections (DOC). Of note, coverage and reimbursement of inpatient services, while an individual is incarcerated, will not change through these proposed changes. These rules are currently in place as emergency rules.

**Budget Impact: The estimated budget impact for SFY 2020 will be an increase in the total amount of $227,512; with $77,309 in state share. The estimated budget impact for future years, beginning in SFY 2021, will be an increase in the total amount of $341,268; with $115,963 in state share.**

**J.** **APA WF # 19-12 High Risk Obstetrical Services (HROB) —** AMENDING agency rules at ***OAC 317:30-5-22.1 and 317:30-5-42.11*** will add "family practice physician - obstetrics (FP/OB)" as a new provider type under the enhanced services for medically high risk pregnancy policy. This policy change will address and improve access to care for obstetrical-related services in rural Oklahoma. Further revisions will update policy to reflect current business practices. These rules are currently in place as emergency rules.

**Budget Impact: The estimated budget impact for SFY 2020 will be an increase in the total amount of $154,549; with $52,516 in state share.**

**K.** **APA WF # 19-13A Long-Term Care Facilities —** ADDING agency rules at ***OAC 317:2-1-17*** will bring the OHCA into compliance with Senate Bill (SB) 280. Revisions will implement an administrative appeals process for disputed long-term care facility cost reports and cost report consideration. These rules are currently in place as emergency rules.
**Budget Impact: Budget neutral**

**L.** **APA WF # 19-16 Behavioral Health Targeted Case Management (TCM) Updates —** AMENDING agency rules at ***OAC 317:30-5-241.6*** will increase new TCM monthly limits that are reimbursable by SoonerCare, at the request of the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS). The TCM limits will be increased from sixteen (16) units per member per year to twelve (12) units per member per month. Other revisions will align case management policy with current practice and correct grammatical errors. These rules are currently in place as emergency rules.
**Budget Impact: The proposed rule changes will not result in any additional costs and/or savings to the agency. Budget allocation for implementation and enforcement of the proposed rules, was approved during promulgation of the emergency rule on September 18, 2019. The state share is the responsibility of ODMHSAS.**

**M.** **APA WF # 19-18 Opioid Standards and Drug Utilization Review (DUR) Program —** AMENDING agency rules at ***OAC 317:30-5-86*** will comply with 42 United States Code (U.S.C.) § 1396a(oo), which requires state Medicaid agencies to implement newly-required DUR activities to better monitor opioid prescribing and dispensing patterns. Opioid safety edits will be implemented to alert pharmacists of potential concerns with a medication prescribed for a member, that have to be resolved before it can be dispensed and safely taken by the member. Additionally, a claims review automated process will be in place to identify refills in excess of state limits and monitor concurrent prescribing of opioids and benzodiazepines and/or antipsychotics. Furthermore, the OHCA will implement a program to monitor the use of antipsychotic medications by members aged eighteen (18) and younger, including foster children. Lastly, the OHCA will implement a process to identify potential fraud and abuse of controlled substances by members, health care professionals prescribing drugs to members, and pharmacies dispensing drugs to members. Other revisions will align and reorganize DUR policy section with current practice. These rules are currently in place as emergency rules.
**Budget Impact: Budget neutral**

**N.** **APA WF # 19-19A Step Therapy Exception Process —** AMENDING agency rules at ***OAC 317:2-1-2 and 317:2-1-13*****;** REVOKING ***OAC 317:2-1-6*****;** and ADDING ***OAC 317:2-1-18*** to comply with Oklahoma Senate Bill (SB) 509, which was signed into law on April 16, 2019. SB 509 directed the OHCA to revise current step therapy protocols for medications approved by the Drug Utilization Review (DUR) Board and provide for exceptions to the drug step therapy protocol. The exception applies to cases when: the required prescribed drug will likely cause an adverse reaction or harm; the prescription drug will likely be ineffective; the patient has already tried the prescription drug and discontinued use; the prescription drug is not in the best interest of the patient; or the patient is stable on another prescription drug. Finally, revisions will establish an appeals process for step therapy exception requests that have been denied. Other revisions are

needed to correct outdated language. These rules are currently in place as emergency rules.
**Budget Impact: The proposed rule changes will not result in any additional costs and/or savings to the agency. Budget allocation for implementation and enforcement of the proposed rules, was approved during promulgation of the emergency rule on November 20, 2019.**

**O.** **APA WF # 19-19B Step Therapy Exception Process —** AMENDING agency rules at ***OAC 317:30-5-77.2 and 317:30-5-77.3*****;** and ADDING agency rules at ***OAC 317:30-5-77.4*** to comply with Senate Bill (SB) 509, which was signed into law on April 16, 2019. SB 509 directed the OHCA to revise current step therapy protocols for medications approved by the Drug Utilization Review (DUR) Board and provide for exceptions to the drug step therapy protocol. The exception applies to cases when: the required prescribed drug will likely cause an adverse reaction or harm; the prescription drug will likely be ineffective; the patient has already tried the prescription drug and discontinued use; the prescription drug is not in the best interest of the patient; or the patient is stable on another prescription drug. Further, revisions will establish an appeals process for step therapy exception requests that have been denied. Other revisions are needed to correct outdated language. These rules are currently in place as emergency rules.
**Budget Impact: The proposed rule changes will not result in any additional costs and/or savings to the agency. Budget allocation for implementation and enforcement of the proposed rules, was approved during promulgation of the emergency rule on November 20, 2019.**

**P.** **APA WF # 19-20 Pharmacy Revisions and American Indians/Alaska Natives (AI/AN) Cost Sharing Exemptions —** AMENDING agency rules at ***OAC 317:30-3-5, 317:30-5-72 and 317:30-5-77.1*** will remove prescription limits of certain frequently monitored prescription drugs and medication-assisted treatment (MAT) drugs for opioid use disorder. The proposed rule changes will also remove co-payments for MAT drugs. Additional rule changes will amend prescription quantity limits when a product is on the maintenance drug list. The proposed rule changes will allow certain products to be dispensed in quantities of up to a 90-day supply. Other revisions will align administrative rules regarding cost sharing exemptions for AI/AN members with Oklahoma's Medicaid State Plan language and federal regulation at 42 CFR § 447.56(a)(x). Finally, revisions will align policy with current practice and correct grammatical errors. These rules are currently in place as emergency rules.
**Budget Impact: The proposed rule changes will not result in any additional costs and/or savings to the agency. Budget allocation for implementation and enforcement of the proposed rule, was approved during promulgation of the emergency rule on November 20, 2019.**

***The following PERMANENT rules HAVE NOT been approved by the Board.***

**Q.** **APA WF # 19-10 American Indian/Alaska Native (AI/AN) Cost Sharing Exemptions —** AMENDING agency rules at ***OAC 317:45-9-4 and 317:45-11-24*** will align agency rules regarding cost sharing exemptions for AI/AN members with Oklahoma's Medicaid State Plan language and 42 Code of Federal Regulations (C.F.R.) § 447.56(a)(x). Section 5006 of the American Recovery and Reinvestment Act (ARRA) precludes states from imposing Medicaid premiums or any other Medicaid cost sharing on Indian applicants and participants served by Indian health providers.

**Budget Impact: Budget neutral**

**R.** **APA WF # 19-15 Rural Health Clinic (RHC) —** AMENDING agency rules at ***OAC 317:30-5-359.1 and 317:30-5-359.2*** to comply with the Benefits Improvement and Protection Act of 2000. Policy changes will reflect a revised payment methodology for RHCs. Further revisions will update policy to reflect current business practices.
**Budget Impact: The estimated budget impact for SFY 2020 will be an increase in the total amount of $17,657,446; with $6,160,683 in state share.**

**S.** **APA WF # 19-24 Urine Drug Screening and Laboratory Services Policy —** AMENDING agency rules at ***OAC 317:30-5-20 and 317:30-5-20.1*** will update policy by removing the word "urine", in order to clarify that this policy applies to multiple specimens and not just urine specimens. Additionally, the proposed revisions will update laboratory services policy to clarify that laboratory testing for routine diagnostic or screening purposes are compensable when they are recommended by the clinical guidelines of nationally recognized professional medical academies or societies, and those sources meet medical necessity criteria, as outlined in OHCA rules.
**Budget Impact: Budget neutral**

**T.** **APA WF # 19-25 Polymerase Chain Reaction (PCR) Testing for Infectious Diseases —** ADDING agency rules at ***OAC 317:30-5-20.2*** to establish guidelines to assure medical necessity and consistency in the prior authorization (PA) process for PCR testing. The guidelines include criteria to meet medical necessity and required documentation for approval of the PA.
**Budget Impact: Agency staff has determined that the proposed rule changes will result in a budget savings by decreasing reimbursement of medically unnecessary PCR tests. The total spending for calendar year 2018, on PCR infectious disease testing CPT codes which will now be subject to prior authorization was $6,282,503. With an estimated denial rate of 50% for lack of medical necessity, total estimated budget savings will be $3,141,252 annually, of which $1,067,397 is state dollars.**

**U.** **APA WF # 19-26 Countable Income and Resources for the Aged, Blind and Disabled (ABD) Eligibility Groups and Eligibility as a Qualified Medicare Beneficiary (QMB) Plus Member —** AMENDING agency rules at ***OAC 317:35-5-41.1, 317:35-5-42, and 317:35-7-40*** will update policy regarding the determination of countable income for individuals in the ABD categorical group. The rule changes will incorporate the federal Supplemental Security Income (SSI) standards, including the exclusion of earned and unearned income, and clarify guidance on how income is deemed from certain individuals to another (i.e. ineligible spouse's income deemed to the applicant). Additional rule changes will update policy to note that the value of a life estate may be established by a written estimate instead of a written appraisal. Finally, rule changes will update QMB Plus policy to align with other Medicare savings programs and to clarify income and resource standards for individuals and couples.
**Budget Impact: Budget neutral**

**V.** **APA WF # 19-27 Ground Emergency Medical Transportation (GEMT) Supplemental Payment Program —** ADDING agency rules at ***OAC 317:30-5-344*** to establish consistency with the Oklahoma Medicaid State Plan which outlines the GEMT Supplemental Payment Program. The GEMT program is a voluntary program which provides supplemental payments to eligible providers for specific allowable and uncompensated costs incurred for providing ground ambulance services to SoonerCare

recipients and certified on an annual cost report. Payments are made in the form of an interim payment and a later reconciliation payment (i.e. settle-up payment).
**Budget Impact: There is no estimated federal budget impact for federal fiscal year (FFY) 2019. The estimated federal budget impact for FFY 2020 is $17,258,031. It is estimated that the revisions will be budget neutral for the State as participating GEMT providers will bear the cost of providing the state share for the program, as well as, any administrative costs.**

**W. APA WF # 19-29 Reasonable Limits for Necessary Medical and Remedial Care not Covered under the Oklahoma Medicaid State Plan —** AMENDING agency rules at ***OAC 317:35-9-68, and 317:35-19-21*** will revise the formula for calculating the vendor payment for SoonerCare members receiving services in a Nursing Facility (NF) or an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). The vendor payment is the monthly amount the member must contribute toward the cost of their care in a long-term care facility. The revisions will establish limitations and/or reasonable requirements before a medical expense can be deducted from the individual's post-eligibility income when determining the vendor payment. Currently, there are no limitations or established criteria by which expenses are quantified or determined to be allowed for deduction. Similar reasonable limits have been implemented by numerous State Medicaid agencies, including that of Arkansas, Colorado, Massachusetts, and Texas.
**Budget Impact: The OHCA anticipates, but cannot reliably estimate, a budget impact for the proposed changes, because the amount of expenses for medical or remedial care that are not subject to third party payment (hereinafter, 'Expenses') will: 1) vary from person to person; and 2) be unknown until the person or his or her representative reports them to the OHCA. Currently, there are no limitations or established criteria by which Expenses are quantified or determined to be allowable for deduction. Accordingly, implementing reasonable limits on these types of Expenses should minimize total potential losses to the agency over the long term.**

**X. APA WF # 19-32 Inpatient Psychiatric Services and Service Quality Review (SQR) Revisions —** AMENDING agency rules at ***OAC 317:30-5-95, 317:30-5-95.4, 317:30-5-95.14, 317:30-5-95.22, 317:30-5-95.24, 317:30-5-95.29, 317:30-5-95.30, 317:30-5-95.31, 317:30-5-95.33, 317:30-5-95.34, 317:30-5-95.35, 317:30-5-95.37, 317:30-5-95.38, 317:30-5-95.40, 317:30-5-95.41, 317:30-5-95.42, 317:30-5-96.2 and 317:30-5-96.3*** and ADDING agency rules at ***OAC 317:30-5-94*** will revise policy for members under twenty-one (21) to reflect current practice, update obsolete references, and reorganize sections for consistent application of policy. The proposed rule changes will also address Service Quality Review (SQR) findings of deficiency regarding inpatient psychiatric facilities' compliance with federal regulations and OHCA administrative rules. Additionally, the proposed rule changes will create a general specialty add-on payment for children and adolescents with specialized treatment needs who are being served in a psychiatric residential treatment facility (PRTF), Acute II unit of a psychiatric hospital and general hospital with an Acute II psychiatric.
**Budget Impact: The proposed rule changes that amend inpatient psychiatric services policy for members under twenty-one is budget neutral. The proposed rule changes that address SQR findings of deficiency will potentially result in savings; however, the agency is unable to provide a measurable savings amount. The proposed rule changes that create a general specialty add-on payment will potentially result in an annual total cost of $5,747,126; with $2,000,000 state share for SFY2021. The state share will be paid by the Oklahoma Department of Mental**

**Health and Substance Abuse Services (ODMHSAS).**

**Y.** **APA WF # 19-34 ADvantage Waiver —** AMENDING agency rules at ***OAC 317:35-17-1 and 317:35-17-3*** and ADDING agency rules at ***OAC 317:35-15-8.2*** will add language addressing the State Plan Personal Care eligibility provider exception criteria. Additionally, revisions will update existing policy that clarifies the criteria an applicant must meet to receive ADvantage services and the type of living arrangements that are not eligible for ADvantage members.
**Budget Impact: Budget neutral**

**Z.** **APA WF # 19-35 Developmental Disabilities Services (DDS) —** AMENDING agency rules at ***OAC 317:40-9-1*** will allow for self-directed services to be an option under the Community Waiver. Additional revisions will add language to note the daily hourly limits on services provided by the self-directed habilitation training specialist. Other revisions will establish guidelines for the DDS home and community-based services waiver's Electronic Visit Verification (EVV) billing procedures.
**Budget Impact: Budget neutral**

**AA.** **APA WF # 19-37 Mobile and Portable Dental Treatment Facilities —** ADDING agency rules at ***OAC 317:30-5-706, 317:30-5-707, 317:30-5-708, 317:30-5-709, 317:30-5-710, and 317:30-5-711*** to establish coverage and reimbursement for preventive dental services received through mobile and portable dental treatment facilities. Additionally, revisions will add provider participation requirements pursuant to the Oklahoma State Dentistry Act and the OHCA contracting requirements, while also defining coverage and limitations for preventive dental services, billing requirements, basic consent form requirements, and follow-up care requirements.
**Budget Impact: The estimated budget impact for SFY 2021 will be an increase in the total amount of $115,753; with $37,921 in state share.**

**BB.** **APA WF # 19-41A Patient-Centered Medical Homes (PCMH), Health Access Networks (HAN) and Health Management Program (HMP) Updates —** AMENDING agency rules at ***OAC 317:25-7-2, 317:25-7-3, 317:25-7-5, 317:25-7-10, 317:25-7-13, 317:25-7-25, 317:25-7-26, 317:25-7-27, 317:25-7-28, 317:25-7-30, 317:25-7-40, 317:25-9-1, 317:25-9-2 and 317:25-9-3*****;*** ADDING agency rules at ***OAC 317:25-11-1, 317:25-11-2, and 317:25-11-3*****,*** and REVOKING agency rules at ***OAC 317:25-7-29*** will update the policy for the Patient-Centered Medical Homes (PCMH) and Health Access Networks (HAN). Additionally, a new section of policy will be added to address the Health Management Program (HMP) which will provide an overview of the program and outline provider participation guidelines. Finally, policy changes will include general policy cleanup and align policy with current business practices.
**Budget Impact: Budget neutral**

**CC.** **APA WF # 19-41B Insure Oklahoma Individual Plan (IP) and Insure Oklahoma Employer Sponsored Insurance (ESI) —** AMENDING agency rules at ***OAC 317:45-11-2 and 317:45-11-22*****;** ADDING agency rules at ***OAC 317:45-9-1.1 and 317:45-11-21.1*** will establish language to the Insure Oklahoma IP and ESI policy on how a newborn child can be deemed eligible on their date of birth for SoonerCare benefits when the child is born to a member of the Insure Oklahoma IP or ESI. Additionally, the proposed policy changes will define eligibility criteria for the newborn to receive SoonerCare benefits.
**Budget Impact: Budget neutral**

**DD.** **APA WF # 19-42 Adult Inpatient Rehabilitation Days —** AMENDING agency rules at ***OAC 317:30-5-111 and 317:30-5-112*** will increase the number of covered inpatient rehabilitation hospital days for adult SoonerCare members from twenty-four (24) days per state fiscal year to ninety (90) days per state fiscal year. These changes are necessary to meet the health care needs of SoonerCare members by increasing access to stabilization services in an inpatient rehabilitation setting.
**Budget Impact: The estimated budget impact for SFY 2021 will be an increase in the total amount of $584,266 total; with $187,023 in state share. The estimated budget impact for SFY 2022 will be an increase in the total amount of $779,021; with $187,023 in state share.**

**EE.** **APA WF # 19-43A Coverage Definitions for Children and Adults —** AMENDING agency rules at ***OAC 317:30-1-3*** and ADDING agency rules at ***OAC 317:30-1-4*** will establish definitions to clarify what the OHCA views as a child and an adult, unless otherwise specified by federal and/or state law. Additional revisions will involve limited rewriting aimed at clarifying text; fixing any grammatical errors; and aligning rules with the current business practice.
**Budget Impact: Budget neutral**

**FF.** **APA WF # 19-43B Coverage Definitions for Children and Adults —** AMENDING agency rules at ***OAC 317:35-1-2*** will establish definitions to clarify what the OHCA views as a child and an adult, unless otherwise specified by federal and/or state law. Additional revisions will involve limited rewriting aimed at clarifying text; fixing any grammatical errors; and aligning rules with the current business practice.
**Budget Impact: Budget neutral**

**GG.** **APA WF # 19-45 Private Duty Nursing (PDN) Revisions —** AMENDING agency rules at ***OAC 317:30-5-555, 317:30-5-556, and 317:30-5-558*** will update and strengthen PDN policy by defining the place of services where/that PDN is allowed. Additional revisions will include adding language to allow for medically necessary PDN services outside of the home if certain requirements are met. Further revisions will clarify which PDN services will and will not be authorized. Finally, the proposed revisions will involve limited rewriting aimed at clarifying text, fixing any grammatical errors, and aligning rules with the current business practice.
**Budget Impact: Budget neutral**

**HH.** **APA WF # 19-46 School-based/Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Revisions —** AMENDING agency rules at ***OAC 317:30-3-65, 317:30-5-1023, 317:30-5-1026 and 317:30-5-1027*** and REVOKING agency rules at ***OAC 317:30-5-1022, 317:30-5-1024, and 317:30-5-1025*** will cleanup the school-based policy to separate and differentiate between services provided in a school setting under EPSDT benefit versus those school-based services that are pursuant to an Individual Education Plan (IEP).
**Budget Impact: Budget neutral**

**II.** **APA WF # 19-47 Medically Necessary Extractions Revisions —** AMENDING agency rules at ***OAC 317:30-5-695, 317:30-5-696, 317:30-5-698, 317:30-5-700, 317:30-5-700.1, 317:30-5-704 and 317:30-5-705*** will amend the rule that limits dental services for adults to "emergency" extractions only by changing it to "medically necessary" extractions. Additionally, the proposed rule revisions will add definitions for medically necessary oral healthcare and medically necessary extractions. Finally, the proposed revisions will

involve limited rewriting aimed at clarifying text; fixing any grammatical errors; and aligning rules with the current business practice.

**Budget Impact: The estimated budget impact for SFY 2020 will be an increase in the total amount of $1,734,313; with $605,102 in state share.**

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

**SUBCHAPTER 3. GENERAL PROVIDER POLICIES**

**PART 1. GENERAL SCOPE AND ADMINISTRATION**

**317:30-3-31. Prior authorization for health care-related goods and services**

(a) Under the ~~Oklahoma~~ SoonerCare program, there are health care-related goods and services that require prior authorization (PA) by the Oklahoma Health Care Authority (OHCA). PA is a process to determine if a prescribed good or service is medically necessary; it is not, however, a guarantee of member eligibility or of SoonerCare payment. All goods or services requiring PA will be authorized on the basis of information submitted to OHCA, including:

(1) ~~the~~The relevant code, as is appropriate for the good or service requested (for example, Current Procedural Terminology (CPT) codes for services; Healthcare Common Procedure Coding System (HCPCS) codes, for durable medical equipment; or National Drug Codes (NDC), for drugs); and/or

(2) ~~any~~Any other information required by OHCA, in the format as prescribed. The OHCA authorization file will reflect the codes that have been authorized.

(b) The OHCA staff will issue a determination for each requested good or service requiring a PA. The provider will be advised of that determination, either through the provider portal, or for requests made for out-of-state services, meals, mileage, transportation and lodging, by letter or other written communication. The member will be advised by letter. Policy regarding member appeal of a denied PA is available at Oklahoma Administrative Code (OAC) 317:2-1-2.

(c) The following is an inexhaustive list of the goods and services that may require a PA, for at least some SoonerCare member populations, under some circumstances. This list is subject to change, with OHCA expressly reserving the right to add a PA requirement to a covered good or service or to remove a PA requirement from a covered good or service.

(1) Physical therapy for children;

(2) Speech therapy for children;

(3) Occupational therapy for children;

(4) High Tech Imaging (for ex. CT, MRA, MRI, PET);

(5) Some dental procedures, including, but not limited to orthodontics (orthodontics are covered for children only);

(6) Inpatient psychiatric services;

(7) Some prescription drugs ~~and/or~~ , physician administered, and/or high-investment drugs;

(8) Ventilators;

(9) Hearing aids (covered for children only);
(10) Prosthetics;
(11) High risk ~~OB~~obstetrical (OB) services;
(12) Drug testing;
(13) Enteral therapy (covered for children only);
(14) Hyperalimentation;
(15) Early and Periodic Screening, ~~Diagnosis~~Diagnostic and Treatment (EPSDT) services, supplies, or equipment that are determined to be medically necessary for a child or adolescent, and which are included within the categories of mandatory and optional services in Section 1905(a) of Title XIX, regardless of whether such services, supplies, or equipment are listed as covered in ~~Oklahoma's~~the Oklahoma Medicaid State Plan;
(16) Adaptive equipment for persons residing in private ~~Intermediate Care Facilities for Individuals with Intellectual Disabilities~~intermediate care facilities for individuals with intellectual disabilities (ICF/IID);
(17) Some ancillary services provided in a ~~long term~~long-term care hospital or in a long term care facility;
(18) Rental of hospital beds, support surfaces, oxygen and oxygen related products, continuous positive airway pressure devices (CPAP and BiPAP), pneumatic compression devices, and lifts;
(19) Allergy testing and immunotherapy;
(20) Bariatric surgery;
(21) Genetic testing;
(22) Out-of-state services; and
(23) Meals, travel, and lodging.

(d) ~~Providers should refer to the relevant Part of OAC 317:30-5 for additional, provider-specific guidance on PA requirements. Providers may also refer to the OHCA Provider Billing and Procedure Manual, available on OHCA's website, and the SoonerCare Medical Necessity Criteria for Inpatient Behavioral Health Services Manual to see how and/or where to submit PA requests, as well as to find information about documentation.~~Providers should refer to the provider-specific Part for PA requirements. For additional PA information and submission requests, providers may refer to the OHCA Provider Billing and Procedure Manual and the SoonerCare Medical Necessity Criteria for Inpatient Behavioral Health Services Manual available at https://okhca.org.

## SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

## PART 3. HOSPITALS

**317:30-5-42.20. High-investment drugs – outpatient hospitals**

(a) The Oklahoma Health Care Authority (OHCA) designates certain high-investment drugs to be reimbursed separately pursuant to the Oklahoma Medicaid State Plan for members receiving services at an

outpatient hospital.
(b) The list of OHCA-designated high-investment drugs is set forth on the Pharmacy page of the OHCA website, which is available at https://okhca.org. This list may be updated as deemed necessary.
(c) All high-investment drugs require prior authorization [refer to Oklahoma Administrative Code (OAC) 317:30-3-31], and the outpatient hospital stay continues to be subject to applicable medical necessity criteria requirements [refer to OAC 317:30-3-1(f)].
(d) OHCA-designated high-investment drugs provided to eligible members, when treated in out-of-state outpatient hospitals, may be reimbursed in the same manner as in-state hospitals. Out-of-state outpatient hospitals must meet applicable out-of-state conditions of payment set forth in OAC 317:30-3-89 through 317:30-3-92, and in the Oklahoma Medicaid State Plan.

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

Reimbursement will be made for inpatient hospital services in the following manner:

(1) Covered inpatient services provided to eligible SoonerCare members admitted to in-state acute care and critical access hospitals will be reimbursed the lesser of the billed charges or the Diagnosis Related Group (DRG) amount. In addition to the billed charges or DRG payment, whichever is less, an outlier payment may be made to the hospital for very high cost stays. Additional outlier payment is applicable if either the amount billed by the hospital or DRG payment, whichever applies, is less than a threshold amount of the hospital cost. Each inpatient hospital claim is tested to determine whether the claim qualified for a cost outlier payment. Payment is equal to a percentage of the cost after the threshold is met.

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

(A) ~~laboratory~~Laboratory services;

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

(C) ~~technical~~Technical component on radiology services;

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

(E) ~~pre-admission~~Pre-admission diagnostic testing performed within ~~72~~seventy-two (72) hours of admission; and

(F) ~~organ~~Organ transplants.

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

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

hospitals will be reimbursed in the same manner as in-state hospitals. Refer to OAC 317:30-3-90 and 317:30-3-91.
(5) Cases which indicate transfer from one (1) acute care hospital to another will be monitored under a retrospective utilization review policy to help ensure that payment is not made for inappropriate transfers.
(6) The transferring hospital will be paid the lesser of the calculated transfer fee or the DRG base payment amount for a non-transfer.
(7) If the transferring or discharge hospital or unit is exempt from the DRG, that hospital or unit will be reimbursed according to the method of payment applicable to the particular facility or units.
(8) Covered inpatient services provided in out-of-state specialty hospitals may be reimbursed at a negotiated rate not to exceed ~~100%~~one-hundred percent (100%) of the cost to provide the service. Negotiation of rates will only be allowed when the OHCA determines that the specialty hospital or specialty unit provides a unique (non-experimental) service required by SoonerCare members and the provider will not accept the DRG payment rate. Prior authorization is required.
(9) New providers entering the SoonerCare program will be assigned a peer group and will be reimbursed at the peer group base rate for the DRG payment methodology or the statewide median rate for per diem methods.
(10) All inpatient services are reimbursed per the methodology described in this ~~section~~Section and/or as approved under the Oklahoma ~~State~~ Medicaid State Plan.
(11) For high-investment drugs, refer to OAC 317:30-5-47.6

**317:30-5-47.6. High-investment drugs - inpatient hospitals**

(a) The Oklahoma Health Care Authority (OHCA) designates certain high-investment drugs to be reimbursed separately pursuant to the Oklahoma Medicaid State Plan for members receiving services at an inpatient hospital.
(b) The list of OHCA-designated high-investment drugs is set forth on the Pharmacy page of the OHCA website, which is available at https://okhca.org. This list may be updated as deemed necessary.
(c) All high-investment drugs require prior authorization [refer to Oklahoma Administrative Code (OAC) 317:30-3-31], and the inpatient hospital stay continues to be subject to applicable medical necessity criteria requirements [refer to OAC 317:30-3-1(f)].
(d) OHCA-designated high-investment drugs provided to eligible members, when treated in out-of-state inpatient hospitals, may be reimbursed in the same manner as in-state hospitals. Out-of-state inpatient hospitals must meet applicable out-of-state conditions of payment set forth in OAC 317:30-3-89 through 317:30-3-92, and in the Oklahoma Medicaid State Plan.

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

**SUBCHAPTER 6. SOONERCARE FOR PREGNANT WOMEN AND FAMILIES WITH CHILDREN**

**PART 7. CERTIFICATION, REDETERMINATION AND NOTIFICATION**

**317:35-6-60. Certification for SoonerCare for pregnant women and families with children**

~~An individual determined eligible for SoonerCare may be certified for a medical service provided on or after the date of certification. The period of certification may not be for a retroactive period unless otherwise prior approved by OHCA. The individual who is categorically needy and related to pregnancy- related services retains eligibility for the period covering prenatal, delivery and postpartum periods without regard to eligibility for other household members in the case. Eligibility during the postpartum period does not apply to women receiving pregnancy-related coverage under Title XXI.~~

(a) **General rules of certification.**

(1) An individual determined eligible for SoonerCare may be certified for a prospective period of coverage on or after the date of certification.

(2) In accordance with 42 Code of Federal Regulations (C.F.R.) § 435.915 and Oklahoma Administrative Code (OAC) 317:35-6-60.2, an individual may also be determined eligible and certified for a retroactive period of coverage during the three (3) month period directly prior to the date of application, if the individual received covered medical services at any time during that period, and would have been eligible for SoonerCare at the time he or she received the services, regardless of whether the individual is alive when application for Medicaid is made. An individual may be eligible for the retroactive period even though ineligible for the prospective period.

(3) The individual who is categorically needy and related to pregnancy-related services retains eligibility for the period covering prenatal, delivery, and postpartum periods without regard to eligibility for other household members in the case. Eligibility during the postpartum period does not apply to women receiving pregnancy-related coverage under Title XXI.

~~(1)~~(b) **Certification as a TANF (cash assistance) recipient.** A categorically needy individual who is determined eligible for TANF is certified effective the first day of the month of TANF eligibility.

~~(2)~~(c) **Certification of non-cash assistance individuals related to the children and parent and caretaker relative groups.** The certification period for the individual related to the children or parent and caretaker relative groups is ~~12~~twelve (12) months. The certification period can be less than ~~12~~twelve (12) months if the individual:

~~(A)~~(1) is certified as eligible in a money payment case during the 12-month period;

~~(B)~~(2) is certified for long-term care during the 12-month period;

~~(C)~~(3) becomes ineligible for SoonerCare after the initial month; or

~~(D)~~(4) becomes financially ineligible.

~~(i)~~(A) If an income change after certification causes the case to exceed the income standard, the case is closed.

~~(ii)~~(B) Individuals, however, who are determined pregnant and financially eligible continue to be eligible for pregnancy-related services through the prenatal, delivery and postpartum period, regardless of income changes. A pregnant individual included in a TANF case which closes continues to be eligible for pregnancy related services through the postpartum period.

~~(3)~~(d) **Certification of individuals related to pregnancy-related services.** The certification period for the individual related to pregnancy-related services will cover the prenatal, delivery and postpartum periods. The postpartum period is defined as the two (2) months following the month the pregnancy ends. Financial eligibility is based on the income received in the first month of the certification period. No consideration is given to changes in income after certification.

~~(4)~~(e) **Certification of newborn child deemed eligible.**

~~(A)~~(1) Every newborn child is deemed eligible on the date of birth for SoonerCare when the child is born to a woman who is eligible for and enrolled in pregnancy-related services as categorically needy. The newborn child is deemed eligible through the last day of the month the newborn child attains the age of one (1) year. The newborn child's eligibility is not dependent on the mother's continued eligibility. The mother's coverage may expire at the end of the postpartum period; however, the newborn child is deemed eligible until age one (1). The newborn child's eligibility is based on the original eligibility determination of the mother for pregnancy-related services, and consideration is not given to any income or resource changes that occur during the deemed eligibility period.

~~(B)~~(2) The newborn child is deemed eligible for SoonerCare as

long as he/she continues to live in Oklahoma. ~~No~~In accordance with 42 C.F.R. § 435.117, no other conditions of eligibility are applicable, including social security number enumeration, child support referral, and citizenship and identity verification. However, it is recommended that social security number enumeration be completed as soon as possible after the newborn child's birth. It is also recommended that a child support referral be completed, if needed, as soon as possible and sent to the Oklahoma Child Support Services (OCSS) division at ~~OKDHS~~DHS. The referral enables child support services to be initiated.

~~(C)~~(3) When a categorically needy newborn child is deemed eligible for SoonerCare, he/she remains eligible through the end of the month that the newborn child reaches age one (1). If the child's eligibility is moved from the case where initial eligibility was established, it is required that the newborn receive the full deeming period. The certification period is shortened only in the event the child:

~~(i)~~(A) loses Oklahoma residence; or

~~(ii)~~(B) expires.

~~(D)~~(4) A newborn child cannot be deemed eligible when the mother's only coverage was presumptive eligibility, and continued eligibility was not established.

**317:35-6-60.2. Retroactive eligibility.**

(a) Retroactive eligibility, as outlined in this section, shall be available to pregnant women and/or members under the age of nineteen (19). For retroactive eligibility rules related to other SoonerCare population groups, refer to Oklahoma Administrative Code (OAC) 317:35-7-60(b).

(b) In addition to the period of eligibility specified in OAC 317:35-6-60, an applicant, or individuals within the applicant's household, shall be eligible for SoonerCare benefits up to three (3) months prior to the date of application if all of the following requirements are met:

(1) The individual for whom retroactive coverage is being requested would have been eligible for SoonerCare coverage if an application for SoonerCare had been made during the retroactive month.

(A) The individual does not have to be eligible for the month of application to be found eligible for one of the three (3) retroactive months.

(B) The eligibility factors (e.g. income, residency, household composition, etc.) are evaluated separately for each retroactive month for which retroactive eligibility is being requested.

(2) The applicant completes the retroactive eligibility application form and provides, within six (6) months of the date the services were provided, documentation for verification purposes as requested by SoonerCare.

(3) The individual applying for retroactive coverage states that the individual for whom retroactive coverage is being requested received reimbursable SoonerCare services which were provided by a SoonerCare-contracted provider during the retroactive month.

(4) An applicant cannot be approved for retroactive coverage for a month in which his or her application was previously denied.

(c) Per 42 Code of Federal Regulations (C.F.R.) § 435.915(b), if an applicant is determined to be eligible for retroactive coverage at any time during the requested retroactive month, then coverage will begin on the first day of the month and be effective for the entire month.

(d) If the applicant is applying for SoonerCare benefits due to pregnancy, then the applicant must have been pregnant during the requested retroactive month.

(e) Regardless of retroactive eligibility being granted, the requirement for the claim to be filed timely, per OAC 317:30-3-11, is still in effect.

(f) Retroactive coverage for SoonerCare health services received during a retroactive month will be secondary to any third-party which has primary responsibility for payment. If the individual eligible for retroactive coverage has already paid for the health services, the provider may refund the payment and bill SoonerCare in accordance with the timely filing requirements in OAC 317:30-3-11.

(g) Retroactive coverage for SoonerCare reimbursable health services that require prior authorization shall not be denied solely because of a failure to secure prior authorization. Medical necessity, however, must be established before reimbursement can be made.

(h) Denials of requests for retroactive eligibility may be appealed in accordance with OAC 317:2-1-2(d)(1)(F).

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

**SUBCHAPTER 6. SOONERCARE FOR PREGNANT WOMEN AND FAMILIES WITH CHILDREN**

**PART 6. COUNTABLE INCOME FOR MAGI**

**317:35-6-51. Exceptions to Internal Revenue Code rules**

(a) The following sources of income are excluded from household income for SoonerCare eligibility under ~~MAGI~~Modified Adjusted Gross Income (MAGI), regardless of whether they are included in MAGI in Section 36B of the Internal Revenue Code:

(1) Scholarships, awards, or fellowship grants used for education purposes and not for living expenses; and

(2) The following types of American Indian / Alaska Native income:

(A) Distributions from any property held in trust, subject to Federal restrictions, located within the most recent boundaries of a prior Federal reservation, or otherwise under the supervision of the Secretary of the Interior;

(B) Distributions and payments from rents, leases, rights of way, royalties, usage rights, or natural resource extraction and harvest from:

(i) Rights of ownership or possession in any lands described in Paragraph (a)(2)(A) of this section; or

(ii) Federally protected rights regarding off-reservation hunting, fishing, gathering, or usage of natural resources;

(C) Distributions resulting from real property ownership interests related to natural resources and improvements:

(i) Located on or near a reservation or within the most recent boundaries of a prior Federal reservation; or

(ii) Resulting from the exercise of federally-protected rights relating to such real property ownership interests;

(D) Payments resulting from ownership interests in or usage rights to items that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable Tribal Law or custom;

(E) Student financial assistance provided under the Bureau of Indian Affairs education programs; and

(F) Distributions from Alaska Native Corporations and Settlement Trusts.

(b) Amounts received as a lump sum are counted as income only in the month received (see also ~~OAC~~Oklahoma Administrative Code (OAC) 317:35-10-26), with the exception of certain lottery or gambling winnings as specified in OAC 317:35-6-55. If a lump sum amount is received from an income source that is not counted in MAGI according to section 36B(d)(2)(B) of the Internal Revenue Code or the exceptions listed in this section, the amount is not counted.

**317:35-6-55. Treatment of Qualified Lottery or Qualified Gambling Winnings**

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

(1) "Qualified lottery winnings" means winnings from a sweepstakes, lottery, or pool described in paragraph three (3) of Section 4402 of the Internal Revenue Code of 1986 or a lottery operated by a multistate or multijurisdictional lottery association paid out in a single payout and not in installments over a period of time.

(2) "Qualified gambling winnings" means monetary winnings from gambling, as defined by Section (§) 1955(b)(4) of Title 18 of the United States Code (U.S.C.).

(3) "Undue hardship" means circumstances resulting from a loss or denial of SoonerCare eligibility that would deprive an individual of medical care, such that the individual's health or life would be endangered, or that would deprive the individual or his or her financially dependent family members of food, clothing, shelter, or other necessities of life.

(b) **Income determinations.** In accordance with 42 U.S.C. § 1396a(e)(14)(K), qualified lottery and gambling winnings shall be considered as income in determining the financial eligibility of individuals whose eligibility is determined based on the application of Modified Adjusted Gross Income (MAGI), as follows:

(1) Winnings less than $80,000 are counted in the month received;

(2) Winnings greater than or equal to $80,000, but less than $90,000, are counted as income over two (2) months, with an equal amount counted in each month;

(3) Winnings greater than or equal to $90,000, but less than $100,000, are counted as income over three (3) months, with an equal amount counted in each month;

(4) Winnings greater than or equal to $100,000 are counted as income over three (3) months, with one (1) additional month for every increment of $10,000 in winnings received over $100,000, with an equal amount counted in each month; and

(5) The maximum period of time over which winnings may be

counted is one hundred and twenty (120) months, which would apply to winnings greater than or equal to $1,260,000.

(c) **Treatment of household members.** Qualified lottery and gambling winnings shall be counted as household income for all household members in the month of receipt; however, the requirement to count qualified lottery and gambling winnings in household income over multiple months applies only to the individual receiving the winnings.

(d) **Undue hardship.** An individual who loses or is denied eligibility due to qualified lottery or gambling winnings may timely file a member appeal, in accordance with Oklahoma Administrative Code 317:2-1-2. If, as part of that appeal, the individual proves by a preponderance of the evidence that loss or denial of eligibility would result in undue hardship, eligibility shall be restored or approved, provided all other conditions of eligibility have been met.

(e) **Notice.** SoonerCare members or applicants who are determined financially ineligible due to the counting of lottery or gambling winnings will receive a notice of the date on which the lottery or gambling winnings will no longer be counted for eligibility purposes. The notice will also inform the member or applicant of the undue hardship exemption and of their opportunity to enroll in a Qualified Health Plan on the Federally Facilitated Exchange.

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

### PART 5. INCOME

**317:35-10-26. Income**

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

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

(2) All available income, except that required to be disregarded by law or OHCA's policy, is taken into consideration in determining need. Income is considered available both when actually available and when the applicant or member has a legal interest in a liquidated sum and has the legal ability to make such sum available for support and maintenance. When an individual's income is reduced due to recoupment of an

overpayment or garnishment, the gross amount before the recoupment or garnishment is counted as income. The member is responsible for reporting all income, the source, amount and how often received.

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

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

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

(D) If the member and spouse are living together or they are living apart but there has not been a clear break in the family relationship, income received by either spouse and income received jointly is considered as family income. Income cannot be diverted to a household member who is not included in the household size for health benefits. Consideration is not given to a SSI recipient's income in computing eligibility for the AFDC or Pregnancy related unit. The ~~MAGI~~Modified Adjusted Gross Income (MAGI) methodology rules determine whose income is considered in a particular household for MAGI eligibility groups as defined in ~~OAC~~Oklahoma Administrative Code (OAC) 317:35-6-1.

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

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

(3) Income that must be verified is verified by the best available information such as pay stubs presented by the member or an interview with the employer. If OHCA is unable to verify income through the Employment Securities Commission, then pay stubs may only be used for verification if they have the member's name and/or social security number indicating that the pay stubs are in fact the member's wages. The stubs should

also include the date(s) of the pay period and the amount of income before deductions. If this information is not included, employer verification is required. The worker verifies medical insurance which may be available at the same time that income is verified. When a member of the benefit group accepts employment and has not received any wages, verification (if necessary) of the amount of income to be considered and the anticipated date of receipt must be obtained from the employer and provided to OHCA within ten (10) days. Income which is expected to be received during a month is considered available to the benefit group and is counted in determining eligibility for the month of receipt.

(4) Monies received in a lump sum from any source are considered income in the month received, with the exception of certain lottery or gambling winnings as specified in OAC 317:35-6-55. Changing a resource from one form to another, such as converting personal property to cash, is not considered a lump sum payment. Exception: lump sum payments used to establish dedicated bank accounts by representative payees in order to receive and maintain retroactive SSI benefits for disabled/blind children under age eighteen (18) are excluded as income. The interest income generated from dedicated bank accounts is also excluded.

(A) Whether a source of income is countable for MAGI eligibility groups is determined in accordance with Part 6 of Subchapter 6 of this Chapter.

(B) Whether a source of income is countable is determined in accordance with Part 6 of Subchapter 6 of this Chapter.

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

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

(E) Recurring lump sum income received from any source for a period covering more than one (1) month, that is received in a lump sum recurrently (such as annual rentals from surface or minerals, Windfall Profits tax refund, etc.) is prorated over a period of time it is intended to cover, beginning with the month of receipt of a lump sum payment.

(F) Net income from oil and gas production (gross minus production taxes withheld), received in varying amounts on a regular or irregular basis for the past six (6) months, will be averaged and considered as income for the next six

(6) months. In instances where an applicant or a member receives new income from oil and gas production and verification for the past six (6) months is not available, the worker accepts the available verification and averages over the period of time intended to cover. Net income may be verified by seeing the individual's production check stub, or by contacting the oil and gas company. Whether a source of income is countable is determined in accordance with Part 6 of Subchapter 6 of this Chapter.

(5) Income that is based on the number of hours worked, as opposed to income based on regular monthly wages, must be computed as irregular income. The income received irregularly or in varying amounts will be averaged using the past two (2) months to establish the amount to be anticipated and considered for prospective budgeting.

(6) MAGI household rules are used to determine whether a caretaker relative or stepparent is included in a household.

(A) MAGI household and income counting rules are used to determine whether a caretaker relative and his/her spouse or a stepparent are included in the household and whether their income is considered for the children.

(B) MAGI household and income counting rules are used to determine whose income is considered and whether that income is counted. If an individual is eligible in the parent or caretaker relative group, his/her spouse, if living with him/her, is also related to the parent or caretaker relative group.

(7) A stepparent, if living with the parent or caretaker relative, can also be related to the parent or caretaker relative group, regardless of whether the parent is incapacitated or not in the home.

(8) MAGI household and income counting rules are used to determine whose income is considered and whether that income is counted.

(b) **Earned income.** The term "earned income" refers to monies earned by an individual through the receipt of wages, salary, commission or profit from activities in which the individual is engaged as self-employed or as an employee. Whether income is countable for MAGI eligibility groups is determined using MAGI income counting rules in Part 6 of Subchapter 6 of this Chapter.

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

(2) **Earned income from wages, salary or commission.** Countable income for MAGI eligibility groups is determined in accordance

with MAGI income counting rules in Part 6 of Subchapter 6 of this Chapter.

(3) **Earned income from work and training programs.** Countable income for MAGI eligibility groups is determined in accordance with MAGI income counting rules in Part 6 of Subchapter 6 of this Chapter.

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

(5) **Formula for determining the individual's net earned income for MAGI eligibility groups.** To determine net income, see MAGI rules in OAC 317:35-6-39.

(c) **Unearned income.** Countable earned and unearned income for MAGI eligibility groups is determined in accordance with MAGI income counting rules in Part 6 of Subchapter 6 of this Chapter.

(d) **Income disregards.** For MAGI eligibility groups, whether a source of income is disregarded is determined in accordance with MAGI income counting rules in Part 6 of Subchapter 6 of this Chapter.

(g) In computing monthly income, cents will be rounded down at each step. Income which is received monthly but in irregular amounts is averaged using two month's income, if possible, to determine income eligibility. Less than two month's income may be used when circumstances (e.g., new employment, unpaid sick leave, etc.) would indicate that previous income amounts would not be appropriate to use in determining future income amounts. Income received more often than monthly is converted to monthly amounts as follows:

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

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

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

(4) **Biweekly.** Income received every two (2) weeks is multiplied by 2.15.

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

**SUBCHAPTER 3. GENERAL PROVIDER POLICIES**

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

**317:30-3-65.12. Applied behavior analysis (ABA) services**

(a) **Purpose and general provisions.** The purpose of this Section is to establish guidelines for the provision of ABA services under the EPSDT benefit.

(1) ABA focuses on the analysis, design, implementation, and evaluation of instructional and other environmental modifications to produce meaningful changes in human behavior. ABA services include the use of direct observation, measurement, and functional analysis of the relations between the environment and behavior. Common ABA-based techniques include, but are not limited to; discrete trial training; pivotal response training; and verbal behavioral intervention.

(2) ABA may be provided in a variety of settings, including home, community, or a clinical setting. It involves development of an individualized treatment plan that includes transition and aftercare planning, and family/caregiver involvement.

(3) At an initial assessment, target symptoms are identified. A treatment plan is developed that identifies core deficits and aberrant behaviors, and includes designated interventions intended to address these deficits and behaviors and achieve individualized goals.

(4) ABA services require prior authorization [refer to Oklahoma Administrative Code (OAC) 317:30-3-31 and 317:30-3-65.12(e)].

(b) **Functional behavior assessment (FBA) and treatment plan components**

(1) The FBA serves as a critical component of the treatment plan and is conducted by a board certified behavior analyst (BCBA) to identify the specific behavioral needs of the member. The FBA consists of:

(A) Description of the problematic behavior (topography, onset/offset, cycle, intensity, severity);

(B) History of the problematic behavior (long-term and recent);

(C) Antecedent analysis (setting, people, time of day, events);

(D) Consequence analysis; and

(E) Impression and analysis of the function of the problematic behavior.

(2) The treatment plan is developed by a BCBA from the FBA. The treatment plan shall:

(A) Be person-centered and individualized;

(B) Delineate the baseline levels of target behaviors;
(C) Specify long and short term objectives that are defined in observable, measureable behavioral terms;
(D) Specify criteria that will be used to determine achievement of objectives;
(E) Include assessment and treatment protocols for addressing each of the target behaviors;
(F) Clearly identify the schedule of services planned and the individuals responsible for delivering the services, including frequent review of data on target behaviors and adjustments in the treatment plan and/or protocols by the BCBA as needed;
(G) Include training and supervision to enable board certified assistant behavior analysts (BCaBAs) and registered behavior technicians (RBTs) to implement assessment and treatment protocols;
(H) Include training and support to enable parents and other caregivers to participate in treatment planning and successfully reinforce the established treatment plan;
(I) Include care coordination involving the parents or caregiver(s), school, state disability programs, and others as applicable; and
(J) Ensure that services are consistent with applicable professional standards and guidelines relating to the practice of applied behavior analysis as well as state Medicaid laws and regulations.

(c) **Eligible providers.** Eligible ABA provider types include:
(1) Board certified behavior analyst® (BCBA®) – A master's or doctoral level independent practitioner who is certified by the national-accrediting Behavior Analyst Certification Board, Inc.® (BACB®) and licensed by Oklahoma Department of Human Services' (OKDHS) Developmental Disabilities Services Division (DDS) to provide behavior analysis services. A BCBA may supervise the work of board certified assistant behavior analysts and registered behavior technicians implementing behavior analytic interventions;
(2) Board certified assistant behavior analyst® (BCaBA®) – A bachelor's level practitioner who is certified by the national-accrediting BACB and certified by OKDHS DDS to provide behavior analysis services under the supervision of a BCBA;
(3) Registered behavior technician™ (RBT®) – A high school level or higher paraprofessional who is certified by the national-accrediting BACB and practices under the close and ongoing supervision of a BCBA. The RBT works under the license number of a BCBA and is primarily responsible for the direct implementation of BCBA designed and prescribed behavior-analytic services; and
(4) Human services professional – A practitioner who is licensed by the State of Oklahoma pursuant to (A) – (H), and certified by

the national-accrediting BACB, and who is working within the scope of his or her practice, to include:

(A) A licensed physical therapist;

(B) A licensed occupational therapist;

(C) A licensed clinical social worker or social worker candidate under the supervision of a licensed clinical social worker;

(D) A licensed psychologist;

(E) A licensed speech-language pathologist or licensed audiologist;

(F) A licensed professional counselor or professional counselor candidate under the supervision of a licensed professional counselor;

(G) A licensed marital and family therapist or marital and family therapist candidate under the supervision of a licensed marital and family therapist; or

(H) A licensed behavioral practitioner or behavioral practitioner candidate under the supervision of a licensed behavioral practitioner.

(d) **Provider criteria.** To direct, supervise, and/or render ABA services, the following conditions shall be met.

(1) A BCBA shall:

(A) Be currently licensed by OKDHS DDS as a BCBA;

(B) Have no sanctions or disciplinary actions by OKDHS DDS or the BACB;

(C) Have no current overpayment(s) due to SoonerCare, and no Medicare or Medicaid sanctions or exclusions from participation in federally funded programs; and

(D) Be fully contracted with SoonerCare as a provider.

(2) A BCaBA shall:

(A) Be currently certified by OKDHS DDS as a BCaBA;

(B) Work under the supervision of a SoonerCare-contracted BCBA provider;

(C) Have no current overpayment(s) due to SoonerCare, and no Medicare or Medicaid sanctions or exclusions from participation in federally funded programs; and

(D) Be fully contracted with SoonerCare as a provider.

(3) An RBT shall:

(A) Be currently certified by the national-accrediting BACB as an RBT;

(B) Work under the supervision of a SoonerCare-contracted BCBA provider;

(C) Have no current overpayment(s) due to SoonerCare, and no Medicare or Medicaid sanctions or exclusions from participation in federally funded programs; and

(D) Be fully contracted with SoonerCare as a provider.

(4) A human services professional shall:

(A) Be currently licensed or certified by the State of Oklahoma, in accordance with Section 1928 of Title 59 of the Oklahoma Statutes;

(B) Be currently certified by the national-accrediting BACB;
(C) Have no sanctions or disciplinary actions by the applicable state licensing board or the BACB;
(D) If working under supervision within the scope of his or her practice, have a documented relationship with a fully-licensed human service professional working in a supervisory capacity;
(E) Have no current overpayment(s) due to SoonerCare, and no Medicare or Medicaid sanctions or exclusions from participation in federally funded programs; and
(F) Be fully contracted with SoonerCare as a provider.

(e) **Medical necessity criteria for members under twenty-one (21) years of age.** ABA services are considered medically necessary when all of the following conditions are met:

(1) The member is under twenty-one (21) years of age with a definitive diagnosis of an Autism Spectrum Disorder (ASD) from the following providers:
(A) Pediatric neurologist or neurologist;
(B) Developmental pediatrician;
(C) Licensed psychologist;
(D) Psychiatrist or neuropsychiatrist; or
(E) Other licensed physician experienced in the diagnosis and treatment of autism.

(2) A comprehensive diagnostic evaluation completed by one (1) of the above identified professionals must:
(A) Be completed within the last two (2) years;
(B) Include a complete pertinent medical and social history, including pre-and perinatal, medical, developmental, family, and social elements; and
(C) Be based on criteria outlined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) or the most current version of the DSM for ASD and/or may also include scores from the use of formal diagnostic tests such as the Autism Diagnostic Interview-Revised (ADI-R), Autism Diagnostic Observation Schedule-2 (ADOS-2), Childhood Autism Rating Scale (CARS) or other tools with acceptable psychometric properties. Screening scales are not sufficient to make a diagnosis and will not be accepted as the only formal scale.

(3) There must be a reasonable expectation that the member will benefit from ABA. The member must exhibit:
(A) The ability/capacity to learn and develop generalized skills to assist with his or her independence; and
(B) The ability to develop generalized skills to assist in addressing maladaptive behaviors associated with ASD.

(4) The member is medically stable and does not require twenty-four (24) hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for individuals with intellectual disabilities (ICF/IID).

(5) The member exhibits atypical or disruptive behavior within the most recent thirty (30) calendar days that significantly interferes with daily functioning and activities. Such atypical or disruptive behavior may include, but is not limited to:

(A) Impulsive aggression toward others;

(B) Self-injury behaviors; or

(C) Intentional property destruction.

(6) The focus of treatment is not custodial in nature (which is defined as care provided when the member "has reached maximum level of physical or mental function and such person is not likely to make further significant improvement" or "any type of care where the primary purpose of the type of care provided is to attend to the member's daily living activities which do not entail or require the continuing attention of trained medical or paramedical personnel.")

(7) It has been determined that there is no other appropriate service which can be safely and effectively provided.

(f) **Prior authorization.** Eligible providers must submit an initial prior authorization request to the Oklahoma Health Care Authority (OHCA) or its designated agent. Prior authorization requests shall be granted up to six (6) months of ABA treatment services at one (1) time unless a longer duration of treatment is clinically indicated. The number of hours authorized may differ from the hours requested on the prior authorization request based on the review by an OHCA reviewer and/or physician. If the member's condition necessitates a change in the treatment plan, the provider must request a new prior authorization. The prior authorization request must meet the following SoonerCare criteria for ABA services.

(1) The criteria includes a comprehensive behavioral and FBA outlining the behaviors consistent with the diagnosis of ASD and its associated comorbidities. In addition to completing the initial request form, providers will be required to submit documentation that will consist of the following:

(A) Information about relevant medical status, prior assessment results, response to prior treatment, and other relevant information gathered from review of records and past assessments.

(B) Information gathered from interview of family and/or caregivers, rating scales, and social validity measures to assess perceptions of the client's skill deficits and behavioral excesses, and the extent to which these deficits impede the daily life of the member and the family.

(C) Direct assessment and observation, including any data related to the identified problem behavior. The analysis of such data serves as the primary basis for identifying pretreatment levels of functioning, developing and adapting treatment protocols, and evaluating response to treatment and progress towards goals.

(D) Functional assessment of problem behavior that includes antecedent factors, skill deficits, and consequences

contributing to the problem behavior. The treatment plan should address all three (3) areas, including antecedent interventions, teaching replacement skills, and modification of consequences.

(2) The prior authorization for ABA treatment will be time limited for up to thirty (30) hours per week unless other hours are deemed medically necessary and authorized through a prior authorization request and must:

(A) Be a one-on-one encounter (face to face between the member and ABA provider) except in the case of family adaptive treatment guidance;

(B) Be child-centered and based upon individualized goals that are strengths-specific, family focused, and community based;

(C) Be culturally competent and the least intrusive as possible;

(D) Clearly define in measurable and objective terms the specific target behaviors that are linked to the function of (or reason for) the behavior;

(E) Record the frequency, rate, symptom intensity/duration, or other objective measures of baseline levels;

(F) Set quantifiable criteria for progress;

(G) Establish and record behavioral intervention techniques that are appropriate to target behaviors. The detailed treatment plan utilizes reinforcement and other behavioral principles and excludes the use of methods or techniques that lack consensus about their effectiveness based on evidence in peer-reviewed publications;

(H) Specify strategies for generalization of learned skills;

(I) Document planning for transition through the continuum of interventions, services, and settings, as well as discharge criteria;

(J) Include parent(s)/legal guardian(s) in behavioral training techniques so that they can practice additional hours of intervention on their own. The treatment plan is expected to achieve the parent(s)/legal guardian(s) ability to successfully reinforce the established plan of care. Frequency of parental involvement will be determined by the treatment provider and listed on the treatment plan;

(K) Document parent(s)/legal guardian(s) participation in the training of behavioral techniques in the member's medical record. Parent(s)/legal guardian(s)' participation is critical to the generalization of treatment goals to the member's environment; and

(L) Ensure that recommended ABA services do not duplicate or replicate services received in a member's primary academic education setting, or provided within an Individualized Education Plan (IEP), Individualized Service Plan (ISP), or any other individual plan of care.

(g) **ABA extension requests.** Extension requests for ABA services

must be submitted to the OHCA or its designated agent. Extension requests must contain the appropriate documentation validating the need for continued treatment and establish the following:

(1) Eligibility criteria in OAC 317:30-3-65.12(d) 1-6;

(2) The frequency of the target behavior has diminished since last review, or if not, there has been modification of the treatment or additional assessments have been conducted;

(3) If progress has not been measurable after two (2) extension requests, a functional analysis will be completed which records the member's maladaptive serious target behavioral symptom(s), and precipitants, as well as makes a determination of the function a particular maladaptive behavior serves for the member in the environmental context;

(4) Appropriate consultations from other staff or experts have occurred (psychiatric consults, pediatric evaluation for other conditions) and interventions have been changed, including the number of hours per week of service or setting (higher level of care);

(5) Parent(s)/legal guardian(s) have received re-training on these changed approaches; and

(6) The treatment plan documents a gradual tapering of higher intensities of intervention and shifting to supports from other sources (i.e., schools) as progress occurs.

(h) **Reimbursement methodology.** SoonerCare shall provide reimbursement for ABA services in accordance with the Medicaid State Plan.

(1) Payment shall only be made to SoonerCare-contracted groups or qualified individual providers who are currently licensed and in good standing. Payment is not made to under supervision ABA practitioners/paraprofessionals, including but not limited to, BCaBAs and RBTs.

(2) Reimbursement for ABA services is only made on a fee-for-services basis. The maximum allowable fee for a unit of service has been determined by OHCA to be a reasonable fee, consistent with efficiency, economy, and quality of care. Payment for covered services is the lower of the provider's actual billed charges, consistent with the provider's usual and customary charge to the general public for the service, or the maximum allowable per unit of service.

(3) Reimbursement shall only be made for services that have been prior-authorized by OHCA or its designee; and performed on an individualized basis and not in a group setting except for family adaptive behavior treatment guidance by a qualified ABA provider [OAC 317:30-3-65.12(b)].

(4) Reimbursement for ABA services shall not be made to or for services rendered by a parent, legal guardian, or other legally responsible person.

## SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

## PART 1. PHYSICIANS

### 317:30-5-2. General coverage by category

(a) **Adults.** Payment for adults is made to physicians for medical and surgical services within the scope of the Oklahoma Health Care Authority's (OHCA) SoonerCare program, provided the services are reasonable and necessary for the diagnosis and treatment of illness or injury, or to improve the functioning of a malformed body member. Coverage of certain services must be based on a determination made by the OHCA's medical consultant in individual circumstances.

(1) Coverage includes the following medically necessary services:

(A) Inpatient hospital visits for all SoonerCare covered stays. All inpatient services are subject to post-payment review by the OHCA, or its designated agent.

(B) Inpatient psychotherapy by a physician.

(C) Inpatient psychological testing by a physician.

(D) One (1) inpatient visit per day, per physician.

(E) Certain surgical procedures performed in a Medicare certified free-standing ambulatory surgery center (ASC) or a Medicare certified hospital that offers outpatient surgical services.

(F) Therapeutic radiology or chemotherapy on an outpatient basis without limitation to the number of treatments per month for members with proven malignancies.

(G) Physician services on an outpatient basis include:

(i) A maximum of four (4) ~~primary care visits per member per month~~visits per member per month, including primary care or specialty, with the exception of SoonerCare Choice members~~, or~~.

~~(ii) A maximum of four (4) specialty visits per member per month.~~

~~(iii)~~ (ii) Additional visits are allowed per month for treatment related to emergency medical conditions and family planning services.

(H) Direct physician services in a nursing facility.

(i) A maximum of two (2) nursing facility visits per month are allowed; and if the visit (s) is for psychiatric services, it must be provided by a psychiatrist or a physician with appropriate behavioral health training.

(ii) To receive payment for a second nursing facility visit in a month denied by Medicare for a Medicare/SoonerCare member, attach the explanation of Medicare benefits (EOMB) showing denial and mark "carrier denied coverage."

(I) Diagnostic x-ray and laboratory services.

(J) Mammography screening and additional follow-up mammograms as per current guidelines.
(K) Obstetrical care.
(L) Pacemakers and prostheses inserted during the course of a surgical procedure.
(M) Prior authorized examinations for the purpose of determining medical eligibility for programs administered by OHCA. A copy of the authorization, Oklahoma Department of Human Services ~~(DHS)~~ (OKDHS) form 08MA016E, Authorization for Examination and Billing, must accompany the claim.
(N) If a physician renders direct care to a member on the same day as a dialysis treatment, payment is allowed for a separately identifiable service unrelated to the dialysis.
(O) Family planning includes sterilization procedures for legally competent members twenty-one (21) years of age and over who voluntarily request such a procedure and execute the federally mandated consent form with his/her physician. A copy of the consent form must be attached to the claim form. Separate payment is allowed for the insertion and/or implantation of contraceptive devices during an office visit. Certain family planning products may be obtained through the Vendor Drug Program. Reversal of sterilization procedures for the purposes of conception is not allowed. Reversal of sterilization procedures are allowed when medically indicated and substantiating documentation is attached to the claim.
(P) Genetic counseling.
(Q) Laboratory testing.
(R) Payment for ultrasounds for pregnant women as specified in Oklahoma Administrative Code (OAC) 317:30-5-22.
(S) Payment to the attending physician in a teaching medical facility for compensable services when the physician signs as claimant and renders personal and identifiable services to the member in conformity with federal regulations.
(T) Payment to the attending physician for the services of a currently Oklahoma licensed physician in training when the following conditions are met:

(i) Attending physician performs chart review and signs off on the billed encounter;
(ii) Attending physician is present in the clinic/or hospital setting and available for consultation; and
(iii) Documentation of written policy and applicable training of physicians in the training program regarding when to seek the consultation of the attending physician.

(U) Payment for services rendered by medical residents in an outpatient academic setting when the following conditions are met:

(i) The resident has obtained a medical license or a special license for training from the appropriate regulatory state medical board; and

(ii) has the appropriate contract on file with the OHCA to render services within the scope of their licensure.

(V) The payment to a physician for medically directing the services of a certified registered nurse anesthetist (CRNA) or for the direct supervision of the services of an anesthesiologist assistant (AA) is limited. The maximum allowable fee for the services of both providers combined is limited to the maximum allowable had the service been performed solely by the anesthesiologist.

(W) Screening and follow up pap smears as per current guidelines.

(X) ~~Medically necessary solid organ and bone marrow/stem cell transplantation services for children and adults are covered services based upon the conditions listed in (i)-(iv) of this subparagraph:~~

~~(i) Transplant procedures, except kidney and cornea, must be prior authorized to be compensable.~~

~~(ii) To be prior authorized all procedures are reviewed based on appropriate medical criteria.~~

~~(iii) To be compensable under the SoonerCare program, all organ transplants must be performed at a facility which meets the requirements contained in Section 1138 of the Social Security Act.~~

~~(iv) Procedures considered experimental or investigational are not covered.~~Medically necessary organ and tissue transplantation services for children and adults are covered services based upon the conditions listed in (i)-(v) of this subparagraph:

(i) All transplantation services, except kidney and cornea, must be prior authorized;

(ii) All transplant procedures are reviewed and prior authorization is based upon appropriate medical criteria;

(iii) All organ transplants must be performed at a Medicare-approved transplantation center;

(iv) Procedures considered experimental or investigational are not covered; and

(v) Donor search and procurement services are covered for transplants consistent with the methods used by the Medicare program for organ acquisition costs.

~~(Y) Donor search and procurement services are covered for transplants consistent with the methods used by the Medicare program for organ acquisition costs.~~

~~(Z)~~(Y) Donor expenses incurred for complications are covered only if they are directly and immediately attributable to the donation procedure. Donor expenses that occur after the ninety (90) day global reimbursement period must be submitted to the OHCA for review.

~~(AA)~~(Z) Total parenteral nutritional (TPN) therapy for identified diagnoses and when prior authorized.

~~(BB)~~(AA) Ventilator equipment.
~~(CC)~~(BB) Home dialysis equipment and supplies.
~~(DD)~~(CC) Ambulatory services for treatment of members with tuberculosis (TB). This includes, but is not limited to, physician visits, outpatient hospital services, rural health clinic visits and prescriptions. Drugs prescribed for the treatment of TB beyond the prescriptions covered under SoonerCare require prior authorization by the University of Oklahoma College of Pharmacy Help Desk using form "Petition for TB Related Therapy." Ambulatory services to members infected with TB are not limited to the scope of the SoonerCare program, but require prior authorization when the scope is exceeded.
~~(EE)~~(DD) Smoking and tobacco use cessation counseling for treatment of members using tobacco.

(i) Smoking and tobacco use cessation counseling consists of the 5As:

(I) Asking the member to describe their smoking use;
(II) Advising the member to quit;
(III) Assessing the willingness of the member to quit;
(IV) Assisting the member with referrals and plans to quit; and
(V) Arranging for follow-up.

(ii) Up to eight (8) sessions are covered per year per individual.

(iii) Smoking and tobacco use cessation counseling is a covered service when performed by physicians, physician assistants (PA), advanced registered nurse practitioners (ARNP), certified nurse midwives (CNM), dentists, Oklahoma State Health Department (OSDH) and Federally Qualified Health Center (FQHC) nursing staff, and maternal/child health licensed clinical social worker trained as a certified tobacco treatment specialist (CTTS). It is reimbursed in addition to any other appropriate global payments for obstetrical care, primary care provider (PCP) care coordination payments, evaluation and management codes, or other appropriate services rendered. It must be a significant, separately identifiable service, unique from any other service provided on the same day.

(iv) Chart documentation must include a separate note that addresses the 5A's and office note signature along with the member specific information addressed in the five (5) steps and the time spent by the practitioner performing the counseling. Anything under three (3) minutes is considered part of a routine visit and not separately billable.

~~(FF)~~(EE) Immunizations as specified by the Advisory Committee on Immunization Practices (ACIP) guidelines.
~~(GG)~~(FF) Genetic testing and other molecular pathology

services are covered when medically necessary. Genetic testing may be considered medically necessary when the following conditions are met:

(i) The member displays clinical features of a suspected genetic condition, is at direct risk of inheriting the genetic condition in question (e.g., a causative familial variant has been identified) or has been diagnosed with a condition where identification of specific genetic changes will impact treatment or management; and

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

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

(iv) A medical geneticist, physician, or licensed genetic counselor provides documentation that supports the recommendation for testing based on a review of risk factors, clinical scenario, and family history.

(2) General coverage exclusions include the following:

(A) Inpatient admission for diagnostic studies that could be performed on an outpatient basis.

(B) Services or any expense incurred for cosmetic surgery.

(C) Services of two (2) physicians for the same type of service to the same member on the same day, except when supplemental skills are required and different specialties are involved.

(D) Routine eye examinations for the sole purpose of prescribing glasses or visual aids, determination of refractive state, treatment of refractive errors or purchase of lenses, frames or visual aids.

(E) Pre-operative care within twenty-four (24) hours of the day of admission for surgery and routine post-operative care as defined under the global surgery guidelines promulgated by Current Procedural Terminology (CPT) and the Centers for Medicare and Medicaid Services (CMS).

(F) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.

(G) Sterilization of members who are under twenty-one (21) years of age, mentally incompetent, or institutionalized or reversal of sterilization procedures for the purposes of conception.

(H) Non-therapeutic hysterectomies.

(I) Medical services considered experimental or investigational.

(J) Payment for more than four (4) outpatient visits per member (home or office) per month, except visits in

connection with family planning, services related to emergency medical conditions, or primary care services provided to SoonerCare Choice members.
(K) Payment for more than two (2) nursing facility visits per month.
(L) More than one (1) inpatient visit per day per physician.
(M) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing, tumor board review or multidisciplinary opinion, dictation, and similar functions.
(N) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.
(O) Payment for the services of social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in OHCA rules.
(P) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or that the pregnancy is the result of an act of rape or incest. (Refer to OAC 317:30-5-6 or 317:30-5-50).
(Q) Speech and hearing services.
(R) Mileage.
(S) A routine hospital visit on the date of discharge unless the member expired.
(T) Direct payment to perfusionist as this is considered part of the hospital reimbursement.
(U) Inpatient chemical dependency treatment.
(V) Fertility treatment.
(W) Payment for removal of benign skin lesions.
(X) Sleep studies.

(b) **Children.** Payment is made to physicians for medical and surgical services for members under the age of twenty-one (21) within the scope of the SoonerCare program, provided the services are medically necessary for the diagnosis and treatment of illness or injury, or to improve the functioning of a malformed body member. Medical and surgical services for children are comparable to those listed for adults. For services rendered to a minor child, the child's parent or court-appointed legal guardian must provide written authorization prior to the service being rendered, unless there is an explicit state or federal exception to this requirement. In addition to those services listed for adults, the following services are covered for children.

(1) **Pre-authorization of inpatient psychiatric services.** All inpatient psychiatric services for members under twenty-one (21) years of age must be prior authorized by an agency designated by

the OHCA. All psychiatric services are prior authorized for an approved length of stay. Non-authorized inpatient psychiatric services are not SoonerCare compensable.

(A) All ~~residential and acute~~inpatient psychiatric services are authorized based on the medical necessity criteria as described in OAC 317:30-5-95.25, 317:30-5-95.27 and 317:30-5-95.29.

(B) For out of state placements, refer to OAC 317:30-3-89 through 317:30-3-92.

(2) **General ~~acute care~~Acute inpatient service limitations.** All general ~~acute care~~Acute inpatient hospital services for members under the age of twenty-one (21) are not limited. All inpatient care must be medically necessary.

(3) **Procedures for requesting extensions for inpatient services.** The physician and/or facility must provide necessary justification to enable OHCA, or its designated agent, to make a determination of medical necessity and appropriateness of treatment options. Extension requests for psychiatric admissions must be submitted to the OHCA or its designated agent. Extension requests must contain the appropriate documentation validating the need for continued treatment in accordance with the medical necessity criteria described in OAC 317:30-5-95.26, 317:30-5-95.28 and 317:30-5-95.30. Requests must be made prior to the expiration of the approved inpatient stay. All decisions of OHCA or its designated agent are final.

(4) **Utilization control requirements for psychiatric beds.** Utilization control requirements for inpatient psychiatric services for members under twenty-one (21) years of age apply to all hospitals and residential psychiatric treatment facilities.

(5) **Early and periodic screening diagnosis and treatment (EPSDT) program.** Payment is made to eligible providers for EPDST of members under age twenty-one (21). These services include medical, dental, vision, hearing and other necessary health care. Refer to OAC 317:30-3-65.2 through ~~317:30-3-65.11~~317:30-3-65.12 for specific guidelines.

(6) **Reporting suspected abuse and/or neglect.** Instances of child abuse and/or neglect are to be reported in accordance with state law, including, but not limited to, ~~10A Oklahoma Statute (O.S.) § 1-2-101~~Section 1-2-101 of Title 10A of the Oklahoma Statutes and 43A O.S. § 10-104. Any person suspecting child abuse or neglect shall immediately report it to the Oklahoma Department of Human Services ~~(DHS)~~ (OKDHS) hotline, at 1-800-522-3511; any person suspecting abuse, neglect, or exploitation of a vulnerable adult shall immediately report it to the local ~~DHS~~OKDHS county office, municipal or county law enforcement authorities, or, if the report occurs after normal business hours, the ~~DHS~~OKDHS hotline. Health care professionals who are requested to report incidents of domestic abuse by adult victims with legal capacity shall promptly make a report to the nearest

law enforcement agency, per 22 O.S. § 58.

(7) **General exclusions.** The following are excluded from coverage for members under the age of twenty-one (21):

(A) Inpatient admission for diagnostic studies that could be performed on an outpatient basis.

(B) Services or any expense incurred for cosmetic surgery unless the physician certifies the procedure emotionally necessary.

(C) Services of two (2) physicians for the same type of service to the same member on the same day, except when supplemental skills are required and different specialties are involved.

(D) Pre-operative care within twenty-four (24) hours of the day of admission for surgery and routine post-operative care as defined under the global surgery guidelines promulgated by CPT and CMS.

(E) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.

(F) Sterilization of members who are under twenty-one (21) years of age, mentally incompetent, or institutionalized or reversal of sterilization procedures for the purposes of conception.

(G) Non-therapeutic hysterectomies.

(H) Medical services considered experimental or investigational.

(I) More than one (1) inpatient visit per day per physician.

(J) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or that the pregnancy is the result of an act of rape or incest. (Refer to OAC 317:30-5-6 or 317:30-5-50).

(K) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing, tumor board review or multidisciplinary opinion, dictation, and similar functions.

(L) Payment for the services of social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in OHCA rules.

(M) Direct payment to perfusionist as this is considered part of the hospital reimbursement.

(N) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.

(O) Mileage.

(P) A routine hospital visit on date of discharge unless the member expired.

(c) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the OHCA allowable for comparable services. Claims filed with Medicare Part B should automatically cross over to OHCA. The EOMB reflects a message that the claim was referred to SoonerCare. If such a message is not present, a claim for coinsurance and deductible must be filed with the OHCA within ninety (90) days of the date of Medicare payment and within one (1) year of the date of service in order to be considered timely filed.

(1) In certain circumstances, some claims do not automatically "cross over." Providers must file a claim for coinsurance and/or deductible to SoonerCare within ninety (90) days of the Medicare payment and within one (1) year from the date of service.

(2) If payment was denied by Medicare Part B and the service is a SoonerCare covered service, mark the claim "denied by Medicare" and attach the EOMB showing the reason for the denial.

## PART 35. RURAL HEALTH CLINICS

### 317:30-5-355.1. Definition of services

The ~~RHC~~Rural Health Clinic (RHC) benefit package, as described in Title 42 of the Code of Federal Regulations ~~(CFR)~~(C.F.R.), ~~part~~ § 440.20, consists of two (2) components: RHC ~~Services and Other Ambulatory Services~~services and other ambulatory services.

(1) **RHC services.** RHC services are covered when furnished to a member at the clinic or other location, including the member's place of residence. These services are described in this Section.

(A) **Core services.** As set out in ~~Federal Regulations at~~ 42 ~~CFR~~C.F.R. § 440.20(b), RHC "core" services include, but are not limited to:

(i) Physician's services;

(ii) Services and supplies incident to a physician's services;

(iii) Services of advanced practice registered nurses ~~(APNs)~~(APRNs), physician assistants (PAs), certified nurse midwives (CNMs), or specialized advanced practice nurse practitioners;

(iv) Services and supplies incident to the services of ~~APNs~~APRNs and PAs (including services furnished by ~~certified nurse midwives~~CNMs);

(v) Visiting nurse services to the homebound;

(vi) Clinical psychologist (CP) and clinical social worker (CSW) services;

(vii) Services and supplies incident to the services of CPs and CSWs.

(B) **Physicians' services.** In addition to the professional services of a physician, and services provided by an ~~APN~~APRN, PA, and ~~NMW~~CNM which would be covered as RHC services under Medicare, certain primary preventive services are covered

under the SoonerCare RHC benefit. The services must be furnished by or under the direct supervision of ~~a~~an RHC practitioner who is a clinic employee:

(i) ~~prenatal~~Prenatal and postpartum care;

(ii) ~~screening~~Screening examination under the Early and Periodic Screening, ~~Diagnosis~~Diagnostic and Treatment (EPSDT) Program for members under ~~21~~twenty-one (21);

(iii) ~~family~~Family planning services;

(iv) ~~medically~~Medically necessary screening mammography and follow-up mammograms ~~when medically necessary~~.

(C) **Services and supplies "incident to".** Services and supplies incident to the service of a physician, ~~physician assistant, advanced practice nurse, clinical psychologist, or clinical social worker~~PA, APRN, CP, or CSW are covered if the service or supply is:

(i) ~~a~~A type commonly furnished in physicians' offices;

(ii) ~~a~~A type commonly rendered either without charge or included in the rural health clinic's bill;

(iii) ~~furnished~~Furnished as an incidental, although integral, part of a physician's professional services; or

(iv) Drugs and biologicals which cannot be self-administered or are specifically covered by Medicare law, are included within the scope of RHC services. Drugs and biologicals commonly used in life saving procedures, such as analgesics, anesthetics (local), antibiotics, anticonvulsants, antidotes and emetics, serums and toxoids are not billed separately.

(D) **Visiting nurse services.** Visiting nurse services are covered if:

(i) ~~the~~The RHC is located in an area in which the Centers for Medicare and Medicaid Services (CMS) has determined there is a shortage of home health agencies;

(ii) ~~the~~The services are rendered to members who are homebound;

(iii) ~~the~~The member is furnished nursing care on a part-time or intermittent basis by a registered nurse, licensed practical nurse, or licensed vocational nurse who is employed by or receives compensation for the services from the RHC; and

(iv) ~~the~~The services are furnished under a written plan of treatment.

(E) **RHC encounter.** RHC "core" services (including preventive services, i.e., prenatal, EPSDT, or family planning) are part of an all-inclusive visit. A "visit" means a face-to-face encounter between a clinic patient and ~~a~~an RHC health professional ~~(i.e., physicians, physician assistants, advanced practice nurses, certified nurse midwives, clinical psychologists and clinical social workers)~~(physicians, PAs, APRNs, CNMs, CPs, and CSWs). 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. Payment is made for one (1) encounter per member per day. Medical review will be required for additional visits for children. Payment is also limited to four (4) visits per member per month for adults.

(F) **Off-site services.** RHC services provided off-site of the clinic are covered as long as the RHC has a compensation arrangement with the RHC practitioner that SoonerCare reimbursement is made to the RHC and the RHC practitioner receives his or her compensation from the RHC. The ~~rural health clinic~~RHC must have a written contract with the physician and other RHC "core" practitioners that specifically identify how the ~~rural health clinic~~RHC services provided off-site are to be billed to SoonerCare. It is expected that services provided in off-site settings are, in most cases, temporary and intermittent, i.e., when the member cannot come to the clinic due to health reasons.

(2) **Other ambulatory services.** ~~A Rural Health Clinic~~An RHC must provide other items and services which are not "RHC services" as described in ~~(a)~~(1) of this Section, and are separately billable ~~to the SoonerCare program~~within the scope of the SoonerCare fee-for-service (FFS) contract. Coverage of services are based upon the scope of coverage under the SoonerCare program.

(A) Other ambulatory services include, but are not limited to:

(i) ~~dental~~Dental services for members under ~~age 21~~the age of twenty-one (21);

(ii) ~~optometric~~Optometric services;

(iii) ~~clinical~~Clinical lab tests performed in the RHC lab, including the lab tests required for RHC certification;

(iv) ~~technical~~Technical component of diagnostic tests such as x-rays and EKGs (interpretation of the test provided by the RHC physician is included in the encounter rate);

(v) ~~durable~~Durable medical equipment;

(vi) ~~emergency ambulance transportation~~Transportation by ambulance [refer to Oklahoma Administrative Code (OAC) 317:30-5-335];

(vii) ~~prescribed~~Prescribed drugs;

(viii) ~~prosthetic~~Prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags) and supplies directly related to colostomy care and the replacement of such devices;

(ix) ~~specialized~~Specialized laboratory services furnished away from the clinic;

(x) ~~inpatient~~Inpatient services;

(xi) ~~outpatient~~Outpatient hospital services~~.~~; and

(xii) Applied behavior analysis (ABA) [refer to OAC

317:30-3-65.12].

(xiii) Diabetes self-management training (DSMT) (refer to OAC 317:30-5-1080 – 1084).

(B) Payment is made directly to the RHC on an encounter basis for on-site dental services by a licensed dentist or optometric services by a licensed optometrist for members under ~~age 21~~the age of twenty-one (21). Encounters are billed as one (1) of the following:

(i) **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.

(ii) **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.

(iii) **Visual analysis.** Visual analysis (initial or yearly) 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. Glasses must be billed separately. Payment is limited to two (2) glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.

(C) Services listed in ~~(a)~~(2)(A), (v)-(viii), of this Section, furnished on-site, require separate provider agreements with the ~~OHCA~~Oklahoma Health Care Authority (OHCA). Service item ~~(a)~~(2)(A)(iii) does not require a separate contract when furnished on-site, however, certain conditions of participation apply. (Refer to OAC 317:30-5-361 for conditions.)

(D) 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.

**317:30-5-357. Coverage for children**

Coverage for rural health clinic (RHC) services and other ambulatory services for children include the same services as for adults in addition to the following:

(1) ~~The receipt of an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) examination by a Medicaid eligible individual under age 21 renders that individual child eligible for all necessary follow-up care, whether or not the medically necessary services are covered under the Medicaid.~~Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services

are covered for eligible members under twenty-one (21) years of age in accordance with Oklahoma Administrative Code (OAC) 317:30-3-65. An EPSDT exam performed by ~~a~~an RHC must be billed on the appropriate claim form with the appropriate ~~Preventative Medicine~~preventive medicine procedure code from the Current Procedural Terminology ~~Manual~~ (CPT) manual. If an EPSDT screening is billed, ~~a~~an RHC encounter should not be billed on the same day. ~~Refer to OAC 317:30-3-47 through 317:30-3-54 for coverages under EPSDT).~~Refer to OAC 317:30-3-65 through 317:30-3-65.12.

(2) Under EPSDT, coverage is allowed for visual screenings and eyeglasses to correct visual defects. Payment is limited to two (2) glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.

(3) An EPSDT screening is considered a comprehensive examination. A provider billing the Medicaid program for an EPSDT ~~screen~~screening may not bill any other visits for that patient on that same day. It is expected that the screening provider will perform necessary treatment as part of the screening charge. Additional services such as tests, immunizations, etc., required at the time of screening may be billed independently from the screening.

(4) The administration fee for immunizations should be billed if provided at the same time as a scheduled EPSDT examination.

(5) Payment may be made directly to the RHC for the professional services of physician assistants performing EPSDT screenings within the certified RHC. The claim form must include the signature of the supervising physician.

## PART 37. ADVANCED PRACTICE REGISTERED NURSE

### 317:30-5-376. Coverage by category

Payment is made to ~~Advanced Practice Nurse~~advanced practice registered nurses (APRNs) as set forth in this Section.

(1) **Adults.** Payment for adults is made for primary care health services, within the scope of practice of ~~Advanced Practice Nurse~~an APRN and within the scope of the Oklahoma Health Care Authority (OHCA) medical programs.

(2) **Children.** Payment for children is made for primary care health services, within the scope of practice of ~~Advanced Practice Nurse~~an APRN, to ~~children and adolescents under 21~~members under twenty-one (21) years of age, including ~~EPSDT~~Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screening services ~~and within the scope of the Oklahoma Health Care Authority medical programs~~.

(A) Payment is made to eligible providers for ~~Early and Periodic Screening, Diagnosis and Treatment of individuals under age 21~~EPSDT services to members under twenty-one (21) years of age. Specific guidelines for the EPSDT program

including the periodicity schedule are found in ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-3-65 through ~~317:30-3-65.11~~317:30-3-65.12.

(B) Comprehensive screening examinations are to be performed by a provider qualified under State law to furnish primary health care services.

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

## PART 75. FEDERALLY QUALIFIED HEALTH CENTERS

### 317:30-5-664.1. Provision of other health services outside of the Health Center core services

(a) If the Center chooses to provide other ~~SoonerCare~~Oklahoma Medicaid State Plan covered health services which are not included in the Health Center core service definition in ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-5-661.1, the practitioners of those services are subject to the same program coverage limitations, enrollment, and billing procedures described by the ~~OHCA~~Oklahoma Health Care Authority (OHCA), and these services (e.g., home health services) are not included in the PPS settlement methodology in OAC 317:30-5-664.12.

(b) Other medically necessary health services that will be reimbursed at the fee-for-service (FFS) rate include, but are not limited to:

(1) ~~dental~~Dental services (refer to OAC 317:30-5-696) except for primary preventive dental services;

(2) ~~eyeglasses (OAC 317:30-5-430 and OAC 317:30-5-450)~~Eyeglasses (refer to OAC 317:30-5-431, 317:30-5-432.1 and 317:30-5-451);

(3) ~~clinical~~Clinical lab tests performed in the Center lab (other than the specific laboratory tests set out for Health Centers' certification and covered as Health Center services);

(4) ~~technical~~Technical component of diagnostic tests such as x-rays and EKGs (interpretation of the test provided by the Center physician is included as physician professional services);

(5) ~~durable~~Durable medical equipment (refer to OAC 317:30-5-210);

(6) ~~emergency ambulance transportation~~Transportation by ambulance (refer to OAC 317:30-5-335);

(7) ~~prescribed~~Prescribed drugs (refer to OAC 317:30-5-70);

(8) ~~prosthetic~~Prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags) and supplies directly related to colostomy care and the replacement of such devices;

(9) ~~specialized~~Specialized laboratory services furnished away from the clinic;

(10) Psychosocial ~~Rehabilitation Services~~rehabilitation services ~~[refer to OAC 317:30-5-241.3]~~(refer to OAC 317:30-5-241.3); ~~and~~

(11) ~~behavioral~~Behavioral health related case management services (refer to OAC 317:30-5-241.6)~~.~~; and

(12) Applied behavior analysis (ABA) (refer to OAC 317:30-3-65.12).
(13) Diabetes self-management training (DSMT) (refer to OAC 317:30-5-1080 through 317:30-5-1084).

## PART 108. NUTRITION SERVICES

### 317:30-5-1076. Coverage by category

Payment is made for ~~Nutritional Services~~nutritional services as set forth in this ~~section~~Section.

(1) **Adults.** Payment is made for six (6) hours of medically necessary nutritional counseling per year by a licensed registered dietician. All services must be prescribed by a physician, physician assistant (PA), advanced practice registered nurse (APRN), or certified nurse midwife (CNW), and be ~~face to face~~face-to-face encounters between a licensed registered dietitian and the member. Services must be expressly for diagnosing, treating or preventing, or minimizing the effects of illness. Nutritional services for the treatment of obesity is not covered unless there is documentation that the obesity is a contributing factor in another illness.

(2) **Children.** Payment is made for medically necessary nutritional counseling as described above for adults. Nutritional services for the treatment of obesity may be covered for children as part of the ~~EPSDT~~Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. Additional services which are deemed medically necessary and allowable under federal regulations may be covered by the EPSDT benefit found at OAC 317:30-3-65 ~~and~~through ~~317:30-3-65.11~~317:30-3-65.12.

(3) **Home and ~~Community Based Waiver Services~~community-based services (HCBS) waiver for the ~~Intellectually Disabled~~intellectually disabled.** All providers participating in the ~~Home and Community Based Waiver Services~~HCBS waiver for the intellectually disabled program must have a separate contract with ~~OHCA~~the Oklahoma Health Care Authority (OHCA) to provide ~~Nutrition Services~~nutrition services under this program. All services are specified in the individual's plan of care.

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

(5) **Obstetrical patients.** Payment is made for a maximum of six (6) hours of medically necessary nutritional counseling per year by a licensed registered dietitian for members at risk for or those who have been recently diagnosed with gestational diabetes. The initial consultation may be in a group setting for a maximum of two (2) hours of class time. Thereafter, four (4) hours of nutritional counseling by a licensed registered dietitian may be provided to the individual if deemed medically

necessary, which may include a post-partum visit, typically done at ~~6~~six (6) weeks after delivery. All services must be prescribed by a physician, ~~physician assistant, advanced practice nurse or a certified nurse midwife~~PA, APRN, or CNM and be ~~face-to-face~~face to face between a licensed registered dietitian and the member(s). Services must be solely for the prevention, diagnosis, or treatment of gestational diabetes.

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

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

(a) Medically necessary SoonerCare covered services that are not included in the I/T/U outpatient encounter rate may be billed outside the encounter rate within the scope of the SoonerCare fee-for-service (FFS) contract. The services will be reimbursed at the ~~fee-for-service~~FFS rate, and will be subject to any limitations, restrictions, or prior authorization requirements. Examples of these services include, but are not limited to:

(1) ~~durable~~Durable medical equipment [refer to Oklahoma Administrative Code (OAC) 317:30-5-210];

(2) ~~glassese~~Eyeglasses (refer to OAC 317:30-5-431, 317:30-5-432.1 and 317:30-5-451);

(3) ~~ambulance~~Transportation by ambulance (refer to OAC 317:30-5-335);

(4) ~~home~~Home health ~~[refer to OAC 317:30-5-546]~~(refer to OAC 317:30-5-546);

(5) ~~inpatient~~Inpatient practitioner services (refer to OAC 317:30-5-1100);

(6) ~~non-emergency~~Non-emergency transportation ~~[refer to OAC 317:35-3-2]~~(refer to OAC 317:35-3-2);

(7) ~~behavioral~~Behavioral health case management ~~[refer to OAC 317:30-5-241.6]~~(refer to OAC 317:30-5-241.6);

(8) ~~psychosocial~~Psychosocial rehabilitative services ~~[refer to OAC 317:30-5-241.3]~~(refer to OAC 317:30-5-241.3); ~~and~~

(9) ~~psychiatric~~Psychiatric residential treatment facility services~~[refer to OAC 317:30-5, Part 6, Inpatient Psychiatric Hospitals].~~ (refer to OAC 317:30-5-95 through 317:30-5-97);

(10) Applied behavior analysis (ABA) (refer to OAC 317:30-3-65.12); and

(11) Diabetes self-management training (DSMT) (refer to OAC 317:30-5-1080 through 317:30-5-1084).

(b) If the I/T/U facility chooses to provide other ~~SoonerCare~~Oklahoma Medicaid State Plan covered health services which are not included in the I/T/U encounter definition, those service providers must be contracted with ~~OHCA~~the Oklahoma Health Care Authority (OHCA) and bill for those services under their assigned provider number consistent with program coverage

limitations and billing procedures described by the OHCA.
(c) Providers may bill for antepartum and postpartum visits, and a cesarean or vaginal delivery as individual encounters, or a provider can bill the packaged/bundled rate for total obstetrical care (OB) (which includes antepartum/postpartum visits and delivery). Providers may not bill for both antepartum/postpartum visits and a packaged/bundled rate for total OB care for the same episode of care. Refer to OAC 317:30-5-22 for more detailed obstetrical care policy.

## PART 112. PUBLIC HEALTH CLINIC SERVICES

**317:30-5-1154. ~~CHD/CCHD~~County health department (CHD)and city-county health department (CCHD) services/limitations**

CHD/CCHD service limitations are:
(1) Child~~ Guidance~~-guidance services ~~(see OAC 317:30-3-65 through OAC 317:30-3-5-65.11 for specifics regarding program requirements).~~(refer to Oklahoma Administrative Code (OAC)317:30-5-1023).
(2) Dental services ~~[OAC 317:30-3-65.4(7)].~~(refer to OAC 317:30-3-65.4(7) for specific coverage).
(3) Early and Periodic Screening, ~~Diagnosis,~~Diagnostic and Treatment (EPSDT) services ~~(including blood lead testing and follow-up services)~~, including blood lead testing and follow-up services (~~see~~refer to OAC 317:30-3-65 through ~~OAC 30-3-65.11~~317:30-3-65.12 for specific coverage).
(4) Environmental investigations.
(5) Family ~~Planning~~planning and SoonerPlan ~~Family Planning~~family planning services (~~see~~refer to OAC 317:30-5-12 for specific coverage guidelines).
(6) Immunizations (adult and child).
(7) Blood lead testing (~~see~~refer to OAC 317:30-3-65.4 for specific coverage).
(8) Newborn hearing screening.
(9) Newborn metabolic screening.
(10) Maternity services (~~see~~refer to OAC 317:30-5-22 for specific coverage).
(11) Public health nursing services.
(12) Tuberculosis case management and directly observed therapy.
(13) Laboratory services.
(14) Targeted case management.

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

**SUBCHAPTER 3. GENERAL PROVIDER POLICIES**

**PART 1. GENERAL SCOPE AND ADMINISTRATION**

**317:30-3-27. Telehealth**

(a) **Definitions.** The following words and terms, when used in this Section, shall have the following meaning, unless the context clearly indicates otherwise.

(1)**"Remote patient monitoring"** means the use of digital technologies to collect medical and other forms of health data (e.g. vital signs, weight, blood pressure, blood sugar) from individuals in one (1) location and electronically transmit that information securely to health care providers in a different location for assessment and recommendations.

(2)**"School-based services"** means medically necessary health-related and rehabilitative services that are provided by a qualified school provider to a student under the age of twenty-one (21), pursuant to an Individualized Education Program (IEP), in accordance with the Individuals with Disabilities Education Act. See Oklahoma Administrative Code (OAC) 317:30-5-1020.

~~(2)~~(3)**"Store and forward technologies"** means the ~~acquisition (storing) of clinical information (e.g. data, document, image, sound, video) that is then electronically transmitted (forwarded to or retrieved by) to another site for clinical evaluation.~~transmission of a patient's medical information from an originating site to the health care provider at the distant site; provided, photographs visualized by a telecommunications system shall be specific to the patient's medical condition and adequate for furnishing or confirming a diagnosis or treatment plan. Store and forward technologies shall not include consultations provided by telephone audio-only communication, electronic mail, text message, instant messaging conversation, website questionnaire, nonsecure video conference, or facsimile transmission.

~~(3)~~(4)**"Telehealth"** means the ~~mode of delivering healthcare services via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of patients, at a distance from health care providers.~~practice of health care delivery, diagnosis, consultation, evaluation and treatment, transfer of medical data or exchange of medical education information by means of a two-way, real-time interactive communication, not to

exclude store and forward technologies, between a patient and a health care provider with access to and reviewing the patient's relevant clinical information prior to the telemedicine visit. Telehealth shall not include consultations provided by telephone audio-only communication, electronic mail, text message, instant messaging conversation, website questionnaire, nonsecure video conference, or facsimile transmission.

(5) **"Telehealth medical service"** means, for the purpose of the notification requirements of OAC 317:30-3-27(d)(2), telehealth services that expressly do not include physical therapy, occupational therapy, and/or speech and hearing services.

(b) **Applicability and scope.** The purpose of this Section is to implement telehealth policy that improves access to health care services, while complying with all applicable ~~Federal and State laws~~state and federal laws and regulations. Telehealth services are not an expansion of ~~SoonerCare covered~~SoonerCare-covered services, but an option for the delivery of certain covered services. However, if there are technological difficulties in performing an objective, thorough medical assessment, or problems in the member's understanding of telehealth, hands-on-assessment and/or ~~in person~~in-person care must be provided for the member. Any service delivered using telehealth technology must be appropriate for telehealth delivery and be of the same quality and otherwise on par with the same service delivered in person. A telehealth encounter must ~~comply with the Health Information Portability and Accountability Act (HIPAA)~~maintain the confidentiality and security of protected health information in accordance with applicable state and federal law, including, but not limited to, 42 Code of Federal Regulations (CFR) Part 2, 45 CFR Parts 160 and 164, and 43A Oklahoma Statutes (O.S.) § 1-109. For purposes of SoonerCare reimbursement, telehealth is the use of interactive audio, video, or other electronic media for the purpose of diagnosis, consultation, or treatment that ~~occur~~occurs in real-time and when the member is actively participating during the transmission. ~~Telehealth does not include the use of audio only telephone, electronic mail or facsimile transmission.~~

(c) ~~**Conditions**~~**Requirements.** The following ~~conditions~~requirements apply to all services rendered via telehealth.

(1) Interactive audio and video telecommunications must be used, permitting encrypted, real-time communication between the physician or practitioner and the SoonerCare member. The telecommunication service must be secure and adequate to protect the confidentiality and integrity of the telehealth information transmitted. As a condition of payment the member must actively participate in the telehealth visit.

(2) The telehealth equipment and transmission speed and image must be technically sufficient to support the service billed. If a peripheral diagnostic scope is required to assess the member, it must provide adequate resolution or audio quality for decision making. Staff involved in the telehealth visit need to be trained in the use of the telehealth equipment and competent in its operation.
(3) The medical or behavioral health related service must be provided at an appropriate site for the delivery of telehealth services. An appropriate telehealth site is one that has the proper security measures in place; the appropriate administrative, physical, and technical safeguards should be in place that ensures the confidentiality, integrity, and security of electronic protected health information. The location of the room for the encounter at both ends should ensure comfort, privacy, and confidentiality. Both visual and audio privacy are important, and the placement and selection of the rooms should consider this. Appropriate telehealth equipment and networks must be used considering factors such as appropriate screen size, resolution, and security. Providers and/or members may provide or receive telehealth services outside of Oklahoma when medically necessary; however, prior authorization may be required, per OAC 317:30-3-89 through 317:30-3-91.
(4) The provider must be contracted with SoonerCare and appropriately licensed ~~for the service to be provided.~~or certified, in good standing. Services that are provided must be within the scope of the practitioner's license or certification. If the provider is outside of Oklahoma, the provider must comply with all laws and regulations of the provider's location, including health care and telehealth requirements.
(5) ~~If the member is a minor child, a parent/guardian must present the minor child for telehealth services unless otherwise exempted by State or Federal law.~~If the member is a minor, the provider must obtain the prior written consent of the member's parent or legal guardian to provide services via telehealth, that includes, at a minimum, the name of the provider; the provider's permanent business office address and telephone number; an explanation of the services to be provided, including the type, frequency, and duration of services. Written consent must be obtained annually, or whenever there is a change in the information in the written consent form, as set forth above. The ~~parent/guardian~~parent or legal guardian need not attend the telehealth session unless attendance is therapeutically appropriate. The requirements of subsection

OAC 317:30-3-27(c)(5), however, do not apply to telehealth services provided in a primary or secondary school setting.

(6) If the member is a minor, the telehealth provider shall notify the parent or legal guardian that a telehealth service was performed on the minor through electronic communication whether a text message or email.

~~(6)~~(7) The member retains the right to withdraw at any time.

~~(7)~~(8) All telehealth activities must comply with ~~the HIPAA Security Standards, OHCA~~Oklahoma Health Care Authority (OHCA) policy, and all other applicable State and Federal laws and regulations, including, but not limited to, 59 O.S. § 478.1.

~~(8)~~(9) The member has access to all transmitted medical information, with the exception of live interactive video as there is often no stored data in such encounters.

~~(9)~~(10) There will be no dissemination of any member images or information to other entities without written consent from the member or member's parent or legal guardian, if the member is a minor.

(11) A telehealth service is subject to the same SoonerCare program restrictions, limitations, and coverage which exist for the service when not provided through telehealth; provided, however, that only certain telehealth codes are reimbursable by SoonerCare. For a list of the SoonerCare-reimbursable telehealth codes, refer to the OHCA's Behavioral Health Telehealth Services and Medical Telehealth Services, available on OHCA's website, www.okhca.org.

(12) Where there are established service limitations, the use of telehealth to deliver those services will count towards meeting those noted limitations. Service limitations may be set forth by Medicaid and/or other third party payers.

(d) **Additional requirements specific to telehealth services in a school setting.** In order for OHCA to reimburse medically necessary telehealth services provided to SoonerCare members in a primary or secondary school setting, all of the requirements in (c) above must be met, with the exception of (c)(5), as well as all of the requirements shown below, as applicable.

(1) **Consent requirements.** Advance parent or legal guardian consent for telehealth services must be obtained for minors, in accordance with 25 O.S. §§ 2004 through 2005. Additional consent requirements shall apply to school-based services provided pursuant to an IEP, per OAC 317:30-5-1020.

(2) **Notification requirements.** For telehealth medical services provided in a primary or secondary school setting, the telehealth practitioner must provide a summary of the service, including, but not limited to, information regarding the exam

findings, prescribed or administered medications, and patient instructions, to:

(A) The SoonerCare member, if he or she is an adult, or the member's parent or legal guardian, if the member is a minor; or

(B) The SoonerCare member's primary care provider, if requested by the member or the member's parent or legal guardian.

(3) **Requirements specific to physical therapy, occupational therapy, and/or speech and hearing services.** Even though physical therapy, occupational therapy, and/or speech and hearing services are not subject to the notification requirements of OAC 317:30-3-27(d)(2), said services must still comply with all other State and Federal Medicaid requirements, in order to be reimbursable by Medicaid. Accordingly, for those physical therapy, occupational therapy, and/or speech and hearing services that are provided in a primary or secondary school setting, but that are not school-based services (i.e., not provided pursuant to an IEP), providers must adhere to all state and federal requirements relating to prior authorization and prescription or referral, including, but not limited to, 42 C.F.R. § 440.110, OAC 317:30-5-291, 317:30-5-296, and 317:30-5-676.

~~(d)~~ (e) **Reimbursement.**

(1) Health care services delivered by telehealth such as Remote Patient Monitoring, Store and Forward, or any other telehealth technology, must be compensable by OHCA in order to be reimbursed.

(2) Services provided by telehealth must be billed with the appropriate modifier.

(3) If the technical component of an X-ray, ultrasound or electrocardiogram is performed during a telehealth transmission, the technical component can be billed by the provider that provided that service. The professional component of the procedure and the appropriate visit code should be billed by the provider that rendered that service.

(4) The cost of telehealth equipment and transmission is not reimbursable by SoonerCare.

~~(e)~~ (f) **Documentation.**

(1) Documentation must be maintained by the rendering provider to substantiate the services rendered.

(2) Documentation must indicate the services were rendered via telehealth, and the location of the services.

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

(A) Chart notes;
(B) Start and stop times;
(C) Service provider's credentials; and
(D) Provider's signature.

~~(f)~~(g) **Final authority.** The OHCA has discretion and the final authority to approve or deny any telehealth services based on agency and/or SoonerCare members' needs.

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

**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**

**PART 9. LONG-TERM CARE FACILITIES**

**317:30-5-132. Cost reports**

Each Medicaid-participating ~~long term~~long-term care facility is required to submit an annual uniform cost report, designed by ~~OHCA,~~the Oklahoma Health Care Authority (OHCA), for the state fiscal year just completed. The state fiscal year is July 1 through June 30. The reports must be submitted to the OHCA on or before ~~the last day of October of the subsequent year.~~ October 31st following the end of the state fiscal year just completed.

(1) The report must be prepared on the basis of generally accepted accounting principles and the accrual basis of accounting, except as otherwise specified in the cost report instructions. The OHCA's cost report instructions are publicly available on the OHCA's website (www.okhca.org), in the Nursing Home Cost Report Instruction Manual: A Guide for Entering Annual Nursing Home Cost Report Data via the OHCA Secure Site (hereinafter referred to as "Cost Report Instruction Manual").

(2) The cost report must be filed using the Secure Website~~.~~, ~~The instructions and data entry screen simulations will be made available on the OHCA public website.~~ as set forth in the Cost Report Instruction Manual.

(3) When there is a change of operation or ownership, the selling or closing ownership is required to file a cost report for that portion of the fiscal year it was in operation. The successor ownership is correspondingly required to file a cost report for that portion of the fiscal year it was in operation. These "Partial Year Reports" must be filed on paper or electronically by e-mail (not on the ~~secure website~~Secure Website system) to the Finance Division of the OHCA on the forms and by the instructions found ~~on the OHCA public website (see directions as noted above).~~in the Cost Report Instruction Manual.

(4) ~~Normally, all ordinary and necessary expenses net of any offsets of credits incurred in the conduct of an economical and efficiently operated business are recognized as allowable. Allowable costs include all items of Medicaid-covered expense which nursing facilities incur in the provision of routine services. "Routine services" include, but are not limited to, regular room, dietary and nursing services, minor medical and surgical supplies, over-the-counter medications, transportation, dental examinations, dentures and related~~

~~services, eye glasses, routine eye examinations, and the use and maintenance of equipment and facilities essential to the provision of routine care. Allowable costs must be considered reasonable, necessary and proper, and shall include only those costs that are considered allowable for Medicare purposes and that are consistent with federal Medicaid requirements. (The guidelines for allowable costs in the Medicare program are set forth in the Medicare Provider Reimbursement Manual ("PRM"), HCFA-Pub. 15.). Ancillary items reimbursed outside the nursing facility rate are not included in the cost report and are not allowable costs.~~A long-term care facility may request an extension of time to submit an annual cost report, not to exceed fifteen (15) calendar days. Extensions of time shall be requested by a letter addressed to the Finance Division or by email, as is set forth in the Cost Report Instruction Manual. Any such request must be received by October 31, and must explain the good faith reason for the extension. OHCA shall provide a written notice of any denial of a request for an extension, which shall become effective on the date it is sent to the long-term care facility. Decisions to deny requests for extensions are solely within the discretion of the OHCA and are not administratively appealable.

(5) All reports ~~are~~may be subject to on-site audits~~ and are deemed public records~~. An on-site audit may result in cost adjustment(s), by which the OHCA, or its designee, identifies and corrects for costs that were included in the cost report. The OHCA or its designee shall provide written notice of any cost adjustment(s) it makes to a cost report, to the long-term care facility affected by the cost adjustment(s). Such notice shall contain, but is not limited to, a written list of the audit findings with a summary explanation of why any cost is deemed non-allowable.

(6) In accordance with 63 Oklahoma Statute § 1-1925.2, a long-term care facility may contest any cost adjustment(s) it disagrees with by requesting reconsideration of the cost adjustment(s), and/or by requesting an administrative appeal of the cost adjustment(s), pursuant to Oklahoma Administrative Code (OAC) 317:30-5-132.1 and OAC 317:2-1-17, respectively.

**317:30-5-132.1. Reconsideration of cost report adjustments**

(a) A long-term care facility may request reconsideration of cost report adjustment(s)/finding(s) within thirty (30) calendar days of the date of notification of the cost adjustment(s) by submitting a request for reconsideration to the Oklahoma Health Care Authority (OHCA), Chief Financial Officer (CFO), Finance/NF Cost Reporting, 4345 North Lincoln Boulevard, Oklahoma City, Oklahoma 73105.

(b) Simultaneous with the request for reconsideration, the long-term care facility shall submit a statement as to why the request for reconsideration is being made and may submit any new or additional information that he or she wishes the CFO or his/her designee to consider. Any request for an informal meeting according to subsection (c), below, must be made at the same time as the request for reconsideration.

(c) At the request of the long-term care facility, the reconsideration may be conducted by the CFO or his/her designee as:

(1) An informal meeting between the long-term care facility and the CFO or his/her designee; or

(2) A review by the CFO or his/her designee of the information described below:

(A) A review of all information submitted by the long-term care facility; and,

(B) A review of the cost report adjustments made by the OHCA, in order to determine the accuracy of the adjustments.

(d) The CFO or his/her designee shall send a written decision of the reconsideration to the long-term care facility within thirty (30) calendar days of the date of OHCA's receipt of the reconsideration request, or the date of any informal meeting, whichever occurs later.

(e) If the provider disagrees with the decision rendered by the CFO or his or her designee, the provider may utilize the administrative appeals process in accordance with Oklahoma Administrative Code 317:2-1-17.

**317:30-5-132.2. Allowable costs**

The Oklahoma Health Care Authority (OHCA) shall reimburse long-term care facilities in accordance with its federally-approved Oklahoma Medicaid Plan. According to the Oklahoma Medicaid Plan, per-diem rates for long-term care facilities are established on, among other things, analyses of annual uniform cost reports. These reports may only include allowable costs, as follows:

(1) To be allowable, the costs shall be reasonable and necessary for services related to resident care, and pertinent to the operation of the long-term care facility. More specifically:

(A) To be reasonable, costs shall be such as would ordinarily be incurred for comparable services provided by comparable facilities, for example, facilities of similar size and level of care; and

(B) To be necessary, costs related to patient care must be common and accepted occurrences; and,

(C) Allowable costs for services and items directly related to resident care include routine services, as established by Oklahoma Administrative Code (OAC) 317:30-5-133.1, and

quality of care assessment fees, as established by OAC 317:30-5-131.2. Ancillary services, as established by OAC 317:30-5-133.2, are not allowable costs, but may be reimbursed outside the long-term care facility rate, unless reimbursement is available from Medicare or other insurance or benefit programs.

(2) The following costs shall not be allowable:

(A) Costs resulting from inefficient operations;

(B) Costs resulting from unnecessary or luxurious care;

(C) Costs related to activities not common and accepted in a long-term care facility, as determined by OHCA or its designee;

(D) Costs that are not actually paid by the provider, including, but not limited to, costs that are discharged in bankruptcy; forgiven; or converted to a promissory note;

(E) Costs that are paid to a related party that has not been identified on the reports;

(F) Cost of services, facilities, and supplies furnished by organizations related to the provider, by common ownership or control, that exceed the price of comparable services, facilities, or supplies purchased by independent providers in Oklahoma, in accordance with 42 Code of Federal Regulations § 413.17; and,

(G) Costs or financial transactions used to circumvent OHCA's applicable reimbursement rules.

(3) Allowable costs shall include only those costs that are considered allowable for Medicare purposes and that are consistent with federal Medicaid requirements. The guidelines for allowable costs in the Medicare program are set forth in the Medicare Provider Reimbursement Manual, HCFA-Pub. 15.

**317:30-5-136.1. ~~Focus on Excellence~~Pay-for-Performance program**

(a) **Purpose.** The ~~Focus on Excellence (FOE)~~Pay-for-Performance (PFP) program was established through Oklahoma State Statute, Title 56, Section 56-1011.5~~.~~ as amended. ~~FOE's~~PFP's mission is to enhance the quality of life for target citizens by delivering effective programs and facilitating partnerships with providers and the community they serve. The program has a full commitment to the very best in quality, service and value which will lead to measurably improved quality outcomes, healthier lifestyles; greater satisfaction and confidence for our members.

(b) **Eligible Providers.** Any Oklahoma long-term care nursing facilities that are licensed and certified by the Oklahoma State Department of Health and accommodate SoonerCare members at their facility as defined in Oklahoma Administrative Code (OAC) 317:30-5-120.

(c) **Quality measure care criteria.** To maintain status in the ~~FOE~~PFP program, each nursing facility ~~must enter quality data either monthly, quarterly, annually for the following care criteria metrics. All metrics in detail can be found on the Oklahoma Health Care Authority's (OHCA) FOE website or on FOE/QOC (Quality of Care) Data Collection Portal.~~shall submit documentation as it relates to program metrics (below) quarterly or upon the request of the Oklahoma Health Care Authority (OHCA). The program metrics can be found on the OHCA's PFP website or on PFP/Quality of Care (QOC) data collection portal. For the period beginning October 1, 2019 and until changed by amendment, qualifying facilities participating in the PFP program have the potential to earn an average of the five dollars ($5.00) quality incentive per Medicaid patient per day. Facility(s) baseline is calculated annually and will remain the same for the twelve (12) month period. Facility(s) will meet or exceed five-percent (5%) relative improvement or the Centers for Medicare and Medicaid Services national average each quarter for the following metrics:

(1) Decrease percent of high risk pressure ulcers for long stay residents.

(2) Decrease percent of unnecessary weight loss for long stay residents.

(3) Decrease percent of use of anti-psychotic medications for long stay residents.

(4) Decrease percent of urinary tract infection for long stay residents.

~~(1) **Person-Centered Care.** Facility must meet six (6) out of ten (10) of the established measurement criteria for this metric to receive the points. This metric is measured quarterly and must be completed by the 15th of the month following the close of the quarter.~~

~~(2) **Direct-Care Staffing.** Facility must maintain a direct care staffing ratio of three and a half (3.5) hours per patient day to receive the points for this metric. This metric must be completed monthly by the 15th of each month.~~

~~(3) **Resident/Family Satisfaction.** Facility must maintain a score of 76 of a possible 100 points on overall satisfaction to receive the points for this metric. This metric is collected in a survey format and must be completed once a year in the fall. Surveys are to be completed by the resident, power of attorney and/or with staff assistance.~~

~~(4) **Employee Satisfaction.** Facility must maintain a score of 70 points or higher in order to receive the points for this metric. Surveys are completed by FOE facility employees and must be completed once a year in the fall.~~

~~(5) **Licensed-Nurse Retention.** Facility must maintain a one-year tenure rate of 60 percent (60%) or higher of its licensed~~

~~nursing staff to receive the points for this metric. This metric must be completed monthly by the 15th of the month.~~

~~(6) **Certified Nurse Assistant (CNA) Retention.** Facility must maintain a one-year tenure rate of 50 percent (50%) or higher of its CNA staff to receive the points for this metric. This metric must be completed monthly by the 15th of the month.~~

~~(7) **Distance Learning Program Participation.** Facility must contract and use an approved distance learning vendor for its frontline staff in order to receive points for this metric. This metric is measured quarterly and must be completed by the 15th of the month following the close of the quarter.~~

~~(8) **Peer Mentoring.** Facility must establish a peer-mentoring program in accordance with OHCA guidelines. This metric is measured quarterly and must be completed by the 15th of the month following the close of the quarter.~~

~~(9) **Leadership Commitment.** Facility must meet six (6) out of ten (10) of the established measurement criteria for this metric to receive the points. This metric is measured quarterly and must be completed by the 15th of the month following the close of the quarter.~~

(d) **Payment.** ~~The amount of eligible dollars is reimbursable based on the SoonerCare FOE nursing facility meeting the quality metric thresholds listed in (b). Facilities must meet a minimal of 100 points to even be eligible for reimbursement.~~Payment to long-term care facilities for meeting the metrics will be awarded quarterly. A facility may earn a minimum of $1.25 per Medicaid patient per day for each qualifying metric. A facility receiving a deficiency of "I" or greater related to a targeted quality measure in the program is disqualified from receiving an award related to that measure for that quarter.

(1) **Distribution of Payment.** OHCA will notify the ~~FOE~~PFP facility of the quality reimbursement amount on a quarterly basis.

(2) **Penalties.** Facilities ~~that do not submit on the appropriate due dates will not receive reimbursable dollars. Facilities that do not submit quality measures will not receive reimbursable dollars for those specific measures. Due dates can be found on the OHCA FOE webpage.~~shall have performance review(s) and provide documentation upon request from OHCA to maintain program compliance. Program payments will be withheld from facilities that fail to submit the requested documentation within fifteen (15) business days of the request.

(e) **Appeals.** Facilities can file an appeal with the Quality Review Committee and in accordance, with the grievance procedures found at OAC 317:2-1-2(c) and 317:2-1-16.

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

**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**

**PART 83. ~~RESIDENTIAL BEHAVIOR MANAGEMENT SERVICES~~THERAPEUTIC FOSTER CARE**

**317:30-5-740. ~~Eligible providers~~Definitions**

~~(a) **Definitions.**~~ The following words or terms used in this Part shall have the following meaning, unless the context clearly indicates otherwise:

~~(1) **Therapeutic foster care (TFC) agencies.** A foster care agency is an agency that provides foster care as defined in the Code of Federal Regulations (CFR) as "24-hour substitute care for children outside their own homes." Therapeutic foster care settings are foster family homes.~~

~~(2) **Therapeutic foster care homes.** Agency-supervised private family homes in which foster parents have been trained to provide individualized, structured services in a safe, nurturing family living environment for children and adolescents with significant emotional or behavioral problems who require a higher level of care than is found in a conventional foster home but do not require placement in a more restrictive setting. Therapeutic foster care homes are considered the least restrictive out-of-home placement for children with severe emotional disorders.~~

~~(b) **TFC Agency Requirements.** Eligible TFC agencies must have:~~

~~(1) current certification from the Oklahoma Department of Human services (OKDHS) as a child placing agency;~~

~~(2) a contract with the Division of Children and Family Services of the Oklahoma Department of Human Services, or OJA;~~

~~(3) a contract with the Oklahoma Health Care Authority; and~~

~~(4) a current accreditation status appropriate to provide behavioral health services in a foster care setting from:~~

~~(A) The Joint Commission formerly the Joint Commission on Accreditation (JCAHO), or~~

~~(B) the Rehabilitation Accreditation Commission (CARF), or~~

~~(C) the Council on Accreditation (COA), or~~

~~(D) the American Osteopathic Association (AOA).~~

(1) **"Therapeutic foster care (TFC) agency"** means a foster care agency that provides foster care as defined in Section 1355.20 of Title 45 of the Code of Federal Regulation as twenty-four (24) hour substitute care for children placed away from their parents or guardians and for whom the title IV-E agency has placement and care responsibility. TFC settings are foster family homes.

(2) **"TFC home"** means an agency-supervised, private family home in which foster parents have been trained to provide individualized, structured services in a safe, nurturing family-living environment. The children receiving services in this setting have moderate behavioral and emotional health needs, and may also present secondary physical, developmental, intellectual, and/or social disorder that is supported alongside the mental health needs. TFC homes are considered the least restrictive out-of-home placement for these children.

(3) **"Therapeutic foster care (TFC) model"** means a model in which children in the TFC environment receive increased individualized behavioral health and other support services from qualified staff. Because TFC members require exceptional levels of skill, time, and supervision, the number of unrelated children placed per home is limited; no more than two (2) TFC members may be placed in a home at any one (1) time unless additional cases are specifically authorized by Child Welfare Services (CWS) of the Oklahoma Department of Human Services (OKDHS), or Oklahoma Office of Juvenile Affairs (OJA).

**317:30-5-740.1. ~~Provider qualifications and requirements~~Eligible providers and requirements**

~~(a) **Therapeutic foster care model.** Children in the TFC environment receive intensive individualized behavioral health and other support services from qualified staff. Because TFC children require exceptional levels of skill, time and supervision, the number of unrelated children placed per home is limited; no more than two TFC children in a home at any one time unless additional cases are specifically authorized by OKDHS, Division of Children and Family Services or OJA.~~

~~(b) **Treatment team.** TFC agencies are primarily responsible for treatment planning and coordination of the child's treatment team. This team is typically composed of an OKDHS or OJA caseworker, the child, the child's parents, others closely involved with the child and family. It also includes the following:~~

~~(1) **Certified Behavioral Health Case Manager II (CM).** A bachelors level team member that may provide support services and case management. In addition to the minimum requirements at OAC 317:30-5-240.3 (c), the CM must have:~~

~~(A) a minimum of one year of experience in providing direct care and/or treatment to children and/or families, and~~

~~(B) have access to weekly consultation with a licensed behavioral health professional or Licensure Candidate.~~

~~(C) CM must also follow requirements at OAC 317:30-5-241.3 for providing psychosocial rehabilitation services.~~

~~(2) **Licensed Behavioral Health Professional (LBHP).** A masters level professional that provides treatment and supervision for~~

~~the treatment staff to maintain clinical standards of care and provide direct clinical services. In addition to the requirements at OAC 317:30-5-240.3(a) and (b), the LBHP or Licensure Candidate in a TFC setting must demonstrate a general professional or educational background in the following areas:~~

~~(A) case management, assessment and treatment planning;~~

~~(B) treatment of victims of physical, emotional, and sexual abuse;~~

~~(C) treatment of children with attachment disorders;~~

~~(D) treatment of children with hyperactivity or attention deficit disorders;~~

~~(E) treatment methodologies for emotionally disturbed children and youth;~~

~~(F) normal childhood development and the effect of abuse and/or neglect on childhood development;~~

~~(G) anger management;~~

~~(H) crisis intervention; and~~

~~(I) trauma informed methodology.~~

~~(3)~~ **~~Licensed Psychiatrist and/or psychologist.~~** ~~TFC agencies must provide staff with access to professional psychiatric or psychological consultation as deemed necessary for the planning, implementation and appropriate management of the resident's treatment. See OAC 317:30-5-240.3(a) and OAC 317:25-275.~~

~~(4)~~ **~~Treatment Parent Specialist (TPS).~~** ~~The TPS serve as integral members of the team of professionals providing services for the child. The TPS receives special training in mental health issues, behavior management and parenting techniques; and implements the in-home portion of the treatment plan with close supervision and support. They provide services for the child, get the child to therapy and other treatment appointments, write daily notes about interventions and attend treatment team meetings. The TPS must be under the supervision of a licensed behavioral health professional of the foster care agency and meet the following criteria:~~

~~(A) have a high school diploma or equivalent;~~

~~(B) have an employment relationship with the foster care agency as a foster parent complete with OSBI and OKDHS background screening;~~

~~(C) completion of therapeutic foster parent training outlined in this section;~~

~~(D) have a minimum of twice monthly face to face supervision with the licensed, or under-supervision for licensure, LBHP, independent of the child's family therapy;~~

~~(E) have weekly contact with the foster care agency professional staff; and~~

~~(F) complete required annual trainings.~~

~~(c) **Agency assurances.** The TFC agency must ensure that each individual that renders treatment services (whether employed by or contracted by the agency) meets the minimum provider qualifications for the service. Individuals eligible for direct enrollment must have a contract on file with the Oklahoma Health Care Authority.~~

~~(d) **Policies and Procedures.** Eligible TFC agency providers that are defined in section OAC 317:30-5-740(a) shall have written policies and procedures for the orientation of new staff and foster parents which is reviewed and updated annually, for the following:~~

~~(1) pre-service training of foster parents in treatment methodologies and service needs of emotionally and behaviorally disturbed children;~~

~~(2) treatment of victims of physical, emotional, and sexual abuse;~~

~~(3) treatment of children with attachment disorders;~~

~~(4) treatment of children with hyperactive or attention deficit disorders;~~

~~(5) normal childhood development and the effect of abuse and/or neglect on childhood development;~~

~~(6) treatment of children and families with substance use disorders;~~

~~(7) the Inpatient Mental Health and Substance Abuse Treatment of Minors Act;~~

~~(8) anger management;~~

~~(9) inpatient authorization procedures;~~

~~(10) crisis intervention;~~

~~(11) grief and loss issues for children in foster care;~~

~~(12) the significance/value of birth families to children receiving behavioral health services in a foster care setting; and~~

~~(13) trauma informed methodology.~~

(a) **TFC Agency.** Eligible TFC agencies must have:

(1) Current certification from the Oklahoma Department of Human Services (OKDHS) as a child placing agency;

(2) A contract with the Child Welfare Division of OKDHS, or Oklahoma Office of Juvenile Affairs (OJA);

(3) A contract with the Oklahoma Health Care Authority (OHCA); and

(4) A current accreditation status appropriate to provide behavioral health services in a foster care setting from:

(A) The Joint Commission; or

(B) The Commission on Accreditation of Rehabilitative Facilities (CARF); or

(C) The Council on Accreditation (COA).

(b) **Treatment team.** TFC agencies are primarily responsible for treatment planning and coordination of the member's treatment

team. This team is typically composed of an OKDHS or OJA caseworker, the member, the member's foster parent(s), as well as others closely involved with the member and family, including the biological parents when applicable.

(1) The team must include the following providers:

(A) **Licensed behavioral health professional (LBHP) and/or licensure candidate.** An LBHP is a master's level professional that provides treatment and supervises other treatment staff in maintaining clinical standards of care and providing direct clinical services. A licensure candidate is a practitioner actively and regularly receiving board-approved supervision, or extended supervision by a fully-licensed clinician if the board's supervision requirement is met but the individual is not yet licensed. In addition to the requirements at OAC 317:30-5-240.3(a) and (b), the LBHP or licensure candidate in a TFC setting must demonstrate a general professional or educational background in the following areas:

(i) Case management, assessment, and treatment planning;

(ii) Treatment of victims of physical, emotional, and sexual abuse;

(iii) Treatment of children with attachment disorders;

(iv) Treatment of children with hyperactivity or attention deficit disorders;

(v) Treatment methodologies for emotionally disturbed children;

(vi) Normal childhood development and the effect of abuse and/or neglect on childhood development;

(vii) Anger management;

(viii) Crisis intervention; and

(ix) Trauma-informed methodology.

(B) **Treatment parent specialist (TPS).** The TPS serves as an integral member of the team of professionals providing services for the member. The TPS receives extensive training in diagnosed mental health issues, and behavior management/modification and skill-based parenting techniques; and implements the in-home portion of the treatment plan with close supervision and support. The TPS renders services for the member, provides or arranges suitable transportation for therapy and other treatment appointments, writes daily detailed notes regarding interventions and practical applications of learned skills, and attends treatment team meetings. The TPS must be under the supervision of an LBHP or licensure candidate of the foster care agency and meet the following criteria:

(i) **Qualifications.**

(I) Have a high school diploma or equivalent;

(II) Have an employment and/or contractual relationship with the foster care agency as a foster parent, and have successfully met all required background screening requirements, including, but not limited to, fingerprint screenings conducted by the Oklahoma State Bureau of Investigation (OSBI) and Federal Bureau of Investigation (FBI), and OKDHS background screenings;

(III) Complete the initial thirty-six (36) hours of pre-service training, prior to becoming a TFC parent;

(ii) **Responsibilities.**

(I) Have a minimum of twice monthly face-to-face supervision with the licensed, or under-supervision for licensure, LBHP, independent of the member's family therapy;

(II) Have weekly contact with the foster care agency professional staff;

(III) Complete the required eighteen (18) hours of in-service training per calendar year; and

(IV) Work with the multidisciplinary team and the member's biological family toward reunification, if appropriate, or other permanency plan.

(2) The team may also include the following providers:

(A) **Certified alcohol and drug counselor (CADC).** A bachelor's level team member with a current certification as a CADC in the state in which services are provided.

(B) **Certified behavioral health case manager (CM) II.** A bachelor's level team member that may provide support services and case management. In addition to the minimum requirements at Oklahoma Administrative Code (OAC) 317:30-5-240.3(h)(1), the CM II must:

(i) Have a minimum of one (1) year of experience in providing direct care and/or treatment to children and/or families; and

(ii) Have access to weekly consultation with a licensed behavioral health professional (LBHP) or licensure candidate.

(iii) The CM II must also follow requirements at OAC 317:30-5-241.3 for providing psychosocial rehabilitation (PSR) services.

(C) **Licensed psychiatrist and/or psychologist.** TFC agencies must provide staff with access to professional psychiatric or psychological consultation as deemed necessary for the planning, implementation, and appropriate management of the member's treatment. See OAC 317:30-5-240.3(a) and 317:25-7-5.

(c) **Agency assurances.** The TFC agency must ensure that each

individual who renders treatment services meets the minimum provider qualifications for the service and, if eligible for direct enrollment, is fully contracted with the OHCA. Additionally, the TFC agency must comply with all state and federal Medicaid law, including, but not limited to, OHCA administrative rules, the Code of Federal Regulations (C.F.R.), and the Oklahoma State Medicaid Plan.

(d) **Policies and procedures.** Eligible TFC agency providers shall have written policies and procedures for the orientation of new staff and foster parents which is reviewed and updated annually, for the following:

(1) Pre-service training of foster parents in treatment methodologies and service needs of emotionally and behaviorally disturbed children;

(2) Treatment of victims of physical, emotional, and sexual abuse;

(3) Treatment of children with attachment disorders;

(4) Treatment of children with hyperactive or attention deficit disorders;

(5) Normal childhood development and the effect of abuse and/or neglect on childhood development;

(6) Treatment of children and families with substance use disorders;

(7) The Inpatient Mental Health and Substance Abuse Treatment of Minors Act;

(8) Anger management;

(9) Inpatient authorization procedures;

(10) Crisis intervention;

(11) Grief and loss issues for children in foster care;

(12) The significance/value of birth families to children receiving behavioral health services in a foster care setting; and

(13) Trauma-informed methodology.

**317:30-5-740.2. Provider selection**

~~Parents who retain legal custody of a client may select any eligible contractor as the provider of services. In the case of children in the custody of the State of Oklahoma, the State, acting in its custodial role, selects the provider agency.~~Parents who retain legal custody of a TFC child may select any eligible TFC agency as the provider of services. In the case of members in the custody of the State of Oklahoma, the State, acting in its custodial role, selects the TFC agency.

**317:30-5-741. Coverage by category**

~~(a) **Adults.** Behavioral health services in therapeutic foster care settings are not covered for adults.~~

~~(b) **Children.** Behavioral health services are allowed in therapeutic foster care settings for certain children and youth as medically necessary. The children and youth receiving services in this setting have special psychological, social and emotional needs, requiring more intensive, therapeutic care than can be found in the traditional foster care setting. The designated children and youth must continually meet medical necessity criteria to be eligible for coverage in this setting.~~

~~(c) **Medical necessity criteria.** Medical necessity criteria is delineated as follows:~~

~~(1) A diagnosis from the most recent edition of "The Diagnostic and Statistical Manual of Mental Disorders" (DSM), with the exception of V codes and adjustment disorders, with a detailed description of the symptoms supporting the diagnosis. Children with a provisional diagnosis may be admitted for a maximum of 30 days. An assessment must be completed by a Licensed Behavioral Health Professional (LBHP) or Licensure Candidate as defined in OAC 317:30-5-240.3(a) and (b) within the 30 day period resulting in a diagnosis from the most recent edition of "the Diagnostic and Statistical Manual of Mental Disorders"(DSM) with the exception of V codes and adjustments disorders, with a detailed description of the symptoms supporting the diagnosis to continue RBMS in a foster care setting.~~

~~(2) Conditions are directly attributed to a mental illness/serious emotional disturbance as the primary need for professional attention.~~

~~(3) It has been determined by the inpatient authorization reviewer that the current disabling symptoms could not have been or have not been manageable in a less intensive treatment program.~~

~~(4) Evidence that the child's presenting emotional and/or behavioral problems prohibit full integration in a family/home setting without the availability of 24 hour crisis response/behavior management and intensive clinical interventions from professional staff, preventing the child from living in a traditional family home.~~

~~(5) The child is medically stable and not actively suicidal or homicidal and not in need of substance abuse detoxification services.~~

~~(6) The legal guardian/parent of the child (OKDHS/OJA if custody child) agrees to actively participate in the child's treatment needs and planning.~~

(a) **Adults.** Behavioral health services in TFC settings are not covered for adults.

(b) **Children.** Behavioral health services are allowed in TFC settings for children under twenty-one (21) as medically

necessary. Members receiving services in this setting have moderate behavioral and emotional health needs, and may also present secondary physical, developmental, intellectual, and/or social disorder that is supported alongside the mental health needs. The designated members must continually meet medical necessity criteria to be eligible for coverage in this setting. Requests for behavioral health services in a TFC setting must be prior authorized and may be approved up to a maximum of six (6) month extensions.

(c) **Medical necessity criteria**. In order to satisfy medical necessity criteria, all of the following conditions must be met:

(1) The member must have a diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM-V), with the exception of V codes and adjustment disorders, with a detailed description of the symptoms supporting the diagnosis. Members with a provisional diagnosis may receive TFC services for a maximum of thirty (30) days.

(2) An assessment must be completed by a licensed behavioral health professional (LBHP) or licensure candidate as defined in Oklahoma Administrative Code (OAC) 317:30-5-240.3(a) and (b) within the thirty (30) day provisional period described above, that confirms a diagnosis from the DSM-V with the exception of V codes and adjustments disorders, and that includes a detailed description of the symptoms supporting the diagnosis to continue treatment in a TFC setting.

(3) Conditions are directly attributed to moderate behavioral and emotional needs as the primary need for professional attention.

(4) The current disabling symptoms could not have been/have not been manageable in a less intensive treatment program, or the level of care is warranted in order to reduce the risk of regression of symptoms and/or sustain the gains made at a higher level of care.

(5) Evidence that the members' needs prohibit full integration in a family/home setting without the availability of twenty-four (24) hour crisis response/behavior management and clinical interventions from professional staff, preventing the member from living in a traditional family home.

(6) The member is medically stable and not actively suicidal or homicidal and not in need of substance abuse detoxification services.

(7) The legal guardian [Oklahoma Department of Human Services (OKDHS)/ Oklahoma Office of Juvenile Affairs (OJA) if custody member] or parent of the member agrees to actively participate in the member's treatment needs and planning.

**317:30-5-742. Description of services**

~~(a) Treatment services must be provided in the least restrictive, non-institutional therapeutic milieu. The foster care setting is restorative in nature, allowing children with emotional and psychological problems to develop the necessary control to function in a less restrictive setting.~~
~~(b) Behavioral health services must include an individual plan of care for each member served. The individual plan of care requirements are set out in OAC 317:30-5-742.2(b)(1). Treatment services in a therapeutic foster care setting may include an array of services listed in (1) - (6) of this subsection as provided in the individual plan of care. Services include, but may not be limited to:~~

~~(1) Individual, family and group therapy;~~
~~(2) Substance abuse/chemical dependency education, prevention, and therapy;~~
~~(3) Psychosocial rehabilitation and support services;~~
~~(4) Behavior management~~
~~(5) Crisis intervention; and~~
~~(6) Case Management.~~

(a) Treatment services must be provided in the least restrictive, non-institutional therapeutic environment. The TFC setting is restorative in nature, allowing members with moderate behavioral and emotional health needs who may also have a secondary physical, developmental, intellectual, and/or social disorder that is supported alongside the mental health needs to develop the necessary control to function in a less restrictive setting.
(b) Behavioral health services must include an individual plan of care (IPC) for each member served. The IPC requirements are set out in Oklahoma Administrative Code (OAC) 317:30-5-742.2.
(c) Treatment services in a TFC setting must include at least one (1) hour of individual, family, and/or group therapy per week, as set forth in OAC 317:30-5-742.2(3). Treatment may also include, but is not limited to, an array of the following services:

(1) Substance abuse/chemical dependency education, prevention, and therapy;
(2) Psychosocial rehabilitation and support services;
(3) Behavior management;
(4) Crisis intervention; and
(5) Case management.

**317:30-5-742.1. Reimbursement**

~~Services provided to a member without a written individual plan of care as described in OAC 317:30-5-742.2(b)(1) will not be reimbursed.~~
(a) TFC services will be paid at the current fee-for-service (FFS) rate. Services provided to a member without a written individual plan of care (IPC) as described in Oklahoma Administrative Code

(OAC) 317:30-5-742.2 will not be reimbursed.
(b) Additional services may require prior authorization by the OHCA, or its designated agent. Refer to OAC 317:30-3-31. Documentation must be provided to ensure that services are not duplicative. If additional services are approved for a member in state custody, the Oklahoma Department of Human Services (OKDHS), or Oklahoma Office of Juvenile Affairs (OJA) will collaborate with the provider of such services as directed by the OHCA.
(c) Reimbursement for TFC services is not available for the following:
(1) Room and board;
(2) Educational costs;
(3) Supported employment;
(4) Inpatient psychiatric services;
(5) Respite care;
(6) Day treatment services;
(7) Partial hospitalization services; and
(8) Intensive outpatient services.
(d) Case management services are reimbursed to government providers as per the methodology in the approved Oklahoma Medicaid State Plan.

**317:30-5-742.2. Individual plan of care (IPC)** ~~**and prior authorization of services**~~

~~(a) All behavioral health services must be prior authorized by the designated agent of the Oklahoma Health Care Authority (OHCA) before the service is rendered by an eligible service provider. Without prior authorization, payment is not authorized. Requests for behavioral health services in a foster care setting may be approved for a maximum of three (3) months per extension request.~~
~~(b) All behavioral health services in a foster care setting are provided as a result of an individual assessment of the members needs and documented in the individual plan of care.~~

~~(1)~~**Assessment.**

~~(A)~~ **Definition.** ~~Gathering and assessment of historical and current bio-psycho-social information which includes face-to-face contact with the person and/or the person's family or other persons resulting in a written summary report, diagnosis and recommendations. All agencies must assess the medical necessity of each individual to determine the appropriate level of care.~~

~~(B)~~ **Qualified professional.** ~~This service is performed by an LBHP or Licensure Candidate.~~

~~(C)~~ **Limitations.** ~~Assessments are compensable on behalf of a member who is seeking services for the first time from the therapeutic foster care agency. This service is not compensable if the member has previously received or is~~

currently receiving services from the agency unless there has been a gap in service of more than six (6) months and it has been more than one (1) year since the previous assessment.

(D) **Documentation requirements.** The assessment must include all elements and tools required by the OHCA. In the case of children under the age of eighteen (18), it is performed with the direct, active face-to-face participation of the child and parent or guardian. The child's level of participation is based on age, developmental and clinical appropriateness. The assessment must include all related diagnoses from the most recent DSM edition. The assessment must contain but is not limited to the following:

(i) Date, to include month, day and year of the assessment session(s);

(ii) Source of information;

(iii) Member's first name, middle initial and last name;

(iv) Gender;

(v) Birth date;

(vi) Home address;

(vii) Telephone number;

(viii) Referral source;

(ix) Reason for referral;

(x) Person to be notified in case of emergency;

(xi) Presenting reason for seeking services;

(xii) Start and stop time for each unit billed;

(xiii) Dated signature of parent or guardian participating in the face-to-face assessment. Signatures are required for members over the age of fourteen (14);

(xiv) Bio-Psychosocial information which must include:

(I) Identification of the member's strengths, needs, abilities and preferences;

(II) History of the presenting problem;

(III) Previous psychiatric treatment history, include treatment for psychiatric; substance use; drug and alcohol addiction; and other addictions;

(IV) Health history and current biomedical conditions and complications;

(V) Alcohol, drug, and/or other addictions history;

(VI) Trauma, abuse, neglect, violence, and/or sexual assault history of self and/or others, including Department of Human Services (DHS) involvement;

(VII) Family and social history including psychiatric, substance use, drug and alcohol addiction, other addictions, and trauma/abuse/neglect;

(VIII) Educational attainment, difficulties and history;

(IX) Cultural and religious orientation;
(X) Vocational, occupational and military history;
(XI) Sexual history, including HIV, AIDS, and STD at-risk behaviors;
(XII) Marital or significant other relationship history;
(XIII) Recreation and leisure history;
(XIV) Legal or criminal record, including the identification of key contacts, (e.g. attorneys, probation officers);
(XV) Present living arrangements;
(XVI) Economic resources; and
(XVII) Current support system, including peer and other recovery supports.

(xv) Mental status and Level of Functioning information, including questions regarding but not limited to the following:
(I) Physical presentation, such as general appearance, motor activity, attention and alertness;
(II) Affective process, such as mood, affect, manner and attitude;
(III) Cognitive process, such as intellectual ability, social-adaptive behavior, thought processes, thought content, and memory; and
(IV) All related diagnoses from the most recent addition of the DSM.

(xvi) Pharmaceutical information to include the following for both current and past medications;
(I) Name of medication;
(II) Strength and dosage of medication;
(III) Length of time on the medication; and
(IV) Benefit(s) and side effects of medication.

(xvii) LBHP's interpretation of findings and diagnosis;
(xviii) Dated signature and credentials of the qualified practitioner who performed the face-to-face behavioral assessment. If performed by a licensure candidate, it must be countersigned by the licensed behavioral health professional who is responsible for the member's care.

(2) **Individual plan of care requirement.**

(A) **Signature Requirement.** A written individual plan of care following a comprehensive evaluation for each member must be formulated by the provider agency staff within thirty (30) days of admission with documented input from the member, legal guardian(OKDHS/Office of Juvenile Affairs (OJA) staff), the foster parent (when applicable) and the treatment provider(s). An individual plan of care is not valid until all dated signatures are present, including

~~signatures from the member (if fourteen (14) or over), the legal guardian, the foster parent (when applicable) and the treatment provider(s). If necessary, an individual plan of care may be faxed to a required signatory to have them review, sign and fax it back to the provider before its implementation; however, the provider must obtain the original signature for the clinical file within thirty (30) days. No stamped or photocopied signatures are allowed. This plan must be revised and updated every three (3) months with documented involvement of the legal guardian and resident.~~

~~(B) **Individualization.** The individual plan of care must be individualized and take into account the member's age, history, diagnosis, assessed functional levels, culture, and the effect of past and current traumatic experiences in the life of the member. It includes the member's documented diagnosis, appropriate goals, and corresponding reasonable and attainable objectives and action steps within the expected time lines. Each member's individual plan of care is to also address the provider agency's plans with regard to the provision of services. Each plan of care must clearly identify the type of services required to meet the child's treatment needs and frequency over a given period of time.~~

~~(C) **Qualified professional.** This service is performed by an LBHP or Licensure Candidate.~~

~~(D) **Time requirements.** Individual plan of care updates must be conducted face-to-face and are required every three (3) months during active treatment. However, updates can be conducted whenever it is clinically needed as determined by the qualified practitioner and member.~~

~~(E) **Documentation requirements.** Comprehensive and integrated service plan content must address the following:~~

~~(i) member strengths, needs, abilities, and preferences (SNAP);~~

~~(ii) identified presenting challenges, problems, needs and diagnosis;~~

~~(iii) specific goals for the member;~~

~~(iv) objectives that are specific, attainable, realistic, and time-limited;~~

~~(v) each type of service and estimated frequency to be received;~~

~~(vi) the practitioner(s) name and credentials that will be providing and responsible for each service;~~

~~(vii) any needed referrals for service;~~

~~(viii) specific discharge criteria; and~~

~~(ix) description of the member's involvement in, and responses to, the treatment plan, and his/her signature and date.~~

(F) **Amendments.** Amendment of an existing individual plan of care to revise or add goals, objectives, service provider, service type, and service frequency, must be documented in either a scheduled three (3) month plan update or within the existing individual plan of care through an addendum until the review/update is due. Any changes must, prior to implementation, be signed and dated by the member (if fourteen (14) or over), the legal guardian, the foster parent (if applicable), as well as the primary LBHP and any new provider(s). Individual plan of care updates must address the following:

(i) update to the bio-psychosocial assessment, re-evaluation of diagnosis, individual plan of care goals and/ or objectives;

(ii) progress, or lack of, on previous individual plan of care goals and/or objectives;

(iii) a statement documenting a review of the current individual plan of care and an explanation if no changes are to be made to the individual plan of care and a statement addressing the status of identified problem behaviors that lead to placement must be included;

(iv) change in goals and/or objectives (including target dates) based upon member's progress or identification of new need, challenges and problems;

(v) change in frequency and/or type of services provided;

(vi) change in practitioner(s) who will be responsible for providing services on the plan;

(vii) change in discharge criteria;

(viii) description of the member's involvement in, and responses to, the treatment plan, and his/her signature and date.

(3) **Description of Services.** Agency services include:

(A) **Individual, family and group therapy.** See OAC 317:30-5-241.2(a), (b), and (c).

(B) **Crisis/behavior management and redirection.** The provider agency must provide crisis/behavior redirection by agency staff as needed twenty-four (24) hours per day, seven (7) days per week. The agency must ensure staff availability to respond to the residential foster parents in a crisis to stabilize members' behavior and prevent placement disruption. This service is to be provided to the member by an LBHP.

(C) **Discharge planning.** The provider agency must develop a discharge plan for each member. The discharge plan must be individualized, child-specific and include an after care plan that is appropriate to the member's needs, identifies the member's needs, includes specific recommendations for

~~follow-up care and outlines plans that are in place at the time of discharge. The plan for children in parental custody must include, when appropriate, reunification plans with the parent(s)/legal guardian. The plan for children who remain in the custody of the OKDHS or the OJA must be developed in collaboration with the case worker and in place at the time of discharge. The discharge plan is to include at a minimum, recommendations for continued treatment services, educational services, and other appropriate community resources. Discharge planning provides a transition from foster care placement into a lesser restrictive setting within the community.~~

~~(D) **Substance use/chemical dependency use therapy.**~~

~~Substance use/chemical dependency therapy can be provided if a member is identified by diagnosis or documented social history as having emotional or behavioral problems directly related to substance use and/or chemical dependency. The modalities employed are provided in order to begin, maintain and enhance recovery from alcoholism, problem drinking, addiction or nicotine use and addiction. This service is to be provided to the member by an LBHP or Licensure Candidate.~~

~~(E) **Substance Use Rehabilitation Services.** Covered substance use rehabilitation services are provided in non-residential settings in regularly scheduled sessions intended for individuals not requiring a more intensive level of care or those who require continuing services following more intensive treatment regimes. The purpose of substance use rehabilitation services is to begin, maintain, and/or enhance recovery from alcoholism, problem drinking, drug use, drug dependency addiction or nicotine use and addiction. Rehabilitation services may be provided individually or in group sessions, and they take the format of an agency approved curriculum based education and skills training. This service is to be provided to the member by a CM II.~~

~~(F) **Psychosocial rehabilitation (PSR).**~~

~~(i) **Definition.** PSR services are face-to-face Behavioral Health Rehabilitation services which are necessary to improve the member's ability to function in the community. They are performed to improve the skills and abilities of members to live interdependently in the community, improve self-care and social skills, and promote lifestyle change and recovery practices. Rehabilitation services may be provided individually or in group sessions, and they take the format of an agency approved curriculum based education and skills training.~~

~~(ii) **Clinical Restrictions.** This service is generally~~

performed with only the members and the qualified provider, but may include a member and the member's family/support system group that focuses on the member's diagnosis, symptom management, and recovery based curriculum. A member who at the time of service is not able to cognitively benefit from the treatment due to active hallucinations, substance use, or other impairments is not suitable for this service. Family involvement is allowed for support of the member and education regarding his/her recovery, but does not constitute family therapy, which requires a licensed provider.

(iii) **Qualified Practitioners.** CM II, LBHP or a Licensure Candidate and LBHP may perform PSR, following development of an individual plan of care curriculum approved by an LBHP or Licensure Candidate. PSR staff must be appropriately and currently trained in a recognized behavioral/management intervention program such as MANDT or Controlling Aggressive Patient Environment (CAPE) or trauma informed methodology. The CM II must have immediate access to an LBHP who can provide clinical oversight of the CM II and collaborate with the CM II in the provision of services. A minimum of one (1) monthly face-to-face consultation with an LBHP is required.

(iv) **Group Sizes.** The maximum staffing ratio is eight (8) to one (1) for children under the age of eighteen (18).

(v) **Limitations.**

(I) In order to develop and improve the member's community and interpersonal functioning and self-care abilities, PSR services may take place in settings away from the behavioral health agency site as long as the setting protects and assures confidentiality. When this occurs, the qualified provider must be present and interacting, teaching, or supporting the defined learning objectives of the member for the entire claimed time.

(II) PSR services are intended for children with Serious Emotional Disturbance (SED), and children with other emotional or behavioral disorders. Children under age six (6), 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, are not eligible for PSR services.

(III) PSR services are time-limited services designed to be provided over the briefest and most effective period possible and as adjunct (enhancing)

~~interventions to complement more intensive behavioral health therapies. Service limits are based on the member's needs according to the Client Assessment Record (CAR) or other approved tool, the requested placement based on the level of functioning rating, medical necessity, and best practice. Service limitations are designed to help prevent rehabilitation diminishing return by remaining within reasonable age and developmentally appropriate daily limits.~~

~~(vi)~~ **~~Progress Notes.~~** ~~In accordance with OAC 317:30-5-241.1, the behavioral health individual plan of care developed by the LBHP must include the member's strengths, functional assets, weaknesses or liabilities, treatment goals, objectives and methodologies that are specific and time-limited, and defines the services to be performed by the practitioners and others who comprise the treatment team. When PSR services are prescribed, the plan must address objectives that are specific, attainable, realistic, measurable, and time-limited. The plan must include the appropriate treatment coordination to achieve the maximum reduction of the mental and/or behavioral health disability and to restore the member to their best possible functional level.~~

~~(I) Start and stop times for each day attended and the physical location in which the service was rendered;~~
~~(II) Specific goal(s) and objectives addressed during the session/group;~~
~~(III) Type of Skills Training provided each day and/or during the week including the specific curriculum used with member;~~
~~(IV) Member satisfaction with staff intervention(s);~~
~~(V) Progress, or barriers made towards goals, objectives;~~
~~(VI) New goal(s) or objective(s) identified;~~
~~(VII) Dated signature of the qualified provider; and~~
~~(VIII) Credentials of the qualified provider;~~

~~(vii)~~ **~~Additional documentation requirements.~~** ~~Documentation of ongoing consultation and/or collaboration with an LBHP or Licensure Candidate related to the provision of PSR services.~~

~~(viii)~~ **~~Non-Covered Services.~~** ~~The following services are not considered PSR and are not reimbursable:~~

~~(I) room and board;~~
~~(II) educational costs;~~
~~(III) supported employment; and~~
~~(IV) respite.~~

~~(G) **Social skills redevelopment.** Goal directed activities for each member to restore, retain and improve the self-help, communication, socialization, and adaptive skills necessary to reside successfully in home and community based settings. These will be daily activities that are age appropriate, culturally sensitive and relevant to the goals of the individual plan of care. These may include self-esteem enhancement, violence alternatives, communication skills or other related skill development. This service is to be provided to the member by the Treatment Parent Specialist (TPS). Services rendered by the TPS are limited to one and one half (1.5) hours daily.~~

All behavioral health services in a TFC setting are provided as a result of an individual assessment of the member's needs and documented in the IPC.

(1)**Assessment.**

(A) **Definition.** Gathering and assessment of historical and current bio-psycho-social information which includes face-to-face contact with the member and the member's foster parent(s) or legal guardian or other person, including biological parent(s) when applicable, who have pertinent information about the member resulting in a written summary report, diagnosis, and recommendations. All TFC agencies must assess each individual to determine whether he or she could be an appropriate candidate for TFC services.

(B) **Qualified professional.** This service is performed by a licensed behavioral health professional (LBHP) or licensure candidate.

(C) **Limitations.** Assessments are compensable on behalf of a member who is seeking services for the first time from the TFC agency. This service is not compensable if the member has previously received or is currently receiving services from the agency, unless there has been a gap in service of more than six (6) months and it has been more than one (1) year since the previous assessment.

(D) **Documentation requirements.** The assessment must include all elements and tools required by the OHCA. In the case of members under the age of eighteen (18), it is performed with the direct, active, face-to-face participation of the member and foster parent(s) or legal guardian or other persons, including biological parent(s) when applicable. The member's level of participation is based on age, developmental, and clinical appropriateness. The assessment must include all related diagnoses from the Diagnostic and Statistical Manual of Mental Disorders (DSM-V). The assessment must contain, but is not limited to, the following:

(i) Date, to include month, day, and year of the

assessment session(s);
(ii) Source of information;
(iii) Member's first name, middle initial, and last name;
(iv) Gender;
(v) Birth date;
(vi) Home address;
(vii) Telephone number;
(viii) Referral source;
(ix) Reason for referral;
(x) Person to be notified in case of emergency;
(xi) Presenting reason for seeking services;
(xii) Start and stop time for each unit billed;
(xiii) Dated signature of foster parent(s) or legal guardian [Oklahoma Department of Human Services (OKDHS) or Oklahoma Office of Juvenile Affairs (OJA)] or other persons, including biological parents(s) (when applicable) participating in the face-to-face assessment. Signatures are required for members fourteen (14) years of age and over;
(xiv) Bio-psychosocial information which must include:
(I) Identification of the member's strengths, needs, abilities, and preferences;
(II) History of the presenting problem;
(III) Previous psychiatric treatment history, including treatment of psychiatric issues, substance use, drug and alcohol addiction, and other addictions;
(IV) Health history and current biomedical conditions and complications;
(V) Alcohol, drug, and/or other addictions history;
(VI) Trauma, abuse, neglect, violence, and/or sexual assault history of self and/or others, including OKDHS involvement;
(VII) Family and social history, including psychiatric, substance use, drug and alcohol addiction, other addictions, and trauma/abuse/neglect;
(VIII) Educational attainment, difficulties, and history;
(IX) Cultural and religious orientation;
(X) Vocational, occupational, and military history;
(XI) Sexual history, including human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), other sexually transmitted diseases (STDs), and at-risk behaviors;
(XII) Marital or significant other relationship history;
(XIII) Recreation and leisure history;

(XIV) Legal or criminal record, including the identification of key contacts (e.g. attorneys, probation officers);
(XV) Present living arrangements;
(XVI) Economic resources; and
(XVII) Current support system, including peer and other recovery supports.
(xv) Mental status and level of functioning information, including, but not limited to, questions regarding the following:
(I) Physical presentation, such as general appearance, motor activity, attention, and alertness;
(II) Affective process, such as mood, affect, manner, and attitude;
(III) Cognitive process, such as intellectual ability, social-adaptive behavior, thought processes, thought content, and memory; and
(IV) All related diagnoses from the DSM-V.
(xvi) Pharmaceutical information for both current and past medications, to include the following:
(I) Name of medication;
(II) Strength and dosage of medication;
(III) Length of time on the medication; and
(IV) Benefit(s) and side effects of medication.
(xvii) LBHP's interpretation of findings and diagnosis; and
(xviii) Dated signature and credentials of the qualified practitioner who performed the face-to-face behavioral assessment. If performed by a licensure candidate, it must be countersigned by the LBHP who is responsible for the member's care.

(2) **IPC requirements.**

(A) **Signature requirement.** A written IPC following a comprehensive evaluation for each member must be formulated by the TFC agency staff within thirty (30) days of admission to the program with documented input from the member, the legal guardian (OKDHS/ OJA), the foster parent(s), the treatment provider(s), and the biological parent(s) when applicable. An IPC is not valid until all dated signatures are present, including signatures from the member [if fourteen (14) years of age and over], the legal guardian, the foster parent, and the treatment provider (s). If the service is performed by a licensure candidate, it must be countersigned by the LBHP who is responsible for the member's care. This plan must be revised and updated every three (3) months with documented involvement of the legal guardian and member.

(B) **Individualization.** The IPC must be individualized and take into account the member's age, history, diagnosis, assessed functional levels, culture, and the effect of past and current traumatic experiences in the life of the member. It includes the member's documented diagnosis, appropriate goals, and corresponding reasonable and attainable treatment objectives, and action steps within the expected timelines. Each member's IPC needs to address the TFC agency's plans with regard to the provision of services. Each plan of care must clearly identify the type of services required to meet the member's treatment needs and frequency over a given period of time.

(C) **Qualified professional.** This service is performed by an LBHP or licensure candidate.

(D) **Time requirements.** IPC updates must be conducted face-to-face and are required at least every ninety (90) days during active treatment. However, updates can be conducted whenever it is clinically needed, as determined by the qualified practitioner and member.

(E) **Documentation requirements.** Comprehensive and integrated service plan content must identify:

(i) Member strengths, needs, abilities, and preferences (SNAP);

(ii) Identified presenting challenges, problems, needs, and diagnosis;

(iii) Specific goals for the member;

(iv) Objectives that are specific, attainable, realistic, and time-limited;

(v) Each type of service and estimated frequency to be received;

(vi) The name and credentials of all the practitioners who will be providing and responsible for each service;

(vii) Any needed referrals for service;

(viii) Specific discharge criteria; and

(ix) Member's involvement in, and responses to, the treatment plan, and his/her signature and date [if fourteen (14) years of age and over].

(F) **Amendments and updates.** Amendment of an existing IPC to revise or add goals, objectives, service provider(s), service type, and service frequency, must be documented in either a scheduled three (3) month plan update or within the existing IPC through an addendum until the review/update is due. Any changes must, prior to implementation, be signed and dated by the member [if fourteen (14) years of age and over], the legal guardian, the foster parent, as well as the primary LBHP and any new provider(s). If the service is performed by a licensure candidate, it must be countersigned

by the LBHP who is responsible for the member's care. IPC updates must address the following:

(i) Update to the bio-psychosocial assessment, re-evaluation of diagnosis, and IPC goals and/ or objectives;

(ii) Progress, or lack of, on previous IPC goals and/or objectives;

(iii) A statement documenting a review of the current IPC, and, if no changes are needed, an explanation and a statement addressing the status of the identified problem behavior that led to TFC placement must be included;

(iv) Change in goals and/or objectives (including target dates) based upon member's progress or identification of new needs, challenges, and problems;

(v) Change in frequency and/or type of services provided;

(vi) Change in practitioner(s) who will be responsible for providing services on the plan;

(vii) Change in discharge criteria; and

(viii) Description of the member's involvement in, and responses to, the treatment plan, and his/her signature and date [if fourteen (14) years of age and over] Refer to Oklahoma Administrative Code (OAC) 317:30-5-742.2.(2)(A).

(3) **Description of services.** Agency services include:

(A) **Individual, family, and/or group therapy.** See Oklahoma Administrative Code (OAC) 317:30-5-241.2(a), (b), and (c). A member must receive one (1) hour of individual, family, and/or group therapy each week that is provided by an LBHP or licensure candidate, and may receive up to two (2) hours each week, if medically needed.

(B) **Crisis intervention.** The provider agency must provide crisis intervention by agency staff as needed twenty-four (24) hours per day, seven (7) days per week. The agency must ensure staff availability to respond to the residential foster parent(s) in a crisis to stabilize a member's behavior and prevent placement disruption. This service is to be provided to the member by an LBHP or a licensure candidate. The licensure candidate must have immediate access to an LBHP who can provide oversight of the licensure candidate and conduct an emergency detention evaluation.

(C) **Discharge planning.** The TFC agency must develop a discharge plan for each member. The discharge plan must be individualized, member-specific, and include an after care plan that is appropriate to the member's needs, identifies the member's needs, includes specific recommendations for follow-up care, and outlines plans that are in place at the time of discharge. The plan for members in parental custody

must include, when appropriate, reunification plans with the parent(s)/legal guardian. The plan for members who remain in the custody of OKDHS or OJA must be developed in collaboration with the case worker and finalized at the time of discharge. The discharge plan is to include, at a minimum, recommendations for continued treatment services, educational services, and other appropriate community resources. Appointments for outpatient therapy and medication management (when applicable) should be scheduled prior to discharge. Discharge planning provides a transition from TFC placement into a less restrictive setting within the community. Discharge planning is performed in partnership between Child Welfare Services (CWS) of the OKDHS and an LBHP within the TFC agency.

(D) **Substance use/chemical dependency use therapy.** Substance use/chemical dependency therapy can be provided if a member is identified by diagnosis or documented social history as having emotional or behavioral problems directly related to substance use and/or chemical dependency. The modalities employed are provided in order to begin, maintain, and enhance recovery from problem drinking, alcoholism, nicotine use and addiction, and/or drug use, drug dependency, and/or drug addiction. This service is to be provided to the member by an LBHP or licensure candidate.

(E) **Substance use rehabilitation services.** Covered substance use rehabilitation services are provided in non-residential settings in regularly scheduled sessions intended for individuals not requiring a more intensive level of care or those who require continuing services following more intensive treatment regimes. The purpose of substance use rehabilitation services is to begin, maintain, and/or enhance recovery from problem drinking, alcoholism, nicotine use and addiction, and/or drug use, drug dependency, and/or drug addiction. Rehabilitation services may be provided individually or in group sessions, and they take the format of an agency-approved, curriculum-based education and skills training. This service is to be provided to the member by a certified behavioral health case manager (CM) II, certified alcohol drug counselor (CADC) or LBHP.

(F) **Psychosocial rehabilitation (PSR).**

(i) **Definition.** PSR services are face-to-face behavioral health rehabilitation services which are necessary to improve the member's ability to function in the community. They are performed to improve the skills and abilities of members to live independently in the community, improve self-care and social skills, and promote lifestyle change and recovery practices.

Rehabilitation services may be provided individually or in group sessions, and they take the format of an agency-approved, curriculum-based education, and skills training.

(ii) **Clinical restrictions.** This service is generally performed with only the member and the qualified provider, but may also include a member and the member's family/support system group that focuses on the member's diagnosis, symptom management, and recovery based curriculum. A member who, at the time of service, is not able to cognitively benefit from the treatment due to active hallucinations and/or substance use, or other impairments is not suitable for this service. Family involvement is allowed for support of the member and education regarding his/her recovery, but does not constitute family therapy, which requires an LBHP or licensure candidate.

(iii) **Qualified practitioners.** A CM II, an LBHP, or a licensure candidate may perform PSR, following development of an IPC curriculum approved by an LBHP or licensure candidate. The CM II must have immediate access to an LBHP who can provide clinical oversight of the CM II and collaborate with the CM II in the provision of services. A minimum of one (1) monthly face-to-face consultation with an LBHP is required.

(iv) **Group sizes.** The maximum staffing ratio is eight (8) members to one (1) practitioner for members under the age of twenty-one (21).

(v) **Limitations.**

(I) In order to develop and improve the member's community and interpersonal functioning and self-care abilities, PSR services may take place in settings away from the behavioral health agency site as long as the setting protects and assures confidentiality. When this occurs, the qualified provider must be present and interacting, teaching, or supporting the defined learning objectives of the member for the entire claimed time.

(II) PSR services are intended for children with Serious Emotional Disturbance (SED), and children with moderate behavioral and emotional health needs who may also have a secondary physical, developmental, intellectual, and/or social disorder that is supported alongside the mental health needs. Members, ages four (4) and five (5), are not eligible for PSR services unless a prior authorization has been granted by OHCA or its designated agent based on a finding of medical

necessity.

(III) PSR services are time-limited services designed to be provided over the briefest and most effective period possible and as adjunct (enhancing) interventions to complement more intensive behavioral health therapies. Service limits are based on the member's needs according to the Client Assessment Record (CAR) or other approved tools. Service limitations are designed to maximize efficacy by remaining within reasonable age and developmentally appropriate daily limits.

(vi) **Progress notes.** In accordance with OAC 317:30-5-241.1, the behavioral health IPC developed by the LBHP or licensure candidate must include the member's strengths, functional assets, weaknesses or liabilities, treatment goals, objectives, and methodologies that are specific and time-limited, and defines the services to be performed by the practitioners and others who comprise the treatment team. When PSR services are prescribed, the plan must address objectives that are specific, attainable, realistic, measurable, and time-limited. The plan must include the appropriate treatment coordination to achieve the maximum reduction of the moderate behavioral and emotional health conditions, and any other secondary physical, developmental, intellectual, and/or social disorder and to restore the member to his or her best possible functional level. Progress notes for PSR services must include:

(I) Start and stop times for each day attended and the physical location in which the service was rendered;

(II) Specific goal(s) and objectives addressed during the session/group;

(III) Type of skills training provided each day and/or during the week including the specific curriculum used with the member;

(IV) Member satisfaction with staff intervention(s);

(V) Progress, towards attaining, or barriers affecting the attainment of, goals and objectives;

(VI) New goal(s) or objective(s) identified;

(VII) Dated signature of the qualified provider; and

(VIII) Credentials of the qualified provider.

(vii) **Additional documentation requirements.** Documentation of ongoing consultation and/or collaboration with an LBHP or licensure candidate related to the provision of PSR services.

(G) **Therapeutic behavioral services (TBS).** Goal directed social skills redevelopment activities for each member to

restore, retain, and improve the self-help, communication, socialization, and adaptive skills necessary to reside successfully in home and community based settings. These will be daily activities that are age appropriate, culturally sensitive, and relevant to the goals of the IPC. These may include self-esteem enhancement, violence alternatives, communication skills, or other related skill development. This service is to be provided to the member by the treatment parent specialist (TPS). Services rendered by the TPS are limited to one and one half (1.5) hours daily.

**317:30-5-743.1. Service ~~Quality Review~~quality review (SQR)**

There will be an ~~on-site Service Quality Review (SQR)~~SQR performed by the ~~OHCA~~Oklahoma Health Care Authority (OHCA) or its designated agent of each ~~Therapeutic Foster Care (TFC)~~TFC agency that provides care to members. The OHCA will designate the members of the SQR ~~Team~~team. This team will consist of at least two (2) team members and will be comprised of ~~Licensed Behavioral Health Professionals and/or Registered Nurses~~licensed behavioral health professionals (LBHPs) and/or registered nurses (RNs). The SQR will consist of a survey of current members receiving services, as well as members for which claims have been filed with OHCA for TFC services. Observation and contact with members may be incorporated. The review includes validation of certain factors, all of which must be met for the services to be compensable. Following the ~~on-site inspection~~review, the SQR ~~Team~~team will report its findings to the TFC agency. The TFC agency will be provided with written notification if the findings of the SQR have resulted in any deficiencies. A copy of the final report will be sent to the TFC agency's accrediting body. Deficiencies found during the SQR may result in a recoupment of the compensation received for that service. The individual plan of care (IPC) is considered to be critical to the integrity of care and treatment and must be completed within the ~~time lines~~timelines designated at ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-5-742.2. If the ~~individual plan of care~~IPC is missing, or it is found that the ~~child~~member did not meet medical necessity criteria at any time, all paid services will be recouped for each day the ~~individual plan of care~~IPC was missing from the date the plan of care was due for completion or the date from which medical necessity criteria was no longer met.

**317:30-5-744. Billing**

(a) Claims must be submitted in accordance with guidelines found at ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-3-11~~ and~~, 317:30-3-11.1, and 317:30-3-20.

(b) Claims for dually eligible individuals (Medicare/Medicaid)

should be filed directly with the ~~OHCA~~Oklahoma Health Care Authority (OHCA).

**317:30-5-745. Documentation of records**

~~All services must be reflected by documentation in the records including the date the service was provided, the beginning and ending time the service was provided, the location in which the service was provided, a description of the resident's response to the service and whether the service provided was an individual, group or family session, group rehabilitative treatment, social skills (re)development, basic living skills (re)development, crisis behavior management and redirection, or discharge planning, and the dated signature with credentials of the person providing the service.~~

Providers must maintain an appropriate records system. Current individual plans of care, case files, and progress notes are maintained in the provider's files during the time the member is receiving services. All services must be reflected by documentation in the records. Documentation of services must include all of the following:

(1) The date the service was provided;

(2) The beginning and ending time the service was provided;

(3) A description of the member's response to the service;

(4) The type of service provided (individual, group, or family session; group rehabilitative treatment; social skills (re)development; basic living skills (re)development; crisis behavior management and redirection; or discharge planning); and

(5) The dated signature with credentials of the person providing the service. If the service is performed by a licensure candidate, it must be countersigned by the licensed behavioral health professional (LBHP) who is responsible for the member's care. Refer to Oklahoma Administrative Code (OAC) 317:30-5-742.2. (2)(A).

**317:30-5-746. ~~Appeal of Prior Authorization Decision~~Prior authorization and appeal of prior authorization decision**

~~If a denial decision is made, an appeal may be initiated by the member or the member's legal guardian. The denial can be appealed to the Oklahoma Health Care Authority within 20 calendar days of the receipt of the notification of the denial by the OHCA or its designated agent.~~

(a) All behavioral health services must be prior authorized by the Oklahoma Health Care Authority (OHCA) or its designated agent before the service is rendered by an eligible provider. Without prior authorization, payment is not authorized.

(b) If a denial decision is made, an appeal may be initiated by

the member or the member's legal guardian. The denial can be appealed to the OHCA within thirty (30) calendar days of the receipt of the notification of the denial by the OHCA or its designated agent.

## PART 84. INTENSIVE TREATMENT FAMILY CARE

### 317:30-5-750. Definitions.

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

(1) **"Intensive treatment family care (ITFC) agency"** means an agency that provides foster care as defined in Section 1355.20 of Title 45 of the Code of Federal Regulation, as twenty-four (24) hour substitute care for children placed away from their parents or guardians and for whom the title IV-E agency has placement and care responsibility. ITFC settings are foster family homes.

(2) **"Intensive treatment family care (ITFC) home"** means an agency-supervised, private family home in which foster parents [at least one (1) parent must be a stay-at home parent] have been trained to provide individualized, structured services in a safe, nurturing family-living environment. These services are provided to children with severe behavioral and emotional health needs. They may also present a secondary physical, developmental, intellectual, and/or social disorder that is supported alongside the mental health needs of the member. These members require a higher level of care that cannot be provided in the traditional foster care or TFC home. ITFC homes provide the higher level of care needed for these children and help prevent placement in a more restrictive setting, including an inpatient setting.

(3) **"Intensive treatment family care (ITFC) model"** means a model in which children in the ITFC environment receive intensive individualized behavioral health and other support services from qualified staff. Because ITFC members require exceptional levels of skill, time, and supervision, the number of unrelated children placed per home is limited; no more than one (1) ITFC member may be placed in a home at any one (1) time unless additional cases are specifically authorized by Child Welfare Services (CWS) of the Oklahoma Department of Human Services (OKDHS), or Oklahoma Office of Juvenile Affairs (OJA).

### 317:30-5-750.1. Eligible providers and requirements

(a) **ITFC agency.** Eligible ITFC agencies must have:

(1) Current certification from the Oklahoma Department of Human Services (OKDHS) as a child placing agency;

(2) A contract with the Child Welfare Division of OKDHS, or

Oklahoma Office of Juvenile Affairs (OJA);

(3) A contract with the Oklahoma Health Care Authority (OHCA); and

(4) A current accreditation status appropriate to provide behavioral health services in a foster care setting from:

(A) The Joint Commission; or

(B) The Commission on Accreditation of Rehabilitative Facilities (CARF); or

(C) The Council on Accreditation (COA).

(b) **Treatment team.** ITFC agencies are primarily responsible for treatment planning and coordination of the member's treatment team. This team is typically composed of an OKDHS or OJA caseworker, the member, the member's foster parent(s), as well as others closely involved with the member and family, including the biological parents when applicable.

(1) The team must include the following providers:

(A) **Licensed behavioral health professional (LBHP).** A master's level professional who provides treatment and supervises other treatment staff in maintaining clinical standards of care and providing direct clinical services. In addition to the requirements at OAC 317:30-5-240.3(a), the LBHP in an ITFC setting must demonstrate a general professional or educational background in the following areas:

(i) Case management, assessment, and treatment planning;

(ii) Treatment of victims of physical, emotional, and sexual abuse;

(iii) Treatment of children with attachment disorders;

(iv) Treatment of children with hyperactivity or attention deficit disorders;

(v) Treatment methodologies for emotionally disturbed children;

(vi) Normal childhood development and the effect of abuse and/or neglect on childhood development;

(vii) Anger management;

(viii) Crisis intervention; and

(ix) Trauma-informed methodology.

(B) **Treatment parent specialist (TPS).** The TPS serves as an integral member of the team of professionals providing services for the members. The TPS receives extensive training in diagnosed mental health issues, and behavior management/modification and skill-based parenting techniques; and implements the in-home portion of the treatment plan with close supervision and support. The TPS renders services for the member, provides or arranges suitable transportation for therapy and other treatment appointments, writes daily detailed notes regarding

interventions and practical applications of learned skills, and attends treatment team meetings. The TPS must be under the supervision of an LBHP of the ITFC agency and meet the following criteria:

(i) **Qualifications.**

(I) Have a high school diploma or equivalent, and either some post-secondary education and/or a combination of at least two (2) years of personal/professional experience working with children with significant needs;

(II) Have an employment and/or contractual relationship with the ITFC agency as a foster parent, and have successfully met all required background screening requirements, including, but not limited to, fingerprint screenings conducted by the Oklahoma State Bureau of Investigation (OSBI) and Federal Bureau of Investigation (FBI), and OKDHS background screenings;

(III) Completed all evidence-informed ITFC foster parent training, as outlined in this Section;

(IV) Complete a minimum of twenty (20) hours of required annual continuing education trainings. Six (6) hours of the twenty (20) training hours must be clinical in nature;

(V) Agree to have at least one (1) parent in the ITFC home serve as a full-time, stay-at-home parent in order to sufficiently meet the significant needs of the member placed in the ITFC home; and

(ii) **Responsibilities.**

(I) Have a minimum of twice monthly face-to-face supervision with the LBHP, independent of the member's family therapy;

(II) Have weekly contact with the ITFC agency professional staff;

(III) Utilize individualized curriculum-based education and support materials with the member to support the member's skill development outside of the clinical setting;

(IV) Agree, by contract with the ITFC agency, to serve the member in his or her ITFC home through completion of the treatment designated on his or her individual plan of care (IPC), and without disruption to the service array; and

(V) Work with the multidisciplinary team and the member's biological family toward reunification, if appropriate, or other permanency plan.

(2) The team may also include the following providers:

(A) **Certified alcohol and drug counselor (CADC).** A

bachelor's level team member with a current certification as a CADC in the state in which services are provided.

(B) **Certified behavioral health case manager (CM) II.** A bachelor's level team member who may provide support services and case management. In addition to the minimum requirements at Oklahoma Administrative Code (OAC) 317:30-5-240.3(h)(1), the CM II must:

(i) Have a minimum of one (1) year of experience in providing direct care and/or treatment to children and/or families; and

(ii) Have access to weekly consultation with a licensed behavioral health professional (LBHP).

(iii) The CM II must also follow requirements at OAC 317:30-5-241.3 for providing psychosocial rehabilitation (PSR) services.

(C) **Licensed psychiatrist and/or psychologist.** ITFC agencies must provide staff with access to professional psychiatric or psychological consultation as deemed necessary for the planning, implementation, and appropriate management of the member's treatment. See OAC 317:30-5-240.3(a) and 317:25-7-5.

(c) **Agency assurances.** The ITFC agency must ensure that each individual who renders treatment services meets the minimum provider qualifications for the service and is fully contracted with the OHCA. Additionally, the ITFC agency must comply with all state and federal Medicaid law, including, but not limited to, OHCA administrative rules, the Code of Federal Regulations (C.F.R.), and the Oklahoma State Medicaid Plan.

(d) **Policies and procedures.** Eligible ITFC agencies shall have written policies and procedures for the orientation of new staff and foster parents which is reviewed and updated annually, for the following:

(1) Pre-service training of foster parents in treatment methodologies and service needs of emotionally and behaviorally disturbed children;

(2) Treatment of victims of physical, emotional, and sexual abuse;

(3) Treatment of children with attachment disorders;

(4) Treatment of children with hyperactive or attention deficit disorders;

(5) Normal childhood development and the effect of abuse and/or neglect on childhood development;

(6) Treatment of children and families with substance use disorders;

(7) The Inpatient Mental Health and Substance Abuse Treatment of Minors Act;

(8) Anger management;

(9) Inpatient authorization procedures;
(10) Crisis intervention;
(11) Grief and loss issues for children in foster care;
(12) The significance/value of birth families to children receiving behavioral health services in a foster care setting; and
(13) Trauma-informed methodology.

**317:30-5-750.2. Provider selection**

Parents who retain legal custody of an ITFC member may select any eligible ITFC agency as the provider of services. In the case of members in the custody of the State of Oklahoma, the State, acting in its custodial role, selects the ITFC agency.

**317:30-5-751. Coverage by category**

(a) **Adults.** Behavioral health services in ITFC settings are not covered for adults.

(b) **Children.** Behavioral health services are allowed in ITFC settings for children under twenty-one (21) as medically necessary. Members receiving services in this setting have severe behavioral and emotional health needs and may also present a secondary physical, developmental, intellectual, and/or social disorder that is supported alongside the mental health needs. ITFC homes provide the higher level of care needed for these children and help prevent placement in an inpatient or more restrictive setting. The designated members must continually meet medical necessity criteria to be eligible for coverage in this setting. Requests for behavioral health services in an ITFC setting must be prior authorized and may be approved up to a maximum of three (3) month extensions.

(c) **Medical necessity criteria.** In order to satisfy medical necessity criteria, all of the following conditions must be met:

(1) The member must have a diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM-V), with the exception of V codes and adjustment disorders, with a detailed description of the symptoms supporting the diagnosis. Members with a provisional diagnosis may receive ITFC services for a maximum of thirty (30) days.

(2) An assessment must be completed by a licensed behavioral health professional (LBHP) as defined in Oklahoma Administrative Code (OAC) 317:30-5-240.3(a) within the thirty (30) day provisional period described above, that confirms a diagnosis from the DSM-V with the exception of V codes and adjustments disorders, and that includes a detailed description of the symptoms supporting the diagnosis to continue treatment in an ITFC setting.

(3) Conditions are directly attributed to a primary medical

diagnosis of a severe behavioral and emotional health need, and may also be attributed to a secondary medical diagnosis of a physical, developmental, intellectual and/or social disorder that is supported alongside the mental health needs.

(4) The current disabling symptoms could not have been/have not been manageable in a less intensive treatment program, or the level of care is warranted in order to reduce the risk of regression of symptoms and/or sustain the gains made at a higher level of care.

(5) Evidence that the members' needs prohibit full integration in a family/home setting without the availability of twenty-four (24) hour crisis response/behavior management and intensive clinical interventions from professional staff, preventing the member from living in a traditional or therapeutic foster home.

(6) The member is medically stable and not actively suicidal or homicidal and not in need of substance abuse detoxification services.

(7) The legal guardian [Oklahoma Department of Human Services (OKDHS)/ Oklahoma Office of Juvenile Affairs (OJA) if custody member] or parent of the member agrees to actively participate in the member's treatment needs and planning.

**317:30-5-752. Description of services**

(a) Treatment services must be provided in the least restrictive, non-institutional therapeutic environment. The ITFC setting is restorative in nature, allowing members with severe behavioral and emotional health needs, who may also present a secondary physical, developmental, intellectual, and/or social disorder that is supported alongside the mental health needs, to develop the necessary control to function in a less restrictive setting.

(b) Behavioral health services must include an individual plan of care (IPC) for each member served. The IPC requirements are set out in Oklahoma Administrative Code (OAC) 317:30-5-753.

(c) Treatment services in an ITFC must include at least two (2) hours of individual, family, and/or group therapy per week, as set forth in OAC 317:30-5-753(3). Treatment may also include, but is not limited to, an array of the following services:

(1) Substance abuse/chemical dependency education, prevention, and therapy;

(2) Psychosocial rehabilitation and support services;

(3) Behavior management;

(4) Crisis intervention; and

(5) Case management.

**317:30-5-753. Individual plan of care (IPC) requirements**

All behavioral health services in an ITFC setting are provided

as a result of an individual assessment of the member's needs and documented in the IPC.

(1)**Assessment.**

(A) **Definition.** Gathering and assessment of historical and current bio-psychosocial information which includes face-to-face contact with the member and the member's foster parent(s) or legal guardian or other person, including biological parent(s) when applicable, who have pertinent information about the member resulting in a written summary report, diagnosis, and recommendations. All ITFC agencies must assess each individual to determine whether they could be an appropriate candidate for ITFC services.

(B) **Qualified professional.** This service is performed by a licensed behavioral health professional (LBHP).

(C) **Limitations.** Assessments are compensable on behalf of a member who is seeking services for the first time from the ITFC agency. This service is not compensable if the member has previously received or is currently receiving services from the agency, unless there has been a gap in service of more than six (6) months and it has been more than one (1) year since the previous assessment.

(D) **Documentation requirements.** The assessment must include all elements and tools required by the Oklahoma Health Care Authority (OHCA). In the case of members under the age of eighteen (18), it is performed with the direct, active, face-to-face participation of the member and foster parent(s) or legal guardian or other persons, including biological parent(s) when applicable. The member's level of participation is based on age, developmental, and clinical appropriateness. The assessment must include all related diagnoses from the Diagnostic and Statistical Manual of Mental Disorders (DSM-V). The assessment must contain, but is not limited to, the following:

(i) Date, including month, day, and year of the assessment session(s);

(ii) Source of information;

(iii) Member's first name, middle initial, and last name;

(iv) Gender;

(v) Birth date;

(vi) Home address;

(vii) Telephone number;

(viii) Referral source;

(ix) Reason for referral;

(x) Person to be notified in case of emergency;

(xi) Presenting reason for seeking services;

(xii) Start and stop time for each unit billed;

(xiii) Dated signature of foster parent(s) or legal

guardian [Oklahoma Department of Human Services (OKDHS) or Oklahoma Office of Juvenile Affairs (OJA)] or other persons, including biological parent(s) (when applicable) participating in the face-to-face assessment. Signatures are required for members fourteen (14) years of age and over;

(xiv) Bio-psychosocial information, which must include:

(I) Identification of the member's strengths, needs, abilities, and preferences;

(II) History of the presenting problem;

(III) Previous psychiatric treatment history, including treatment of psychiatric issues, substance use, drug and alcohol addiction, and other addictions;

(IV) Health history and current biomedical conditions and complications;

(V) Trauma, abuse, neglect, violence, and/or sexual assault history of self and/or others, including OKDHS involvement;

(VI) Family and social history, including psychiatric, substance use, drug and alcohol addiction, other addictions, and trauma/abuse/neglect;

(VII) Educational attainment, difficulties, and history;

(VIII) Cultural and religious orientation;

(IX) Vocational, occupational, and military history;

(X) Sexual history, including human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), other sexually transmitted diseases (STDs), and at-risk behaviors;

(XI) Marital or significant other relationship history;

(XII) Recreation and leisure history;

(XIII) Legal or criminal record, including the identification of key contacts (e.g. attorneys, probation officers);

(XIV) Present living arrangements;

(XV) Economic resources; and

(XVI) Current support system, including peer and other recovery supports.

(xv) Mental status and level of functioning information, including, but not limited to, questions regarding the following:

(I) Physical presentation, such as general appearance, motor activity, attention, and alertness;

(II) Affective process, such as mood, affect, manner, and attitude;

(III) Cognitive process, such as intellectual ability,

social-adaptive behavior, thought processes, thought content, and memory; and

(IV) All related diagnoses from the DSM-V.

(xvi) Pharmaceutical information for both current and past medications, to include the following;

(I) Name of medication;

(II) Strength and dosage of medication;

(III) Length of time on the medication; and

(IV) Benefit(s) and side effects of medication.

(xvii) LBHP's interpretation of findings and diagnosis; and

(xviii) Dated signature and credentials of the LBHP who performed the face-to-face behavioral assessment.

(2) **IPC requirements.**

(A) **Signature requirement.** A written IPC following a comprehensive evaluation for each member must be formulated by the ITFC agency staff within thirty (30) days of admission to the program with documented input from the member, the legal guardian (OKDHS/OJA), the foster parent(s), the treatment provider(s), and the biological parent(s) when applicable. An IPC is not valid until all dated signatures are present, including signatures from the member [if fourteen (14) years of age and over], the legal guardian, the foster parent, and the treatment provider(s). This plan must be reviewed every thirty (30) days with documented involvement of the legal guardian and member. The review includes an evaluation of the member's progress in the treatment setting, as well as in other environments, such as home, school, social engagements, etc.

(B) **Individualization.** The IPC must be individualized and take into account the member's age, history, diagnosis, functional levels, culture, and the effect of past and current traumatic experiences in the life of the member. It includes the member's documented diagnosis, appropriate goals, corresponding reasonable and attainable treatment objectives, and action steps within the expected timelines. Each member's IPC needs to address the ITFC agency's plans with regard to the provision of services. Each plan of care must clearly identify the type of services required to meet the member's treatment needs and frequency over a given period of time.

(C) **Qualified professional.** This service is performed by an LBHP.

(D) **Time requirements.** IPC updates must be conducted face-to-face and are required at least every ninety (90) days during active treatment. However, updates can be conducted whenever it is clinically needed, as determined by an LBHP.

Updates should reflect changes to treatment based on the members' progress or lack thereof.

(E) **Documentation requirements.** Comprehensive and integrated service plan content must address the following:

(i) Member strengths, needs, abilities, and preferences (SNAP);

(ii) Identified presenting challenges, problems, needs and diagnosis;

(iii) Specific goals for the member;

(iv) Objectives that are specific, attainable, realistic, and time-limited;

(v) Each type of service and estimated frequency to be received;

(vi) The name and credentials of all the practitioners who will be providing and responsible for each service;

(vii) Any needed referrals for service;

(viii) Specific discharge criteria; and

(ix) Description of the member's involvement in, and responses to, the treatment plan, and his/her signature and date [if fourteen (14) years of age and older].

(F) **Amendments and updates.** Amendment of an existing IPC to revise or add goals, objectives, service provider(s), service type, and service frequency must be documented in the existing IPC through an addendum until the review/update is due. Any changes must, prior to implementation, be signed and dated by the member [if fourteen (14) years of age and over], the legal guardian, the foster parent, as well as the primary LBHP and any new provider(s). IPC updates must address the following:

(i) Update to the bio-psychosocial assessment, re-evaluation of diagnosis, and IPC goals and/ or objectives;

(ii) Progress, or lack of, on previous IPC goals and/or objectives;

(iii) A statement documenting a review of the current IPC, and, if no changes are needed, an explanation and a statement addressing the status of identified problem behaviors that led to ITFC placement must be included;

(iv) Change in goals and/or objectives (including target dates) based upon member's progress or identification of new needs, challenges, and problems;

(v) Change in frequency and/or type of services provided;

(vi) Change in practitioner(s) who will be responsible for providing services on the plan;

(vii) Change in discharge criteria; and

(viii) Description of the member's involvement in, and responses to, the treatment plan, and his/her signature

and date [if fourteen (14) years of age and older].

(3) **Description of services.** Agency services include:

(A) **Individual, family, and/or group therapy.** See OAC 317:30-5-241.2(a), (b), and (c). The number of units of individual, family, and/or group therapy within the ITFC setting differ from the number of units available in the outpatient setting. A member must receive two (2) hours of individual, family, and/or group therapy each week that is provided by an LBHP, and may receive up to three (3) hours each week, if medically needed.

(B) **Crisis intervention.** The provider agency must provide crisis intervention by ITFC agency staff as needed twenty-four (24) hours per day, seven (7) days per week. The agency must ensure staff is available to respond to the ITFC foster parent(s) in a crisis to stabilize a member's behavior and prevent placement disruption. This service is to be provided to the member by an LBHP.

(C) **Discharge planning.** The ITFC agency must develop a discharge plan for each member. The discharge plan must be individualized, member-specific, and include an after-care plan that is appropriate to the member's needs, identifies the member's needs, includes specific recommendations for follow-up care, and outlines plans that are in place at the time of discharge. The plan for members in parental custody must include, when appropriate, reunification plans with the parent(s)/legal guardian. The plan for members who remain in the custody of OKDHS or OJA must be developed in collaboration with the case worker and be finalized at the time of discharge. The discharge plan is to include, at a minimum, recommendations for continued treatment services, educational services, and other appropriate community resources. Appointments for outpatient therapy and medication management (when applicable) should be scheduled prior to discharge. Discharge planning provides a transition from ITFC placement into a lesser restrictive setting within the community. Discharge planning is performed in partnership between Child Welfare Services (CWS) of the Oklahoma Department of Human Services (OKDHS) and an LBHP within the ITFC agency.

(D) **Substance use/chemical dependency use therapy.** Substance use/chemical dependency therapy can be provided if a member is identified by diagnosis or documented social history as having emotional or behavioral problems directly related to substance use and/or chemical dependency. The modalities employed are provided in order to begin, maintain, and/or enhance recovery from problem drinking, alcoholism, nicotine use and addiction, and/or drug use, drug dependency, and/or

drug addiction. This service is provided to the member by an LBHP.

(E) **Substance use rehabilitation services.** Covered substance use rehabilitation services are provided in non-residential settings in regularly scheduled sessions intended for individuals not requiring a more intensive level of care or those who require continuing services following more intensive treatment regimes. The purpose of substance use rehabilitation services is to begin, maintain, and/or enhance recovery from problem drinking, alcoholism, nicotine use and addiction, and/or drug use, drug dependency, and/or drug addiction. Rehabilitation services may be provided individually or in group sessions, and they take the format of an agency-approved, curriculum-based education and skills training. This service is provided to the member by a certified behavioral health case manager (CM) II, a certified alcohol drug counselor (CADC), or an LBHP.

(F) **Psychosocial rehabilitation (PSR).**

(i) **Definition.** PSR services are face-to-face behavioral health rehabilitation services which are necessary to improve the member's ability to function in the community. They are performed to improve the skills and abilities of members to live independently in the community, improve self-care and social skills, and promote lifestyle change and recovery practices. Rehabilitation services may be provided individually or in group sessions, and they take the format of an agency-approved, curriculum-based education and skills training.

(ii) **Clinical restrictions.** This service is generally performed with only the member and the qualified provider, but may also include the member's family/support system group that focuses on the member's diagnosis, symptom management, and recovery-based curriculum. A member who, at the time of service, is not able to benefit from the treatment due to active hallucinations and/or substance use, or other impairment, is not suitable for this service. Family involvement is allowed for support of the member and education regarding his/her recovery, but does not constitute family therapy, which requires an LBHP.

(iii) **Qualified practitioners.** A CM II or an LBHP may perform PSR, following development of an IPC curriculum. The CM II must have immediate access to an LBHP who can provide clinical oversight of the CM II and collaborate with the CM II in the provision of services. A minimum of one (1) monthly face-to-face consultation with an LBHP is

required.

(iv) **Group sizes.** The maximum staffing ratio is eight (8) members to one (1) service provider for members under the age of twenty-one (21).

(v) **Limitations.**

(I) In order to develop and improve the member's community and interpersonal functioning and self-care abilities, PSR services may take place in settings away from the behavioral health agency site as long as the setting protects and assures confidentiality. When this occurs, the qualified provider must be present and interacting, teaching, or supporting the defined learning objectives of the member for the entire claimed time.

(II) PSR services are intended for members with Serious Emotional Disturbance (SED), and members with severe behavioral and emotional health needs who may also have a secondary physical, developmental, intellectual, and/or social disorder that is supported alongside the mental health needs. Members, ages four (4) and five (5), are not eligible for PSR services unless a prior authorization has been granted by OHCA or its designated agent, based on a finding of medical necessity.

(III) PSR services are time-limited services designed to be provided over the briefest and most effective period possible and as adjunct (enhancing) interventions to complement more intensive behavioral health therapies. Service limits are based on the member's needs according to the Client Assessment Record (CAR) or other approved tools. Service limitations are designed to maximize efficacy by remaining within reasonable age and developmentally appropriate daily limits.

(vi) **Progress notes.** In accordance with OAC 317:30-5-241.1, the behavioral health IPC developed by the LBHP must include the member's strengths, functional assets, weaknesses or liabilities, treatment goals, objectives, and methodologies that are specific and time-limited, and defines the services to be performed by the practitioners and others who comprise the treatment team. When PSR services are prescribed, the plan must address objectives that are specific, attainable, realistic, measurable, and time-limited. The plan must include the appropriate treatment coordination to achieve the maximum reduction of the severe behavioral and emotional health conditions, and any other secondary physical, developmental,

intellectual, and/or social disorders and to restore the member to his or her best possible functional level. Progress notes for PSR services must include:

(I) Start and stop times for each day attended and the physical location in which the service was rendered;

(II) Specific goal(s) and objectives addressed during the session/group;

(III) Type of skills training provided each day and/or during the week including the specific curriculum used with the member;

(IV) Member satisfaction with staff intervention(s);

(V) Progress towards attaining, or barriers affecting the attainment of, goals and objectives;

(VI) New goal(s) or objective(s) identified;

(VII) Dated signature of the qualified provider; and

(VIII) Credentials of the qualified provider.

(vii) **Additional documentation requirements.** Documentation of ongoing consultation and/or collaboration with an LBHP related to the provision of PSR services.

(G) **Therapeutic behavioral services (TBS).** Goal-directed social skills redevelopment activities for each member to restore, retain, and improve the self-help, communication, socialization, and adaptive skills necessary to reside successfully in home and community based settings. These will be daily activities that are age appropriate, culturally sensitive, and relevant to the goals of the IPC. These may include self-esteem enhancement, violence alternatives, communication skills, or other related skill development. This service is to be provided to the member by the treatment parent specialist (TPS). Services rendered by the TPS are limited to one and a half (1.5) hours daily.

**317:30-5-754. Service quality review (SQR)**

(a) Providers must maintain an appropriate records system. Current individual plans of care, case files, and progress notes are maintained in the provider's files during the time the member is receiving services. All services must be reflected by documentation in the records. Documentation of services must include all of the following:

(1) The date the service was provided;

(2) The beginning and ending time the service was provided;

(3) A description of the member's response to the service;

(4) The type of service provided (individual, group, or family session; group rehabilitative treatment; social skills (re)development; basic living skills (re)development; crisis

behavior management and redirection; or discharge planning); and

(5) The dated signature with credentials of the person providing the service.

(b) There will be an SQR review performed by the Oklahoma Health Care Authority (OHCA) or its designated agent of each ITFC agency that provides care to members. The OHCA will designate the members of the SQR team. This team will consist of at least two (2) team members and will be comprised of licensed behavioral health professionals (LBHPs) and/or registered nurses (RNs). The SQR will consist of a survey of current members receiving services, as well as members for which claims have been filed with OHCA for ITFC services. Observation and contact with members may be incorporated. The review includes validation of certain factors, all of which must be met for the services to be compensable. Following the review, the SQR team will report its findings to the ITFC agency. The ITFC agency will be provided with written notification if the findings of the SQR have resulted in any deficiencies. A copy of the final report will be sent to the ITFC agency's accrediting body. Deficiencies found during the SQR may result in a recoupment of the compensation received for that service. The individual plan of care (IPC) is considered to be critical to the integrity of care and treatment and must be completed within the timelines designated at Oklahoma Administrative Code (OAC) 317:30-5-753. If the IPC is missing, or it is found that the member did not meet medical necessity criteria at any time, all paid services will be recouped for each day the IPC was missing from the date the plan of care was due for completion or the date from which medical necessity criteria was no longer met.

**317:30-5-755. Billing**

(a) Claims must be submitted in accordance with guidelines found at Oklahoma Administrative Code (OAC) 317:30-3-11, 317:30-3-11.1 and 317:30-3-20.

(b) Claims for dually eligible individuals (Medicare/Medicaid) should be filed directly with the Oklahoma Health Care Authority (OHCA).

**317:30-5-756. Reimbursement**

(a) ITFC services will be paid at the current fee-for-service (FFS) rate. Services provided to a member without a written individual plan of care (IPC) as described in Oklahoma Administrative Code (OAC) 317:30-5-753 will not be reimbursed.

(b) Additional services may require prior authorization by the OHCA, or its designated agent. Refer to OAC 317:30-3-31.

Documentation must be provided to ensure that services are not duplicative. If additional services are approved for a member in state custody, the Oklahoma Department of Human Services (OKDHS), or Oklahoma Office of Juvenile Affairs (OJA) will collaborate with the provider of such services as directed by the OHCA.

(c) Reimbursement for ITFC services is not available for the following:

(1) Room and board;

(2) Educational costs;

(3) Supported employment;

(4) Inpatient psychiatric services;

(5) Respite care;

(6) Day treatment services;

(7) Partial hospitalization services; and

(8) Intensive outpatient services.

(d) Case management services are reimbursed to government providers as per the methodology in the approved Medicaid State Plan.

**317:30-5-757. Prior authorization and appeal of prior authorization decision**

(a) All behavioral health services must be prior authorized by the Oklahoma Health Care Authority (OHCA) or its designated agent before the service is rendered by an eligible provider. Without prior authorization, payment is not authorized.

(b) If a denial decision is made, an appeal may be initiated by the member or the member's legal guardian. The denial can be appealed to the OHCA within thirty (30) calendar days of the receipt of the notification of the denial by the OHCA or its designated agent.

**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 ~~OHCA~~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 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 ~~(see OAC 317:30-5-41)~~[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~~hospital-based setting. Coverage is limited to one (1) evaluation/re-evaluation visit (unit) per discipline per calendar year and ~~15~~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 training (DSMT) is provided to members diagnosed with diabetes. DSMT services are comprised of one (1) hour of individual instruction (face-to-face encounters between the certified 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 DSMT per

calendar year. Refer to OAC 317:30-5-1080 through 317:30-5-1084 for specific provider and program requirements, and reimbursement methodology.

## PART 109. DIABETES SELF-MANAGEMENT TRAINING

### 317:30-5-1080. Definitions

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

**"AADE"** means American Association of Diabetes Educators.

**"ADA"** means American Diabetes Association.

**"CDE"** means certified diabetes educator.

**"DSMT"** means diabetes self-management training.

**"OAC"** means Oklahoma Administrative Code.

**"OHCA"** means Oklahoma Health Care Authority.

**"Qualified non-physician provider"** means a physician assistant or advanced practice registered nurse.

### 317:30-5-1081. Eligible providers and requirements

(a) Eligible DSMT providers include any of the following professionals:

(1) A registered dietician (RD) who is licensed and in good standing in the state in which s/he practices, and who is:

(A) Certified as a CDE; and

(B) Fully contracted with SoonerCare as a CDE provider.

(2) A registered nurse (RN) who is licensed and in good standing in the state in which s/he practices, and who is:

(A) Certified as a CDE; and

(B) Fully contracted with SoonerCare as a CDE provider.

(3) A pharmacist who is licensed and in good standing in the state in which s/he practices, and who is:

(A) Certified as a CDE; and

(B) Fully contracted with SoonerCare as a CDE provider.

(b) In order to receive Medicaid reimbursement for DSMT services, professional service groups, outpatient hospitals, Indian Health Services, Tribal Programs and Urban Indian Clinics (I/T/Us), Rural Health Clinics (RHCs), and Federally Qualified Health Centers (FQHCs) must have a DSMT program that meets the quality standards of one (1) of the following accreditation organizations:

(1) The ADA; or

(2) The AADE.

(c) All DSMT programs must adhere to the national standards for diabetes self-management education.

(1) Each member of the instructional team must:

(A) Be a CDE; or

(B) Have documentation of at least fifteen (15) hours of recent diabetes education or diabetes management experience.

(2) At a minimum, every instructional team must consist of at

least one (1) of the CDE professionals listed in subsection a, above.

(d) All members of the instructional team must obtain the nationally recommended annual continuing education hours for diabetes management.

**317:30-5-1082. Scope of services**

(a) **General provisions.** The OHCA covers medically necessary DSMT services when all the following criteria are met:

(1) The member has been diagnosed with diabetes by a physician or qualified non-physician provider working within the scope of his/her licensure;

(2) The services have been ordered by a physician or qualified non-physician provider who is actively managing the member's diabetes;

(3) The services are provided by a qualified DSMT provider [Refer to OAC 317:30-5-1081(b)(2)]; and

(4) The program meets the current ADA or ADE training standards.

(b) **Training.** DSMT services shall provide one (1) initial assessment per lifetime. Initial DSMT shall be comprised of up to ten (10) hours [can be performed in any combination of thirty (30) minute increments] of diabetes training within a consecutive twelve (12) month period beginning with the initial training date, including:

(1) One (1) hour of individual instruction, consisting of face-to-face encounters between the CDE and the member; and

(2) Nine (9) hours of group instruction.

(c) **Follow-up DSMT.** After the first twelve (12) month period has concluded, members shall only be eligible for two (2) hours of individual or group DSMT instruction per calendar year.

**317:30-5-1083. Coverage by category**

The purpose of DSMT services must be to provide the member with the knowledge, skill, and ability necessary for diabetes self-care.

(1) **Adults.** Payment is made for medically necessary DSMT provided by a registered nurse (RN), registered dietitian (RD), or pharmacist certified as a diabetes educator, as described in OAC 317:30-5-1081.Refer to OAC 317:30-5-1082 for units of DSMT training allowed.

(2) **Children/adolescents.** Payment is made for medically necessary DSMT for members under twenty-one (21) years of age provided by a RN, RD, or pharmacist certified as a diabetes educator, as described in OAC 317:30-5-1081. DSMT coverage for children is the same as for adults. Additional DSMT services may be covered under EPSDT provisions if determined to be medically necessary.

**317:30-5-1084. Reimbursement methodology**

SoonerCare shall provide reimbursement for DSMT services as

follow:

(1) Payment shall be made to fully-contracted providers. If the rendering provider operates through an enrolled SoonerCare provider, or is contracted to provide services by an enrolled SoonerCare provider, payment may be made to that enrolled SoonerCare provider.

(2) Reimbursement for DSMT services is only made on a fee-for-service basis. The maximum allowable fee for a unit of service has been determined by OHCA to be a reasonable fee, consistent with efficiency, economy, and quality of care. Payment for covered services is the lower of the provider's actual billed charges, consistent with the provider's usual and customary charge to the general public for the service, or the maximum allowable per unit of service.

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

**SUBCHAPTER 6. SOONERCARE FOR PREGNANT WOMEN AND FAMILIES WITH CHILDREN**

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

**317:35-6-45. Eligibility for inmates**

(a) The Oklahoma Health Care Authority (OHCA) shall receive applications from and make eligibility determinations for individuals residing in correctional institutions, including juvenile facilities. However, the SoonerCare program will only pay for services rendered to individuals residing in a correctional institution as specified in Oklahoma Administrative Code (OAC) 317:35-5-26.

(b) In accordance with federal law, including, but not limited to, 42 United States Code (U.S.C.) § 1396a(a)(84), individuals residing in correctional institutions who are under the age of twenty-one (21) or who meet the former foster care child requirements found at OAC 317:35-5-2, shall have their eligibility suspended for the duration of the incarceration period, except for periods of time that inpatient services are provided as specified in OAC 317:35-5-26.

(c) The effective date of the suspension is the calendar day following the date on which an individual described in (b) of this section becomes incarcerated.

(d) A redetermination of eligibility for an individual described in (b) of this section shall be conducted prior to release to determine if the individual continues to meet the eligibility requirements for SoonerCare. A new application will not be required to redetermine eligibility.

(e) Suspended eligibility shall be restored to the release date after a redetermination of eligibility, when:

(1) The Oklahoma Department of Human Services (DHS), using the release date supplied by the Oklahoma Office of Juvenile Affairs (OJA) or the Oklahoma Department of Corrections (DOC), removes the suspension;

(2) The individual reports his or her release to the Oklahoma Health Care Authority (OHCA) within ten (10) calendar days of the release date; or

(3) The individual reports his or her release to OHCA more than ten (10) calendar days from the release date, and there is good cause for the delay in reporting.

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

**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**

**PART 1. PHYSICIANS**

**317:30-5-22.1. Enhanced services for medically high risk pregnancies**

(a) **Enhanced services.** Enhanced services are available for pregnant women eligible for SoonerCare and are in addition to services for uncomplicated maternity cases. Women deemed high risk based on criteria established by the ~~OHCA~~Oklahoma Health Care Authority (OHCA) must receive prior authorization for medically necessary enhanced benefits which include:

(1) prenatal at risk antepartum management;

(2) a combined maximum of five (5) fetal non stress test(s) and biophysical profiles (additional units can be prior authorized for multiple fetuses)with one (1) test per week beginning at ~~32~~thirty-two (32) weeks gestation and continuing to ~~38~~thirty-eight (38) weeks; and

(3) a maximum of three (3) follow-up ultrasounds not covered under OAC 317:30-5-22(b)(2).

(b) **Prior authorization.** To receive enhanced services, the following documentation must be received by the OHCA Medical Authorizations Unit for review and approval:

(1) ~~ACOG~~A comprehensive prenatal assessment from the American College of Obstetricians and Gynecologist (ACOG) or other comparable comprehensive prenatal assessment; and

(2) ~~appropriate~~Appropriate documentation supporting medical necessity from a ~~Board Eligible/Board Certified~~board eligible/board certified Maternal Fetal Medicine (MFM) specialist, ~~or~~a ~~Board Eligible/Board Certified~~board eligible/board certified Obstetrician-Gynecologist (OB-GYN)~~.~~, or a board eligible/board certified Family Practice Physician who has completed an Accreditation Council for Graduate Medical Education (ACGME) approved residency. The medical residency program must include appropriate obstetric training, and the physician must be credentialed by the hospital at which they provide obstetrical services in order to perform such services. The documentation must include information identifying and detailing the qualifying high risk condition. Non-MFM obstetrical providers requesting enhanced services are limited to a specific set of diagnoses as outlined on the OHCA website (www.okhca.org).

(c) **Reimbursement.** When prior authorized, enhanced benefits will be reimbursed as follows:

(1) Antepartum management for high risk is reimbursed to the primary obstetrical provider. If the primary provider of obstetrical care is not the MFM and wishes to request authorization of the antepartum management fee, the treatment plan must be signed by the primary provider of OB care. Additionally, reimbursement for enhanced at risk antepartum management is not made during an in-patient hospital stay.

(2) Non stress tests, biophysical profiles and ultrasounds [in addition to those covered under OAC 317:30-5-22(a)(2) subparagraphs (A) through (C)] are reimbursed when prior authorized.

(3) Reimbursement for enhanced at risk antepartum management is not available to physicians who already qualify for enhanced reimbursement as state employed physicians.

## PART 3. HOSPITALS

**317:30-5-42.11. Observation/treatment**

(a) Payment is made for the use of a treatment room associated with outpatient observation services. Observation services must be ordered by a physician or other individual authorized by state law. Observation services are furnished by the hospital on the hospital's premises and include use of the bed and periodic monitoring by hospital staff. Observation services must include a minimum of ~~8~~eight (8) hours of continuous care. Outpatient observation services are not covered when they are provided:

(1) On the same day as an emergency department visit.

(2) Prior to an inpatient admission, as those observation services are considered part of the inpatient DRG.

(3) For the convenience of the member, member's family or provider.

(4) When specific diagnoses are not present on the claim.

(5) As part of another service, i.e. for post operative monitoring; recovery after diagnostic testing or concurrently with therapeutic services such as chemotherapy.

(b) Payment is made for observation services in a labor or delivery room. Observation services must include a minimum of eight (8) hours of continuous care. Specific pregnancy-related diagnoses are required. ~~During active labor, a fetal non-stress test is covered in addition to the labor and delivery room charge.~~

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**
**CHAPTER 2. GRIEVANCE PROCEDURES AND PROCESS**

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

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

(1) The following are appealable issues of the program:

(A) Any disputed adjustment(s) that are made by the OHCA to the facility's annual cost report, in accordance with OAC 317:30-5-132(5); or

(B) Any disputed cost report adjustment reconsideration decision, made by OHCA's chief financial officer or his/her designee in accordance with OAC 317:30-5-132.1.

(2) Appeals are heard by the OHCA administrative law judge (ALJ).

(3) To file an appeal, the provider shall submit an LD-2 form within thirty (30) days of the date of the written notice of the OHCA's report adjustment(s) that resulted from an on-site audit, or a cost report reconsideration decision, as applicable.

(4) The LD-2 shall only be filed by the provider or the provider's attorney in accordance with five (5) below.

(5) Consistent with Oklahoma rules of practice, the provider shall be represented by an attorney licensed to practice within the State of Oklahoma. Attorneys not licensed to practice in Oklahoma shall comply with Article II, Section (§) 5 of Title 5 of the Oklahoma Statutes (O.S.), and rules of the Oklahoma Bar Association.

(6) Parties who fail to appear at a hearing, after notification of said hearing date, will have their cases dismissed for failure to prosecute.

(7) The long-term care facility has the burden of proof by the preponderance of the evidence standard as defined by the Oklahoma Supreme Court.

(8) The docket clerk will send the long-term care facility and any other necessary party a notice which states the hearing location, date, and time.

(9) The ALJ may:

(A) Identify and rule on issues being appealed which will be determined at the administrative hearing;

(B) Require the parties to state their positions concerning appeal issue(s);

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

**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**

**317:30-5-241.6. Behavioral ~~Health Case Management~~health targeted case management**

Payment is made for behavioral health targeted case management services as set forth in this Section. The limitations set forth in this Section do not apply to case management provided in programs and service delivery models which are not reimbursed for case management on a fee-for-service basis.

(1) **Description of behavioral health case management services.** Behavioral health case management services are provided to assist eligible individuals in gaining access to needed medical, social, educational and other services essential to meeting basic human needs. Services under behavioral health targeted case management are not comparable in amount, duration and scope. The target ~~group~~groups for behavioral health case management services are persons under age twenty-one (21) who are in imminent risk of out-of-home placement for psychiatric or substance abuse reasons or are in out-of-home placement due to psychiatric or substance abuse reasons, and chronically and/or severely mentally ill adults who are institutionalized or are at risk of institutionalization. All behavioral health case management services will be authorized ~~for the target group~~ based on established medical necessity criteria.

(A) ~~Behavioral health case management services are provided to assist eligible individuals in gaining access to needed medical, social, educational and other services essential to meeting basic human needs.~~ The behavioral health case manager provides assessment of case management needs, development of a case management care plan, referral, linkage, monitoring and advocacy on behalf of the member to gain access to appropriate community resources. The behavioral health case manager must monitor the progress in gaining access to services and continued appropriate utilization of necessary community resources. Behavioral case management is designed to promote recovery, maintain community tenure, and to assist individuals in accessing services for themselves following the case management guidelines established by ~~Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS)~~ODMHSAS. In order to be compensable, the service must be performed utilizing the Strengths Based model of case management. This model of case management assists individuals in identifying and securing the range of resources, both environmental and

personal, needed to live in a normally interdependent way in the community. The focus for the helping process is on strengths, interests, abilities, knowledge and capacities of each person, not on their diagnosis, weakness or deficits. The relationship between the service member and the behavioral health case manager is characterized by mutuality, collaboration, and partnership. Assistive activities are designed to occur primarily in the community, but may take place in the behavioral health case manager's office, if more appropriate.

(B) The provider will coordinate transition services with the member and family (if applicable) by phone or ~~face-to-face~~face to face, to identify immediate needs for return to home/community no more than seventy-two (72) hours after notification that the member/family requests case management services. For members discharging from a higher level of care than outpatient, the higher level of care facility is responsible for scheduling an appointment with a case management agency for transition and post discharge services. The case manager will make contact with the member and family (if applicable) for transition from the higher level of care other than outpatient back to the community, within seventy-two (72) hours of discharge, and then conduct a follow-up appointment/contact within seven (7) days. The case manager will provide linkage/referral to physicians/medication services, psychotherapy services, rehabilitation and/or support services as described in the case management service plan.

(C) Case ~~Managers~~managers may also provide crisis diversion (unanticipated, unscheduled situation requiring supportive assistance, ~~face-to-face~~face to face or telephone, to resolve immediate problems before they become overwhelming and severely impair the individual's ability to function or maintain in the community) to assist member(s) from progression to a higher level of care. During the follow-up phase of these referrals or links, the behavioral health case manager will provide aggressive outreach if appointments or contacts are missed within two (2) business days of the missed appointments. Community/home based case management to assess the needs for services will be scheduled as reflected in the case management service plan, but not less than one (1) time per month. The member/parent/guardian has the right to refuse behavioral health case management and cannot be restricted from other services because of a refusal of behavioral health case management services.

~~(B)~~(D) An eligible member/parent/guardian will not be restricted and will have the freedom to choose a behavioral health case management provider as well as providers of other medical care.

~~(C)~~ (E) In order to ensure that behavioral health case management services appropriately meet the needs of the member and family and are not duplicated, behavioral health case management activities will be provided in accordance with an individualized plan of care.

~~(D)~~ (F) The individual plan of care must include general goals and objectives pertinent to the overall recovery of the member's (and family, if applicable) needs. Progress notes must relate to the individual plan of care and describe the specific activities to be performed. The individual plan of care must be developed with participation by, as well as, reviewed and signed by the member, the parent or guardian [if the member is under eighteen (18)], the behavioral health case manager, and ~~a licensed behavioral health professional (LBHP)~~an LBHP or licensure candidate as defined in OAC 317:30-5-240.3(a) and (b).

~~(E)~~ (G) SoonerCare reimbursable behavioral health case management services include the following:

(i) Gathering necessary psychological, educational, medical, and social information for the purpose of individual plan of care development.

(ii) Face-to-face meetings with the member and/or the parent/guardian/family member for the implementation of activities delineated in the individual plan of care.

(iii) Face-to-face meetings with treatment or service providers, necessary for the implementation of activities delineated in the individual plan of care.

(iv) Supportive activities such as ~~non-face-to-face~~non face-to-face communication with the member and/or parent/guardian/family member.

(v) Non face-to-face communication with treatment or service providers necessary for the implementation of activities delineated in the individual plan of care.

(vi) Monitoring of the individual plan of care to reassess goals and objectives and assess progress and or barriers to progress.

(vii) Crisis diversion (unanticipated, unscheduled situation requiring supportive assistance, ~~face-to-face~~face to face or telephone, to resolve immediate problems before they become overwhelming and severely impair the individual's ability to function or maintain in the community) to assist member(s) from progression to a higher level of care.

(viii) Behavioral ~~Health Case Management~~health targeted case management is available to individuals transitioning from institutions to the community [except individuals ages twenty-two (22) to sixty-four (64) who reside in an ~~institution for mental diseases (IMD)~~IMD or individuals who are inmates of public institutions]. Individuals are

considered to be transitioning to the community during the last thirty (30) consecutive days of a covered institutional stay. This time is to distinguish case management services that are not within the scope of the institution's discharge planning activities from case management required for transitioning individuals with complex, chronic, medical needs to the community. Transition services provided while the individual is in the institution are to be claimed as delivered on the day of discharge from the institution.

~~(2) **Levels of Case Management.**~~

~~(A) Resource coordination services are targeted to adults with serious mental illness and children and adolescents with mental illness or serious emotional disturbance, and their families, who need assistance in accessing, coordination, and monitoring of resources and services. Services are provided to assess an individual's strengths and meet needs in order to achieve stability in the community. Standard managers have caseloads of thirty (30) to thirty-five (35) members. Basic case management/resource coordination is limited to sixteen (16) units per member per year. Additional units may be authorized up to twenty-five (25) units per member per month if medical necessity criteria are met.~~

~~(B) Intensive Case Management (ICM) is targeted to adults with serious and persistent mental illness in PACT programs and Wraparound Facilitation Case Management (WFCM) is targeted to children with serious mental illness and emotional disorders being treated in a System of Care Network who are deemed high risk and in need of more intensive CM services. It is designed to ensure access to community agencies, services, and people whose functions are to provide the support, training and assistance required for a stable, safe, and healthy community life, and decreased need for higher levels of care. To produce a high fidelity wraparound process, a facilitator can facilitate between eight (8) and ten (10) families. To ensure that these intense needs are met, case manager caseloads are limited between ten (10) to fifteen (15) caseloads. The ICM shall be a Certified Behavioral Health Case Manager, have a minimum of two (2) years Behavioral Health Case Management experience, crisis diversion experience, must have attended the ODMHSAS six (6) hours ICM training, and twenty-four (24) hour availability is required. ICM/WFCM is limited to fifty-four (54) units per member per month.~~

~~(3) **Excluded Services**. SoonerCare reimbursable behavioral health case management does not include the following activities:~~

~~(A) physically escorting or transporting a member or family to scheduled appointments or staying with the member during an appointment;~~

~~(B) managing finances;~~

~~(C) providing specific services such as shopping or paying bills;~~

~~(D) delivering bus tickets, food stamps, money, etc.;~~

~~(E) counseling, rehabilitative services, psychiatric assessment, or discharge planning;~~

~~(F) filling out forms, applications, etc., on behalf of the member when the member is not present;~~

~~(G) filling out SoonerCare forms, applications, etc.;~~

~~(H) mentoring or tutoring;~~

~~(I) provision of behavioral health case management services to the same family by two separate behavioral health case management agencies;~~

~~(J) non-face-to-face time spent preparing the assessment document and the service plan paperwork;~~

~~(K) monitoring financial goals;~~

~~(L) services to nursing home residents;~~

~~(M) psychotherapeutic or rehabilitative services, psychiatric assessment, or discharge; or~~

~~(N) services to members residing in ICF/IID facilities.~~

~~(O) leaving voice or text messages for clients and other failed communication attempts.~~

~~(4) **Excluded Individuals.** The following SoonerCare members are not eligible for behavioral health case management services:~~

~~(A) children/families for whom behavioral health case management services are available through Oklahoma Department of Human Services (OKDHS) and Oklahoma Office of Juvenile Affairs (OJA) staff without special arrangements with OKDHS, OJA, and the Oklahoma Health Care Authority (OHCA);~~

~~(B) members receiving Residential Behavior Management Services (RBMS) in a foster care or group home setting unless transitioning into the community;~~

~~(C) residents of Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) and nursing facilities unless transitioning into the community;~~

~~(D) members receiving services under a Home and Community Based services (HCBS) waiver program; or~~

~~(E) members receiving services in the Health Home program.~~

~~(5) **Filing Requirements.** Case management services provided to Medicare eligible members should be filed directly with the fiscal agent.~~

~~(6) **Documentation requirements.** The service plan must include general goals and objectives pertinent to the overall recovery needs of the member. Progress notes must relate to the service~~

~~plan and describe the specific activities performed. Behavioral health case management service plan development is compensable time if the time is spent communicating with the member and it must be reviewed and signed by the member, the behavioral health case manager, and a licensed behavioral health professional or licensure candidate as defined at OAC 317:30-5-240.3(a) and (b). All behavioral health case management services rendered must be reflected by documentation in the records. In addition to a complete behavioral health case management service, plan documentation of each session must include but is not limited to:~~

~~(A) date;~~
~~(B) person(s) to whom services are rendered;~~
~~(C) start and stop times for each service;~~
~~(D) original signature or the service provider [original signatures for faxed items must be added to the clinical file within thirty (30) days];~~
~~(E) credentials of the service provider;~~
~~(F) specific service plan needs, goals and/or objectives addressed;~~
~~(G) specific activities performed by the behavioral health case manager on behalf of the child related to advocacy, linkage, referral, or monitoring used to address needs, goals and/or objectives;~~
~~(H) progress and barriers made towards goals, and/or objectives;~~
~~(I) member (family when applicable) response to the service;~~
~~(J) any new service plan needs, goals, and/or objectives identified during the service; and~~
~~(K) member satisfaction with staff intervention.~~

~~(7) **Case Management Travel Time.** The rate for case management services assumes that the case manager will spend some amount of time traveling to the member for the face-to-face service. The case manager must only bill for the actual face-to-face time that they spend with the member and not bill for travel time. This would be considered duplicative billing since the rate assumes the travel component already.~~

(2) **Levels of case management.**

(A) Standard case management/resource coordination services are targeted to adults with serious mental illness or children with serious emotional disturbance, or who have or are at-risk for mental disorders, including substance use disorders (SUD), and their families, who need assistance in accessing, coordination, and monitoring of resources and services. Services are provided to assess an individual's strengths and meet needs in order to achieve stability in the community. Standard case managers have caseloads of thirty (30) to thirty-five (35) members. Standard case

management/resource coordination is limited to twelve (12) units per member per month. Additional units may be authorized up to twenty-five (25) units per member per month if medical necessity criteria for transitional case management are met.

(B) Intensive case management (ICM) is targeted to adults with serious and persistent mental illness in PACT programs. To ensure that these intense needs are met, caseloads are limited to between ten (10) to fifteen (15) members. The ICM shall: be a certified behavioral health case manager II; have a minimum of two (2) years' behavioral health case management experience; have crisis diversion experience; have attended the ODMHSAS six (6) hour ICM training and be available twenty-four (24) hours a day. ICM is limited to fifty-four (54) units per member per month.

(C) Wraparound facilitation case management (WFCM) is targeted to children with significant mental health conditions being treated in a System of Care (SOC) Network who are deemed at imminent risk of out-of-home placement due to psychiatric or SUD reasons and in need of more intensive case management services. It is designed to ensure access to community agencies, services, and people whose functions are to provide the support, training and assistance required for a stable, safe, and healthy community life, and decreased need for higher levels of care. To produce a high fidelity wraparound process, a facilitator can facilitate between eight (8) and ten (10) families. Staff providing WFCM must meet the requirements for the SOC/WFCM. WFCM is limited to fifty-four (54) units per member per month.

(3) **Excluded services.** SoonerCare reimbursable behavioral health case management does not include the following activities:

(A) Physically escorting or transporting a member or family to scheduled appointments or staying with the member during an appointment;

(B) Managing finances;

(C) Providing specific services such as shopping or paying bills;

(D) Delivering bus tickets, food stamps, money, etc.;

(E) Counseling, rehabilitative services, psychiatric assessment, or discharge planning;

(F) Filling out forms, applications, etc., on behalf of the member when the member is not present;

(G) Filling out SoonerCare forms, applications, etc.;

(H) Mentoring or tutoring;

(I) Provision of behavioral health case management services to the same family by two (2) separate behavioral health case management agencies;

(J) Non-face-to-face time spent preparing the assessment document and the service plan paperwork;

(K) Monitoring financial goals;

(L) Leaving voice or text messages for clients and other failed communication attempts.

(4) **Excluded individuals.** The following SoonerCare members who are receiving similar services through another method are not eligible for behavioral health case management services without special arrangements with the Oklahoma Department of Human Services (OKDHS), OJA, OHCA or ODMHSAS as applicable, in order to avoid duplication in payment. Services/programs include, but may not be limited to:

(A) Members/families (when applicable) for whom at-risk case management services are available through OKDHS and OJA staff;

(B) Members in out-of-home placement and receiving targeted case management services through staff in a foster care or group home setting, unless transitioning into the community;

(C) Residents of ICF/IIDs and nursing facilities unless transitioning into the community;

(D) Members receiving targeted case management services under a Home and Community Based Services (HCBS) waiver program;

(E) Members receiving services in the health home program;

(F) Members receiving case management through the ADvantage waiver program;

(G) Members receiving targeted case management available through a Certified Community Behavioral Health Center (CCBHC);

(H) Members receiving case management services through Programs of All-Inclusive Care for the Elderly (PACE); or

(I) Members receiving Early Intervention case management (EICM);

(J) Members receiving case management services through certified school-based targeted case management (SBTCM) providers;

(K) Members receiving partial hospitalization services; or

(L) Members receiving MST.

(5) **Filing requirements.** Case management services provided to Medicare eligible members should be filed directly with the fiscal agent.

(6) **Documentation requirements.** The service plan must include general goals and objectives pertinent to the overall recovery needs of the member. Progress notes must relate to the service plan and describe the specific activities performed. Behavioral health case management service plan development is compensable time if the time is spent communicating with the member and it must be reviewed and signed by the member, the behavioral health

case manager, and an LBHP or licensure candidate as defined at OAC 317:30-5-240.3(a) and (b). All behavioral health case management services rendered must be reflected by documentation in the records. In addition to a complete behavioral health case management service, plan documentation of each session must include but is not limited to:

(A) Date;

(B) Person(s) to whom services are rendered;

(C) Start and stop times for each service;

(D) Original signature or the service provider [original signatures for faxed items must be added to the clinical file within thirty (30) days];

(E) Credentials of the service provider;

(F) Specific service plan needs, goals, and/or objectives addressed;

(G) Specific activities performed by the behavioral health case manager on behalf of the member related to advocacy, linkage, referral, or monitoring used to address needs, goals, and/or objectives;

(H) Progress and barriers made towards goals, and/or objectives;

(I) Member/family (when applicable) response to the service;

(J) Any new service plan needs, goals, and/or objectives identified during the service; and

(K) Member satisfaction with staff intervention.

(7) **Case management travel time.** The rate for case management services assumes that the case manager will spend some amount of time traveling to the member for the face-to-face service. The case manager must only bill for the actual face-to-face time that they spend with the member and not bill for travel time. This would be considered duplicative billing since the rate assumes the travel component already.

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

**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**

**PART 5. PHARMACIES**

**317:30-5-86. Drug Utilization Review (DUR) ~~Program~~program**

~~(a) OHCA is authorized by federal statute to conduct prospective and retrospective review of pharmacy claims to insure that prescriptions are:~~

~~(1) appropriate,~~

~~(2) medically necessary, and~~

~~(3) not likely to result in adverse medical results.~~

~~(b) OHCA is authorized to use this program to educate physicians, other prescribers, pharmacists, and patients and also to conserve program funds and personal expenditures and prevent fraud, abuse and misuse of prescriptions.~~

~~(c) OHCA utilizes a DUR Board managed by an outside contractor to review and analyze clinical and economic data available. The DUR Board reviews and makes recommendations based on predetermined standards submitted to them by the OHCA contractor(s) and, in concert with the retrospective review of claims data, makes recommendations for educational interventions, prospective DUR and the prior authorization process.~~

(a) The Oklahoma Health Care Authority (OHCA) Drug Utilization Review (DUR) program is authorized by regulations contained in the Omnibus Budget Reconciliation Act of 1990 (OBRA 90) to conduct prospective and retrospective review of pharmacy claims to ensure that prescriptions are:

(1) Appropriate;

(2) Medically necessary; and

(3) Not likely to result in adverse medical results.

(b) The OHCA is authorized to use this program to educate physicians, other prescribers, pharmacists, and patients and also to conserve program funds and personal expenditures and prevent fraud, abuse, and misuse of prescriptions.

(c) The OHCA utilizes a DUR Board managed by an outside contractor to review and analyze clinical and economic data available. The DUR Board reviews and makes recommendations based on predetermined standards submitted to it by the OHCA contractor(s) and, in concert with the retrospective review of claims data, makes recommendations for educational interventions, prospective DUR, and the prior authorization process.

(d) The DUR Board assesses data on drug use in accordance with predetermined standards, including, but not limited to:

(1) Monitoring for therapeutic appropriateness;

(2) Overutilization and underutilization;
(3) Appropriate use of generic products;
(4) Therapeutic duplication;
(5) Drug-disease contraindications;
(6) Drug-drug interaction;
(7) Incorrect drug dosage or duration of drug treatment; and
(8) Clinical abuse or misuse.

(e) The DUR Board is comprised of ten (10) members that are appointed according to 63 O.S. § 5030.1. DUR Board members with a conflict of interest with respect to OHCA, Medicaid members, and/or pharmaceutical manufacturers must recuse themselves/abstain from voting on any DUR actions related to the conflict of interest.

(f) The DUR program shall adhere to the provisions of Section 1396a(oo) of Title 42 of the United States Code.

(1) The OHCA has implemented the following claims review requirements:

(A) Opioid safety edits at the point-of-sale, including, but not limited to, day supply, early refills, duplicate fills, quantity limitations, and maximum daily morphine milligram equivalent (MME) safety edits. MME safety edits will automatically decline reimbursement of prescription drugs that exceed an established daily MME limit.

(B) Claims review automated process that monitors concurrent use of opioid(s) with benzodiazepine(s) and/or antipsychotic(s).

(C) The prescriptions in (A) and (B) may be reimbursed upon a showing of medical necessity, as evidenced by a prior authorization approved by OHCA or its designee or contractor.

(2) The OHCA has implemented a program to monitor the appropriate use of antipsychotic prescribing for children. The OHCA, or its contractor or designee, regularly reviews a sample of all antipsychotics prescribed to members aged eighteen (18) and younger, including, but not limited to, foster children, that were reimbursed by Medicaid, for safety and appropriate utilization.

(3) The OHCA has implemented a process to identify potential fraud or abuse of controlled substances by members, pharmacies, and prescribing clinicians.

(g) All prescribing clinicians and/or pharmacists shall adhere to appropriate prescribing practices that are consistent with state and federal regulations or may be subject to agency review processes, audits, recoupment, and/or termination of Medicaid contracts [refer to the Oklahoma Administrative Code (OAC), including, but not limited to, 317:30-3-2.1, 317:30-3-19.5, 317:30-3-33, and 317:30-5-70.1].

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**
**CHAPTER 2. GRIEVANCE PROCEDURES AND PROCESS**

**317:2-1-2. Appeals**

(a) **Request for ~~Appeal~~appeals.**

(1) For the purpose of calculating the timeframe for requesting an administrative appeal of an agency action, the date on the written notice shall not be included. The last day of the ~~thirty-day (30-day)~~ timeframe shall be included, unless it is a legal holiday as defined by Title 25 of the Oklahoma Statutes (O.S.) ~~§~~ Section (§) 82.1, or any other day the Oklahoma Health Care Authority (OHCA) is closed or closes early, in which case, the timeframe runs until the close of the next full business day.

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

(b) **Member ~~Process Overview~~process overview.**

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

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

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

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

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

(6) Upon receipt of the member's appeal, a fair hearing before the ALJ will be scheduled. The member will be notified in writing of the date and time of the hearing. The member must appear at the hearing, either in person or telephonically. Requests for a telephone hearing must be received in writing on

OHCA's LD-4 (Request for Telephonic Hearing) form no later than ten (10) calendar days prior to the scheduled hearing date. Telephonic hearing requests will only be granted by the OHCA's ~~Chief Executive Officer~~chief executive officer (CEO) or his/her designee, at his/her sole discretion, for good cause shown, including, for example, the member's physical condition, travel distances, or other limitations that either preclude an in-person appearance or would impose a substantial hardship on the member.

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

(8) Member appeals are ordinarily decided within ninety (90) days from the date on which the member's timely request for a fair hearing is received, unless~~, in accordance with Section 431.244(f) of Title 42 of the Code of Federal Regulations~~:

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

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

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

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

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

(c) **Provider ~~Process Overview~~process overview.**

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

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

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

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

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

appeal.

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

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

(1) **Member ~~Appeals~~appeals.**

(A) Discrimination complaints regarding the SoonerCare program;

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

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

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

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

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

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

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

(2) **Provider ~~Appeals~~appeals.**

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

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

(C) Appeals by ~~Long Term Care~~long-term care facilities for administrative penalty determinations as a result of findings made under OAC 317:30-5-131.2(b)(5)(B) and (d)(8);

(D) Appeals of Professional Service Contract awards and other matters related to the Central Purchasing Act pursuant to Title 74 O.S. § 85.1 et seq.;

(E) Drug rebate appeals;

(F) Provider appeals of OHCA Program Integrity audit findings pursuant to OAC 317:2-1-7. This is the final and only appeals process for appeals of OHCA Program Integrity audit findings;

(G) Oklahoma Electronic Health Records Incentive program appeals related only to incentive payments, incentive payment amounts, provider eligibility determinations, and

demonstration of adopting, implementing, upgrading, and meaningful use eligibility for incentives;
(H) Supplemental Hospital Offset Payment Program (SHOPP) annual assessment, ~~Supplemental Payment~~supplemental payment, fees or penalties as specifically provided in OAC 317:2-1-15; ~~and~~
(I) The Nursing Facility Supplemental Payment Program (NFSPP) and its issues consisting of the amount of each component of the ~~Intergovernmental~~intergovernmental transfer, the Upper Payment Limit payment, the Upper Payment Limit gap, and the penalties specifically provided in OAC 317:30-5-136. This is the final and only process for appeals regarding NFSPP~~.~~; and
(J) Appeals from any adjustment made to a long-term care facility's cost report pursuant to OAC 317:30-5-132, including any appeal following a request for reconsideration made pursuant to OAC 317:30-5-132.1.

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

~~Other grievance procedures and processes include those set out in Oklahoma Administrative Code (OAC) 317:2-1-7 (Program Integrity Audit Appeals); OAC 317:2-1-9 (OHCA's Designated Agent's Appeal Process for QIO Services); OAC 317:2-1-10 (Drug Rebate Appeal Process); OAC 317:2-1-11 [Medicaid Drug Utilization Review Board (DUR) Appeal Process]; OAC 317:2-1-12 (For Cause and Immediate Provider Contract Termination Appeals Process); OAC 317:2-1-14 (Contract Award Protest Process); and OAC 317:2-1-15 (Supplemental Hospital Offset Payment Program (SHOPP) Appeals).~~

**317:2-1-13. Appeal to the ~~Chief Executive Officer~~chief executive officer**

(a) The Oklahoma Health Care Authority offers approximately forty (40) different types of administrative appeals. Some of the appeals are appealable to the ~~Chief Executive Officer~~chief executive officer (CEO) and some are not. The following appeals may be heard by the CEO following the decision of an ~~Administrative Law Judge~~administrative law judge:
(1) Appeals under Oklahoma Administrative Code (OAC) 317:2-1-2(d)(1)(A) to (d)(1)~~(G)~~(H), with the exception of subsection (d)(1)(E);
(2) Appeals under OAC 317:2-1-2(d)(2)(A) to (d)(2)(I), with the exceptions of subsections (d)(2)(F) and (G); and
(3) Appeals under 317:2-1-10.
(b) Appeals to the CEO must be filed with the OHCA within thirty (30) days of the date of the Order, or decision by OHCA.
(c) No new evidence may be presented to the CEO.
(d) Appeals to the CEO under (a) of this Section may be filed by the provider, member, or agency. The CEO will ordinarily render

decisions within sixty (60) days of the receipt of the appeal.

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

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

(1) Appeals will be heard by the Oklahoma Health Care Authority (OHCA) administrative law judge (ALJ).

(2) Appeals must be filed by the member within thirty (30) days of the date of the denial of a requested exception. Appeals must be filed electronically using a form LD-5 and must set forth the basis for the appeal. The form LD-5 shall be made available on the OHCA's public website. If the LD-5 is not completely filled out or if necessary documentation is not included, the appeal will not be considered.

(3) Appeals shall be heard at a time and place and in a manner as may be decided by the ALJ. Hearings may be conducted telephonically.

(4) The docket clerk will send the member or his/her authorized representative an electronic notice setting forth the location, date, and time of the hearing.

(5) A member can waive the right to an evidentiary hearing and permit the ALJ to consider and rule on the appeal based upon the parties' submissions.

(6) The member shall have the burden of proof by the preponderance of the evidence standard as defined by the Oklahoma Supreme Court.

(7) Absent exigent circumstances, as defined in OAC 317:30-5-77.4(a), the ALJ shall respond to any request for appeal within seventy-two (72) hours of receipt of the request. In the case of exigent circumstances, the ALJ shall respond within twenty-four (24) hours of receipt. Provided, however, that if the timeframe for response ends on a weekend, or on any other day the OHCA is closed or closes early, including, but not limited to, legal holidays as defined by 25 O.S. § 82.1, the timeframe for response shall run until the close of the next full business day. An appeal request that is not responded to within this timeframe shall be deemed granted.

(8) All orders shall be considered non-precedential decisions.

(9) The hearing shall be digitally recorded.

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

**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**

**PART 5. PHARMACIES**

**317:30-5-77.2. Prior authorization**

(a) **Definition.** The term prior authorization in pharmacy means an approval for payment by ~~OHCA~~the Oklahoma Health Care Authority (OHCA) to the pharmacy before a prescription is dispensed by the pharmacy. An updated list of all products requiring prior authorization is available at the agency's website.

(b) **Process.** Because of the required interaction between a prescribing provider (such as a physician) and a pharmacist to receive a prior authorization, OHCA allows a pharmacist up to thirty (30) calendar days from the point of sale notification to provide the data necessary for OHCA to make a decision regarding prior authorization. Should a pharmacist fill a prescription prior to the actual authorization he/she takes a business risk that payment for filling the prescription will be denied. In the case that information regarding the prior authorization is not provided within the thirty (30) days, claims will be denied.

(c) **Documentation.** Prior authorization petitions with clinical exceptions must be mailed or faxed to the Medication Authorization Unit of OHCA's contracted prior authorization processor. Other authorization petitions, claims processing questions and questions pertaining to ~~DUR~~Drug Utilization Review (DUR) alerts must be addressed by contacting the pharmacy help desk. Authorization petitions with complete information are reviewed and a response returned to the dispensing pharmacy within twenty-four (24) hours. Petitions and other claim forms are available on the OHCA public website.

(d) **Emergencies.** In an emergency situation, the OHCA will authorize a seventy-two (72) hour supply of medications to a member. The authorization for a seventy-two (72) hour emergency supply of medications does not count against the SoonerCare limit described in OAC 317:30-5-72(a)(1).

(e) **Utilization and scope.** There are three (3) reasons for the use of prior authorization: utilization controls, scope controls and product based controls. ~~Product based prior authorizations is~~ Product-based prior authorizations, including step therapy protocols as defined by Section 7310(A)(4) of Title 63 of the Oklahoma Statutes, are covered in OAC 317:30-5-77.3. The ~~Drug Utilization Review~~DUR Board recommends the approved clinical criteria and any restrictions or limitations.

(1) **Utilization controls.** Prior authorizations that fall under this category generally apply to the quantity of medication or

duration of therapy approved.

(2) **Scope controls.** Scope controls are used to ensure a drug is used for an approved indication and is clinically appropriate, medically necessary and cost effective.

(A) Medications which have been approved by the ~~FDA~~Food and Drug Administration (FDA) for multiple indications may be subject to a scope-based prior authorization when at least one (1) of the approved indications places that drug into a therapeutic category or treatment class for which a prior authorization is required. Prior authorizations for these drugs may be structured as step therapy or a tiered approach as recommended by the ~~Drug Utilization Review~~DUR Board and approved by the OHCA~~ Board of Directors~~.

(B) Prior authorization may be required to assure compliance with FDA approved and/or medically accepted indications, dosage, duration of therapy, quantity, or other appropriate use criteria including pharmacoeconomic consideration.

(C) Prior authorization may be required for certain non-standard dosage forms of medications when the drug is available in standard dosage forms.

(D) Prior authorization may be required for certain compounded prescriptions if the allowable cost exceeds a predetermined limit as published on the agency's website.

**317:30-5-77.3. ~~Product-Based Prior Authorization~~Product-based prior authorization (PBPA)**

~~The Oklahoma Health Care Authority utilizes a prior authorization system subject to their authority under 42 U.S.C. 1396r-8 and 63 O.S. 5030.3(B). The prior authorization program is not a drug formulary which is separately authorized in 42 U.S.C 1396r-8. Drugs are placed into two or more tiers based on similarities in clinical efficacy, side-effect profile and cost-effectiveness after recommendation by the Drug Utilization Review Board and approved by the OHCA Board of Directors. Drugs placed in tier number one generally require no prior authorization. Drugs placed in any tier other than tier number one may require prior authorization.~~

~~(1) Three general exceptions exist to the requirement of prior authorization:~~

~~(A) inadequate response to one or more tier one products,~~

~~(B) a clinical exception for a certain product in the particular therapeutic category, or~~

~~(C) the manufacturer or labeler of a product may opt to participate in the state supplemental drug rebate program to move a product from a higher tier to a lower tier which will remove or reduce the prior authorization requirement for that product.~~

~~(i) After a drug or drug category has been added to the~~

~~Prior Authorization program, OHCA or its contractor may establish a cost-effective benchmark value for each therapeutic category or individual drug. The benchmark value may be calculated based on an average cost, an average cost per day, a weighted average cost per day or any other generally accepted economic formula. A single formula for all drugs or drug categories is not required. Supplemental rebate offers from manufacturers which are greater than the minimum required supplemental rebate will be accepted and may establish a new benchmark rebate value for the category.~~

~~(ii) Manufacturers of products assigned to tiers number two and higher may choose to pay a supplemental rebate to the state in order to remove or reduce a prior authorization requirement on their product or products assigned to the higher tier.~~

~~(iii) Supplemental rebate agreements shall be in effect for one year and may be terminated at the option of either party with a 60 day notice. Supplemental rebate agreements are subject to the approval of CMS. Termination of a Supplemental Rebate agreement will result in the specific product reverting to the previously assigned higher tier in the PBPA program.~~

~~(iv) The supplemental unit rebate amount for a tier two or higher product will be calculated by subtracting the federal rebate amount per unit from the benchmark rebate amount per unit.~~

~~(v) Supplemental rebates will be invoiced concurrent with the federal rebates and are subject to the same terms with respect to payment due dates, interest, and penalties for non-payment as specified at 42 U.S.C. Section 1396r-8. All terms and conditions not specifically listed in federal or state law shall be included in the supplemental rebate agreement as approved by CMS.~~

~~(vi) Drugs or drug categories which are not part of the Product Based Prior Authorization program as outlined in 63 O.S. Section 5030.5 may be eligible for supplemental rebate participation. The OHCA Drug Utilization Review Board shall recommend supplemental rebate eligibility for drugs or drug categories after considering clinical efficacy, side effect profile, cost-effectiveness and other applicable criteria.~~

~~(2) All clinical exceptions are recommended by the Drug Utilization Review Board and demonstrated by documentation sent by the prescribing physician and/or pharmacist.~~

The Oklahoma Health Care Authority (OHCA) utilizes a PBPA system pursuant to its authority under Section 1396r-8 of Title 42 of the

United States Code and Section 5030.3(A) of Title 63 of the Oklahoma Statutes. The PBPA program, which includes step therapy protocols as defined in 63 O.S. § 7310(A)(4), is not a drug formulary, which is separately authorized in 42 U.S.C. § 1396r-8. In the PBPA system, drugs are placed into two (2) or more tiers based on similarities in clinical efficacy, side-effect profile, and cost-effectiveness, after recommendation by the Drug Utilization Review (DUR) Board and approval by the OHCA Board. Drugs placed in tier one (1) generally require no prior authorization; however, drugs placed in any tier may be subject to prior authorization.

(1) Exceptions to the requirement of prior authorization shall be granted based upon a properly-supported justification submitted by the prescribing provider demonstrating one (1) or more of the bases for exception identified in Oklahoma Administrative Code (OAC) 317:30-5-77.4(b)(3).

(2) The manufacturer or labeler of a product may opt to participate in the state supplemental drug rebate program to move a product from a higher tier to a lower tier which will remove or reduce the prior authorization requirement for that product. Supplemental rebate negotiations are done through Sovereign States Drug Consortium (SSDC); a multi-state purchasing pool.

(A) Supplemental rebate agreements shall be in effect for one (1) year and may be terminated at the option of either party with a sixty (60) day notice. Supplemental rebate agreements are subject to the approval of the Centers for Medicare and Medicaid Services (CMS). Termination of a supplemental rebate agreement will result in the specific product reverting to the previously assigned higher tier in the PBPA program.

(B) Drugs or drug categories which are not part of the PBPA program as outlined in 63 O.S. § 5030.5 may be eligible for supplemental rebate participation. The OHCA DUR Board may recommend supplemental rebate eligibility for drugs or drug categories after considering clinical efficacy, side effect profile, cost-effectiveness, and other applicable criteria.

**317:30-5-77.4. Step therapy exception process**

(a) **Definitions.**

(1) **"Exigent circumstances"** means circumstances in which a delay in receiving a prescription drug will jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.

(2) **"Step therapy"** or **"step therapy protocol"** means a protocol or program that establishes a specific sequence in which prescription drugs for a specified medical condition that are medically appropriate for a particular patient are covered by

Medicaid. Step therapy protocols are based upon the recommendation of the Drug Utilization Review (DUR) Board, as approved by the Oklahoma Health Care Authority (OHCA) Board.

(3) A **"step therapy exception"** means the process by which a step therapy protocol is overridden in favor of immediate coverage of a SoonerCare provider's selected prescription drug.

(b) **Process.** The step therapy exception process shall be initiated by a SoonerCare provider on behalf of a SoonerCare member. An exception can be requested following a denial of a prior authorization request for the specified prescription drug(s), or can be requested at the outset. In either case, the provider shall:

(1) Submit the exception request using the step therapy exception request form, which is available on the OHCA website and/or provider portal; and

(2) Submit with the step therapy exception request form, documentation or other information adequate to support the medical necessity for overriding the otherwise-applicable step therapy protocol for the particular prescription drug.

(3) A properly-supported step therapy exception request will be granted if it demonstrates that any of the following circumstances exists:

(A) The required prescription drug is contraindicated or will likely cause an adverse reaction or physical or mental harm to the patient;

(B) The required prescription drug is expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug;

(C) The patient has tried the required prescription drug while under the patient's current or a previous health insurance plan and such prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event;

(D) The required prescription drug is not in the best interest of the patient, based on medical necessity; or

(E) The patient is stable on a prescription drug selected by the patient's healthcare provider for the medical condition under consideration while on the patient's current or a previous health insurance plan.

(4) The OHCA or its contractor or designee may request additional information that is reasonably necessary to determine whether a step therapy exception request should be granted, as provided by Oklahoma law.

(c) **Notification.**

(1) The OHCA or its contractor or designee shall respond to any step therapy exception request within seventy-two (72) hours of the submission of a completed and properly-supported request. For exigent circumstances, the OHCA shall respond to the

exception request within twenty-four (24) hours of receipt. Provided, however, that if the timeframe for response ends on a weekend, or on any other day the OHCA is closed or closes early, including, but not limited to, legal holidays as defined by 25 O.S. § 82.1, the timeframe for response shall run until the close of the next full business day. Any exception request not responded to within this timeframe shall be deemed granted.

(2) The OHCA shall respond to a request for a step therapy exception by:

(A) Notifying the provider that the request is approved;

(B) Notifying the provider that the request is not approved based on medical necessity;

(C) Notifying the provider that the medical necessity of the requested exception cannot be approved or denied as a result of missing or incomplete documentation or information necessary to approve or disapprove the request;

(D) Notifying the provider that the member is no longer eligible for coverage; or

(E) Notifying the provider that the step therapy exemption request cannot be processed because it was not properly submitted using the required form.

(3) The rejection of a step therapy exception request based upon missing or incomplete documentation or other information, or because it was not properly submitted using the required form is not a denial, and shall not be subject to further appeal. It must, instead, be resubmitted as a new request for exception pursuant to this rule before it will be considered for approval.

(d) **Appeal.** If a step therapy exception request is denied, an appeal may be initiated by the member within thirty (30) days of the denial pursuant to Oklahoma Administrative Code (OAC) 317:2-1-18.

**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~~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 contract"** means the provider agreement specified in ~~OAC~~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) **"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~~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~~program.

(b) **Assignment in fee-for-service.** ~~The OHCA's~~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~~fee-for-service 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~~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 ~~Oklahoma Health Care Authority~~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 and SoonerCare programs.

(d) **Cost ~~Sharing-Copayments~~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~~fee-for-service 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 ~~21~~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 Service~~Community-Based Services (HCBS) waiver members except for prescription drugs.

(D) ~~Native Americans providing documentation of ethnicity in accordance with OAC 317:35-5-25 who receive items and services furnished by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services~~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~~tobacco cessation counseling and products.

(E) ~~Diabetic supplies.~~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 Nurses,~~practice registered nurses;

(iii) Physician ~~Assistants,~~assistants;

(iv) Optometrists~~,~~;

(v) Home ~~Health Agencies,~~health agencies;

(vi) Certified ~~Registered Nurse Anesthetists,~~registered nurse anesthetists;

(vii) Anesthesiologist ~~Assistants,~~assistants;

(viii) Durable ~~Medical Equipment~~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.

## SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

## PART 5. PHARMACIES

### 317:30-5-72. Categories of service eligibility

(a) **Coverage for adults.** Prescription drugs for categorically needy adults are covered as set forth in this subsection.

(1) With the exception of (2) and (3) of this subsection, categorically needy adults are eligible for a maximum of six (6) covered prescriptions per month with a limit of two (2) brand name prescriptions. A prior authorization may be granted for a third brand name if determined to be medically necessary by OHCA and if the member has not already utilized their six (6) covered prescriptions for the month.

(2) Subject to the limitations set forth in ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-5-72.1, 317:30-5-77.2, and 317:30-5-77.3, exceptions to the six (6) medically necessary prescriptions per month limit are:

(A) ~~unlimited~~Unlimited monthly medically necessary prescriptions for categorically related individuals who are residents of nursing facilities (NF) or ~~ICF/IID~~ intermediate care facilities for individuals with an intellectual disability (ICF/IID); and

(B) ~~seven~~Seven (7) additional medically necessary prescriptions which are generic products per month to the six (6) covered under the State Plan ~~(including three (3) brand name prescriptions)~~[including three (3) brand name prescriptions] are allowed for adults receiving services under the 1915(c) ~~HCBS Waivers~~Home and Community-Based Services (HCBS) waivers. Medically necessary prescriptions beyond the three (3) brand name or thirteen (13) total prescriptions will be covered with prior authorization.

(3) ~~Drugs exempt from the prescription limit include: Antineoplastics, anti-retroviral agents for persons diagnosed with Acquired Immune Deficiency Syndrome (AIDS) or who have tested positive for the Human Immunodeficiency Virus (HIV), certain prescriptions that require frequent laboratory monitoring, birth control prescriptions, over the counter contraceptives, hemophilia drugs, compensable smoking cessation products, naloxone for use in opioid overdose, certain carrier or diluent solutions used in compounds (i.e. sodium chloride, sterile water, etc.), and drugs used for the treatment of~~

~~tuberculosis. For purposes of this Section, exclusion from the prescription limit means claims filed for any of these prescriptions will not count toward the prescriptions allowed per month.~~For purposes of this Section, "exempt from the prescription limit" means claims filed for any of these prescriptions will not count toward the prescriptions allowed per month. Drugs exempt from the prescription limit include:

(A) Antineoplastics;

(B) Anti-retroviral agents for persons diagnosed with Acquired Immune Deficiency Syndrome (AIDS) or who have tested positive for the Human Immunodeficiency Virus (HIV);

(C) Frequently monitored prescription drugs. A complete list of the selected drugs considered as frequently monitored can be viewed on the agency's website at www.okhca.org.

(D) Medication-assisted treatment (MAT) drugs for opioid use disorder;

(E) Contraceptives;

(F) Hemophilia drugs;

(G) Compensable smoking and tobacco cessation products;

(H) Naloxone for use in opioid overdose;

(I) Certain carrier or diluent solutions used in compounds (i.e. sodium chloride, sterile water, etc.);

(J) Drugs used for the treatment of tuberculosis; and

(K) Prenatal vitamins.

(4) When a brand drug is preferred over its generic equivalent due to lower net cost, that drug shall not count toward the brand limit; however, it will count toward the monthly prescription limit.

(b) **Coverage for children.** Prescription drugs for SoonerCare eligible individuals under twenty-one (21) years of age are not limited in number per month, but may be subject to prior authorization, quantity limits or other restrictions.

(c) **Individuals eligible for Part B of Medicare.** Individuals eligible for Part B of Medicare are also eligible for the Medicare Part D prescription drug benefit. Coordination of benefits between Medicare Part B and Medicare Part D is the responsibility of the pharmacy provider. The SoonerCare pharmacy benefit does not include any products which are available through either Part B or Part D of Medicare.

(d) **Individuals eligible for a prescription drug benefit through a Prescription Drug Plan (PDP) or Medicare Advantage - Prescription Drug (MA-PD) plan as described in the Medicare Modernization Act (MMA) of 2003.** Individuals who qualify for enrollment in a PDP or MA-PD are specifically excluded from coverage under the SoonerCare pharmacy benefit. This exclusion applies to these individuals in any situation which results in a loss of Federal Financial Participation for the SoonerCare program. This exclusion shall not

apply to items covered at OAC 317:30-5-72.1(2) unless those items are required to be covered by the prescription drug provider in the MMA or subsequent federal action.

**317:30-5-77.1. Dispensing ~~Quantity~~quantity**

(a) Prescription quantities ~~are to~~ shall be limited to a ~~34~~thirty-four (34) day supply, except in the following situations:

(1) The Drug Utilization Review (DUR) Board has recommended a different day supply or quantity limit based on published medical data, including the manufacturer's package insert~~, provided the Chief Executive Officer of the OHCA has approved the recommendation~~;

(2) The product is included on the Maintenance List of medications, which are ~~exempt~~exempted from this limit, and may be dispensed up to ~~100 units~~a ninety (90) day supply;

(3) The manufacturer of the drug recommends a dispensing quantity less than a ~~34~~thirty-four (34) day supply~~;~~.

(b) Refills are to be provided only if authorized by the prescriber, allowed by law, and should be in accordance with the ~~best~~current medical and pharmacological practices. A provider may not generate automated refills unless the member has specifically requested such service. Documentation of this request must be available for review by OHCA auditors.

(c) The ~~Drug Utilization Review~~DUR Board shall develop a Maintenance List of medications which are used in general practice on a continuing basis. These drugs shall be made available through the ~~vendor drug program~~Vendor Drug Program in quantities up to ~~100 units~~a ninety (90) day supply when approved by the prescriber. The ~~Drug Utilization Review~~DUR Board shall review the Maintenance List at least annually. ~~The Maintenance List shall be approved by the Chief Executive Officer of OHCA.~~ When approved by the prescriber, all maintenance medications must be filled at the maximum quantity allowed after a sufficient stabilization period when dispensed to SoonerCare members who do not reside in a ~~long term~~long-term care facility. For members residing in a ~~long term~~long-term care facility, chronic medications, including all products on the Maintenance List, must be dispensed in quantities of not less than a ~~28~~twenty-eight (28) day supply.

(d) For products covered by the Oklahoma Vendor Drug Program, the metric quantity shown on the claim form must be in agreement with the descriptive unit of measure applicable to the specific ~~NDC~~National Drug Code (NDC). Only numeric characters should be entered. Designations, such as the form of drug, i.e., ~~Tabs, Caps, Suppositories,~~tabs, caps, suppositories, etc., must not be used. Products should be billed in a manner consistent with quantity measurements.

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**
**CHAPTER 45. INSURE OKLAHOMA**

**SUBCHAPTER 9. INSURE OKLAHOMA ESI EMPLOYEE ELIGIBILITY**

**317:45-9-4. Employee cost sharing**

Employees are responsible for up to ~~15 percent~~fifteen percent (15%) of their benefit plan premium. The employees are also responsible for up to ~~15 percent~~fifteen percent (15%) of their dependent's benefit plan premium if the dependent is included in the program. The combined portion of the employee's cost sharing for benefit plan premiums cannot exceed three percent of his/her annual gross household income computed monthly. ~~Native American children providing documentation of ethnicity are exempt from cost-sharing requirements, including premium payments and out-of-pocket expenses~~Cost-sharing, including premium payments and copayments, are not required of American Indian and Alaska Native members, as is established in the federally-approved Oklahoma Medicaid State Plan.

**SUBCHAPTER 11. INSURE OKLAHOMA IP**

**PART 5. INSURE OKLAHOMA IP MEMBER ELIGIBILITY**

**317:45-11-24. Member cost sharing**

(a) Members are given monthly invoices for their benefit plan premiums. IP health plan premiums are established by the OHCA. The premiums are due monthly and must be paid in full.

(1) Members are responsible for their monthly premiums, in an amount not to exceed four percent (4%) of their monthly gross household income.

(2) Working disabled individuals are responsible for their monthly premiums in an amount not to exceed four percent (4%) of their monthly gross household income, based on a family size of one and capped at ~~100 percent~~one-hundred percent (100%) of the Federal Poverty Level.

(3) ~~Native Americans providing documentation of ethnicity are exempt from premium payments~~Cost-sharing, including premium payments and copayments, are not required of American Indian and Alaska Native members, as is established in the federally-approved Oklahoma Medicaid State Plan.

(b) IP coverage is not provided until the premium and any other amounts due are paid in full. Other amounts due may include but are not limited to any fees, charges, or other costs incurred as a result of returned payments.

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

**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**

**PART 35. RURAL HEALTH CLINICS**

**317:30-5-359.1. Cost reports**

(a) Provider-based ~~RHCs~~Rural Health Clinics (RHC) are required to report each RHC on a separate clinic line cost center on the Medicare Cost Report (HCFA 2552). A copy of the HCFA 2552, including the Medicaid Supplemental Worksheet S-2, is submitted to the ~~OHCA~~Oklahoma Health Care Authority (OHCA) as part of the year-end cost report process of the parent hospital. ~~(Refer to OAC 317:30-5-48).~~

(b) Independent RHCs are required to submit to the OHCA a completed copy of the Medicare Cost Report for the annual cost reporting period (HCFA 222-92) within the due date for filing the cost report to the fiscal intermediary. Preventive services, i.e., prenatal, EPSDT and family planning visits, should not be counted in total visits in the Medicare cost report. The associated cost for the ~~rural health clinic~~RHC services covered by Medicaid only should be reported as a non-reimbursable cost on the clinic's Medicare cost report.

~~(c) If the clinic does not submit an adequate annual report on time, the OHCA may reduce or suspend payments to preclude excess payment to the clinic.~~

**317:30-5-359.2. Reimbursement**

(a) **Provider-based clinics.** ~~Interim payments for provider-based clinics will be made for RHC "core" services based on an all-inclusive visit fee established by reference to payments to other Rural Health Clinics in the same or adjacent areas or by cost reporting methods. The interim rate for core services will be reviewed and revised as appropriate, based on cost data from an initial cost report. Costs will be determined from the parent hospital's cost-to-charge ratios per the HCFA-2552 Medicare (or Medicaid, when filed) Worksheet C, Part 1, Computation of Ratio of Costs to Charges. Lower of cost or charge provision will be calculated using the lesser of costs or two times charges (as determined by averaged cost to charge ratios based on FY 95 cost reports). After the initial year and the per visit rate are established, the rate will be updated annually by the increase in the MEI.~~Payments for provider-based clinics will be made for RHC "core" services based on an all-inclusive visit fee established by one of the following:

(1) An interim rate established by calculating a statewide average rate for RHCs in the state; and

(2) The statewide average rate will be updated annually by the increase in the Medicare Economic Index (MEI); or

(3) An Alternative Payment Methodology (APM) established by the RHC periodic rate notification from the Medicare Fiscal Intermediary. In order to receive this rate, the RHC must submit a copy of the periodic rate notification letter for its most recent full cost reporting year received from the fiscal intermediary to the state. The APM rate cannot be lower than mentioned above in (a)(1) or (a)(2).

(b) **Independent clinics.** ~~Interim payments for independent clinics will be made for RHC "core" services based on the all-inclusive rate established by reference to payments to other Rural Health Clinics in the same or adjacent areas or by cost reporting methods. The interim rate for core services will be reviewed and revised as appropriate, based on cost data from an initial 12 month cost report and payments may be subject to adjustment at the end of the reporting period. After the initial year and the per visit rate are established, the rate will be updated annually by the increase in the MEI. For clinics that offer "other ambulatory" services and preventive services, payment will be made on a reasonable charge basis in accordance with Medicaid fee schedule guidelines.~~ Payments for independent clinics will be made for RHC "core" services based on an all-inclusive visit fee established by one of the following:

(1) An interim rate established by calculating a statewide average rate for RHCs in the state; and

(2) The statewide average rate will be updated annually by the increase in the MEI; or

(3) An APM established by the RHCs periodic rate notification from the Medicare Fiscal Intermediary. In order to receive this rate, the RHC must submit a copy of the periodic rate notification letter for its most recent full cost reporting year received from the fiscal intermediary to the state. The APM rate cannot be lower than mentioned above in (b)(1) or (b)(2).

**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 ~~renedering~~rendering laboratory into two 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.

(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 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 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.

(B) Interpretation of clinical laboratory procedures.

**317:30-5-20.1. ~~Urine drug~~Drug screening and testing**

(a) **Purpose.** ~~Urine~~ Drug Testing ~~(UDT)~~ 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 ~~urine~~ 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 ~~urine~~ 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 ~~urine~~ 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.** ~~Urine drug~~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 ~~urine~~ 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) ~~urine~~ 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 ~~urine~~ 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 ~~urine~~ 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 ~~30~~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 ~~UDT~~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 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**

**PART 1. PHYSICIANS**

**317:30-5-20.2. Molecular Diagnostic Testing Utilizing Polymerase Chain Reaction for Infectious Diseases**

(a) **Definitions.** The following words and terms, when used in this Section, shall have the following meaning, unless the context clearly indicates otherwise.

(1) **"Polymerase Chain Reaction (PCR)"** means a biochemical laboratory technique used to make thousands or even millions of copies of a segment of DNA. It is commonly used to amplify a small amount of specifically targeted DNA from among a mixture of DNA samples. It is also known as Nucleic Acid Amplification Test (NAAT).

(2) **"Direct Probe Technique"** means detection methods where nucleic acids are detected without initial amplification processing.

(3) **"Amplified Probe Technique"** means technique without quantification, a detection method in which the sensitivity of the assay is improved over direct probe techniques.

(4) **"Probe with Quantification Technique"** means methods used to report absolute or relative amounts of nucleic acid sequences in the original sample.

(c) **Medical necessity.**

(1) PCR testing for infectious diseases, following clinical guidelines such as those set forth by the Infectious Disease Society of America's (IDSA) or other nationally recognized medical professional academy or society standards of care, may be compensable.

(2) For the full PCR guideline which includes medically necessity and prior authorization criteria, and a list of codes that require authorization, please refer to www.okhca.org.

(d) **Documentation.**

(1) The medical record must contain documentation that the testing is expected to influence treatment of the condition towards which the testing is directed.

(2) The laboratory or billing provider must have on file the physician requisition which sets forth the diagnosis or condition that warrants the test(s).

(3) Examples of documentation requirements for the ordering provider include, but are not limited to, history and physical exam findings that support the decision making, problems/diagnoses, relevant data (e.g., lab testing results).

(4) Documentation requirements for the performing laboratory include, but are not limited to, lab accreditation, test requisition, test records, preliminary and final report, and quality control record.
(5) Documentation requirements for lab developed tests/protocols include diagnostic test/assay, lab manufacturer, names of comparable assays/services (if relevant), descriptions of assay, analytical validity evidence, clinical validity evidence, and clinical utility.
(6) Billing providers are required to code specificity; however, if an unlisted or not otherwise specified Current Procedural Terminology (CPT) code is used, the documentation must clearly identify the unique procedure performed. When multiple procedure codes are submitted (unique, unlisted, and/or not otherwise specified), the documentation supporting each code should be easily identifiable. If on review the billed code cannot be linked to the documentation, this service may be denied.
(7) When the documentation does not meet the criteria for the service rendered/requested or the documentation does not establish the medical necessity for the service, the service may be denied as not reasonable and necessary.

**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**

**317:35-5-41.1. Home/real property**

(a) Home property is excluded from resources regardless of value unless the individual is applying for long-term care services [See Oklahoma Administrative Code (OAC) 317:35-5-41.8(a) (relating to eligibility for long-term care services)]. For purposes of the home property resource exclusion, a home is defined as any shelter in which the individual has an ownership interest and which is used by the individual as his/her principal place of residence. The home may be either real or personal property, fixed or mobile.

(1) Home property includes all property which is adjacent to the home. Land is considered adjacent even if separated by a boundary line, street, alley, highway, or waterway.

(2) Property has a value regardless of whether there is an actual offer to purchase. Verification of home/real property value is established by collateral contacts with specialized individuals knowledgeable in the type and location of property being considered. Mineral rights and wind rights associated with the home property are not valued separate from the surface.

(3) The home may be retained without affecting eligibility during periods when it is necessary to be absent for illness or other necessity. When it is determined that the member does not have a feasible plan for and cannot be expected to return to his/her home, the market value of the property is considered in relation to the resource. The member is responsible for taking all steps necessary to convert the resource for use in meeting current needs. If the member is making an effort to make the resource available, a reasonable period of time is given [not to exceed ninety (90) days] to convert the resource. He/she is advised in writing that the ninety-day (90-day) period begins with the determination that the property be considered in relation to the resource. The ninety-day (90-day) period is given only if efforts are in progress to make the resource available. Any extension beyond the initial ninety-day (90-day) period is justified only after interviewing the member, determining that a good faith effort to sell is still being made and failure to sell is due to circumstances beyond the control of the member. A written notification is also provided to the member at any time an extension is allowed. Detailed documentation in the case record is required.

(4) If the member fails or is unwilling to take steps necessary to convert the resource for use in meeting current needs, continuing eligibility cannot be established and the member is advised as to the effective date of closure and of the right to receive assistance when the resources are within the maximum allowable resources provided other conditions of eligibility continue to be met.

(5) When a member sells his/her home with the intention of purchasing another home or when an insurance payment for damage to the home is received, a reasonable period of time is given to reinvest the money in another home. A reasonable period of time is considered to not exceed a ninety-day (90-day) period. Extensions beyond the ninety (90) days may be justified only after interviewing the member; and determining that a good faith effort is still being made; and that completion of the transaction is beyond his/her control. This must be documented in the case record.

(6) At the point a member decides not to reinvest the proceeds from the sale of his/her home in another home, the member's plan for use of the proceeds is evaluated in relation to rules on resources disposed of while receiving assistance.

(7) A home traded for another home of equal value does not affect the member's eligibility status. If the home is traded for a home of lesser value, the difference may be invested in improvement of the new home.

(8) Absences from home for up to ninety (90) days for trips or visits or six (6) months for medical care (other than nursing facilities) do not affect receipt of assistance or the home exclusion as long as the individual intends to return home. Such absences, if they extend beyond those limits, may indicate the home no longer serves as the principal place of residence.

(9) Mineral rights, associated with the home property, are considered along with the surface rights and are excluded as a resource.

(b) Real property other than home property shall be treated as follows:

(1) Mineral rights which are not associated with the home property are considered as a resource. Since evaluation and ~~scalability~~salability of mineral rights fluctuate, the establishment of the value of mineral rights are established based on the opinion of collateral sources. Actual offers of purchase are used when established as a legitimate offer through a collateral source. Mineral rights not associated with home property which are income producing are considered in the same way as income producing property. Refer to OAC 317:35-5-41.12(c)(3) for treatment of mineral rights as non-trade or non-business property.

(2) The market value of real estate other than home property owned by the member or legal dependent and encumbrances against such property are ascertained in determining the equity (including the cost to the member of a merchantable title to be determined when the resource approaches the maximum). The market value of real estate other than the home owned by the applicant is established on the basis of oral or written information which the applicant has on hand and counsel with persons who have specialized knowledge about this kind of resource. Refer to OAC 317:35-5-41.12(c) for exclusion of real estate that produces income.

(3) For any individual (and spouse, if any) who is of Indian descent from a federally recognized Indian tribe, any interest in land which is held in trust by the United States for an individual Indian or tribe, or which is held by an individual Indian or tribe and which can only be sold, transferred, or otherwise disposed of with the approval of other individuals, his or her tribe, or an agency of the federal government, shall be excluded from resource determinations, in accordance with 20 Code of Federal Regulations (C.F.R.) ' 416.1234.

(4) A life estate conveys upon an individual or individuals for his/her lifetime, certain rights in property. Its duration is measured by the lifetime of the tenant or of another person; or by the occurrence of some specific event, such as remarriage of the tenant. The owner of a life estate has the right of possession, the right to use the property, the right to obtain profits from the property and the right to sell his/her life estate interest. However, the contract establishing the life estate may restrain one or more rights of the individual. The individual does not have title to all interest in the property and does not have the right to sell the property other than the interest owned during his/her lifetime. He/she may not usually pass it on to heirs in the form of an inheritance.

(A) When a life estate in property is not used as the member's home, it is necessary to establish the value. A computer procedure is available to compute the value of a life estate by input of the current market value of the property and the age of the life estate owner.

(B) The value of a life estate on mortgaged property is based on equity rather than market value and the age of the individual.

(C) In the event the member does not accept as valid the value of the life estate as established through this method, the member must secure a written ~~appraisal~~estimate by two (2) persons who are familiar with current values. If there is substantial unexplained divergence between these appraisals, the worker and the member will jointly arrange

for the market value to be established by an appraisal made by a third (3rd) person who is familiar with current market values and who is acceptable to both the member and the worker.

(5) Real and/or personal property which produces income is excluded if it meets the following conditions established in OAC 317:35-5-41.12.

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

(a) **General.** The term income is defined as ~~that~~a gross gain or gross recurrent benefit ~~which is derived~~that derives from labor, business, property, retirement and other benefits~~, and many other forms which can be counted on as currently~~or sources that are available for use on a regular basis. ~~When an individual's income is reduced due to recoupment of an overpayment or garnishment, the gross amount before the recoupment or garnishment is counted as income. Verification of the member's countable income or resources held in bank accounts or at other financial institutions can be established through an Asset Verification System (AVS).~~

(1) If it appears the applicant or SoonerCare member is eligible for any type of income (excluding Supplemental Security Income (SSI)) or resources, ~~he/she~~Oklahoma Department of Human Services (OKDHS) staff must ~~be notified~~notify the individual in writing ~~by the Agency~~ of his/her potential eligibility, per Section 416.210 of Title 20 of the Code of Federal Regulations (20 C.F.R. § 416.210). ~~The notice must contain the information that failure to file for and take all appropriate steps to obtain such benefit within thirty (30) days from the date of the notice will result in a determination of ineligibility.~~

(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 ~~a husband and wife are living~~spouses live in their own home, the couple's total income and/or ~~resource is~~resources are divided equally between the two 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).

~~(3)~~(4) If only one spouse in a couple is eligible and the couple ~~ceases to live~~stops living together, only the income and resources ~~of~~that the ineligible spouse ~~that are~~ actually ~~contributed~~contributes to the eligible spouse are considered in determining the eligible spouse's eligibility, beginning with the month after the month ~~which~~ they ~~ceased to live~~stop living together ~~are considered~~.

(4) ~~In calculating monthly income, cents are included in the computation until the monthly amount of each individual's source of income has been established. When the monthly amount of each income source has been established, cents are rounded to the nearest dollar (1 - 49 cents is rounded down, and 50 - 99 cents is rounded up). For example, an individual's weekly earnings of $99.90 are multiplied by 4.3 and the cents rounded to the nearest dollar ($99.90 x 4.3 = $429.57 rounds to $430). See rounding procedures in OAC 340:65-3-4 when using BENDEX to verify Retirement, Survivors, and Disability Insurance (RSDI) benefits.~~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.

(5) 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.

(6) 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.

(7) The individual is responsible for reporting and verifying income changes within ten (10) calendar days of the change occurring.

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

~~(1) The value of Supplemental Nutrition Assistance Program (food stamps) received;~~

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

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

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

~~(A) An acknowledgment of obligation to repay or evidence that the loan was from an individual or financial institution in the loan business. If the loan agreement is not written, an OKDHS 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, detailed case documentation must include information that the loan is bona fide and how the debt amount and date of receipt was verified.~~

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

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

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

(6) Indian payments (including judgment funds or funds held in trust) distributed by the Secretary of the Interior (Bureau of Indian Affairs) or distributed by the tribe subject to approval by the Secretary of the Interior. Also, any interest or investment income accrued on such funds while held in trust or any purchases made with judgment funds, trust funds, interest or investment income accrued on such funds. Any income from mineral leases, from tribal business investments, etc. However, any interest or income derived from the principal or produced by purchases made with funds after distribution is considered as any other income;

(7) Special allowance for school expenses made available upon petition (in writing) for funds held in trust for the student;

(8) Title III benefits from State and Community Programs on Aging;

(9) Payment for supportive services or reimbursement of out-of-pocket expenses made to individual volunteers serving as foster grandparents, senior health aides, or senior companions, and to persons serving in the Service Corps of Retired Executives (SCORE) and Active Corps of Executives (ACE);

(10) Payments to volunteers under the Domestic Volunteer Services Act of 1973 (VISTA), unless the gross amount of VISTA payments equals or exceeds the state or federal minimum wage, whichever is greater;

(11) The value of supplemental food assistance received under the Child Nutrition Act or the special food service program for children under the National School Lunch Act;

(12) Any portion of payments made under the Alaska Native Claims Settlement Act to an Alaska Native which are exempt from taxation under the Settlement Act;

(13) Reimbursements from an employer for out-of-pocket expenditures and allowances for travel or training to the extent the funds are used for expenses directly related to such travel or training and uniform allowance if the uniform is uniquely identified with company names or logo;

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

(15) Experimental Housing Allowance Program (EHAP) payments made under Annual Contributions Contracts entered into prior to January 1, 1975, under Section 23 of the U.S. Housing Act of 1937, as amended;

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

~~(17) Governmental rental or housing subsidies by governmental agencies, e.g., HUD (received in-kind or in cash) for rent, mortgage payments, or utilities;~~
~~(18) Low Income Home Energy Assistance Program (LIHEAP) payments for energy assistance and payments for emergency situations under Emergency Assistance to Needy Families with Children;~~
~~(19) Payments made from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In Re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.);~~
~~(20) Payments made from the Radiation Exposure Compensation Trust Fund as compensation for injuries or deaths resulting from the exposure to radiation from nuclear testing and uranium mining;~~
~~(21) Federal major disaster and emergency assistance provided under the Disaster Relief Act of 1974, and comparable disaster assistance provided by States, local governments, and disaster assistance organizations;~~
~~(22) Income of a sponsor to the sponsored eligible alien;~~
~~(23) Income that is set aside under an approved Plan for Achieving Self-Support for Blind or Disabled People (PASS). The Social Security Administration (SSA) approves the plan, the amount of income excluded and the period of time approved. A plan can be approved for an initial period of eighteen (18) months. The plan may be extended for an additional eighteen (18) months if needed, and an additional twelve (12) months (total forty- eight (48) months) when the objective involves a lengthy educational or training program;~~
~~(24) Payments made to individuals because of their status as victims of Nazi persecution (PL 103-286);~~
~~(25) Payments received under the Civil Liberties Act of 1988. These payments are to be made to individuals of Japanese ancestry who were detained in internment camps during World War II;~~
~~(26) Payments received as a result of participation in a class action lawsuit entitled "Factor VIII or IX Concentrate Blood Products Litigation". These payments are made to hemophilia patients who are infected with HIV. However, if the payments are placed in an interest-bearing account, or some other investment medium that produces income, the income generated by the account may be countable as income to the individual;~~
~~(27) Payments made to certain Vietnam veterans' children with spina bifida (PL 104-204);~~
~~(28) Payments made to certain Korea service veterans' children with spina bifida (PL 108-183);~~

~~(29) Payments made to the children of women Vietnam veterans who suffer from certain birth defects (PL 106-419);~~
~~(30) Additional payments of regular unemployment compensation in the amount of $25 per week ending June 30, 2010, and any amount of emergency unemployment compensation paid through May 31, 2010, as authorized under the American Recovery and Reinvestment Tax Act of 2009;~~
~~(31) Wages paid by the Census Bureau for temporary employment related to Census activities;~~
~~(32) Income tax refunds;~~
~~(33) Home energy assistance;~~
~~(34) Food or shelter based on need provided by nonprofit agencies;~~
~~(35) Money someone else spends to pay your expenses for items other than food or shelter (e.g., someone pays for your telephone or medical bills);~~
~~(36) Earned income for working students younger than twenty-two (22) years of age when they regularly attend a school, college, university or a course of vocational or technical training. Refer to Appendix C-1, Schedule VIII.E; Maximum Income, Resource and Payment Standards for the maximum monthly and yearly exclusion amounts;~~
~~(37) The cost of impairment-related work expenses for items or services that a disabled person needs in order to work; and~~
~~(38) The first $2,000 of compensation received per calendar year for participating in certain clinical trials.~~

(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 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 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 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 reduction rule.** The one-third 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 of the SSI federal benefit rate, per OKDHS Appendix C-1, Schedule VIII.C is counted as income.

(i) The one-third reduction rule applies in full or not at all. When the individual lives in another person's household and the one-third reduction rule applies, no income exclusions are applied to the reduction amount.

(ii) When the one-third reduction rule applies and the individual receives other support and maintenance, the other support and maintenance is not counted.

(iii) The one-third 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 reduction rule does not apply. The maximum presumed value is one-third of the SSI FBR, per OKDHS Appendix C-1, Schedule VIII.C plus the $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 of the SSI FBR, per OKDHS Appendix C-1, Schedule VIII.C plus the $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;

(5) Unused portions of a monthly exclusion must not be carried over for use in a subsequent month;

(6) Other than the $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 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

(F) 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 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 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 of child support payments received on behalf of the minor child with disabilities;

(12) The first twenty dollars ($20) of any unearned income received in a month other than income in the form of in-kind support and maintenance received in the household of another per (b)(8) of this Section and need-based income. Need-based income is a benefit that uses financial need as a factor to determine eligibility. The twenty dollars ($20) exclusion does not apply to a needs-based benefit that is totally or partially funded by the federal government or by a nongovernmental agency. However, assistance which is based on need and funded wholly by a State or one of its political subdivisions, such as SSP, is excluded totally from income. When the individual has less than twenty dollars ($20) of unearned income in a month, the rest of the twenty dollars ($20) exclusion may be deducted from the individual's countable earned income;

(13) Any unearned income received and used to fulfill an approved plan to achieve self-support (PASS) for an individual with disabilities or blindness. The Social Security Administration (SSA) approves the plan, the amount of income excluded, and the period of time approved;

(14) Federal housing assistance provided under:

(A) The U.S. Housing Act of 1937;

(B) The National Housing Act;

(C) Section 101 of the Housing and Urban Development Act of 1965;

(D) Title V of the Housing Act of 1949; or

(E) Section 202(h) of the Housing Act of 1959;

(15) Any interest accrued on and left to accumulate as part of the value of an excluded burial space purchase agreement. This exclusion from income applies to interest accrued on or after April 1, 1990;

(16) The value of any commercial transportation ticket among the fifty states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands, that is received as a gift and is not converted to cash;

(17) Payments received by an individual from a fund established by a state to aid crime victims;

(18) Relocation assistance provided by a state or local government that is comparable to assistance provided under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 that is subject to the treatment required by Section 216 of that Act;

(19) Special pay received from one of the uniformed services, per 37 U.S.C. § 310;

(20) Interest or other earnings on a dedicated account established for an eligible individual under eighteen (18) years of age when past due benefit payments must or may be paid

into such an account, per 20 C.F. R. § 416.1247;

(21) Gifts to children under eighteen (18) years of age with life-threatening conditions from an organization described in Section 501(c)(3) of the Internal Revenue Code of 1986, provided that:

(A) In-kind gifts not converted to cash; or

(B) Cash gifts do not exceed two-thousand dollars ($2,000) within a calendar year;

(22) Interest and dividend income from a countable resource or from a resource excluded under a federal statute other than Section 1613(a) of the Social Security Act;

(23) AmeriCorps State and National and Americorps National Civilian Community Corps cash or in-kind payments made to participants or on their behalf, such as food, shelter, and clothing allowances;

(24) Any annuity paid by a state to an individual, or his or her spouse, based on the State's determination that the individual is a veteran and is blind, disabled, or aged; and

(25) The first two-thousand dollars ($2,000) per calendar year received as compensation for participation in clinical trials that meet the criteria, per Section 1612(b)(26) of the Social Security Act.

(g) **Earned income exclusions.** Per 20 C.F.R. § 416.1112, earned income exclusions are applied after the unearned income exclusions, and in the order listed per (1) through (11) of this subsection. Earned income exclusions must not exceed the amount earned and include:

(1) Earned income tax credit and child tax credit payments;

(2) The first $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:

(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;

(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 of any remaining earned income in a month;

(9) Actual work expenses paid by individuals who are blind and under age sixty-five (65) or who receive SSI as a blind person the month before reaching the age of sixty-five (65), such as transportation expenses to and from work and job performance or improvement expenses;

(10) Earned income received and used to fulfill an approved plan to achieve self-support (PASS) for individuals who are blind or disabled and under sixty-five (65) years of age or who are blind and disabled and received SSI as a blind or disabled person for the month before reaching sixty-five (65) years of age. The SSA approves the plan, the amount of income excluded, and the period of time approved; and

(11) Payments made to participants in AmeriCorps State and National and AmeriCorps National Civilian Community Corps (NCCC). These payments may be made in cash or in-kind and may be made directly to the AmeriCorps participant or on the AmeriCorps participant's behalf. These payments include, but are not limited to: living allowance payments, stipends, educational awards, and payments in lieu of educational awards.

(h) **Unused exclusions.** Unused:

(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.

~~(c)~~ (i) ~~**Determination of income**~~**Monthly income determination**. ~~The member is responsible for reporting information regarding all sources of available income. This information is verified and used by the worker in determining eligibility.~~The total gross amount of earned and unearned income available to the eligible individual and eligible or ineligible spouse is determined before subtracting applicable unearned and earned income exclusions per (d) through (g) of this section. In calculating monthly income, cents are

included in the computation until the monthly amount of each income source is established. Once the monthly amount of each income source is established, cents are rounded to the nearest dollar (one (1) to forty-nine (49) cents is rounded down, and fifty (50) to ninety-nine (99) cents is rounded up).

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

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

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

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

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

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

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

~~(III) by using BENDEX and SDX.~~

~~(ii) Determination of OASDI benefits to be considered (disregarding COLA's) for former State Supplemental recipients who are reapplying for medical benefits under the Pickle Amendment must be computed according to OKDHS Form 08AX011E.~~

~~(iii) The Veterans Administration allows their recipients the opportunity to request a reimbursement for medical~~

~~expenses not covered by SoonerCare. If a recipient is eligible for the readjustment payment, it is paid in a lump sum for the entire past year. This reimbursement is disregarded as income and a resource in the month it is received; however, any amount retained in the month following receipt is considered a resource.~~

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

~~(I) **Nursing facility care.** VA Aid and Attendance or Champus payment whether paid directly to the member or to the facility, are considered as third party resources and do not affect the income eligibility or the vendor payment of the member.~~

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

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

~~(B) **SSI benefits.** SSI benefits may be continued up to three months for a recipient who enters a public medical or psychiatric institution, a SoonerCare approved hospital, extended care facility, intermediate care facility for 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.~~

(C) **Lump sum payments.**

(i) Any income received in a lump sum (with the exception of SSI and Retirement, Survivors, and Disability Insurance (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 from any lump sum source, excluding RSDI and SSI (with the exception of dedicated bank accounts for disabled/blind children under age eighteen (18)), retained on the first day of the next month is considered as a resource. Such lump sum payments may include, but are not limited to, accumulation of wages, VA benefits, Workers' Compensation, bonus lease payments and annual rentals from land and/or minerals.

(ii) OASDI and SSI retroactive payments do not count as income in the month of receipt. Any unspent portion of retroactive SSI and RSDI benefits is excluded from resources for nine (9) calendar months following the month of receipt. 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 will count toward the resource limit. Refer to 20 Code of Federal Regulations (CFR) ' 416.1233.

(iii) Lump sum payments used to establish dedicated bank accounts by representative payees in order to receive and maintain retroactive SSI benefits for disabled/blind children under age eighteen (18) are excluded as income. The interest income generated from dedicated bank accounts is also excluded. The dedicated bank account consisting of the retroactive SSI lump sum payment and accumulated interest is excluded as a resource in both the month received and any subsequent months.

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

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

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

(i) If royalty income is received monthly but in irregular

amounts, an average based on the previous six (6) months' royalty income is computed and used to determine income eligibility. When the difference between the gross and net income represents a production or severance tax (e.g., most oil royalties are reduced by this tax), the OHCA only uses the net figure when determining income eligibility. The production or severance tax is the cost of producing the income, and, therefore, is deducted from the gross income. Exception: At any time that the county becomes aware of and can establish a trend showing a dramatic increase or decrease in royalty income, the previous two (2) months' royalty income is averaged to compute countable monthly income.

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

(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 member is considered as income.

(E) **Earned income/self-employment**. The term "earned income" includes income in cash earned by an individual through the receipt of wages, salary, commission, or profit from activities in which he/she is engaged as a self-employed individual or as an employee. See subparagraph (G) of this paragraph for earnings received in fluctuating amounts. "Earned Income" is also defined to include in-kind benefits received by an employee from an employer in lieu of wages or in conjunction with wages. Such benefits received in-kind are considered as earned income only when the employee/employer relationship has been established. The cash value of the in-kind benefits must be verified by the employer. Income from self-employment also includes in-kind benefits for a work activity or service for which the self-employed person ordinarily receives payment in his/her business enterprise. An exchange of labor or services, e.g., barter, is considered as an in-kind benefit. Medical insurance secured through the employer, whether purchased or as a benefit, is not considered in-kind but is recorded on the case computer input document for coordination with SoonerCare benefits.

(i) Work study received by an individual who is attending school is considered as earned income with appropriate

~~earned income disregards applied.~~

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

(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 per calendar quarter of earned income; and

(ii) $60 per calendar quarter of unearned income.

~~(iii) Self-employment income is determined as follows:~~

(4) **Self-employment income determination.** Self-employment income is determined per (A) through (E) of this paragraph:

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

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

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

~~(IV) If a tax return is not available because one has not been filed due to recent establishment of the self-employment enterprise, a profit and loss statement must be seen to establish the monthly income amount.~~

~~(V) The purchase price and/or payment(s) on the principal of loans for capital assets, equipment, machinery, and other durable goods is not considered as a cost of producing self-employed income. Also not considered are net losses from previous periods, depreciation of capital assets, equipment, machinery, and other durable goods; and federal, state and local income taxes, FICA, money set aside for retirement purposes, and other work related personal expenses, such as meals and necessary transportation (these expenses are accounted for by the work related expense deduction given in OAC 340:10-3-33(1)).~~

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

(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.

~~(F) **Infrequent or irregular income.**~~

~~(i) 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.~~

~~(ii) Income is considered to be irregular if the individual cannot reasonably expect to receive it.~~

~~(iii) OHCA excludes the following amount of infrequent or irregular income:~~

~~(I) the first $30 per calendar quarter of earned income; and~~

~~(II) the first $60 per calendar quarter of unearned income.~~

~~(iv) Infrequent or irregular income, whether earned or unearned, that exceeds these amounts is considered countable income in the month it is received.~~

~~(G) **Monthly income received in fluctuating amounts.** Income~~

~~which is received monthly but in irregular amounts is averaged using two (2) months' income, if possible, to determine income eligibility. Less than two (2) months' income may be used when circumstances (e.g., new employment, unpaid sick leave, etc.) would indicate that previous income amounts would not be appropriate to use in determining future income amounts. Income received more often than monthly is converted to monthly amounts as follows:~~

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

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

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

~~(iv) **Biweekly.** Income received every two (2) weeks is multiplied by 2.15.~~

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

~~(I) **Income from the Job Training and Partnership Act (JTPA).** Unearned income received by an adult, such as a needs based payment, cash assistance, compensation in lieu of wages, allowances, etc., from a program funded by JTPA is considered as any other unearned income. JTPA earned income received as wages is considered as any other earned income.~~

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

(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.

~~(d)~~(j) **Computation of income.** After determining the individual's and his/her spouse's monthly income.

(1) ~~**Earned**~~**General income ~~or unearned income~~exclusion.** The general income exclusion of ~~$20~~twenty dollars ($20) per month

is ~~allowed for~~subtracted from ~~earned or unearned income, unless the unearned income is SSP, on~~ the combined unearned income of the eligible individual and eligible or ineligible spouse, unless the only unearned income is SSP. ~~See paragraph (5) of this subsection if there are ineligible minor children. After the $20 exclusion, deduct $65 and one-half of the remaining combined earned income. The total gross amount of unearned income of the eligible individual and eligible or ineligible spouse is considered.~~ 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.

~~(2) **Countable income.** The countable income is the sum of the earned income and the total gross unearned income after exclusions.~~

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

~~(A) An intellectually disabled child living in the home who is ineligible for SSP due to the deeming process may be approved for SoonerCare under the Home and Community Based Services Waiver (HCBS) Program as outlined in OAC 317:35-9-5.~~

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

~~(4) **Premature infants.** Premature infants (i.e., thirty-seven (37) weeks or less) whose birth weight is less than twelve hundred (1200) grams (approximately two (2) pounds ten (10) ounces) will be considered disabled by SSA even if no other medical impairment(s) exist. In this event, the parents' income is not deemed to the child until the month following the month in which the child leaves the hospital and begins living with his/her parents.~~

~~(5) **Procedures for deducting ineligible minor child allocation.** When an eligible individual has an ineligible spouse and ineligible minor children (not receiving TANF), the computation~~

~~is as follows:~~

~~(A) Each ineligible child's allocation (OKDHS Form 08AX001E, Schedule VII. C.) minus each child's gross countable income is deducted from the ineligible spouse's income. Deeming of income is not done from child to parent.~~

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

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

~~(6) **Special exclusions for blind individuals.** Any blind individual who is employed may deduct the general income exclusion and the work exclusion from the gross amount of earned income. After the application of these exclusions, one-half of the remaining income is excluded. The actual work expense is then deducted from the remaining half to arrive at the amount of countable income. If this blind individual has a spouse who is also eligible due to blindness and both are working, the amount of ordinary and necessary expenses attributable to the earning of income for each of the blind individuals may be deducted. Expenses are deductible as paid but may not exceed the amount of earned income. To be deductible, an expense need not relate directly to the blindness of the individual, it need only be an ordinary and necessary work expense of the blind individual. Such expenses fall into three (3) broad categories:~~

~~(A) transportation to and from work;~~

~~(B) job performance; and~~

~~(C) job improvement.~~

**(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 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.). 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.), 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 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 Affairs, State or local government assistance programs based on need;

(3) Any of the ineligible spouse's or parent's income that is used by a public income-maintenance program to determine that program's benefits to someone else;

(4) Income used to comply with the terms of court-ordered support, or support payments enforced under Title IV-D of the Social Security Act;

(5) Income the ineligible spouse or ineligible parent was paid under a federal, state, or local government program to provide the eligible spouse or child with chore, attendant, or homemaker services, such as payments under Title XX of the Social Security Act;

(6) Any portion of a grant, scholarship, fellowship, or gift used or set aside to pay tuition, fees or other necessary educational expenses;
(7) Money received for providing foster care to an ineligible child;
(8) The value of Supplemental Nutrition Assistance Program food benefits and the value of Department of Agriculture donated foods;
(9) Food raised by the spouse or parent and consumed by members of the household in which you live;
(10) Tax refunds on income, real property, or food purchased by the family;
(11) Income used to fulfill an approved plan for achieving self-support, per 20 C.F.R. §§ 416.1180 through 416.1182 and OAC 317:35-5-42(f)(13) and (g)(10);
(12) The value of in-kind support and maintenance as described in OAC 317:35-5-42(b)(8);
(13) Alaska longevity bonus payments;
(14) Disaster assistance, per 20 C.F.R. §§ 416.1150 and 416.1151;
(15) Income received infrequently or irregularly, per 20 C.F.R. §§ 416.1112(c)(1) and 416.1124(c)(6) and OAC 317:35-5-42(f)(6) and (g)(2);
(16) Work expenses if the ineligible spouse or parent is blind such as transportation expenses to and from work and job performance or improvement expenses;
(17) Certain support and maintenance assistance, per 20 C.F.R. § 416.1157(c) and OAC 317:35-5-42(e)(10);
(18) Housing assistance, per 20 C.F.R. §416.1124(c)(14);
(19) The value of a commercial transportation ticket, per 20 C.F.R. § 416.1124(c)(16). However, if such a ticket is converted to cash, the cash is income in the month your spouse or parent receives the cash;
(20) Refunds of Federal income taxes and advances made by an employer relating to an earned income tax credit, per 20 C.F.R. § 416.1112(c);
(21) Payments from a fund established by a State to aid victims of crime, per 20 C.F.R. § 416.1124(c)(17));
(22) Relocation assistance, per 20 C.F.R. §416.1124(c)(18);
(23) Special pay received from one of the uniformed services pursuant to Section 310 of Title 37 of the United States Code;
(24) Impairment-related work expenses, per 20 C.F.R. 404.1576 and OAC 317:35-5-42(g)(7), incurred and paid by an ineligible spouse or parent, if the ineligible spouse or parent receives disability benefits under Title II of the Social Security Act;
(25) Interest earned on excluded burial funds and appreciation in the value of excluded burial arrangements which are left to

accumulate and become part of separate burial funds, and interest accrued on and left to accumulate as part of the value of agreements representing the purchase of excluded burial spaces per 20 C.F.R. § 416.1124(c)(9) and (15));

(26) Interest and dividend income from a countable resource or from a resource excluded under a Federal statute other than Section 1613(a) of the Social Security Act;

(27) Earned income of a student, per 20 C.F.R. § 416.1112(c)(3) and OAC 317:35-5-42(g)(3); and(28) Any additional increment in pay, other than any increase in basic pay, received while serving as a member of the uniformed services, if the ineligible spouse or parent:

(A) Received the pay as a result of deployment to or service in a combat zone; and

(B) Was not receiving the additional pay immediately prior to deployment to or service in a combat zone.

(m) **Deeming from an ineligible spouse.** When the eligible individual lives with an ineligible spouse who has income, the deeming steps in (1) through (5) of this paragraph are used to calculate the amount of income to deem to the eligible individual.

(1) The ineligible's spouse's total gross unearned and earned income is determined and appropriate exclusions per (l) of this Section are applied.

(2) An ineligible child allocation is then subtracted for each ineligible child in the home, per OKDHS Appendix C-1, Maximum Income, Resource, and Payment Standards, Schedule VIII.C.

(A) The ineligible child allocation is subtracted from the ineligible spouse's unearned income before subtracting any remaining allocation from his/her earned income.

(B) An ineligible child allocation is not allowed for a child who receives a public income-maintenance payment~~s~~, 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) 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).

(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 general exclusion from the couple's unearned income and $65 plus one-half 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).

(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 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.

## SUBCHAPTER 7. MEDICAL SERVICES

## PART 5. DETERMINATION OF ELIGIBILITY FOR MEDICAL SERVICES

**317:35-7-40. Eligibility as Qualified Medicare Beneficiary Plus**

An individual determined to be categorically related to aged, blind or disabled is eligible for Medical Services as a Qualified Medicare Beneficiary Plus (QMBP) if he/she meets the conditions of eligibility shown in paragraphs (1)-(3) of this subsection. For persons age 65 and older in mental health hospitals, refer to Oklahoma Administrative Code 317:35-9-7.

(1) ~~The individual's/couple's income and resources do not exceed the standards as shown on DHS Appendix C-1, Schedule VI, of which the income standard is based on 100 percent of the Federal Poverty Level~~The individual's income and resources do not exceed the standard as shown on OKDHS Appendix C-1, Schedule VI, of which the income standard is based on 100 percent (100%) of the Federal Poverty Level. For an individual whose spouse is not eligible for Medicare, total countable income of the eligible individual must be equal to or less than the QMBP standards for an individual, and the income of both must be equal to or less than the QMBP standards for a couple. For a couple who are both eligible for Medicare, total countable income must be equal to or less than the QMBP standards for a couple.

(2) Countable income and resources are determined using the same rules followed in determining eligibility for individuals categorically related to Aged, Blind or Disabled, except that a $20 general income disregard is applied to either earned or unearned income, but not both. For couples, only one $20 general income disregard is given.

(3) The individual meets all other eligibility conditions for SoonerCare.

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

**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**

**PART 33. TRANSPORTATION BY AMBULANCE**

**317:30-5-344. Ground Emergency Medical Transportation (GEMT) Supplemental Payment Program**

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

(1) **"Advanced life support"** means emergency medical care and services which are provided by a licensed ground ambulance services provider in accordance with Oklahoma Administrative Code (OAC) 310:641, to include, but not limited to, advanced airway management, intravenous therapy, administration of drugs and other medicinal preparations, and other invasive medical procedures and specified techniques that are limited to the Intermediate, Advanced EMT, and Paramedic scope of practice in accordance with OAC 310:641, Subchapter 5.

(2) **"Allowable costs"** means an expenditure that complies with the regulatory principles as listed in Title 2 of the Code of Federal Regulations (C.F.R.), Section 200.

(3) **"Basic life support"** means emergency medical care and services which are provided by a licensed ground ambulance service in accordance with OAC 310:641 to include, but not limited to, cardiopulmonary resuscitation procedures (CPR), hemorrhage control, stabilization of actual or possible skeletal injuries, spinal immobilization, extrication, transportation, and other non-invasive medical care.

(4) **"Contracts with a local government"** means contracts pursuant to a county plan for ambulance and emergency medical services with a:

(A) City, county, or an Indian tribe as defined in Section 4 of the Indian Self-Determination and Education Assistance Act; or

(B) Local service district, including, but not limited to, a rural fire protection district, or all administrative subdivisions of such city, county, or local service district.

(5) **"Eligible GEMT provider"** means a GEMT provider that meets all eligibility requirements in OAC 317:30-5-344 and the Oklahoma Medicaid State Plan (State Plan).

(6) **"Federal financial participation (FFP)"** means the portion of medical assistance expenditures for emergency medical

services that are paid or reimbursed by the Centers for Medicare and Medicaid Services (CMS) in accordance with the State Plan.

(7) **"GEMT services"** means the act of transporting an individual by ground from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient, as well as the advanced, limited-advanced, and basic life support services provided to an individual by eligible GEMT providers before or during the act of transportation.

(8) **"Governmental unit"** means the entire state, local, or federally-recognized Indian tribal government, including any component thereof.

(9) **"Publically owned or operated"** means a unit of government that is a state, a city, a county, a special purpose district, or other governmental unit in a state that has taxing authority, has direct access to tax revenues, or is an Indian tribe as defined in Section 4 of the Indian Self-Determination and Education Assistance Act.

(b) **Purpose.** In accordance with 63 Oklahoma Statutes (O.S.) § 3242, the GEMT Supplemental Payment Program is a voluntary program which makes supplemental payments above the Medicaid fee schedule reimbursement rate to eligible GEMT providers for specific allowable, certified, and uncompensated costs incurred for providing GEMT Services to SoonerCare members.

(b) **Provider eligibility.** To be eligible for supplemental payments, a GEMT provider must meet all of the following requirements:

(1) Be enrolled as an Oklahoma SoonerCare provider for the time period claimed on its annual cost report;

(2) Provide ground ambulance transportation services to SoonerCare members;

(3) Be classified as a governmental unit provider in accordance with 2 C.F.R. 200;

(4) Comply with all applicable state and federal law;

(5) Be an organization that:

(A) Is publicly owned or operated; or

(B) Is under contract with a local government unit. A copy of any such contract must be submitted to the Oklahoma Health Care Authority (OHCA) simultaneous with the submission of the GEMT provider's annual cost report; and

(6) Timely submit all relevant information requested by the OHCA, in the format as prescribed by the OHCA, including, but not limited to, a certification that conforms with 42 C.F.R. § 433.51 that certifies that the claimed expenditures for GEMT Services are eligible for FFP.

(d) **Allowable costs.**

(1) Supplemental payments provided by this program are

available only for the specific allowable costs per medical transport of a SoonerCare member that are in excess of the reimbursement paid by Medicaid and all other insurers and/or third-party resources.

(2) Total reimbursement from SoonerCare, including the supplemental payment, when combined with all other sources of reimbursement, must not exceed one-hundred percent (100%) of actual costs of providing services to SoonerCare members.

(e) **Payments and recoupment.**

(1) The OHCA will make annual supplemental payments after the conclusion of each state fiscal year (SFY) and in accordance with the methodology outlined in the State Plan. The payments will be made in the form of an interim payment and a later reconciliation payment (i.e., settle-up payment). The payments are not an increase to current fee-for-service (FFS) reimbursement rates.

(2) The interim supplemental payment will be equal to seventy-five percent (75%) of the total allowable costs as indicated on the annual approved cost report.

(3) The reconciliation payment will be computed by the OHCA based on the difference between the interim supplemental payment and total allowable costs from the approved cost report.

(4) Any excess payments determined in the reconciliation process are recouped and the federal share is returned to CMS.

(5) Cost reconciliation and cost settlement processes will be completed within twelve (12) months of the end of the cost reporting period.

(f) **Reporting requirements.**

(1) Eligible GEMT providers will:

(A) Submit a CMS-approved cost report annually, no later than ninety (90) days after the close of the SFY, on a form approved by the OHCA, unless a provider has made a written request for an extension and such request is granted by the OHCA;

(i) After the ninety (90) day deadline, an extension of no more than fifteen (15) calendar days can be granted; and

(ii) Extensions of time shall be requested by a letter addressed to the Finance Division. Any such request must be received by October 1, and must explain the good faith reason for the extension. OHCA shall provide a written notice of any denial of a request for an extension, which shall become effective on the date it is mailed.

(B) Provide supporting documentation simultaneous with the cost report, as required by the OHCA;

(C) Keep, maintain, and have readily retrievable, such

records as specified by the OHCA to fully disclose reimbursement amounts to which the eligible governmental entity is entitled, and any other records required by CMS; and

(D) Comply with the allowable cost requirements provided in 42 C.F.R. Part 413, 2 C.F.R. Part 200, and federal Medicaid non-institutional reimbursement policy.

(2) Penalties for false statements or misrepresentations made by or on behalf of the provider are established by 42 U.S.C. Section 1320a-7b which states, in part, "Whoever… (2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment…shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be under the program, be guilty of a felony and upon conviction thereof fined not more than $100,000 or imprisoned for not more than 10 years or both, or (ii) in the case of such a statement, representation, concealment, failure, conversion, or provision of counsel or assistance by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $20,000 or imprisoned for not more than one (1) year, or both."

(g) **Agency responsibilities.** The OHCA will:

(1) Submit claims to CMS based on total computable certified expenditures for GEMT services provided, that are allowable and in compliance with federal laws and regulations and Medicaid non-institutional reimbursement policy;

(2) Submit on an annual basis, any necessary materials to the federal government to provide assurances that claims will include only those expenditures that are allowable under federal law; and

(3) Complete the audit and final reconciliation process of the interim cost settlement payments for the services provided within twelve (12) months of the postmark date of the cost report and conduct on-site audits as necessary.

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

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

**PART 7. DETERMINATION OF FINANCIAL ELIGIBILITY**

**317:35-9-68. Determining financial eligibility for care in an ~~ICF/MR~~Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (public and private), for ~~HCBW/MR~~HCBW/IID services, and for persons age ~~65~~sixty-five (65) or older in mental health hospitals**

(a) **Determining financial eligibility for care in an ~~ICF/MR~~ICF/IID.** Financial eligibility and spenddown for individuals in an ~~ICF/MR~~ICF/IID is determined according to whether or not a spouse remains in the home.

(1) **Individual without a spouse.** For an individual without a spouse, the following rules are used to determine financial eligibility for ~~ICF/MR~~ICF/IID care.

(A) **Income eligibility.** To determine the income of the individual without a spouse, the rules in (i) - (iii) of this subparagraph apply.

(i) If payment of income is made to the individual and another person(s), the income is considered in proportion to the individual's interest.

(ii) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

(iii) After determination of income, the gross income of the individual cannot exceed the categorically needy standard in ~~OKDHS~~Oklahoma Department of Human Services (OKDHS) Form 08AX001E (Appendix C-1), Schedule VIII. B. 1., to be eligible for ~~ICF/MR~~ICF/IID services. If the individual's gross income exceeds this standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC 317:35-5-41.6(a)(6)(B)].

(B) **Resource eligibility.** In order for an individual without a spouse to be eligible for ~~ICF/MR~~ICF/IID services, his/her countable resources cannot exceed the maximum resource standard listed in OKDHS Form 08AX001E (Appendix C-1), Schedule VIII. D.

(C) **Vendor payment.** When eligibility for ~~ICF/MR~~ICF/IID services has been determined, the vendor payment is computed. For an individual eligible for long-term care in an ~~ICF/MR~~ICF/IID, the individual's share of the vendor payment is not prorated over the month. As SoonerCare is

the payer of last resort, the full amount of the member's share of the vendor payment must first be applied to the facility's charges before SoonerCare reimbursement begins. See (b) of this Section for calculation of the vendor payment after financial eligibility has been determined.

(D) **First month.** For the first month of care, the following procedures apply when determining the vendor payment:

(i) When an individual enters the facility on the first day of the month, all countable income is considered with the facility maintenance standard allowed.

(ii) When an individual enters the facility after the first day of the month, all countable income is considered with the own home standard allowed in computation of the vendor payment. Only the remaining income actually available is used to compute the vendor payment.

(E) **Equity in capital resources.** If the equity in capital resources is in excess of the standards, certification is delayed up to ~~30~~thirty (30) days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources, along with excess income to be considered against the vendor payment, are in excess of one month's vendor payment, the application is denied.

(2) **Individual with a spouse who is institutionalized in a NF or ~~ICF/MR~~ICF/IID, or who receives ADvantage or ~~HCBW/MR~~HCBW/IID services, or is ~~65~~sixty-five (65) or over and in a mental health hospital.** For an individual with a spouse who is institutionalized in a NF or ~~ICF/MR~~ICF/IID, or who receives ADvantage or ~~HCBW/MR~~HCBW/IID services, or is ~~65~~sixty-five (65) or over and in a mental health hospital, resources are determined for each individual as the amount owned by each individual plus one-half of the jointly owned resources of the couple. Once this separation of assets is made, a resource of either spouse is not considered available to the other during institutionalization.

(A) **Income eligibility.** To determine income for an individual whose spouse is institutionalized in a NF or ~~ICF/MR~~ICF/IID, or who receives ADvantage or ~~HCBW/MR~~HCBW/IID services, or is ~~65~~sixty-five (65) or over and in a mental health hospital, income determination is made individually. The income of either spouse is not considered as available to the other during institutionalization for determination of financial eligibility. See (b) of this Section for post-eligibility calculation of the vendor payment and the community spouse income allowance, if applicable. The rules

in (i) - (v) of this subparagraph apply in this situation.

(i) If payment of income is made solely to one or the other, the income is considered available only to that individual.

(ii) If payment of income is made to both, one-half is considered for each individual.

(iii) If payment of income is made to either one or both and another person(s), the income is considered in proportion to either spouse's interest (if payment is to that spouse) or one-half of the joint interest if no interest is specified.

(iv) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

(v) After determination of income, the gross income of the individual cannot exceed the categorically needy standard in OKDHS Form 08AX001E (Appendix C-1), Schedule VIII. B. 1., to be eligible for ~~ICF/MR~~ICF/IID care. If the individual's gross income exceeds this standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC 317:35-5-41.6(a)(6)(B)].

(B) **Resource eligibility.** In order for an individual with a spouse who is institutionalized in a NF or ~~ICF/MR~~ICF/IID, receives ADvantage or ~~HCBW/MR~~HCBW/IID services, or is ~~65~~sixty-five (65) or older and in a mental health hospital to be eligible for ~~ICF/MR~~ICF/IID services, his/her countable resources cannot exceed the maximum resource standard for an individual listed in OKDHS Form 08AX001E (Appendix C-1), Schedule VIII. D.

(C) **Vendor payment.** When eligibility for ~~ICF/MR~~ICF/IID services has been determined, the vendor payment is computed. For an individual eligible for long-term care in an ~~ICF/MR~~ICF/IID, the individual's share of the vendor payment is not prorated over the month. As SoonerCare is the payer of last resort, the full amount of the member's share of the vendor payment must first be applied to the facility's charges before SoonerCare reimbursement begins. See (b) of this Section for calculation of the vendor payment after financial eligibility has been determined.

(D) **First month.** For the first month of care, the following procedures apply when determining the vendor payment:

(i) When an individual enters the facility on the first day of the month, all countable income is considered with the facility maintenance standard allowed.

(ii) When an individual enters the facility after the first day of the month, all countable income is considered with the own home standard allowed in computation of the vendor payment. Only the remaining income actually

available is used to compute the vendor payment.

(E) **Equity in capital resources.** If the equity in capital resources is in excess of the standards, certification is delayed up to ~~30~~thirty (30) days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources, along with excess income to be considered against the vendor payment, are in excess of one month's vendor payment, the application is denied.

(3) **Individual with a spouse remaining in the home who does not receive ADvantage or ~~HCBW/MR~~HCBW/IID services.** When an individual and spouse are separated due to the individual entering an ~~ICF/MR~~ICF/IID, income and resources are determined separately. However, the income and resources of the community spouse must be included on the application form. At redetermination of eligibility, the community spouse's income must be included in the review process. During any month that the individual is in the ~~ICF/MR~~ICF/IID, income of the community spouse is not considered available to that individual. The following rules are used to determine the income and resources of each:

(A) **Income eligibility.** To determine the income of both spouses, the rules in this subparagraph apply:

(i) If payment of income is made solely to one or the other, the income is considered available only to that individual.

(ii) If payment of income is made to both, one-half is considered for each individual.

(iii) If payment of income is made to either one or both and another person(s), the income is considered in proportion to either the spouse's interest (if payment is to that spouse) or one-half of the joint interest if no interest is specified.

(iv) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

(v) If the individual's gross income exceeds the categorically needy standard as shown on OKDHS Form 08AX001E (Appendix C-1), Schedule VIII. B. 1., refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC 317:35-5-41.6(a)(6)(B)].

(B) **Resource eligibility.** To determine resource eligibility, it is necessary to determine the amount of resources for both spouses for the month of the individual's entry into the nursing facility. Of the resources available

to the couple (both individual and joint ownership) an amount will be protected for the community spouse which will not be considered available to the spouse in the ~~ICF/MR~~ICF/IID. OKDHS Form 08MA011E, Assessment of Assets, is used for the assessment prior to application for SoonerCare. The amount determined as the spousal share is used for all subsequent applications for SoonerCare, regardless of changes in the couple's resources. The protected spousal share cannot be changed for any reason. When application for SoonerCare is made at the same time the individual enters the ~~ICF/MR~~ICF/IID, OKDHS Form 08MA012E, Title XIX Worksheet, is used in lieu of OKDHS Form 08MA011E.

(i) The first step in the assessment process is to establish the total amount of resources for the couple during the first month of the entry of the spouse into the ~~ICF/MR~~ICF/IID.

(ii) The community spouse's share is equal to one-half of the total resources of the couple not to exceed the maximum amount of resource value that can be protected for the community spouse, as shown on OKDHS Appendix C-1, Section XI.

(iii) The minimum resource standard for the community spouse is found on OKDHS Appendix C-1, Schedule XI. When the community spouse's share is less than the minimum standard, an amount may be deemed from the other spouse's share to ensure the minimum resource standard for the community spouse. If the community spouse's share equals or exceeds the minimum resource standard, deeming cannot be done.

(iv) If deeming is necessary to meet the minimum resource standard for the community spouse, the amount that is deemed must be legally transferred to the community spouse within one (1) year of the effective date of certification for SoonerCare. At the first redetermination of eligibility, the worker must document that the resources have been transferred. After the first year of SoonerCare eligibility, resources of the community spouse will not be available to the other spouse and resources cannot be deemed to the community spouse.

(v) After the month in which the institutionalized spouse and community spouse have met the resource standards and the institutionalized spouse is determined eligible for benefits, no resources of the community spouse, regardless of value, will be considered available to the institutionalized spouse. If the resources of the community spouse grow to exceed the original deemed amount, the State cannot require the community spouse to apply any of these excess resources toward the cost of

the care of the institutionalized spouse.
(vi) When determining eligibility for SoonerCare, the community spouse's share of resources is protected and the remainder considered available to the spouse in the ~~ICF/MR~~ICF/IID.
(vii) The resources determined for the individual in the ~~ICF/MR~~ICF/IID cannot exceed the maximum resource standard for an individual as shown in OKDHS Form 08AX001E (Appendix C-1), Schedule VIII. D.
(viii) Once the dollar value of the community spouse's share of resources is established for the month of the other spouse's entry into an ~~ICF/MR~~ICF/IID, that amount is used when determining resource eligibility for a subsequent SoonerCare application for ~~ICF/MR~~ICF/IID.
(ix) Once a determination of eligibility for SoonerCare is made, either spouse is entitled to a fair hearing. Any such hearing regarding the determination of the community spouse's resource allowance is held within ~~30~~thirty (30) days of the date of the request for the hearing. Either spouse is entitled to a fair hearing if dissatisfied with a determination of:

(I) ~~the~~The community spouse's monthly income allowance;

(II) ~~the~~The amount of monthly income otherwise available to the community spouse;

(III) ~~determination~~Determination of the spousal share of resource;

(IV) ~~the~~The attribution of resources (amount deemed); or

(V) ~~the~~The determination of the community spouse's resource allowance.

(x) The rules on determination of income and resources are applicable only when an individual has entered an ~~ICF/MR~~ICF/IID and is likely to remain under care for ~~30~~thirty (30) consecutive days. The ~~30-day~~thirty-day requirement is considered to have been met even if it is interrupted by a hospital stay or the individual is deceased before the ~~30-day~~thirty-day period ends.
(xi) The rules on resources included in this Section apply only to those cases in which an individual begins a continuous period of care in an ~~ICF/MR~~ICF/IID on or after September 30, 1989.
(xii) If the individual was admitted prior to September 30, 1989, there is not a protected amount for the community spouse. Resources are separated according to spousal ownership with one-half of jointly owned resources counted for each. In this instance, each spouse's resources are considered separately and the

resources of the community spouse does not affect the eligibility of the spouse in the ~~ICF/MR~~ICF/IID.

(C) **Vendor payment.** After the institutionalized spouse has been determined eligible for long-term care, the vendor payment is computed. For an individual eligible for long-term care in an ~~ICF/MR~~ICF/IID, the individual's share of the vendor payment is not prorated over the month. As SoonerCare is the payer of last resort, the full amount of the member's share of the vendor payment must first be applied to the facility's charges before SoonerCare reimbursement begins. See (b) of this Section for calculation of the vendor payment after financial eligibility has been determined.

(D) **Excess resources.** If the equity in capital resources is in excess of the standards but less than the amount of one month's vendor payment, certification is delayed up to ~~30~~thirty (30) days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources, along with excess income to be considered against the vendor payment, are in excess of the vendor payment, the application is denied.

(b) **Determination of the vendor payment for ~~ICF/MR~~ICF/IID.** Calculation of the vendor payment after financial eligibility for care in an ~~ICF/MR~~ICF/IID has been established is determined according to whether or not a spouse remains in the home. For the purpose of calculating the community spouse income allowance, spouses receiving ADvantage or ~~HCBW/MR~~HCBW/IID services are considered community spouses. The formula for determining the vendor payment for individuals without a spouse or other dependents is in accordance with Oklahoma Administrative Code (OAC) 317:35-19-21(b).

~~(1) The formula for determining the vendor payment for individuals without a spouse or other dependents is:~~

~~(A) Countable income;~~

~~(B) Minus the institutional or own home standard; and~~

~~(C) Minus the verified countable medical expenses (only the actual monthly payments being made for medical insurance premiums including Medicare premiums).~~

~~(2) The own home standard is the categorically needy standard found on OKDHS Form 08AX001E (Appendix C-1), Schedule VI.~~

~~(3) The computation for the community spouse's share of resources for individuals with a spouse remaining in the home is the total countable resources divided by two. This amount cannot exceed the maximum resource standard. If it is less than the minimum resource standard, resources are deemed from the institutionalized spouse to the community spouse, up to the~~

~~minimum standard.~~

~~(4) The formula for determining the vendor payment for an individual with a spouse remaining in the home, regardless of whether the spouse receives ADvantage or HCBW/MR services, is:~~

~~(A) Determine the institutionalized spouse's monthly income as described in (b)(1) of this Section.~~

~~(B) Determine how much of the institutionalized spouse's income can be deemed to the community spouse:~~

~~(i) Subtract the community spouse's gross income from the maximum monthly income standard on OKDHS Form 08AX001E (Appendix C-1), Schedule XI.~~

~~(ii) The resulting amount is the maximum amount that can be deemed from the institutionalized spouse to the community spouse.~~

~~(C) The amount actually deemed from the institutionalized spouse to the community spouse is subtracted from the institutionalized spouse's monthly income as described in (b)(1) of this Section. Any amount remaining is the vendor payment if there are no minor dependent children, parents, or siblings residing with the community spouse.~~

~~(D) If there are minor dependent children, parents, or siblings residing with the community spouse, the formula for determining their allowance is:~~

~~(i) Divide the maximum monthly income standard from OKDHS Form 08AX001E (Appendix C-1), Schedule XI by 3;~~

~~(ii) Subtract the gross income of each dependent child, parent, or sibling residing with the community spouse from the amount in (i);~~

~~(iii) If there is more than one dependent, add the amounts from (ii) together;~~

~~(iv) This amount is deemed to the dependents residing with the community spouse.~~

~~(E) The amount actually deemed to the dependents residing with the community spouse is subtracted from the amount determined in (b)(4)(C) of this Section. Any amount of the institutionalized spouse's income remaining is the vendor payment.~~

(c) **Determining financial eligibility for ~~HCBW/MR~~**~~HCBW/MR~~HCBW/IID. For individuals determined eligible for ~~HCBW/MR~~HCBW/IID services, there is no vendor payment. Financial eligibility for ~~HCBW/MR~~HCBW/IID services for a single individual is determined the same as for ~~ICF/MR~~ICF/IID services as outlined in paragraph (a)(1) of this Section with the exception of the vendor payment. Financial eligibility for ~~HCBW/MR~~HCBW/IID services for an individual with a spouse who is institutionalized in a NF or ~~ICF/MR~~ICF/IID, or who receives ADvantage or ~~HCBW/MR~~HCBW/IID services, or is ~~65~~sixty-five (65) or over and in a mental health hospital is determined the same as for ~~ICF/MR~~ICF/IID services as

outlined in paragraph (a)(2) of this Section with the exception of the vendor payment. Financial eligibility for ~~HCBW/MR~~HCBW/IID services for an individual with a spouse in the home who does not receive ADvantage or ~~HCBW/MR~~HCBW/IID services is determined the same as for an individual with a community spouse according to paragraph (a)(3) of this Section. If the individual is a minor child who can be determined categorically needy and SSP eligible by considering the parent(s)' income and resources in the deeming process, the case is handled in the usual manner. If the child is not eligible for SSP only because of the deeming of parent(s)' income/resources, financial eligibility for ~~HCBW/MR~~HCBW/IID services is determined using only the child's income/resources and exempting the parent(s)' income and resources from the deeming process.

(d) **Determining financial eligibility for persons age ~~65~~sixty-five (65) years or older in mental health hospitals.** The eligibility determination for an individual age ~~65~~sixty-five (65) or older in a mental health hospital as categorically needy is the same as for any other person who is institutionalized. (Refer to subsection (a) in this Section.) The same procedure for determining excess income to be applied to the vendor payment as described in this Section is applicable.

## SUBCHAPTER 19. NURSING FACILITY SERVICES

### 317:35-19-21. Determining financial eligibility for care in ~~NF~~nursing facility

(a) Financial eligibility and vendor payment calculations for individuals in ~~an~~a ~~NF~~nursing facility (NF) are determined according to whether or not a spouse remains in the home.

(1) **Individual without a spouse.** For an individual without a spouse, the following rules are used to determine financial eligibility.

(A) **Income eligibility.** To determine the income of the individual without a spouse, the rules in (i) - (iii) of this subparagraph apply.

(i) If payment of income is made to the individual and another person(s), the income is considered in proportion to the individual's interest.

(ii) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

(iii) After determination of income, the gross income of the individual cannot exceed the categorically needy standard in ~~OKDHS~~Oklahoma Department of Human Services (DHS) Form 08AX001E (Appendix C-1), Schedule VIII. B. 1., to be eligible for NF services. If the individual's gross

income exceeds this standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [~~OAC~~Oklahoma Administrative Code (OAC) 317:35-5-41.6(a)(6)(B)].

(B) **Resource eligibility.** In order for an individual without a spouse to be eligible for NF services, his/her countable resources cannot exceed the maximum resource standard listed in ~~OKDHS~~DHS Form 08AX001E (Appendix C-1), Schedule VIII. D.

(C) **Vendor payment.** When eligibility for NF care has been determined, the vendor payment is computed. For an individual eligible for long-term care in a NF, the individual's share of the vendor payment is not prorated over the month. As SoonerCare is the payer of last resort, the full amount of the member's share of the vendor payment must first be applied to the facility's charges before SoonerCare reimbursement begins. See (b) of this Section for calculation of the vendor payment after financial eligibility has been determined.

(D) **First month.** For the first month of care, the following procedures apply when determining the vendor payment:

(i) When an individual enters the facility on the first day of the month, all countable income is considered with the facility maintenance standard allowed.

(ii) When an individual enters the facility after the first day of the month, all countable income is considered with the own home standard allowed in computation of the vendor payment. Only the remaining income actually available is used to compute the vendor payment.

(E) **Equity in capital resources.** If the equity in capital resources is in excess of the standards, certification is delayed up to ~~30~~thirty (30) days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources, along with excess income to be considered against the vendor payment, are in excess of ~~one~~one month's vendor payment, the application is denied.

(2) **Individual with a spouse who is institutionalized in a NF or ICF/MR, or who receives ADvantage or HCBW/MR services, or is 65 or over and in a mental health hospital.** For an individual with a spouse who is institutionalized in a NF or ICF/MR, or who receives ADvantage or HCBW/MR services, or is ~~65~~sixty-five (65) or over and in a mental health hospital, resources are determined for each individual as the amount owned by each individual plus one-half of the jointly owned resources of the

couple. Once this separation of assets is made, a resource of either spouse is not considered available to the other during institutionalization.

(A) **Income eligibility.** To determine income for an individual whose spouse is institutionalized in a NF or ICF/MR, or who receives ADvantage or HCBW/MR services, or is 65 or over and in a mental health hospital, income determination is made individually. The income of either spouse is not considered as available to the other during institutionalization for determination of financial eligibility. See (b) of this Section for post-eligibility calculation of the vendor payment and the community spouse income allowance, if applicable. The rules in (i) - (v) of this subparagraph apply in this situation.

(i) If payment of income is made solely to ~~one~~one or the other, the income is considered available only to that individual.

(ii) If payment of income is made to both, one-half is considered for each individual.

(iii) If payment of income is made to either one or both and another person(s), the income is considered in proportion to either spouse's interest (if payment is to that spouse) or one-half of the joint interest if no interest is specified.

(iv) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

(v) After determination of income, the gross income of the individual cannot exceed the categorically needy standard in ~~OKDHS~~DHS Form 08AX001E (Appendix C-1), Schedule VIII. B. 1., to be eligible for Nursing Facility services. If the individual's gross income exceeds this standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC 317:35-5-41.6(a)(6)(B)].

(B) **Resource eligibility.** In order for an individual with a spouse who is institutionalized in a NF or ICF/MR, receives ADvantage or HCBW/MR services, or is 65 or older and in a mental health hospital to be eligible for NF services, his/her countable resources cannot exceed the maximum resource standard for an individual listed in ~~OKDHS~~DHS Form 08AX001E (Appendix C-1), Schedule VIII. D.

(C) **Vendor payment.** When eligibility for NF services has been determined, the spenddown calculation is used to compute the vendor payment. For an individual eligible for long-term care in a NF, the individual's share of the vendor payment is not prorated over the month. As SoonerCare is

the payer of last resort, the full amount of the member's share of the vendor payment must first be applied to the facility's charges before SoonerCare reimbursement begins. See (b) of this Section for calculation of the vendor payment after financial eligibility has been determined.

(D) **First month.** For the first month of care, the following procedures apply when determining the vendor payment:

(i) When an individual enters the facility on the first day of the month, all countable income is considered with the facility maintenance standard allowed.

(ii) When an individual enters the facility after the first day of the month, all countable income is considered with the own home standard allowed in computation of the vendor payment. Only the remaining income actually available is used to compute the vendor payment.

(E) **Equity in capital resources.** If the equity in capital resources is in excess of the standards, certification is delayed up to ~~30~~thirty (30) days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources, along with excess income to be considered against the vendor payment, are in excess of ~~one~~one (1) month's vendor payment, the application is denied.

(3) **Individual with a spouse remaining in the home who does not receive ADvantage or HCBW/MR services.** When an individual and spouse are separated due to the individual entering an NF, income and resources are determined separately. However, the income and resources of the community spouse must be included on the application form. At redetermination of eligibility, the community spouse's income must be included in the review process. During any month that the individual is in the NF, income of the community spouse is not considered available to that individual. The following rules are used to determine the income and resources of each:

(A) **Income eligibility.** To determine the income of both spouses, the following rules in this subparagraph apply:

(i) If payment of income is made solely to one or the other, the income is considered available only to that individual.

(ii) If payment of income is made to both, one-half is considered for each individual.

(iii) If payment of income is made to either one or both and another person(s), the income is considered in proportion to either the spouse's interest (if payment is

to that spouse) or one-half of the joint interest if no interest is specified.

(iv) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

(v) If the individual's gross income exceeds the categorically needy standard as shown on ~~OKDHS~~DHS Form 08AX001E (Appendix C-1), Schedule VIII. B. 1., refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC 317:35-5-41.6(a)(6)(B)].

(B) **Resource eligibility.** To determine resource eligibility, it is necessary to determine the amount of resources for both spouses for the month of the individual's entry into the nursing facility. Of the resources available to the couple (both individual and joint ownership) an amount will be protected for the community spouse which will not be considered available to the spouse in the NF. ~~OKDHS~~DHS Form 08MA011E, Assessment of Assets, is used for the assessment prior to application for SoonerCare. The amount determined as the spousal share is used for all subsequent applications for SoonerCare, regardless of changes in the couple's resources. The protected spousal share cannot be changed for any reason. When application for SoonerCare is made at the same time the individual enters the NF, ~~OKDHS~~DHS Form 08MA012E, Title XIX Worksheet, is used in lieu of ~~OKDHS~~DHS Form 08MA011E.

(i) The first step in the assessment process is to establish the total amount of resources for the couple during the first month of the entry of the spouse into the NF.

(ii) The community spouse's share is equal to one-half of the total resources of the couple not to exceed the maximum amount of resource value that can be protected for the community spouse, as shown on ~~OKDHS~~DHS Form 08AX001E (Appendix C-1), Schedule XI.

(iii) The minimum resource standard for the community spouse, as established by the ~~OHCA~~Oklahoma Health Care Authority (OHCA), is found on ~~OKDHS~~DHS Form 08AX001E (Appendix C-1), Schedule XI. When the community spouse's share is less than the minimum standard, an amount may be deemed from the other spouse's share to ensure the minimum resource standard for the community spouse. If the community spouse's share equals or exceeds the minimum resource standard, deeming cannot be done.

(iv) If deeming is necessary to meet the minimum resource standard for the community spouse, the amount that is deemed must be legally transferred to the community

spouse within ~~one~~one (1) year of the effective date of certification for SoonerCare. At the first redetermination of eligibility, the worker must document that the resources have been transferred. After the first year of SoonerCare eligibility, resources of the community spouse will not be available to the other spouse and resources cannot be deemed to the community spouse.

(v) After the month in which the institutionalized spouse and community spouse have met the resource standards and the institutionalized spouse is determined eligible for benefits, no resources of the community spouse, regardless of value, will be considered available to the institutionalized spouse. If the resources of the community spouse grow to exceed the original deemed amount, the State cannot require the community spouse to apply any of these excess resources toward the cost of the care of the institutionalized spouse.

(vi) When determining eligibility for SoonerCare, the community spouse's share of resources is protected and the remainder considered available to the spouse in the NF.

(vii) The resources determined above for the individual in the NF cannot exceed the maximum resource standard for an individual as shown in ~~OKDHS~~DHS Form 08AX001E (Appendix C-1), Schedule VIII. D.

(viii) Once the dollar value of the community spouse's share of resources is established for the month of the other spouse's entry into NF, that amount is used when determining resource eligibility for a subsequent SoonerCare application for NF.

(ix) Once a determination of eligibility for SoonerCare is made, either spouse is entitled to a fair hearing. Any such hearing regarding the determination of the community spouse's resource allowance is held within ~~30~~thirty (30) days of the date of the request for the hearing. Either spouse is entitled to a fair hearing if dissatisfied with a determination of:

(I) the community spouse's monthly income allowance;

(II) the amount of monthly income otherwise available to the community spouse;

(III) determination of the spousal share of resource;

(IV) the attribution of resources (amount deemed); or

(V) the determination of the community spouse's resource allowance.

(x) The rules on determination of income and resources are applicable only when an individual has entered an NF and is likely to remain under care for ~~30~~thirty (30)

consecutive days. The ~~30-day~~thirty (30) day requirement is considered to have been met even if it is interrupted by a hospital stay or the individual is deceased before the ~~30-day~~thirty (30) day period ends.

(xi) The rules on resources included in this Section apply only to those cases in which an individual begins a continuous period of care in an NF on or after September 30, 1989.

(xii) If the individual was admitted prior to September 30, 1989, there is not a protected amount for the community spouse. Resources are separated according to spousal ownership with one-half of jointly owned resources counted for each. In this instance, each spouse's resources are considered separately and the resources of the community spouse do not affect the eligibility of the spouse in the NF.

(C) **Vendor payment.** After the institutionalized spouse has been determined eligible for long-term care, the vendor payment is computed. For an individual eligible for long-term care in a NF, the individual's share of the vendor payment is not prorated over the month. As SoonerCare is the payer of last resort, the full amount of the member's share of the vendor payment must first be applied to the facility's charges before SoonerCare reimbursement begins. See (b) of this Section for calculation of the vendor payment after financial eligibility has been determined.

(D) **Excess resources.** If the equity in capital resources is in excess of the standards but less than the amount of ~~one~~one month's vendor payment, certification is delayed up to ~~30~~thirty (30) days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources, along with excess income to be considered against the vendor payment, are in excess of the vendor payment, the application is denied.

(b) Calculation of the vendor payment after financial eligibility for care in a NF has been determined is performed according to whether or not a spouse remains in the home. For the purpose of calculating the community spouse income allowance, spouses receiving ADvantage or ~~HCBW/MR~~HCBW/IID services are considered community spouses.

(1) The formula for determining the vendor payment for individuals without a spouse or other dependents is:

(A) Countable income;

(B) Minus the institutional or own home standard; and

(C) Minus ~~the verified countable medical expenses (only~~ the actual monthly payments being made for medical insurance premiums including Medicare premiums~~).~~; and

(D) Minus incurred expenses for necessary medical and remedial care not covered under Medicaid, as set forth in the Oklahoma State Medicaid Plan.

(i) In order to be allowed to be deducted, expenses must:

(I) Have been incurred during the three (3) month period immediately preceding the month of application;

(II) Have been prescribed by a medical professional;

(III) Be certified as being medically necessary by a treating physician, physician assistant, or advanced practice registered nurse working within the scope of his or her licensure; and

(IV) Be no more than the least of the fee recognized by Medicaid, Medicare, or the average cost allowed by a commercial health insurance plan in Oklahoma.

(ii) The following expenses are not allowed to be deducted:

(I) Expenses incurred as the result of the imposition of a transfer penalty;

(II) Expenses for which a third party (including Medicaid) is liable, even if provided by an out-of-state network provider;

(III) Expenses resulting from the failure to obtain prior approval from applicable private insurance, Medicare, or Medicaid, due to the service being medically unnecessary;

(IV) Expenses that had been the subject of a prior authorization denial by Medicaid, due to lack of medical necessity; and

(V) Health insurance premiums paid by an individual who is not a financially responsible relative, for which repayment is not expected.

(2) The own home standard is the categorically needy standard found on ~~OKDHS~~DHS Form 08AX001E (Appendix C-1), Schedule VI.

(3) The computation for the community spouse's share of resources for individuals with a spouse remaining in the home is the total countable resources divided by ~~two~~two (2). This amount cannot exceed the maximum resource standard. If it is less than the minimum resource standard, resources are deemed from the institutionalized spouse to the community spouse, up to the minimum standard.

(4) The formula for determining the vendor payment for an individual with a spouse remaining in the home, regardless of whether the spouse receives ADvantage or HCBW/MR services, is:

(A) Determine the institutionalized spouse's monthly income

as described in Paragraph (b)(1) of this Section.

(B) Determine how much of the institutionalized spouse's income can be deemed to the community spouse:

(i) Subtract the community spouse's gross income from the maximum monthly income standard on OKDHS Form 08AX001E (Appendix C-1), Schedule XI.

(ii) The resulting amount is the maximum amount that can be deemed from the institutionalized spouse to the community spouse.

(C) The amount actually deemed from the institutionalized spouse to the community spouse is subtracted from the institutionalized spouse's monthly income as described in Paragraph (b)(1) of this Section. Any amount remaining is the vendor payment if there are no minor dependent children, parents, or siblings residing with the community spouse.

(D) If there are minor dependent children, parents, or siblings residing with the community spouse, the formula for determining their allowance is:

(i) Divide the maximum monthly income standard from OKDHS Form 08AX001E (Appendix C-1), Schedule XI by 3;

(ii) Subtract the gross income of each dependent child, parent, or sibling residing with the community spouse from the amount in (i);

(iii) If there is more than ~~one~~one dependent, add the amounts from (ii) together;

(iv) This amount is deemed to the dependents residing with the community spouse.

(E) The amount actually deemed to the dependents residing with the community spouse is subtracted from the amount determined in Subparagraph (b)(4)(C) of this Section. Any amount of the institutionalized spouse's income remaining is the vendor payment.

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

**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**

**PART 6. INPATIENT PSYCHIATRIC HOSPITALS**

**317:30-5-94. Definitions**

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

**"Adult"** means an individual twenty-one (21) and over, unless otherwise specified. Refer to Oklahoma Administrative Code (OAC) 317:30-1-4.

**"C.F.R."** means Code of Federal Regulations.

**"Child"** means an individual under the age of twenty (21) in an inpatient psychiatric setting as per 42 C.F.R. § 441. 151(a)(3). If an individual is receiving services before he or she reaches twenty-one (21), then the individual can continue to receive services until the individual no longer requires the services or the date the individual turns twenty-two (22), whichever comes first. For services other than inpatient psychiatric services or otherwise specified by statute, regulation, and/or policy adopted by the Oklahoma Health Care Authority (OHCA), refer to OAC 317:30-1-4.

**"C.M.S"** means Centers for Medicare and Medicaid Services.

**"General hospital"** means a general medical surgical hospital, as defined by Section 1-701 (2) of Title 63 of the Oklahoma Statutes.

**"Institution for Mental Diseases (IMD)"** means a hospital, nursing facility, or other institution of more than sixteen (16) beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services, as defined by 42 C.F.R. § 435.1010.

**"Licensed behavioral health professional (LBHP)"** means any of the following practitioners:

(A) An allopathic or osteopathic physician with a current license and board certification in psychiatry or board eligible in the state in which services are provided, or a current resident in psychiatry practicing as described in OAC 317:30-5-2.

(B) A practitioner with a current license to practice in the state in which services are provided, within one (1) of the areas of practice listed in (i) through (vi).

(i) Psychology;
(ii) Social work (clinical specialty only);
(iii) Professional counselor;
(iv) Marriage and family therapist;
(v) Behavioral practitioner; or

(vi) Alcohol and drug counselor.

(C) An advanced practice registered nurse certified in a psychiatric mental health specialty, and licensed as a registered nurse (RN) with a current certification of recognition from the board of nursing in the state in which services are provided.

(D) A physician assistant who is licensed and in good standing in the state and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or counseling functions.

**"Licensure candidate"** means a practitioner actively and regularly receiving board approved supervision, and extended supervision by a fully licensed clinician if board's supervision requirement is met but the individual is not yet licensed, to become licensed by one (1) of the areas of practice listed in (B)(i) through (vi) above. The supervising LBHP responsible for the member's care must:

(1) Staff the member's case with the candidate;

(2) Be personally available, or ensure the availability of an LBHP to the candidate for consultation while they are providing services;

(3) Agree with the current plan for the member;

(4) Confirm that the service provided by the candidate was appropriate; and

(5) The member's medical record must show that the requirements for reimbursement were met and the LBHP responsible for the member's care has reviewed, countersigned, and dated the service plan and any updates thereto so that it is documented that the licensed professional is responsible for the member's care.

**"OHCA"** means Oklahoma Health Care Authority.

**"OAC"** means Oklahoma Administrative Code.

**"O.S."** means Oklahoma Statutes.

**"Psychiatric hospital"** means an institution which is primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons, as defined by Section 1395x(f) of Title 42 of the United States Code.

**"Psychiatric residential treatment facility (PRTF)"** means a non-hospital facility contracted with the OHCA to provide inpatient psychiatric services to SoonerCare-eligible members under the age of twenty-one (21), as defined by 42 C.F.R. § 483.352.

**"U.S.C."** means United States Code.

**317:30-5-95. General provisions and eligible providers**

~~(a) **Definitions.** The following words and terms, when used in this Part, shall have the following meaning, unless the context clearly indicates otherwise:~~

~~(1) **"C.F.R."** means Code of Federal Regulations.~~

~~(2) **"CMS"** means Centers for Medicare and Medicaid Services.~~

(3) **"General Hospital"** means a general medical surgical hospital, as defined by 63 Oklahoma Statutes, Sec. 1-701(2).

(4) **"Institution for Mental Diseases (IMD)"** means a hospital, nursing facility, or other institution of more than sixteen (16) beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services, as defined by 42 C.F.R. § 435.1010.

(5) **"OHCA"** means Oklahoma Health Care Authority.

(6) **"O.S."** means Oklahoma Statutes.

(7) **"Psychiatric Hospital"** means an institution which is primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons, as defined by 42 United States Code, Sec. 1395x(f).

(8) **"Psychiatric Residential Treatment Facility (PRTF)"** means a non-hospital facility contracted with the OHCA to provide inpatient psychiatric services to SoonerCare-eligible members under the age of twenty-one (21), as defined by 42 C.F.R. § 483.352.

(9) **"U.S.C."** means United States Code.

(b) **Eligible settings for inpatient psychiatric services.** The following individuals may receive SoonerCare-reimbursable inpatient psychiatric services in the following eligible settings:

(1) Individuals twenty-one (21) to sixty-four (64) years of age may receive SoonerCare-reimbursable inpatient psychiatric and/or chemical dependency/substance use/detoxification services in a psychiatric unit of a general hospital, provided that such hospital is not an IMD.

(2) Individuals sixty-five (65) years of age or older may receive SoonerCare-reimbursable inpatient psychiatric services in a psychiatric unit of a general hospital, or in a psychiatric hospital.

(3) Individuals under twenty-one (21) years of age, in accordance with OAC 317:30-5-95.23, may receive SoonerCare-reimbursable inpatient psychiatric services in a psychiatric unit of a general hospital, a psychiatric hospital, or a PRTF.

(c) **Psychiatric hospitals and psychiatric units of general hospitals.** To be eligible for payment under this Part, inpatient psychiatric programs must be provided to eligible SoonerCare members in a hospital that:

(1) is a psychiatric hospital that:

(A) successfully underwent a State survey to determine whether the hospital meets the requirements for participation in Medicare as a psychiatric hospital per 42 C.F.R. § 482.60; or

(B) is accredited by a national organization whose psychiatric accrediting program has been approved by CMS; or

(2) is a general hospital with a psychiatric unit that:

~~(A) successfully underwent a State survey to determine whether the hospital meets the requirements for participation in Medicare as a hospital as specified in 42 C.F.R. Part 482; or~~

~~(B) is accredited by a national accrediting organization whose accrediting program has been approved by CMS; and~~

~~(3) meets all applicable federal regulations, including, but not limited to:~~

~~(A) Medicare Conditions of Participation for Hospitals (42 C.F.R. Part 482), including special provisions applying to psychiatric hospitals (42 C.F.R. §§ 482.60-.62);~~

~~(B) Medicaid for Individuals Age 65 or over in Institutions for Mental Diseases (42 C.F.R. Part 441, Subpart C);~~

~~(C) Inpatient Psychiatric Services for Individuals under Age 21 in Psychiatric Facilities or Programs (42 C.F.R. Part 441, Subpart D); and/or~~

~~(D) Utilization Control [42 C.F.R. Part 456, Subpart C (Utilization Control: Hospitals) or Subpart D (Utilization Control: Mental Hospitals)]; and~~

~~(4) is contracted with the OHCA; and~~

~~(5) if located within Oklahoma and serving members under eighteen (18) years of age, is appropriately licensed by the Oklahoma Department of Human Services (DHS) as a residential child care facility (10 O.S. §§ 401 to 402) that is providing services as a residential treatment facility in accordance with OAC 340:110-3-168.~~

~~(d) **PRTF.** Every PRTF must:~~

~~(1) be individually contracted with OHCA as a PRTF;~~

~~(2) meet all of the state and federal participation requirements for SoonerCare reimbursement, including, but not limited to, 42 C.F.R. § 483.354, as well as all requirements in 42 C.F.R. 483 Subpart G governing the use of restraint and seclusion;~~

~~(3) be appropriately licensed by DHS as a residential child care facility (10 O.S. §§ 401 to 402) that is providing services as a residential treatment facility in accordance with OAC 340:110-3-168; and~~

~~(4) be accredited by TJC, the Council on Accreditation of Rehabilitation Facilities (CARF), or the Council on Accreditation (COA).~~

~~(e) **Out-of-state PRTF.** Any out-of-state PRTF must be appropriately licensed and/or certified in the state in which it does business, and must provide an attestation to OHCA that the PRTF is in compliance with the condition of participation for restraint and seclusion, as is required by federal law. Any out-of-state PRTF must also be accredited in conformance with OAC 317:30-5-95(d)(4).~~

~~(f) **Required documents.** The required documents for enrollment for each participating provider can be downloaded from the OHCA's website.~~

(a) **Eligible settings for inpatient psychiatric services.** The

following individuals may receive SoonerCare-reimbursable inpatient psychiatric services in the following eligible settings:

(1) Individuals twenty-one (21) to sixty-four (64) years of age may receive SoonerCare-reimbursable inpatient psychiatric and/or chemical dependency/substance use/detoxification services in a psychiatric unit of a general hospital, provided that such hospital is not an IMD.

(2) Individuals sixty-five (65) years of age or older may receive SoonerCare-reimbursable inpatient psychiatric services in a psychiatric unit of a general hospital, or in a psychiatric hospital.

(3) Individuals under twenty-one (21) years of age, in accordance with OAC 317:30-5-95.23, may receive SoonerCare-reimbursable inpatient psychiatric services in a psychiatric unit of a general hospital, a psychiatric hospital, or a PRTF.

(b) **Psychiatric hospitals and psychiatric units of general hospitals.** To be eligible for payment under this Part, inpatient psychiatric programs must be provided to eligible SoonerCare members in a hospital that:

(1) Is a psychiatric hospital that:

(A) Successfully underwent a State survey to determine whether the hospital meets the requirements for participation in Medicare as a psychiatric hospital per 42 C.F.R. § 482.60; or

(B) Is accredited by a national organization whose psychiatric accrediting program has been approved by CMS; or

(2) Is a general hospital with a psychiatric unit that:

(A) Successfully underwent a State survey to determine whether the hospital meets the requirements for participation in Medicare as a hospital as specified in 42 C.F.R. Part 482; or

(B) Is accredited by a national accrediting organization whose accrediting program has been approved by CMS; and

(3) Meets all applicable federal regulations, including, but not limited to:

(A) Medicare Conditions of Participation for Hospitals (42 C.F.R. Part 482), including special provisions applying to psychiatric hospitals (42 C.F.R. § 482.60-.62);

(B) Medicaid for Individuals Age 65 or over in Institutions for Mental Diseases (42 C.F.R. Part 441, Subpart C);

(C) Inpatient Psychiatric Services for Individuals under Age 21 in Psychiatric Facilities or Programs (42 C.F.R. Part 441, Subpart D); and/or

(D) Utilization Control [42 C.F.R. Part 456, Subpart C (Utilization Control: Hospitals) or Subpart D (Utilization Control: Mental Hospitals)]; and

(4) Is contracted with the OHCA; and

(5) If located within Oklahoma and serving members under eighteen (18) years of age, is appropriately licensed by the

Oklahoma Department of Human Services (OKDHS) as a residential child care facility (10 O.S. §§ 401 to 402) that is providing services as a residential treatment facility in accordance with OAC 340:110-3-168.

(c) **PRTF.** Every PRTF must:

(1) Be individually contracted with OHCA as a PRTF;

(2) Meet all of the state and federal participation requirements for SoonerCare reimbursement, including, but not limited to, 42 C.F.R. § 483.354, as well as all requirements in 42 C.F.R. 483 Subpart G governing the use of restraint and seclusion;

(3) Be appropriately licensed by OKDHS as a residential child care facility (10 O.S. § 401 to 402) that is providing services as a residential treatment facility in accordance with OAC 340:110-3-168;

(4) Be appropriately certified by the State Survey Agency, the Oklahoma State Department of Health (OSDH) as meeting Medicare Conditions of Participation; and

(5) Be accredited by TJC, the Council on Accreditation of Rehabilitation Facilities (CARF), or the Council on Accreditation (COA).

(d) **Out-of-state PRTF.** Any out-of-state PRTF must be appropriately licensed and/or certified in the state in which it does business, and must provide an attestation to OHCA that the PRTF is in compliance with the condition of participation for restraint and seclusion, as is required by federal law. Any out-of-state PRTF must also be accredited in conformance with OAC 317:30-5-95(c)(5).

(e) **Required documents.** The required documents for enrollment for each participating provider can be downloaded from the OHCA's website.

**317:30-5-95.4. Individual plan of care for adults aged twenty-one (21) to sixty-four (64)**

(a) Before admission to a psychiatric unit of a general hospital or immediately after admission, the attending physician or staff physician must establish a written plan of care for each member aged twenty-one (21) to sixty-four (64). The plan of care must include:

(1) Diagnoses, symptoms, complaints, and complications indicating the need for admission;

(2) A description of the functional level of the individual;

(3) Objectives;

(4) Any order for medication, treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the member;

(5) Plans for continuing care, including review and modification to the plan of care; and

(6) Plans for discharge.

(b) The attending or staff physician and other treatment team

personnel involved in the member's care must review each plan of care at least every seven (7) days.
(c) All plans of care and plan of care reviews must be clearly identified as such in the member's medical records. All must be signed and dated by the physician, RN, LBHP or licensure candidate, member, and other treatment team members that provide individual, family, and group therapy in the required review interval. Licensure candidate signatures must be co-signed. All plans of care and plan of care reviews must be signed by the member upon completion, except when a member is too physically ill or his or her acuity level precludes him or her from signing. If the member has designated an advocate, the advocate's signature is also required on all plans of care and plan of care reviews. If the member was too physically ill or his or her acuity level precluded him or her from signing the plan of care and/or the plan of care review at the time of completion, the member must sign the plan when his or her condition improves, but before discharge.
(d) The plan of care must document appropriate member participation in the development and implementation of the treatment plan.

**317:30-5-95.14. Individual plan of care for persons sixty-five (65) years of age or older receiving inpatient acute psychiatric services**

(a) Before admission to a psychiatric hospital or psychiatric unit of a general hospital or immediately after admission, the attending physician or staff physician must establish a written plan of care for each applicant or member. The plan of care must include:

(1) Diagnoses, symptoms, complaints, and complications indicating the need for admission;
(2) A description of the functional level of the individual;
(3) Objectives;
(4) Any order for medication, treatments, restorative and rehabilitative services, activities, therapies, social services, diet, and special procedures recommended for the health and safety of the member;
(5) Plans for continuing care, including review and modification to the plan of care; and
(6) Plans for discharge.

(b) The attending or staff physician and other treatment team personnel involved in the member's care must review each plan of care at least every seven (7) days.
(c) All plans of care and plan of care reviews must be clearly identified as such in the member's medical records. All must be signed and dated by the physician, RN, LBHP or licensure candidate, member, and other treatment team members that provide individual, family, and group therapy in the required review interval. Licensure candidate signatures must be co-signed. All plans of care

and plan of care reviews must be signed by the member upon completion, except when a member is too physically ill or his or her acuity level precludes him or her from signing. If the member has designated an advocate, the advocate's signature is also required on all plans of care and plan of care reviews. If the member was too physically ill or his or her acuity level precluded him or her from signing the plan of care and/or the plan of care review at the time of completion, the member must sign the plan when his or her condition improves, but before discharge.
(d) The plan of care must document appropriate member participation in the development and implementation of the treatment plan.

**317:30-5-95.22. Coverage for children**

~~(a) In order for services to be covered, services in acute hospitals, free-standing hospitals, and Psychiatric Residential Treatment Facilities must meet the requirements in OAC 317:30-5-95.25 through 317:30-5-95.30. OHCA rules that apply to inpatient psychiatric coverage for children are found in Sections OAC 317:30-5-95.24 through 317:30-5-95.42.~~

~~(b) **Definitions.** The following words and terms, when used in Sections OAC 317:30-5-95.22 through 317:30-5-95.42, shall have the following meaning, unless the context clearly indicates otherwise:~~

~~(1) **"Acute care"** means care delivered in a psychiatric unit of a general hospital or free-standing psychiatric hospital that provides assessment, medical management and monitoring, and short-term intensive treatment and stabilization to individuals experiencing acute episodes of behavioral health disorders.~~

~~(2) **"Border Placement"** means a placement in a facility that is in one of the states that borders Oklahoma (Arkansas, Colorado, Kansas, Missouri, New Mexico, and Texas). Border "status" may include other states that routinely provide PRTF services. Providers are subject to the same OHCA rules and program requirements as in-state providers, including claims submission procedures and are paid the same daily per diem as Oklahoma providers.~~

~~(3) **"Chemical Dependency/Substance Abuse services/ Detoxification"** means services offered to individuals with a substance-related disorder whose biomedical and emotional/behavioral problems are sufficiently severe to require inpatient care.~~

~~(4) **"Community Based Extended"** means a PRTF with 16 beds or more but less than 30 beds. The typical facility is not a locked facility.~~

~~(5) **"Community based transitional residential treatment"** means a level of care designed for children that require the continued structure, psychiatric intervention of 24 hour care but are ready to begin transitioning from more intense residential treatment into the community. It is the intent that members admitted to this level of care should be able to attend public~~

~~school. Community based transitional are non- secure PRTFs with 16 beds or less.~~

~~(6) **"Designated Agent"** means the entity contracted with the OHCA to provide certain services to meet federal and state statutory obligations of the OHCA.~~

~~(7) **"Enhanced Treatment Unit or Specialized Treatment Unit"** means an intensive residential treatment unit that provides a program of care to a population with a special need or issues requiring increased staffing requirements, co-morbidities, environmental accommodations, specialized treatment programs, and longer lengths of stay.~~

~~(8) **"Evidenced Based Practice (EBP)"** according to the Substance Abuse and Mental Health Services Administration (SAMHSA) means programs or practices that are supported by research methodology and have produced consistently positive patterns of results.~~

~~(9) **"Freestanding PRTFs"** are generally for profit secure facilities which range from 50 to over 100 beds and are generally staffed higher with RN personnel.~~

~~(10) **"Out-of-State Placement"** means a placement for intensive or specialized services not available in Oklahoma requiring additional authorization procedures and approval by the OHCA Behavioral Health Unit.~~

~~(11) **"Provider Based"** facilities are secure residential treatment facilities that are affiliated with private medical/surgical hospitals. The RN hours per day average 2.4 hours.~~

~~(12) **"Public facilities"** are Oklahoma government owned or operated facilities.~~

~~(13) **"Residential Treatment services"** means psychiatric services that are designed to serve children who need longer term, more intensive treatment, and a more highly structured environment than they can receive in family and other community based alternatives to hospitalization.~~

~~(14) **"Trauma Informed"** means the recognition and responsiveness to the presence of the effects of past and current traumatic experiences in the lives of members~~.

(a) In order for services to be covered, services in psychiatric units of general hospitals, psychiatric hospitals, and PRTF programs must meet the requirements in OAC 317:30-5-95.25 through 317:30-5-95.30. OHCA rules that apply to inpatient psychiatric coverage for individuals aged twenty-one (21) and under are found in Sections OAC 317:30-5-95.22 through 317:30-5-95.42.

(b) The following words and terms, when used in OAC 317:30-5-95.22 through 317:30-5-95.42, shall have the following meaning, unless the context clearly indicates otherwise:

(1) "Acute" means care delivered in a psychiatric unit of a general hospital or psychiatric hospital that provides assessment, medical management and monitoring, and short-term intensive treatment and stabilization to individuals

experiencing acute episodes of behavioral health disorders.
(2) "Acute II" means care delivered in a psychiatric unit of a general hospital or psychiatric hospital; however, services at this level of care are designed to serve individuals under twenty-one (21) who need longer-term, more intensive treatment, and a more highly-structured environment than they can receive in family and other community-based alternatives to hospitalization. However, care delivered in this setting is less intense than the care provided in Acute.
(3) "Border placement" means placement in an inpatient psychiatric facility that is in one (1) of the states that borders Oklahoma (Arkansas, Colorado, Kansas, Missouri, New Mexico, and Texas).
(4) "Border status" means placement in a facility in a state that does not border Oklahoma, but which facility routinely provides inpatient psychiatric services to SoonerCare members.
(5) "Chemical dependency/substance abuse services/detoxification" means services offered to individuals with a substance-related disorder whose biomedical and emotional/behavioral problems are sufficiently severe to require inpatient care.
(6) "Community-based extended" means a PRTF with sixteen (16) beds or more but less than thirty (30) beds. The typical facility is not a locked facility.
(7) "Community-based transitional (CBT)" means a PRTF level of care designed for individuals under twenty-one (21) who require the continued structure and psychiatric intervention of twenty-four (24) hour care, but are ready to begin transitioning from more intense residential treatment into the community. It is the intent that members admitted to this level of care should be able to attend public school. Community-based transitional facilities are non-secure PRTFs with sixteen (16) beds or less.
(8) "Enhanced treatment unit or specialized treatment" means an intensive residential treatment unit that provides a program of care to a population with special needs or issues requiring increased staffing requirements, co-morbidities, environmental accommodations, specialized treatment programs, and longer lengths of stay.
(9) "Evidence-based practice (EBP)" means programs or practices that are supported by research methodology and have produced consistently positive patterns of results in accordance with the Substance Abuse and Mental Health Services Administration (SAMHSA).
(10) "Out-of-state placement" means a placement for intensive or specialized services not available in Oklahoma requiring additional authorization procedures and approval by the OHCA Behavioral Health Unit.
(11) "Public facilities" means Oklahoma government owned or operated facilities.
(12) "Trauma-informed" means the recognition and responsiveness

to the presence of the effects of past and current traumatic experiences in the lives of members.

**317:30-5-95.24. Prior ~~Authorization~~authorization of inpatient psychiatric services for ~~children~~individuals under twenty-one (21)**

~~(a) All inpatient psychiatric services for members under twenty-one (21) years of age must be prior authorized by the Oklahoma Health Care Authority (OHCA) or its designated agent. All inpatient acute and residential psychiatric services will be prior authorized for an approved length of stay. Admission requirements for services must be provided in accordance with Code of Federal Regulations, Title 42 Public Health, Part 441 and 456. Additional information will be required for a SoonerCare compensable approval on enhanced treatment units or in special population programs.~~

~~(b) Staffing ratios shall always be present for each individual unit not by facility or program. Patients shall be grouped for accommodation by gender, age, and treatment needs. At a minimum, children, adolescent, and adult treatment programs shall be separate with distinct units for each population. A unit is determined by separate and distinct sleeping, living, and treatment areas often separated by walls and/or doors. A unit that does not allow clear line of sight due to the presence of walls or doors is considered a separate unit. Each individual unit shall have assigned staff to allow for appropriate and safe monitoring of patients and to provide active treatment.~~

~~(c) In an acute care setting, at least one Registered Nurse (RN) must be on duty per unit at all times, with additional RNs to meet program needs. RNs must adhere to Oklahoma Department of Health policy at Oklahoma Administrative Code (OAC) 310:667-15-3 and OAC 310:667-33-2(a)(3).~~

~~(d) Regular residential treatment programs require a staffing ratio of 1:6 during routine waking hours and 1:8 during time residents are asleep with twenty-four (24) hour nursing care supervised by an RN for management of behaviors and medical complications. At a minimum, the supervising RN must be available by phone and on-site within one (1) hour. If the supervising RN is off-site, then an RN or LPN must be on-site to adhere to a twenty-four (24) hour nursing care coverage ratio of 1:30 during routine waking hours and 1:40 during time residents are asleep.~~

~~(e) Specialty residential treatment at this level is a longer term treatment that requires a higher staff to member ratio because of the need for constant, intense, and immediate reinforcement of new behaviors to develop an understanding of the behaviors. The environment of specialized residential treatment centers requires special structure and configuration (e.g., sensory centers for autistic members) and specialized training for the staff in the area of the identified specialty. The physician will see the child at least one (1) time a week.~~

~~(f) A Psychiatric Residential Treatment Facility (PRTF) will not be considered a specialty treatment program for SoonerCare without~~

~~prior approval of the OHCA behavioral health unit.~~

~~(g) A treatment program that has been approved as a specialized treatment program must maintain medical records that document the degree and intensity of the psychiatric care delivered to the children.~~

~~(h) Criteria for classification as a specialized PRTF will require a staffing ratio of 1:3 at a minimum during routine waking hours and 1:6 during time residents are asleep with twenty-four (24) hour nursing care supervised by a RN for management of behaviors and medical complications. The PRTF will be a secure unit, due to the complexity of needs and safety considerations. Admissions will be restricted to children that meet the medical necessity criteria for Residential Treatment Center (RTC) and also meet at least two or more of the following:~~

~~(1) Have failed at other levels of care or have not been accepted at other levels of care;~~

~~(2) Behavioral, emotional, and cognitive problems requiring secure residential treatment that includes 1:1, 1:2, or 1:3 staffing due to the member being a danger to themselves and others, for impairments in socialization problems, communication problems, and restricted, repetitive and stereotyped behaviors. These symptoms are severe and intrusive enough that management and treatment in a less restrictive environment places the child and others in danger but, do not meet acute medical necessity criteria. These symptoms which are exhibited across multiple environments must include at least two or more of the following:~~

~~(A) Marked impairments in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction;~~

~~(B) Inability to regulate impulse control with frequent displays of aggression or other dangerous behavior toward self and/or others regularly;~~

~~(C) Failure to develop peer relationships appropriate to developmental level;~~

~~(D) Lack of spontaneously seeking to share enjoyment, interests, or achievements with other people;~~

~~(E) Lack of social or emotional reciprocity;~~

~~(F) Lack of attachment to caretakers;~~

~~(G) Require a higher level of assistance with activities of daily living requiring multiple verbal cues 50 percent of the time to complete tasks;~~

~~(H) Delay, or total lack of, the development of spoken language which is not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime;~~

~~(I) Marked impairment in individuals with adequate speech in the ability to initiate or sustain a conversation with others;~~

~~(J) Stereotyped and repetitive use of language or idiosyncratic language;~~

~~(K) Lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level;~~

~~(L) Encompassing preoccupation with one or more stereotyped and restricted pattern and interest that is abnormal in intensity of focus;~~

~~(M) Inflexible adherence to specific, nonfunctional routines or rituals;~~

~~(N) Stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting or complex whole body movements);~~

~~(O) Persistent occupation with parts of objects;~~

~~(3) Member is medically stable, but has co-morbid medical conditions which require specialized medical care during treatment;~~

~~(4) Full scale IQ below 40 (profound mental retardation intellectual disability).~~

~~(i) Non-authorized inpatient psychiatric services will not be SoonerCare compensable.~~

~~(j) The designated agent will prior authorize all services for an approved length of stay based on the medical necessity criteria described in OAC 317:30-5-95.25 through 317:30-5-95.31.~~

~~(k) For out-of-state placement policy, refer to OAC 317:30-3-89 through 317:30-3-92. A prime consideration for placements will be proximity to the family or guardian in order to involve the family or guardian in Active Treatment, including discharge and reintegration planning. Out of state facilities are responsible for insuring appropriate medical care as needed under SoonerCare provisions as part of the per-diem rate.~~

~~(l) Inpatient psychiatric services in all acute hospitals and psychiatric residential treatment facilities are limited to the approved length of stay. OHCA, or its designated agent, will approve lengths of stay using the current OHCA Behavioral Health medical necessity criteria as described in OAC 317:30-5-95.25 through OAC 317:30-5-95.31. The approved length of stay applies to both hospital and physician services. The Child and Adolescent Level of Care Utilization System (CALOCUS®) is a level of care assessment that will be used as a tool to determine the most appropriate level of care treatment for a member by LBHPs in the community.~~

(a) All inpatient psychiatric services for members under twenty-one (21) years of age must be prior authorized by the OHCA or its designated agent. All inpatient Acute, Acute II, and PRTF services will be prior authorized for an approved length of stay. Admission requirements for services must be provided in accordance with 42 C.F.R. Part 441 and 456. Additional information will be required for SoonerCare-compensable approval on enhanced treatment units or in special population programs.

(b) Unit staffing ratios shall always meet the requirements in OAC 317:30-5-95.24 (c), (d) and (h). The facility cannot use staff that is also on duty in other units of the facility in order to meet the

unit staffing ratios. Patients shall be grouped for accommodation by gender, age, and treatment needs. At a minimum, children, adolescent, and adult treatment programs shall be separate with distinct units for each population. A unit is determined by separate and distinct sleeping, living, and treatment areas often separated by walls and/or doors. A unit that does not allow clear line of sight due to the presence of walls or doors is considered a separate unit. Each individual unit shall have assigned staff to allow for appropriate and safe monitoring of patients and to provide active treatment.

(c) In Acute and Acute II settings, at least one (1) registered nurse (RN) must be on duty per unit at all times, with additional RNs to meet program needs. RNs must adhere to Oklahoma State Department of Health (OSDH) policy at OAC 310:667-15-3 and 310:667-33-2(a)(3).

(d) Acute, non-specialty Acute II, and non-specialty PRTF programs require a staffing ratio of one (1) staff: six (6) patients during routine waking hours and one (1) staff: eight (8) patients during time residents are asleep with twenty-four (24) hour nursing care supervised by an RN for management of behaviors and medical complications. For PRTF programs, at a minimum, a supervising RN must be available by phone and on-site within one (1) hour. If the supervising RN is off-site, then an RN or licensed practical nurse (LPN) must be on-site to adhere to a twenty-four (24) hour nursing care coverage ratio of one (1) staff: thirty (30) patients during routine waking hours and one (1) staff: forty (40) patients during time residents are asleep.

(e) Specialty treatment at Acute II or PRTF is a longer-term treatment that requires a higher staff-to-member ratio because of the need for constant, intense, and immediate reinforcement of new behaviors to develop an understanding of the behaviors. The environment of specialized residential treatment centers requires special structure and configuration (e.g., sensory centers for autistic members) and specialized training for the staff in the area of the identified specialty. The physician will see the child at least one (1) time a week.

(f) An Acute II or PRTF will not be considered a specialty treatment program for SoonerCare without prior approval of the OHCA behavioral health unit.

(g) A treatment program that has been approved as a specialized treatment program must maintain medical records that document the degree and intensity of the psychiatric care delivered to the members.

(h) Criteria for classification as a specialty Acute II or PRTF will require a staffing ratio of one (1) staff: three (3) patients at a minimum during routine waking hours and one (1) staff: six (6) patients during time residents are asleep with twenty-four (24) hour nursing care supervised by a RN for management of behaviors and medical complications. The specialty Acute II or PRTF will be a secure unit, due to the complexity of needs and safety

considerations. Admissions will be restricted to members who meet the medical necessity criteria for the respective level of care and also meet at least two (2) or more of the following:

(1) Have failed at other levels of care or have not been accepted by other non-specialty levels of care;

(2) Have behavioral, emotional, and cognitive problems requiring secure treatment that includes one (1) staff: one (1) patient, one (1) staff: two (2) patients, or one (1) staff: three (3) patients staffing due to the member being a danger to themselves and others, for impairments in socialization problems, communication problems, and restricted, repetitive, and stereotyped behaviors. These symptoms must be severe and intrusive enough that management and treatment in a less restrictive environment places the member and others in danger but, do not meet acute medical necessity criteria. These symptoms must be exhibited across multiple environments and must include at least two (2) or more of the following:

(A) Marked impairments in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction;

(B) Inability to regulate impulse control with frequent displays of aggression or other dangerous behavior toward self and/or others regularly;

(C) Failure to develop peer relationships appropriate to developmental level;

(D) Lack of spontaneously seeking to share enjoyment, interests, or achievements with other people;

(E) Lack of social or emotional reciprocity;

(F) Lack of attachment to caretakers;

(G) Require a higher level of assistance with activities of daily living requiring multiple verbal cues at least fifty (50) percent of the time to complete tasks;

(H) Delay, or total lack of, the development of spoken language which is not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime;

(I) Marked impairment in individuals with adequate speech in the ability to initiate or sustain a conversation with others;

(J) Stereotyped and repetitive use of language or idiosyncratic language;

(K) Lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level;

(L) Encompassing preoccupation with one (1) or more stereotyped and restricted pattern and interest that is abnormal in intensity of focus;

(M) Inflexible adherence to specific, nonfunctional routines or rituals;

(N) Stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting or complex whole body

movements); and/or

(O) Persistent occupation with parts of objects;

(3) Member is medically stable, but has co-morbid medical conditions which require specialized medical care during treatment; and/or

(4) Has full-scale IQ below forty (40) (profound intellectual disability).

(i) Non-authorized inpatient psychiatric services will not be SoonerCare compensable.

(j) The OHCA, or its designated agent, will prior authorize all services for an approved length of stay based on the medical necessity criteria described in OAC 317:30-5-95.25 through 317:30-5-95.30.

(k) For out-of-state placement policy, refer to OAC 317:30-3-89 through 317:30-3-92. A prime consideration for placements will be proximity to the family or guardian in order to involve the family or guardian in active treatment, including discharge and reintegration planning. Out-of-state facilities are responsible for insuring appropriate medical care, as needed under SoonerCare provisions, as part of the per-diem rate.

(l) Inpatient psychiatric services in all psychiatric units of general hospitals, psychiatric hospitals, and PRTFs are limited to the approved length of stay. OHCA, or its designated agent, will approve lengths of stay using the current OHCA Behavioral Health medical necessity criteria as described in OAC 317:30-5-95.25 through OAC 317:30-5-95.30. The approved length of stay applies to both facility and physician services.

**317:30-5-95.29. Medical necessity criteria ~~for admission – psychiatric residential treatment~~ Acute II and PRTF admissions for children**

~~(a) Psychiatric Residential Treatment facility admissions for children must meet the terms and conditions in (1), (2), (3), (4), (6) and one of (5)(A) through (5)(D) of this subsection.~~

~~(1) A primary diagnosis from the most recent edition of "The Diagnostic and Statistical Manual of Mental Disorders" (DSM) with the exception of V-codes, adjustment disorders, and substance related disorders, accompanied by detailed symptoms supporting the diagnosis. Children 18-20 years of age may have a diagnosis of any personality disorder. Adjustment or substance related disorders may be a secondary diagnosis.~~

~~(2) Conditions are directly attributed to a mental disorder as the primary reason for professional attention (this does not include placement issues, criminal behavior or status offenses).~~

~~(3) Patient has either received treatment in an acute care setting or it has been determined by the OHCA designated agent that the current disabling symptoms could not or have not been manageable in a less intensive treatment program.~~

~~(4) Child must be medically stable.~~

~~(5) Within the past 14 calendar days, the patient has~~

~~demonstrated an escalating pattern of self-injurious or assaultive behaviors as evidenced by any of (A) through (D) below. Exceptions to the 14 day requirement may be made in instances when evidence of the behavior could not have reasonably been discovered within 14 days (e.g., sexual offenses).~~

~~(A) Suicidal ideation and/or threat.~~

~~(B) History of or current self-injurious behavior.~~

~~(C) Serious threats or evidence of physical aggression.~~

~~(D) Current incapacitating psychosis or depression.~~

~~(6) Requires 24-hour observation and treatment as evidenced by:~~

~~(A) Intensive behavioral management.~~

~~(B) Intensive treatment with the family/guardian and child in a structured milieu.~~

~~(C) Intensive treatment in preparation for re-entry into community.~~

~~(b) Community Based Transitional Residential Treatment (CBT) facility admissions for children must meet the terms and conditions in (1) through (6) of this subsection.~~

~~(1) A primary diagnosis from the most recent edition of the DSM with the exception of V-codes, adjustment disorders, and substance related disorders, accompanied by detailed symptoms supporting the diagnosis. Children 18-20 years of age may have a diagnosis of any personality disorder.~~

~~(2) Conditions are directly attributed to a mental disorder as the primary reason for professional attention (this does not include placement issues, criminal behavioral or status offenses).~~

~~(3) Patient has either received treatment in an acute, RTC or children's crisis unit care setting or it has been determined by OHCA or its designated agent that the current disabling symptoms could not or have not been manageable in a less intensive treatment program.~~

~~(A) Patient must have tried and failed a lower level of care or is stepping down from a higher level of care.~~

~~(B) Clinical documentation must support need for CBT, rather than facility based crisis stabilization, therapeutic foster care, or intensive outpatient services.~~

~~(C) There is clear evidence to support a reasonable expectation that stepping down to a lower level of care would result in rapid and marked deterioration of functioning in at least 2 of the 5 critical areas, listed below, placing the member at risk of need for acute stabilization/inpatient care.~~

~~(i) Personal safety.~~

~~(ii) Cognitive functioning.~~

~~(iii) Family relations.~~

~~(iv) Interpersonal relations.~~

~~(v) Educational/vocational performance.~~

~~(4) Child must be medically stable and not require 24 hour on-~~

~~site nursing or medical care.~~

~~(5) Within the past 14 calendar days, the patient must have demonstrated an escalating pattern of self-injurious or assaultive behavior as evidenced by any of (a)(5)(A) through (D) above. Exceptions to the 14 day requirement may be made in instances when evidence of the behavior could not have reasonably been discovered within 14 days (e.g., sexual offenses).~~

~~(6)Within the past 14 calendar days, the patient's behaviors have created significant functional impairment.~~

(a) Acute II and PRTF admissions for individuals under twenty-one (21) must meet the terms and conditions in (1), (2), (3), (4), (5) and one (1) of the terms and conditions of (6)(A) through (D) of this subsection.

(1) A primary diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) with the exception of V-codes, adjustment disorders, and substance-related disorders, accompanied by detailed symptoms supporting the diagnosis. Members eighteen (18) to twenty (20) years of age may have a diagnosis of any personality disorder. Adjustment or substance-related disorders may be a secondary diagnosis.

(2) Conditions are directly attributed to a mental disorder as the primary reason for professional attention (this does not include placement issues, criminal behavior, or status offenses).

(3) Patient has either received treatment in an acute setting or it has been determined by the OHCA or its designated agent that the current disabling symptoms could not or have not been manageable in a less-intensive treatment program.

(4) Member must be medically stable.

(5) Requires twenty-four (24) hour observation and treatment as evidenced by:

(A) Intensive behavioral management;

(B) Intensive treatment with the family/guardian and child in a structured milieu; and

(C) Intensive treatment in preparation for re-entry into community.

(6) Within the past fourteen (14) calendar days, the patient has demonstrated an escalating pattern of self-injurious or assaultive behaviors as evidenced by any of (A) through (D) below. Exceptions to the fourteen (14) day requirement may be made in instances when evidence of the behavior could not have reasonably been discovered within fourteen (14) days (e.g., sexual offenses).

(A) Suicidal ideation and/or threat.

(B) History of/or current self-injurious behavior.

(C) Serious threats or evidence of physical aggression.

(D) Current incapacitating psychosis or depression.

(b) CBT admissions for children must meet the terms and conditions in (1) through (6) of this subsection.

(1) A primary diagnosis from the DSM-V with the exception of V-codes, adjustment disorders, and substance-related disorders, accompanied by detailed symptoms supporting the diagnosis. Members eighteen (18) to twenty (20) years of age may have a diagnosis of any personality disorder.
(2) Conditions are directly attributed to a mental disorder as the primary reason for professional attention (this does not include placement issues, criminal behavioral, or status offenses).
(3) Patient has either received treatment in Acute, Acute II, PRTF or children's crisis unit setting (refer to OAC 317:30-5-241.4), or it has been determined by OHCA or its designated agent that the current disabling symptoms could not or have not been manageable in a less-intensive treatment program.
(A) Patient must have tried and failed a lower level of care or is stepping down from a higher level of care.
(B) Clinical documentation must support need for CBT, rather than facility-based crisis stabilization, therapeutic foster care, intensive treatment foster care, or intensive outpatient services.
(C) There is clear evidence to support a reasonable expectation that stepping down to a lower level of care would result in rapid and marked deterioration of functioning in at least two (2) of the five (5) critical areas, listed below, placing the member at risk of need for acute stabilization/inpatient care.
(i) Personal safety;
(ii) Cognitive functioning;
(iii) Family relations;
(iv) Interpersonal relations; or
(v) Educational/vocational performance.
(4) Child must be medically stable.
(5) Within the past fourteen (14) calendar days, the patient must have demonstrated an escalating pattern of self-injurious or assaultive behavior as evidenced by any of (a)(5)(A) through (D) above. Exceptions to the fourteen (14) day requirement may be made in instances when evidence of the behavior could not have reasonably been discovered within fourteen (14) days (e.g., sexual offenses).
(6) Within the past fourteen (14) calendar days, the patient's behaviors have created significant functional impairment.

**317:30-5-95.30. Medical necessity criteria for ~~continued stay - psychiatric residential treatment center for children~~Acute II and PRTF continued stay for children**

~~(a) For continued stay Psychiatric Residential Treatment Facilities for children, admissions must meet the terms and conditions contained in (1), (2), (5), (6), and either (3) or (4) of this subsection.~~
~~(1) A primary diagnosis from the most recent edition of "The~~

~~Diagnostic and Statistical Manual of Mental Disorders" (DSM) with the exception of V codes, adjustment disorders, and substance abuse related disorders, accompanied by detailed symptoms supporting the diagnosis. In lieu of a qualifying primary diagnosis, children 18-20 years of age may have a secondary diagnosis of any personality disorder.~~

~~(2) Conditions are directly attributed to a psychiatric disorder as the primary reason for continued stay (this does not include placement issues, criminal behavior, status offenses).~~

~~(3) Patient is making measurable progress toward the treatment objectives specified in the treatment plan.~~

~~(A) Progress is measured in behavioral terms and reflected in the patient's treatment and discharge plans.~~

~~(B) Patient has made gains toward social responsibility and independence.~~

~~(C) There is active, ongoing psychiatric treatment and documented progress toward the treatment objective and discharge.~~

~~(D) There are documented efforts and evidence of active involvement with the family, guardian, child welfare worker, extended family, etc.~~

~~(4) Child's condition has remained unchanged or worsened.~~

~~(A) Documentation of regression is measured in behavioral terms.~~

~~(B) If condition is unchanged, there is evidence of re-evaluation of the treatment objectives and therapeutic interventions.~~

~~(5) There is documented continuing need for 24-hour observation and treatment as evidenced by:~~

~~(A) Intensive behavioral management.~~

~~(B) Intensive treatment with the family/guardian and child in a structured milieu.~~

~~(C) Intensive treatment in preparation for re-entry into community.~~

~~(6) Documented efforts of working with child's family, legal guardian and/or custodian and other human service agencies toward a tentative discharge date.~~

~~(b) For continued stay Community Based Transitional Residential Treatment (CBT), children must meet the terms and conditions found in (1) through (5) of this subsection.~~

~~(1) A primary diagnosis from the most recent DSM with the exception of V codes, adjustment disorders, and substance use disorders, accompanied by detailed symptoms supporting the diagnosis. Children 18-20 years of age may have a diagnosis of any personality disorder.~~

~~(2) Conditions are directly attributed to a psychiatric disorder as the primary reason for continued stay (this does not include placement issues, criminal behavior, status offenses, etc.).~~

~~(3) There is documented continued need for 24 hour observation and treatment as evidenced by:~~

~~(A) Patient making measurable progress toward the treatment objectives specified in the treatment plan.~~

~~(B) Clinical documentation clearly indicates continued significant functional impairment in two of the following five critical areas, as evidenced by specific clinically relevant behavior descriptors:~~

~~(i) Personal safety.~~

~~(ii) Cognitive functioning.~~

~~(iii) Family relations.~~

~~(iv) Interpersonal relations.~~

~~(v) Educational/vocational performance.~~

~~(4) Clinical documentation includes behavioral descriptors indicating patient's response to treatment and supporting patient's ability to benefit from continued treatment at this level of care.~~

~~(5) Documented, clear evidence of consistent, active involvement by patient's primary caregiver(s) in the treatment process.~~

(a) For continued stay in Acute II and PRTF programs, members must meet the terms and conditions contained in (1), (2), (3), (4), and either (5) or (6) of this subsection:

(1) A primary diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) with the exception of V codes, adjustment disorders, and substance abuse-related disorders, accompanied by detailed symptoms supporting the diagnosis. In lieu of a qualifying primary diagnosis, members eighteen (18) to twenty (20) years of age may have a secondary diagnosis of any personality disorder.

(2) Conditions are directly attributed to a psychiatric disorder as the primary reason for continued stay (this does not include placement issues, criminal behavior, or status offenses).

(3) There is documented continuing need for twenty-four (24) hour observation and treatment as evidenced by:

(A) Intensive behavioral management.

(B) Intensive treatment with the family/guardian and child in a structured milieu.

(C) Intensive treatment in preparation for re-entry into community.

(4) Documented efforts of working with child's family, legal guardian and/or custodian and other human service agencies toward a tentative discharge date.

(5) Patient is making measurable progress toward the treatment objectives specified in the treatment plan.

(A) Progress is measured in behavioral terms and reflected in the patient's treatment and discharge plans.

(B) Patient has made gains toward social responsibility and independence.

(C) There is active, ongoing psychiatric treatment and documented progress toward the treatment objective and discharge.

(D) There are documented efforts and evidence of active

involvement with the family, guardian, child welfare worker, extended family, etc.

(6) Child's condition has remained unchanged or worsened.

(A) Documentation of regression is measured in behavioral terms.

(B) If condition is unchanged, there is evidence of re-evaluation of the treatment objectives and therapeutic interventions.

(b) For continued stay in a CBT, members must meet the terms and conditions found in (1) through (5) of this subsection.

(1) A primary diagnosis from the DSM-V with the exception of V codes, adjustment disorders, and substance use disorders, accompanied by detailed symptoms supporting the diagnosis. Members eighteen (18) to twenty (20) years of age may have a diagnosis of any personality disorder.

(2) Conditions are directly attributed to a psychiatric disorder as the primary reason for continued stay (this does not include placement issues, criminal behavior, or status offenses).

(3) There is documented continued need for twenty-four (24) hour observation and treatment as evidenced by:

(A) Patient making measurable progress toward the treatment objectives specified in the treatment plan.

(B) Clinical documentation clearly indicates continued significant functional impairment in two (2) of the following five (5) critical areas, as evidenced by specific clinically relevant behavior descriptors:

(i) Personal safety;

(ii) Cognitive functioning;

(iii) Family relations;

(iv) Interpersonal relations; or

(v) Educational/vocational performance.

(4) Clinical documentation includes behavioral descriptors indicating patient's response to treatment and supporting patient's ability to benefit from continued treatment at this level of care.

(5) Documented, clear evidence of consistent, active involvement by patient's primary caregiver(s) in the treatment process.

**317:30-5-95.31. Prior ~~Authorization~~authorization and extension procedures for children**

~~(a) Prior authorization for inpatient psychiatric services for children must be requested from the Oklahoma Health Care Authority (OHCA) or its designated agent. The OHCA or its designated agent will evaluate and render a decision within twenty-four (24) hours of receiving the request. A prior authorization will be issued by the OHCA or its designated agent, if the member meets medical necessity criteria. For the safety of SoonerCare members, additional approval from OHCA, or its designated agent is required for placement on specialty units or in special population programs or for members with special needs such as very low intellectual~~

~~functioning.~~
~~(b) Extension requests (psychiatric) must be made through OHCA, or its designated agent. All requests are made prior to the expiration of the approved extension. Requests for the continued stay of a child who has been in an acute psychiatric program for a period of fifteen (15) days and in a psychiatric residential treatment facility for three (3) months will require a review of all treatment documentation completed by the OHCA designated agent to determine the efficiency of treatment.~~
~~(c) Providers seeking prior authorization will follow OHCA's, or its designated agent's, prior authorization process guidelines for submitting behavioral health case management requests on behalf of the SoonerCare member.~~
~~(d) In the event a member disagrees with the decision by OHCA, or its designated agent, the member receives an evidentiary hearing under Oklahoma Administrative Code 317:2-1-2(b). The member's request for such an appeal must be received within thirty (30) calendar days of the initial decision.~~
(a) Prior authorization for inpatient psychiatric services for members must be requested from the OHCA or its designated agent. The OHCA or its designated agent will evaluate and render a decision within twenty-four (24) hours of receiving the request. A prior authorization will be issued by the OHCA or its designated agent, if the member meets medical necessity criteria. For the safety of SoonerCare members, additional approval from OHCA, or its designated agent, is required for placement on specialty units or in special population programs or for members with special needs such as very low intellectual functioning.
(b) Extension requests (psychiatric) must be made through OHCA or its designated agent. All requests are made prior to the expiration of the approved extension. Requests for the continued stay of a member who has been in an Acute psychiatric program for a period of fifteen (15) days and an Acute II or PRTF program for three (3) months will require a review of all treatment documentation completed by the OHCA, or its designated agent, to determine the efficiency of treatment.
(c) Providers seeking prior authorization will follow OHCA's, or its designated agent's, prior authorization process guidelines for submitting behavioral health case management requests on behalf of the SoonerCare member.
(d) In the event a member disagrees with the decision by OHCA, or its designated agent, the member may request an evidentiary hearing under OAC 317:2-1-2(b). The member's request for such an appeal must be received within thirty (30) calendar days of the date of the notice of the initial decision.

**317:30-5-95.33. Individual plan of care for ~~members under the age of twenty-one (21)~~children**

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

otherwise:

(1) **"Licensed behavioral health professional (LBHP)"** means licensed psychologists, licensed clinical social workers (LCSW), licensed marital and family therapists (LMFT), licensed professional counselors (LPC), licensed behavioral practitioners (LBP), licensed alcohol and drug counselors (LADC), and advanced practice registered nurses (APRN).

(2) **"Licensure candidate"** means practitioners actively and regularly receiving board approved supervision, and extended supervision by a fully licensed clinician if board's supervision requirement is met but the individual is not yet licensed, to become licensed by one of the following licensing boards:

(A) Psychology,

(B) Social Work (clinical specialty only),

(C) Professional Counselor,

(D) Marriage and Family Therapist,

(E) Behavioral Practitioner, or

(F) Alcohol and Drug Counselor.

(3) **"Individual plan of care (IPC)"** means a written plan developed for each member within four (4) calendar days of admission to an acute psychiatric facility or a PRTF that directs the care and treatment of that member. The IPC must be recovery focused, trauma informed, and specific to culture, age, and gender and include:

(A) A primary diagnosis from the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) with the exception of V-Codes, adjustment disorders, and substance abuse related disorders, accompanied by a detailed description of the symptoms supporting the diagnosis. Members eighteen (18) to twenty (20) years of age may have a diagnosis of any personality disorder. Adjustment or substance related disorders may be a secondary diagnosis;

(B) The current functional level of the individual;

(C) Treatment goals and measurable, time-limited objectives;

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

(E) Plans for continuing care, including review and modification to the IPC; and

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

(b) The IPC:

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

(2) Must be developed by a team of professionals in consultation

with the member, his or her parents or legal guardians [for members under the age of eighteen (18)], or others in whose care he or she will be released after discharge. This team must consist of professionals as specified below:

(A) For a member admitted to a psychiatric hospital or PRTF, by the "interdisciplinary team" as defined by Oklahoma Administrative Code (OAC) 317:30-5-95.35(b)(2), per 42 C.F.R. §§ 441.155 and 483.354; or

(B) For a member admitted to a psychiatric unit of a general hospital, by a team comprised of at least:

(i) An allopathic or osteopathic physician with a current license and a board certification/eligible in psychiatry, or a current resident in psychiatry practicing as described in OAC 317:30-5-2(a)(1)(U); and

(ii) A registered nurse (RN) with a minimum of two (2) years of experience in a mental health treatment setting; and

(iii) An LBHP.

(3) Must establish treatment goals that are general outcome statements and reflective of informed choices of the member served. Additionally, the treatment goals must be appropriate to the member's age, culture, strengths, needs, abilities, preferences, and limitations;

(4) Must establish measurable and time-limited treatment objectives that reflect the expectations of the member served and parents/legal guardians (when applicable), as well as being age, developmentally, and culturally appropriate. When modifications are being made to accommodate age, developmental level, or a cultural issue, the documentation must be reflected on the IPC. The treatment objectives must be achievable and understandable to the member and the parents/legal guardians (when applicable). The treatment objectives also must be appropriate to the treatment setting and list the frequency of the service;

(5) Must prescribe an integrated program of therapies, activities, and experiences designed to meet the objectives;

(6) Must include specific discharge and after care plans that are appropriate to the member's needs and effective on the day of discharge. At the time of discharge, after care plans will include referral to medication management, outpatient behavioral health counseling, and case management, to include the specific appointment date(s), names, and addresses of service provider(s) and related community services to ensure continuity of care and reintegration for the member into his or her family, school, and community;

(7) Must be reviewed, at a minimum, every five (5) to nine (9) calendar days for members admitted to an acute care setting; every fourteen (14) calendar days for members admitted to a regular PRTF; every twenty-one (21) calendar days for members

admitted to an OHCA-approved longer-term treatment program or specialty PRTF; and every thirty (30) calendar days for members admitted to a Community Based Transitional PRTF. Review must be undertaken by the appropriate team specified in OAC 317:30-5-95.33(b)(2), above, to determine that services being provided are or were required on an inpatient basis, and to recommend changes in the IPC as indicated by the member's overall adjustment, progress, symptoms, behavior, and response to treatment;

(8) Development and review must satisfy the utilization control requirements for recertification [42 C.F.R. §§ 456.60(b), 456.160(b), and 456.360(b)], and establishment and periodic review of the IPC (42 C.F.R. §§ 456.80, 456.180, and 456.380); and,

(9) Each IPC and IPC review must be clearly identified as such and be signed and dated individually by the member, parents/legal guardians [for members under the age of eighteen (18)], and required team members. All IPCs and IPC reviews must be signed by the member upon completion, except when a member is too physically ill or the member's acuity level precludes him or her from signing. If the member is too physically ill or the member's acuity level precludes him or her from signing the IPC and/or the IPC review at the time of completion, the member must sign the plan when his or her condition improves, but before discharge. The documentation should indicate the reason the member was unable to sign and when the next review will occur to obtain the signature. IPCs and IPC reviews are not valid until completed and appropriately signed and dated. All requirements for the IPCs and IPC reviews must be met; otherwise, a partial per diem recoupment will be merited. If the member's parent/legal guardian is unable to sign the IPC or IPC review on the date it is completed, then within seventy-two (72) hours the provider must in good faith and with due diligence attempt to telephonically notify the parent/legal guardian of the document's completion and review it with them. Documentation of reasonable efforts to make contact with the member's parent/legal guardian must be included in the clinical file. In those instances where it is necessary to mail or fax an IPC or IPC review to a parent/legal guardian or Oklahoma Department of Human Services/Oklahoma Office of Juvenile Affairs (DHS/OJA) worker for review, the parent/legal guardian and/or DHS/OJA worker may fax back his or her signature. The provider must obtain the original signature for the clinical file within thirty (30) days. Stamped or photocopied signatures are not allowed for any parent/legal guardian or member of the treatment team.

(10) Medically necessary Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services shall be provided to members, under the age of twenty-one (21), who are residing in an inpatient psychiatric facility, regardless of whether such

~~services are listed on the IPC. Reimbursement for the provision of medically necessary EPSDT services to individuals under age twenty-one (21), while the member is residing in an inpatient psychiatric facility, will be provided in accordance with the Oklahoma Medicaid State Plan.~~

(a) An individual plan of care (IPC) is a written plan developed for each member within four (4) calendar days of admission to an Acute, Acute II, or a PRTF that directs the care and treatment of that member. The IPC must be recovery-focused, trauma-informed, and specific to culture, age, and gender and include:

(1) A primary diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) with the exception of V-codes, adjustment disorders, and substance abuse-related disorders, accompanied by a detailed description of the symptoms supporting the diagnosis. Members eighteen (18) to twenty (20) years of age may have a diagnosis of any personality disorder. Adjustment or substance-related disorders may be a secondary diagnosis;

(2) The current functional level of the individual;

(3) Treatment goals and measurable, time-limited objectives;

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

(5) Plans for continuing care, including review and modification to the IPC; and

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

(b) The IPC:

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

(2) Must be developed by a team of professionals in consultation with the member, his or her parents or legal guardians [for members under the age of eighteen (18)], or others in whose care he or she will be released after discharge. This team must consist of professionals as specified below:

(A) For a member admitted to a psychiatric hospital or PRTF, by the "interdisciplinary team" as defined by OAC 317:30-5-95.35(b)(2), per 42 C.F.R. §§ 441.155 and 483.354; or

(B) For a member admitted to a psychiatric unit of a general hospital, by a team comprised of at least:

(i) An allopathic or osteopathic physician with a current license and a board certification/eligible in psychiatry, or a current resident in psychiatry practicing as described in OAC 317:30-5-2(a)(1)(U); and

(ii) A registered nurse (RN) with a minimum of two (2)

years of experience in a mental health treatment setting; and

(iii) An LBHP.

(3) Must establish treatment goals that are general outcome statements and reflective of informed choices of the member served. Additionally, the treatment goals must be appropriate to the member's age, culture, strengths, needs, abilities, preferences, and limitations;

(4) Must establish measurable and time-limited treatment objectives that reflect the expectations of the member served and parents/legal guardians (when applicable), as well as being age, developmentally, and culturally appropriate. When modifications are being made to accommodate age, developmental level, or a cultural issue, the documentation must be reflected on the IPC. The treatment objectives must be achievable and understandable to the member and the parents/legal guardians (when applicable). The treatment objectives also must be appropriate to the treatment setting and list the frequency of the service;

(5) Must prescribe an integrated program of therapies, activities, and experiences designed to meet the objectives;

(6) Must include specific discharge and aftercare plans that are appropriate to the member's needs and effective on the day of discharge. At the time of discharge, aftercare plans will include referral to medication management, outpatient behavioral health counseling, and case management, to include the specific appointment date(s), names, and addresses of service provider(s) and related community services to ensure continuity of care and reintegration for the member into his or her family, school, and community;

(7) Must be reviewed, at a minimum, every nine (9) calendar days for members admitted to Acute; every fourteen (14) calendar days for members admitted to Acute II or non-specialty PRTF; every twenty-one (21) calendar days for members admitted to an OHCA-approved longer-term treatment program or specialty Acute II or PRTF; and every thirty (30) calendar days for members admitted to a CBT PRTF. Review must be undertaken by the appropriate team specified in OAC 317:30-5-95.33(b)(2), above, to determine that services being provided are or were required on an inpatient basis, and to recommend changes in the IPC as indicated by the member's overall adjustment, progress, symptoms, behavior, and response to treatment;

(8) Development and review must satisfy the utilization control requirements for recertification [42 C.F.R. §§ 456.60(b), 456.160(b), and 456.360(b)], and establishment and periodic review of the IPC (42 C.F.R. §§ 456.80, 456.180, and 456.380); and,

(9) Each IPC and IPC review must be clearly identified as such and be signed and dated individually by the member, parents/legal guardians [for members under the age of eighteen

(18)], and required team members. All IPCs and IPC reviews must be signed by the member upon completion, except when a member is too physically ill or the member's acuity level precludes him or her from signing. If the member is too physically ill or the member's acuity level precludes him or her from signing the IPC and/or the IPC review at the time of completion, the member must sign the plan when his or her condition improves, but before discharge. The documentation should indicate the reason the member was unable to sign and when the next review will occur to obtain the signature. IPCs and IPC reviews are not valid until completed and appropriately signed and dated. All requirements for the IPCs and IPC reviews must be met; otherwise, a partial per diem recoupment will be merited. If the member's parent/legal guardian is unable to sign the IPC or IPC review on the date it is completed, then within seventy-two (72) hours the provider must in good faith and with due diligence attempt to telephonically notify the parent/legal guardian of the document's completion and review it with them. Documentation of reasonable efforts to make contact with the member's parent/legal guardian must be included in the clinical file. In those instances where it is necessary to mail or fax an IPC or IPC review to a parent/legal guardian or Oklahoma Department of Human Services/Oklahoma Office of Juvenile Affairs (OKDHS/OJA) worker for review, the parent/legal guardian and/or OKDHS/OJA worker may fax back his or her signature. The provider must obtain the original signature for the clinical file within thirty (30) days. Stamped or photocopied signatures are not allowed for any parent/legal guardian or member of the treatment team.

(10) Medically necessary Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services shall be provided to members, under the age of twenty-one (21), who are residing in an inpatient psychiatric facility, regardless of whether such services are listed on the IPC. Reimbursement for the provision of medically necessary EPSDT services to individuals under age twenty-one (21), while the member is residing in an inpatient psychiatric facility, will be provided in accordance with the Oklahoma Medicaid State Plan.

**317:30-5-95.34. Active treatment for children**

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

~~(1) **"Discharge/transition planning"** means a patient-centered, interdisciplinary process that begins with an initial assessment of the patient's potential needs at the time of admission and continues throughout the patient's stay. Active collaboration with the patient, family and all involved outpatient practitioners and agencies should be ongoing throughout treatment so that effective connections remain intact. Needed~~

~~services may consist of the wraparound process through Systems of Care, counseling, case management and other supports in their community. The linkages with these supports should be made prior to discharge to allow for a smooth transition.~~

~~(2) **"Expressive group therapy"** means art, music, dance, movement, poetry, drama, psychodrama, structured therapeutic physical activities, experiential (e.g. ropes course), recreational, or occupational therapies that encourage the member to express themselves emotionally and psychologically.~~

~~(3) **"Family therapy"** means interaction between a licensed behavioral health providers (LBHP) or licensure candidate, member and family member(s) to facilitate emotional, psychological or behavioral changes and promote successful communication and understanding.~~

~~(4) **"Group rehabilitative treatment"** means behavioral health remedial services, as specified in the individual care plan, which are necessary for the treatment of the existing primary behavioral health disorders and/or any secondary alcohol and other drug (AOD) disorders in order to increase the skills necessary to perform activities of daily living (ADL).~~

~~(5) **"Individual rehabilitative treatment"** means a face-to-face, one-on-one interaction which is performed to assist members who are experiencing significant functional impairment due to the existing primary behavioral health disorder and/or any secondary AOD disorder in order to increase the skills necessary to perform ADL.~~

~~(6) **"Individual therapy"** means a method of treating existing primary behavioral health disorders and/or any secondary AOD disorders using face-to-face, one-on-one interaction between an LBHP or licensure candidate and a member to promote emotional or psychological change to alleviate disorders.~~

~~(7) **"Process group therapy"** means a method of treating existing primary behavioral health disorders and/or secondary AOD disorders using the interaction between an LBHP or licensure candidate as defined in OAC 317:30-5-240.3, and two (2) or more members to promote positive emotional and/or behavioral change.~~

~~(b) Inpatient psychiatric programs must provide "active treatment." Active treatment involves the member and their family or guardian from the time of an admission throughout the treatment and discharge process. Families and/or guardians must be notified of the dates and times of treatment team meetings and be welcomed to attend. Family members must attend family therapy weekly for continued SoonerCare reimbursement. Reasons for exceptions to this requirement must be well documented in the member's treatment plan. For individuals in the age range of eighteen (18) up to twenty-one (21), it is understood that family members and guardians will not always be involved in the member's treatment. Active treatment also includes an ongoing program of assessment, diagnosis, intervention, evaluation of care and treatment, and planning for discharge and~~

~~aftercare under the direction of a physician. Evidence-based practices such as trauma informed methodology should be utilized to minimize the use of restraint and seclusion.~~

~~(c) For individuals age eighteen (18) up to twenty-one (21), the active treatment program must be appropriate to the needs of the member and be directed toward restoring and maintaining optimal levels of physical and psychiatric-social functioning. The services and individual plan of care must be recovery focused, trauma informed, specific to culture, age and gender, and provided face to face. Services, including type and frequency, will be specified in the individual plan of care.~~

~~(d) For individuals under age eighteen (18), the components of active treatment consist of face-to-face integrated therapies that are provided on a regular basis and will remain consistent with the member's ongoing need for care. The services and individual plan of care must be recovery focused, trauma informed, and specific to culture, age, and gender. Individuals in acute care must receive seventeen (17) hours of documented active treatment services each week, with seven (7) of those hours being dedicated to core services as described in (1) below. Individuals in PRTFs must receive fourteen (14) hours of documented active treatment services each week, with four and a half (4.5) of those hours being dedicated to core services as described in (1) below. Individuals in Community Based Transitional (CBT) treatment must receive ten (10) hours of documented active treatment services each week, with four and a half (4.5) of those hours being dedicated to core services as described in (1) below. The remainder of the active treatment services may include any or all of the elective services listed in (2) below or additional hours of any of the core services. Sixty (60) minutes is the expectation to equal one (1) hour of treatment. When appropriate to meet the needs of the child, the sixty (60) minute timeframe may be split into sessions of no less than fifteen (15) minutes each on the condition that the active treatment requirements are fully met by the end of the treatment week. The following components meet the minimum standards required for active treatment, although an individual child's needs for treatment may exceed this minimum standard:~~

~~(1)~~ **~~Core Services.~~**

~~(A)~~ **~~Individual treatment provided by the physician.~~** ~~Individual treatment provided by the physician is required three (3) times per week for acute care and one (1) time a week in PRTFs. Individual treatment provided by the physician will never exceed ten (10) calendar days between sessions in PRTFs, never exceed seven (7) calendar days in a specialty PRTF and never exceed thirty (30) calendar days in CBTs. Individual treatment provided by the physician may consist of therapy or medication management intervention for acute and residential programs.~~

~~(B)~~ **~~Individual therapy.~~** ~~LBHPs or licensure candidates performing this service must use and document an approach to~~

~~treatment such as cognitive behavioral treatment, narrative therapy, solution focused brief therapy or another widely accepted theoretical framework for treatment. Ongoing assessment of the member's status and response to treatment as well as psycho-educational intervention are appropriate components of individual therapy. Individual therapy must be provided in a confidential setting. The therapy must be goal directed utilizing techniques appropriate to the individual member's plan of care and the member's developmental and cognitive abilities. Individual therapy must be provided two (2) hours per week in acute care and one (1) hour per week in residential treatment by an LBHP or licensure candidate as described in OAC 317:30-5-240.3. One (1) hour of family therapy may be substituted for one (1) hour of individual therapy at the treatment team's discretion.~~

~~(C) **Family therapy.** The focus of family therapy must be directly related to the goals and objectives on the individual member's plan of care. Family therapy must be provided one (1) hour per week for acute care and residential. One (1) hour of individual therapy addressing relevant family issues may be substituted for a family session in an instance in which the family is unable to attend a scheduled session by an LBHP or licensure candidate as described in OAC 317:30-5-240.3.~~

~~(D) **Process group therapy.** The focus of process group therapy must be directly related to goals and objectives on the individual member's plan of care. The individual member's behavior and the focus of the group must be included in each member's medical record. This service does not include social skills development or daily living skills activities and must take place in an appropriate confidential setting, limited to the therapist, appropriate hospital staff, and group members. Group therapy must be provided three (3) hours per week in acute care and two (2) hours per week in residential treatment by an LBHP or licensure candidate as defined in OAC 317:30-5-240.3. In lieu of one (1) hour of process group therapy, one (1) hour of expressive group therapy provided by an LBHP, licensure candidate, or licensed therapeutic recreation specialist may be substituted.~~

~~(E) **Transition/discharge planning.** Transition/discharge planning must be provided one (1) hour per week in acute care and thirty (30) minutes per week in residential and CBT. Transition/discharge planning can be provided by any level of inpatient staff.~~

~~(2) **Elective services.**~~

~~(A) **Expressive group therapy.** Through active expression, inner-strengths are discovered that can help the member deal with past experiences and cope with present life situations in more beneficial ways. The focus of the group must be~~

directly related to goals and objectives on the individual member's plan of care. Documentation must include how the member is processing emotions/feelings. Expressive therapy must be a planned therapeutic activity, facilitated by staff with a relevant bachelor's degree and/or staff with relevant training, experience, or certification to facilitate the therapy.

(B) **Group rehabilitative treatment.** Examples of educational and supportive services, which may be covered under the definition of group rehabilitative treatment services, are basic living skills, social skills (re)development, interdependent living, self-care, lifestyle changes and recovery principles. Each service provided under group rehabilitative treatment services must have goals and objectives, directly related to the individual plan of care.

(C) **Individual rehabilitative treatment.** Services will be for the reduction of psychiatric and behavioral impairment and the restoration of functioning consistent with the requirements of independent living and enhanced self-sufficiency. This service includes educational and supportive services regarding independent living, self-care, social skills (re)development, lifestyle changes and recovery principles and practices. Each individual rehabilitative treatment service provided must have goals and objectives directly related to the individualized plan of care and the member's diagnosis.

(D) **Recreation therapy.** Services will be provided to reduce psychiatric and behavioral impairment as well as to restore, remediate and rehabilitate an individual's level of functioning and independence in life activities. Services will also be provided in such a way as to promote health and wellness as well as reduce or eliminate the activity limitations and restrictions to participation in life situations caused by an illness or disabling condition. Recreational therapy can be provided in an individual or group setting. If the only activities prescribed for the individual are primarily diversional in nature, (i.e. to provide some social or recreational outlet for the individual), it will not be regarded as active treatment. If provided, recreational therapy must be a planned therapeutic activity, facilitated by a licensed therapeutic recreation specialist.

(E) **Occupational therapy.** Services will be provided to address developmental and/or functional needs related to the performance of self-help skills, adaptive behavioral, and/or sensory, motor and postural development. Services include therapeutic goal-directing activities and/or exercises used to improve mobility and ADL functions when such functions have been impaired due to illness or injury. Services must be provided by an occupational therapist appropriately licensed

~~in the state in which they practice.~~

~~(F) **Wellness resource skills development.** Services include providing direction and coordinating support activities that promote good physical health. The focus of these activities should include areas such as nutrition, exercise, support with averting or managing physical health concerns like heart disease, diabetes, and cholesterol, and support regarding the effects of medications have on physical health. Services can include support groups, exercise groups, and individual physical wellness plan development, implementation assistance and support.~~

~~(3) **Modifications to active treatment.** When a member is too physically ill or their acuity level precludes them from active behavioral health treatment, documentation must demonstrate that alternative clinically appropriate services were provided.~~

~~(c) The expectation is that active treatment will occur regularly throughout the treatment week. A treatment week in acute is based on the number of days of acute service, beginning the day of admission (day 1). Required active treatment components will be based upon the length of stay as described below. A treatment week in a residential treatment center (RTC), PRTF and CBT is considered to be a calendar week (i.e. Sunday through Saturday). When a child is admitted to RTC, PRTF or CBT level of care on a day other than Sunday, or discharges on a day other than Saturday, the week will be considered a partial week and services will be required as described below. Active treatment components may include assessments/evaluations to serve as the initial individual or family session if completed by an LBHP or licensure candidate. Start and stop time must be documented. Active treatment begins the day of admission. Days noted are calendar days.~~

~~(1) **Individual treatment provided by the physician.**~~

~~(A) In acute, by day two (2), one (1) visit is required. By day four (4), two (2) visits are required. By day seven (7), three (3) visits are required.~~

~~(B) In RTC, PRTF or CBT, one (1) visit during admission week is required. In RTCs, one (1) visit during the admission week is required, then once a week thereafter. In PRTFs, one (1) visit during the admission week is required, then once a week thereafter. In CBT, one (1) visit is required within seven (7) days of admission. Individual treatment provided by the physician will never exceed ten (10) days between sessions in PRTFs, never exceed seven (7) days in a specialty PRTF and never exceed thirty (30) days in CBTs. The completion of a psychiatric evaluation or a combined psychiatric evaluation and a history and physical (H&P) evaluation may count as the first visit by the physician if the evaluation was personally rendered by the psychiatrist. If the member is admitted on the last day of the admission week, then the member must be seen by a physician within sixty (60) hours of admission time.~~

(2) **Individual therapy.**

(A) In acute, by day three (3), thirty (30) minutes of treatment are required. By day five (5), one (1) hour of treatment is required. Beginning on day seven (7), two (2) hours of treatment are required each week. This does not include admission assessments/evaluations or psychosocial evaluations unless personally (face to face) rendered by the LBHP or licensure candidate.

(B) In residential treatment (including PRTF and CBT), by day six (6), thirty (30) minutes of treatment must be documented. Beginning on day seven (7), one (1) hour of treatment is required each week. The treatment week is defined as Sunday through Saturday. Individual therapy may not exceed a total of ten (10) days between sessions. This does not include admission assessment/evaluation or psychosocial evaluations unless personally (face to face) rendered by the LBHP or licensure candidate.

(3) **Family therapy.**

(A) In acute, by day six (6), thirty (30) minutes of treatment must be documented. Beginning on day seven (7), one (1) hour of treatment is required each week. This does not include admission assessments/evaluation or psychosocial evaluations unless personally (face to face) rendered by the LBHP or licensure candidate and the assessments/evaluation or psychosocial evaluation has not been used to substitute the initial individual therapy requirement.

(B) In residential treatment (including PRTF and CBT), by day six (6), thirty (30) minutes of treatment must be documented. Beginning on day seven (7), one (1) hour of treatment is required each week. This does not include admissions assessment/evaluation or psychosocial evaluation unless personally (face to face) rendered by the LBHP or licensure candidate and the assessment/evaluation or psychosocial evaluation has not been used to substitute the initial individual therapy requirement. Family therapy provided by the LBHP or licensure candidate should not exceed ten (10) days in between sessions.

(4) **Process group therapy.**

(A) In acute, by day three (3), one (1) hour of treatment is required. By day five (5), two (2) hours of treatment are required. Beginning on day seven (7), three (3) hours of treatment are required each week.

(B) In residential treatment (including PRTF and CBT), by day five (5), one (1) hour of treatment is required. Beginning on day seven (7), two (2) hours of treatment are required each week.

(f) When an individual is determined to be too ill to participate in treatment, as determined by medical/nursing staff (registered nurse (RN)/licensed practical nurse (LPN)), documentation must be in the record clearly indicating the reason, limitations, and

~~timeframe for those services to be excused without penalty.~~

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

(1) **"Active treatment"** means implementation of a professionally developed and supervised individual plan of care (IPC) that involves the member and his or her family or guardian from the time of an admission, and through the treatment and discharge process.

(2) **"Discharge/transition planning"** means a patient-centered, interdisciplinary process that begins with an initial assessment of the member's needs at the time of admission and continues throughout the member's stay. Active collaboration with the member, family, and all involved outpatient practitioners and agencies should be ongoing throughout treatment so that effective connections remain intact. Needed services may consist of the wraparound process through Systems of Care, counseling, case management, and other supports in the member's community. The linkages with these supports should be made prior to discharge to allow for a smooth transition.

(3) **"Expressive group therapy"** means art, music, dance, movement, poetry, drama, psychodrama, structured therapeutic physical activities, and experiential (e.g. ropes course), recreational, or occupational therapies that encourage the member to express themselves emotionally and psychologically.

(4) **"Family therapy"** means interaction between an LBHP or licensure candidate, member, and family member(s) to facilitate emotional, psychological, or behavioral changes and promote successful communication and understanding.

(5) **"Group rehabilitative treatment"** means behavioral health remedial services, as specified in the individual care plan, which are necessary for the treatment of the existing primary behavioral health disorders and/or any secondary alcohol and other drug (AOD) disorders in order to increase the skills necessary to perform activities of daily living (ADL).

(6) **"Individual rehabilitative treatment"** means a face-to-face, one-on-one interaction which is performed to assist a member who is experiencing significant functional impairment due to the existing primary behavioral health disorder and/or any secondary AOD disorder, in order to increase the skills necessary to perform ADL.

(7) **"Individual therapy"** means a method of treating existing primary behavioral health disorders and/or any secondary AOD disorders using face-to-face, one-on-one interaction between an LBHP or licensure candidate and a member to promote emotional or psychological change to alleviate disorders.

(8) **"Process group therapy"** means a method of treating existing primary behavioral health disorders and/or secondary AOD disorders using the interaction between an LBHP or licensure

candidate, and two (2) or more members to promote positive emotional and/or behavioral change.

(b) Inpatient psychiatric programs must provide "active treatment". Families and/or guardians must be notified of the dates and times of treatment team meetings and be welcomed to attend. Family members must attend family therapy weekly for continued SoonerCare reimbursement. Reasons for exceptions to this requirement must be well-documented in the member's treatment plan. Family therapy attendance by family members is not a requirement for individuals in the age range of eighteen (18) up to twenty-one (21). Active treatment also includes ongoing assessment, diagnosis, intervention, evaluation of care and treatment, and planning for discharge and aftercare under the direction of a physician.

(c) For individuals age eighteen (18) up to twenty-one (21), the active treatment program must be appropriate to the needs of the member and be directed toward restoring and maintaining optimal levels of physical and psychiatric-social functioning. The services and the IPC must be recovery-focused, trauma-informed, specific to culture, age, and gender, and provided face to face. Services, including type and frequency, will be specified in the IPC.

(d) A treatment week consists of seven (7) calendar days. In an Acute setting, the treatment week begins the day of admission. In Acute II and PRTF, the treatment week starts on Sunday and ends on Saturday. Active treatment service components are provided as per item (e) below if the services are provided within a seven (7) day treatment week. A chart outlining active treatment component requirements and timelines may also be found at www.okhca.org. If a member has a length of stay of less than seven (7) days, the treatment week is considered a partial treatment week. Active treatment requirements, when provided during a partial treatment week, are delivered as per item (f) below. An hour of treatment must be sixty (60) minutes. When appropriate to meet the needs of the child, the sixty (60) minute timeframe may be split into sessions of no less than fifteen (15) minutes each, on the condition that the active treatment requirements are fully met by the end of the treatment week.

(e) For individuals under age eighteen (18), the components of active treatment consist of face-to-face integrated therapies that are provided on a regular basis and will remain consistent with the member's ongoing need for care. The services and IPC must be recovery-focused, trauma-informed, and specific to culture, age, and gender. Individuals in Acute must receive seventeen (17) hours of documented active treatment services each week, with seven (7) of those hours dedicated to core services as described in (1) below. Individuals in Acute II and PRTFs must receive fourteen (14) hours of documented active treatment services each week, with four and a half (4.5) of those hours dedicated to core services as described in (1) below. Individuals in CBT PRTFs must receive ten (10) hours of documented active treatment services each week, with four and a half (4.5) of those hours dedicated to core services as

described in (1) below. Upon fulfilling the core service hours requirement, the member may receive either the elective services listed in (2) below or additional core services to complete the total required hours of active treatment. The following components meet the minimum standards required for active treatment, although an individual child's needs for treatment may exceed this minimum standard:

(1) **Core services.**

(A) **Individual treatment provided by the physician.** Individual treatment provided by the physician is required three (3) times per week for Acute and one (1) time a week in Acute II and PRTFs. Individual treatment provided by the physician will never exceed ten (10) calendar days between sessions in Acute II and PRTFs, never exceed seven (7) calendar days in a specialty Acute II and specialty PRTF, and never exceed thirty (30) calendar days in CBTs. Individual treatment provided by the physician may consist of therapy or medication management intervention for Acute, Acute II, and PRTF programs.

(B) **Individual therapy.** LBHPs or licensure candidates performing this service must use and document an approach to treatment such as cognitive behavioral treatment, narrative therapy, solution-focused brief therapy, or another widely accepted theoretical framework for treatment. Ongoing assessment of the member's status and response to treatment, as well as psycho-educational intervention, are appropriate components of individual therapy. Individual therapy must be provided in a confidential setting. The therapy must be goal-directed, utilizing techniques appropriate to the member's plan of care and the member's developmental and cognitive abilities. Individual therapy must be provided two (2) hours per week in Acute and one (1) hour per week in Acute II and PRTFs by an LBHP or licensure candidate. One (1) hour of family therapy may be substituted for one (1) hour of individual therapy at the treatment team's discretion.

(C) **Family therapy.** The focus of family therapy must be directly related to the goals and objectives on the individual member's plan of care. Family therapy must be provided one (1) hour per week in Acute, Acute II, and PRTFs. One (1) hour of individual therapy addressing relevant family issues may be substituted for a family session in an instance in which the family is unable to attend a scheduled session by an LBHP or licensure candidate.

(D) **Process group therapy.** The focus of process group therapy must be directly related to goals and objectives on the individual member's plan of care. The individual member's behavior and the focus of the group must be included in each member's medical record. This service does not include social skills development or daily living skills activities and must

take place in an appropriate confidential setting, limited to the therapist, appropriate hospital staff, and group members. Group therapy must be provided three (3) hours per week in Acute and two (2) hours per week in Acute II and PRTFs by an LBHP or licensure candidate. In lieu of one (1) hour of process group therapy, one (1) hour of expressive group therapy provided by an LBHP, licensure candidate, or licensed therapeutic recreation specialist may be substituted.

(E) **Transition/discharge planning.** Transition/discharge planning must be provided one (1) hour per week in Acute and thirty (30) minutes per week in Acute II and PRTFs. Transition/discharge planning can be provided by any level of inpatient staff.

(2) **Elective services.**

(A) **Expressive group therapy.** Through active expression, inner-strengths are discovered that can help the member deal with past experiences and cope with present life situations in more beneficial ways. The focus of the group must be directly related to goals and objectives on the individual member's plan of care. Documentation must include how the member is processing emotions/feelings. Expressive therapy must be a planned therapeutic activity, facilitated by staff with a relevant bachelor's degree and/or staff with relevant training, experience, or certification to facilitate the therapy.

(B) **Group rehabilitative treatment.** Examples of educational and supportive services, which may be covered under the definition of group rehabilitative treatment services, are basic living skills, social skills (re)development, interdependent living, self-care, lifestyle changes, and recovery principles. Each service provided under group rehabilitative treatment services must have goals and objectives directly related to the IPC.

(C) **Individual rehabilitative treatment.** Services are provided to reduce psychiatric and behavioral impairment and to restore functioning consistent with the requirements of independent living and enhanced self-sufficiency. This service includes educational and supportive services regarding independent living, self-care, social skills (re)development, lifestyle changes, and recovery principles and practices. Each individual rehabilitative treatment service provided must have goals and objectives directly related to the IPC and the member's diagnosis.

(D) **Recreation therapy.** Services are provided to reduce psychiatric and behavioral impairment and to restore, remediate, and rehabilitate an individual's level of functioning and independence in life activities. Services are provided to promote health and wellness, as well as reduce or eliminate barriers caused by illness or disabling conditions

that limit or restrict a member from participating in life activities. Recreational therapy can be provided in an individual or group setting. If the only activities prescribed for the individual are primarily diversional in nature, (i.e., to provide some social or recreational outlet for the individual), it will not be regarded as active treatment. If provided, recreational therapy must be a planned therapeutic activity, facilitated by a licensed therapeutic recreation specialist.

(E) **Occupational therapy.** Services are provided to address developmental and/or functional needs related to the performance of self-help skills, adaptive behavioral, and/or sensory, motor, and postural development. Services include therapeutic goal-directed activities and/or exercises used to improve mobility and ADL functions when such functions have been impaired due to illness or injury. Services must be provided by an occupational therapist appropriately licensed in the state in which he or she practices.

(F) **Wellness resource skills development.** Services include providing direction and coordinating support activities that promote physical health. The focus of these activities should include areas such as nutrition, exercise, support to avert and manage physical health concerns like heart disease, diabetes, and cholesterol, and guidance on the effects that medications have on physical health. Services can include individual/ group support, exercise groups, and individual physical wellness plan development, implementation, and assistance.

(3) **Modifications to active treatment.** When a member is too physically ill, or his or her acuity level precludes him or her from active behavioral health treatment, documentation must demonstrate that alternative clinically-appropriate services were provided.

(f) Active treatment components, furnished during a partial treatment week, are provided as per item (1) through (4) below. A chart outlining active treatment component requirements and timelines may also be found at www.okhca.org. Assessments/evaluations may serve as the initial individual or family session if completed by an LBHP or licensure candidate. Start and stop time must be documented. Active treatment begins the day of admission. Days noted are calendar days.

(1) **Individual treatment provided by the physician.**

(A) In Acute, by day two (2), one (1) visit is required. By day four (4), two (2) visits are required. By day seven (7), three (3) visits are required.

(B) In Acute II and PRTFs, one (1) visit during admission week is required. In PRTFs, not including CBTs, one (1) visit during the admission week is required, then once a week thereafter. In CBT, one (1) visit is required within seven (7) days of admission, then once a month thereafter.

Individual treatment provided by the physician will never exceed ten (10) days between sessions in Acute II and PRTFs, never exceed seven (7) days in specialty Acute II and specialty PRTFs and never exceed thirty (30) days in CBTs. The completion of a psychiatric evaluation or a combined psychiatric evaluation and a history and physical (H&P) evaluation may count as the first visit by the physician if the evaluation was personally rendered by the psychiatrist. If the member is admitted on the last day of the admission week, then the member must be seen by a physician within sixty (60) hours of admission time.

(2) **Individual therapy.**

(A) In Acute, by day three (3), thirty (30) minutes of treatment are required. By day five (5), one (1) hour of treatment is required. Beginning on day seven (7), two (2) hours of treatment are required each week. This does not include admission assessments/evaluations or psychosocial evaluations unless personally (face to face) rendered by the LBHP or licensure candidate.

(B) In Acute II and PRTFs, by day six (6), thirty (30) minutes of treatment must be documented. Beginning on day seven (7), one (1) hour of treatment is required each week. The treatment week is defined as Sunday through Saturday. Individual therapy may not exceed a total of ten (10) days between sessions. This does not include admission assessment/evaluation or psychosocial evaluations unless personally (face to face) rendered by the LBHP or licensure candidate.

(3) **Family therapy.**

(A) In Acute, by day six (6), thirty (30) minutes of treatment must be documented. Beginning on day seven (7), one (1) hour of treatment is required each week. This does not include admission assessments/evaluation or psychosocial evaluations unless personally (face to face) rendered by the LBHP or licensure candidate and the assessments/evaluation or psychosocial evaluation has not been used to substitute the initial individual therapy requirement.

(B) In Acute II and PRTFs, by day six (6), thirty (30) minutes of treatment must be documented. Beginning on day seven (7), one (1) hour of treatment is required each week. This does not include admissions assessment/evaluation or psychosocial evaluation unless personally (face to face) rendered by the LBHP or licensure candidate and the assessment/evaluation or psychosocial evaluation has not been used to substitute the initial individual therapy requirement. Family therapy provided by the LBHP or licensure candidate should not exceed ten (10) days in between sessions.

(4) **Process group therapy.**

(A) In Acute, by day three (3), one (1) hour of treatment is

required. By day five (5), two (2) hours of treatment are required. Beginning on day seven (7), three (3) hours of treatment are required each week.

(B) In Acute II and PRTFs, by day five (5), one (1) hour of treatment is required. Beginning on day seven (7), two (2) hours of treatment are required each week.

(g) When an individual is determined to be too ill to participate in treatment, as determined by medical/nursing staff [registered nurse (RN)/licensed practical nurse (LPN)], documentation must be in the record clearly indicating the reason, limitations, and timeframe for those services to be excused without penalty.

**317:30-5-95.35. Certificate of need requirements for ~~members under the age of twenty-one (21)~~children in psychiatric ~~hospital~~hospitals and PRTFs**

~~(a) **General requirements.** This Section establishes the requirements for certification of the need for inpatient psychiatric services provided to members under twenty-one (21) years of age in psychiatric hospitals, in accordance with Section 1905(a) 16 and (h) of the Social Security Act, and in PRTFs, in accordance with 42 C.F.R. § 483.354. Pursuant to this federal law, a team, consisting of physicians and other qualified personnel, shall determine that inpatient services are necessary and can reasonably be expected to improve the member's condition. These requirements do not apply to an admission to a psychiatric unit of a general hospital.~~

~~(b) **Definitions.** The following words and terms, when used in this chapter, shall have the following meanings unless the context clearly indicates otherwise.~~

~~(1) **"Independent team"** means a team that is not associated with the facility, such that no team member has an employment or consultant relationship with the admitting facility. The independent team shall include a licensed physician who has competence in diagnosis and treatment of mental illness, preferably child psychiatry, and who has knowledge of the member's clinical condition and situation. The independent team shall also include at least one other licensed behavioral health professional, as defined by OAC 317:30-5-240.3.~~

~~(2) **"Interdisciplinary team"** as defined by 42 C.F.R. § 441.156, means a team of physicians and other personnel who are employed by, or who provide services to, SoonerCare members in the facility or program. The interdisciplinary team must include, at a minimum, either a board-eligible or board-certified psychiatrist; or, a licensed physician and a psychologist licensed by the Oklahoma State Board of Examiners of Psychologists (OSBED) who has a doctoral degree in clinical psychology; or, a licensed physician with specialized training and experience in the diagnosis and treatment of mental diseases, and a psychologist licensed by the OSBED. The interdisciplinary team must also include one of the following:~~

~~(A) a licensed clinical social worker;~~
~~(B) a Registered Nurse with specialized training or one (1) year of experience in treating mentally ill individuals;~~
~~(C) and a psychologist licensed by the OSBED who has a doctoral degree in clinical psychology; or,~~
~~(D) an occupational therapist who is licensed by the state in which the individual is practicing, if applicable, and who has specialized training or one (1) year of experience in treating mentally ill individuals.~~

~~(c) **Certification of the need for services.** As described in 42 C.F.R. § 441.152, the certification shall be made by a team, either independent or interdisciplinary, as specified in (d), below, and shall certify that:~~

~~(1) Ambulatory care resources available in the community do not meet the treatment needs of the member;~~
~~(2) Proper treatment of the member's psychiatric condition requires services on an inpatient basis under the direction of a physician; and~~
~~(3) Services can reasonably be expected to improve the member's condition or prevent further regression so that inpatient services would no longer be needed.~~

~~(d) **Certification for admission.** The certification of the need for services, as stated in (c), above, shall be made by the appropriate team, in accordance with 42 C.F.R. § 441.153 and as specified as follows:~~

~~(1) Certification for the admission of an individual who is a member when admitted to a facility or program shall be made by an independent team, as described in (b)(1), above.~~
~~(2) Certification for an inpatient applying for SoonerCare while in the facility or program shall be made by an interdisciplinary team responsible for the plan of care and as described in (b)(2), above.~~
~~(3) Certification of an emergency admission of a member shall be made by the interdisciplinary team responsible for the plan of care within fourteen (14) days after admission, in accordance with 42 C.F.R. § 441.156.~~

~~(e) Services provided by treatment team members not meeting the above credentialing requirements are not SoonerCare compensable and can not be billed to the SoonerCare member.~~

(a) **General requirements.** This Section establishes the requirements for certification of the need for inpatient psychiatric services provided to individuals under twenty-one (21) years of age in psychiatric hospitals, in accordance with Section 1905(a) 16 and (h) of the Social Security Act, and in PRTFs, in accordance with 42 C.F.R. § 483.354. Pursuant to this federal law, a team, consisting of physicians and other qualified personnel, shall determine that inpatient services are necessary and can reasonably be expected to improve the member's condition. These requirements do not apply to an admission to a psychiatric unit of a general hospital.

(b) **Definitions.** The following words and terms, when used in this chapter, shall have the following meanings unless the context clearly indicates otherwise.

(1) **"Independent team"** means a team that is not associated with the facility, such that no team member has an employment or consultant relationship with the admitting facility. The independent team shall include a licensed physician who has competence in diagnosis and treatment of mental illness, preferably child psychiatry, and who has knowledge of the member's clinical condition and situation. The independent team shall also include at least one (1) other LBHP.

(2) **"Interdisciplinary team"** as defined by 42 C.F.R. § 441.156, means a team of physicians and other personnel who are employed by, or who provide services to, SoonerCare members in the facility or program. The interdisciplinary team must include, at a minimum, either a board-eligible or board-certified psychiatrist; or, a licensed physician and a psychologist licensed by the Oklahoma State Board of Examiners of Psychologists (OSBEP) who has a doctoral degree in clinical psychology; or, a licensed physician with specialized training and experience in the diagnosis and treatment of mental diseases, and a psychologist licensed by the OSBEP. The interdisciplinary team must also include one (1) of the following:

(A) A licensed clinical social worker;

(B) A registered nurse (RN) with specialized training or one (1) year of experience in treating mentally ill individuals;

(C) A psychologist licensed by the OSBEP who has a doctoral degree in clinical psychology; or

(D) An occupational therapist who is licensed by the state in which the individual is practicing, if applicable, and who has specialized training or one (1) year of experience in treating mentally ill individuals.

(c) **Certification of the need for services.** As described in 42 C.F.R. § 441.152, the certification shall be made by a team, either independent or interdisciplinary, as specified in (d), below, and shall certify that:

(1) Ambulatory care resources available in the community do not meet the treatment needs of the member;

(2) Proper treatment of the member's psychiatric condition requires services on an inpatient basis under the direction of a physician; and

(3) Services can reasonably be expected to improve the member's condition or prevent further regression so that inpatient services would no longer be needed.

(d) **Certification for admission.** The certification of the need for services, as stated in (c), above, shall be made by the appropriate team, in accordance with 42 C.F.R. § 441.153 and as specified as follows:

(1) Certification for the admission of an individual who is a member when admitted to a facility or program shall be made by an independent team, as described in (b)(1), above.
(2) Certification for an inpatient applying for SoonerCare while in the facility or program shall be made by an interdisciplinary team responsible for the plan of care and as described in (b)(2), above.
(3) Certification of an emergency admission of a member shall be made by the interdisciplinary team responsible for the plan of care within fourteen (14) days after admission, in accordance with 42 C.F.R. § 441.156.

**317:30-5-95.37. Medical, psychiatric and social evaluations for inpatient services for children**

~~The member's medical record must contain complete medical, psychiatric and social evaluations.~~

~~(1) These evaluations are considered critical documents to the integrity of care and treatment and must be completed as follows:~~

~~(A) History and physical evaluation must be completed within 24 hours of admission by a licensed independent practitioner (M.D., D.O., A.P.N., or P.A.) and within 7 days in a CBT.~~

~~(B) Psychiatric evaluation must be completed within 60 hours of admission by an allopathic or osteopathic physician with a current license and a board certification/eligible in psychiatry and within 7 calendar days in a CBT.~~

~~(C) Psychosocial evaluation must be completed within 72 hours of an acute admission, within seven calendar days of admission to a PRTF and within 7 calendar days in a CBT by a licensed independent practitioner (M.D., D.O., A.P.N., or P.A.), a licensed behavioral health professional (LBHP), or Licensure Candidate as defined in OAC 317:30-5-240.3.~~

~~(2) Each of the evaluations must be clearly identified as such and must be signed and dated by the evaluators.~~

~~(3) Each of the evaluations must be completed when the member changes levels of care if the existing evaluation is more than 30 calendar days from admission. For continued stays at the same level of care, evaluations remain current for 12 months from the date of admission and must be updated annually within seven calendar days of that anniversary date.~~

~~(4) Existing evaluations of 30 days or less may be used when a member changes provider or level of care. The evaluation(s) must be reviewed, updated as necessary and signed and dated by the appropriate level of professional as defined by the type of evaluation.~~

The member's medical record must contain complete medical, psychiatric, and social evaluations.

(1) These evaluations are considered critical documents to the integrity of care and treatment and must be completed as follows:

(A) History and physical evaluation must be completed within twenty-four (24) hours of admission by a licensed independent practitioner (M.D., D.O., A.P.N., or P.A.) in Acute, Acute II, and PRTFs, excluding CBTs, and within seven (7) calendar days of admission in a CBT.

(B) Psychiatric evaluation must be completed within sixty (60) hours of admission by an allopathic or osteopathic physician with a current license and a board certification/eligible in psychiatry in Acute, Acute II, and PRTFs, excluding CBTs, and within seven (7) calendar days of admission in a CBT.

(C) Psychosocial evaluation must be completed within seventy-two (72) hours of an Acute admission, and within seven (7) calendar days of admission to Acute II and PRTFs, including CBTs, by a licensed independent practitioner (M.D., D.O., A.P.N., or P.A.), LBHP, or licensure candidate.

(2) Each of the evaluations must be clearly identified as such and must be signed and dated by the evaluators.

(3) Each of the evaluations must be completed when the member changes levels of care if the existing evaluation is more than thirty (30) calendar days from admission. For continued stays at the same level of care, evaluations remain current for twelve (12) months from the date of admission and must be updated annually within seven (7) calendar days of that anniversary date.

(4) Existing evaluations of thirty (30) days or less may be used when a member changes provider or level of care. The evaluation(s) must be reviewed, updated as necessary, and signed and dated by the appropriate level of professional as defined by the type of evaluation.

**317:30-5-95.38. Nursing services for children**

~~Each facility must have a qualified Director of Psychiatric Nursing. In addition to the Director of Nursing, there must be adequate numbers of registered nurses, licensed practical nurses, and mental health workers to provide nursing care necessary under the active treatment program and to maintain progress notes on each member. In a Community Based Transitional RTC, an RN must be on site at least one hour each day and be available 24 hours a day when not on site. A registered nurse must document member progress at least weekly except in a CBT where the requirement will be twice a month. The progress note must contain recommendations for revisions in the individual plan of care, as needed, as well as an assessment of the member's progress as it relates to the individual plan of care goals and objectives.~~

Each facility must have a qualified director of psychiatric nursing. In addition to the director of nursing, there must be adequate numbers of registered nurses (RNs), licensed practical nurses (LPNs), and mental health workers to provide nursing care necessary under the active treatment program and to maintain

progress notes on each member. In a CBT, an RN must be on site at least one (1) hour each day and be available twenty-four (24) hours a day when not on site. An RN must document member progress at least weekly, except in a CBT where the requirement will be twice a month. The progress note must contain recommendations for revisions in the individual plan of care (IPC), as needed, as well as an assessment of the member's progress as it relates to the IPC goals and objectives.

**317:30-5-95.40. Other required standards**

~~The provider is required to maintain all programs and services according to applicable Code of Federal Regulations (CFR) requirements, TJC/AOA standards for Behavioral Health care, State Department of Health's Hospital Standards for Psychiatric Care, and State of Oklahoma Department of Human Services Licensing Standards for Residential Treatment Facilities. Psychiatric Residential Treatment Facilities may substitute CARF accreditation in lieu of TJC or AOA accreditation.~~

The provider is required to maintain all programs and services according to applicable C.F.R. requirements, the Joint Commission' (TJC) and American Osteopathic Association' (AOA) standards for behavioral health care, Oklahoma State Department of Health's (OSDH) hospital standards for psychiatric care, and Oklahoma Department of Human Services' (OKDHS) licensing standards for residential treatment facilities. PRTFs may substitute the Commission on Accreditation of Rehabilitation Facilities (CARF) accreditation in lieu of TJC or AOA accreditation.

**317:30-5-95.41. Documentation of records for ~~children's~~children receiving inpatient services**

~~(a) All documentation for services provided under active treatment must be documented in an individual note and reflect the content of each session provided. Individual, Family, Process Group, Expressive Group, Individual Rehabilitative and Group Rehabilitative Services documentation must include, at a minimum, the following:~~

~~(1) date;~~

~~(2) start and stop time for each session;~~

~~(3) dated signature of the therapist and/or staff that provided the service;~~

~~(4) credentials of the therapist;~~

~~(5) specific problem(s) addressed (problems must be identified on the plan of care);~~

~~(6) method(s) used to address problems;~~

~~(7) progress made towards goals;~~

~~(8) member's response to the session or intervention; and~~

~~(9) any new problem(s) identified during the session.~~

~~(b) Signatures of the member, parent/guardian for members under the age of 18, doctor, Licensed Behavioral Health Professional (LBHP), and RN are required on the individual plan of care and all plan of~~

~~care reviews. The individual plan of care and plan of care review are not valid until signed and separately dated by the member, parent/legal guardian for members under the age of 18, doctor, RN, LBHP, and all other requirements are met. All treatment team staff providing individual therapy, family therapy and process group therapy must sign the individual plan of care and all plan of care reviews. All plans of care and plan of care reviews must be signed by the member upon completion, except when a member is too physically ill, or the member's acuity level precludes him/her from signing. If the member is too physically ill or the member's acuity level precludes him/her from signing the plan of care and/or the plan of care review at the time of completion, the member must sign the plan when his/her condition improves but before discharge. Documentation should indicate the reason the member was unable to sign and when the next review will occur to obtain the signature.~~

(a) All documentation for services provided under active treatment must be documented in an individual note and reflect the content of each session provided. Individual, family, process group, expressive group, individual rehabilitative, and group rehabilitative services documentation must include, at a minimum, the following:

(1) Date;

(2) Start and stop time for each session;

(3) Dated signature of the therapist and/or staff that provided the service;

(4) Credentials of the therapist;

(5) Specific problem(s) addressed (problems must be identified on the plan of care);

(6) Method(s) used to address problems;

(7) Progress made towards goals;

(8) Member's response to the session or intervention; and

(9) Any new problem(s) identified during the session.

(b) Signatures of the member, parent/guardian for members under the age of eighteen (18), physician, LBHP, and registered nurse (RN) are required on the individual plan of care (IPC) and all plan of care reviews. The IPC and plan of care review are not valid until signed and separately dated by the member, parent/legal guardian for members under the age of eighteen (18), physician, RN, LBHP, and all other requirements are met. All treatment team staff providing individual therapy, family therapy, and process group therapy must sign the IPC and all plan of care reviews. All plans of care and plan of care reviews must be signed by the member upon completion, except when a member is too physically ill, or the member's acuity level precludes him/her from signing. If the member is too physically ill or the member's acuity level precludes him/her from signing the plan of care and/or the plan of care review at the time of completion, the member must sign the plan when his/her condition improves but before discharge. Documentation should indicate the reason the member was unable to sign and when the next review will occur to obtain the signature.

(c) Candidates for licensure for licensed professional counselor, social work (clinical specialty only), licensed marital and family therapist, licensed behavioral practitioner, licensed alcohol and drug counselor, and psychology (mental health specialty only) can provide assessments, psychosocial evaluations, individual therapy, family therapy, and process group therapy as long as they are involved in supervision that complies with their respective, approved licensing regulations and licensing boards. Additionally, their work must be co-signed and dated by a fully-licensed LBHP in good standing, who is a member on the treatment team. Individuals who have met their supervision requirements and are waiting to be licensed in one (1) of the areas of practice in OAC 317:30-5-240.3(a)(2) must have their work co-signed by a fully-licensed LBHP in good standing, who is a member on the treatment team. All co-signatures by fully-licensed LBHPs in good standing, must be accompanied by the date that the co-signature was made. Documentation of the service is not considered complete until it is signed and dated by a fully-licensed LBHP in good standing.

**317:30-5-95.42. Service quality review (SQR) of psychiatric facilities ~~providing services to children~~**

~~(a) The Service Quality Review conducted by OHCA or its designated agent meets the utilization control requirements as set forth in 42 CFR 456.~~

~~(b) There will be an on-site Service Quality Review (SQR) of each in-state psychiatric facility that provides care to SoonerCare eligible children which will be performed by the OHCA or its designated agent. Out-of-state psychiatric facilities that provide care to SoonerCare eligible children will be reviewed according to the procedures outlined in the Medical Necessity Manual. OHCA or its designated agent may conduct ad hoc reviews. Ad hoc reviews may be conducted at the discretion of the agency.~~

~~(c) The Oklahoma Health Care Authority will designate the members of the Service Quality Review team. The SQR team will consist of one to three team members and will be comprised of Licensed Behavioral Health Professionals (LBHP) or Registered Nurses.~~

~~(d) The review will include observation and contact with members. The Service Quality Review will consist of members present or listed as facility residents at the beginning of the Service Quality Review visit as well as members on which claims have been filed with OHCA for acute or PRTF levels of care. The review includes validation of certain factors, all of which must be met for the services to be compensable.~~

~~(e) Following the on-site inspection, the SQR Team will report its findings to the facility. The facility will be provided with written notification if the findings of the review have resulted in any deficiencies. A copy of the final report will be sent to the facility's accrediting agency.~~

~~(f) Deficiencies found during the SQR may result in a partial per-diem recoupment or a full per-diem recoupment of the compensation~~

~~received. The following documents are considered to be critical to the integrity of care and treatment, must be completed within the time lines designated in OAC 317:30-5-95.37, and cannot be substituted with any other evaluation/assessments not specifically mentioned:~~

~~(1) History and physical evaluation;~~

~~(2) Psychiatric evaluation;~~

~~(3) Psychosocial evaluation; and~~

~~(4) Individual Plan of Care.~~

~~(g) For each day that the History and Physical evaluation, Psychiatric evaluation, Psychosocial evaluation and/or Individual Plan of Care are not contained within the member's records, those days will warrant a partial per-diem recoupment.~~

~~(h) If the review findings have resulted in a partial per-diem recoupment of $50.00 per event, the days of service involved will be reported in the notification. If the review findings have resulted in full per-diem recoupment status, the non-compensable days of service will be reported in the notification. In the case of non-compensable days full per diem or partial per diem, the facility will be required to refund the amount.~~

~~(i) In the event that CMS recoups from OHCA an amount that exceeds the provider's liability for findings described in this Section, the provider will not be held harmless and will be required to reimburse OHCA the total federal amount identified by CMS and/or its designated audit contractor.~~

~~(j)Penalties of non-compensable days which are the result of the facility's failure to appropriately provide and document the services described herein, or adhere to applicable accreditation, certification, and/or state licensing standards, are not compensable or billable to the member or the member's family.~~

(a) The service quality review (SQR) conducted by the OHCA or its designated agent meets the utilization control requirements as set forth in 42 C.F.R. Part 456.

(b) There will be an SQR of each in-state psychiatric facility that provides services to SoonerCare members which will be performed by the OHCA or its designated agent. Out-of-state psychiatric facilities that provide services to SoonerCare members will be reviewed according to the procedures outlined in the Medical Necessity Manual. Ad hoc reviews may be conducted at the discretion of the agency.

(c) The OHCA will designate the members of the SQR team. The SQR team will consist of one (1) to three (3) team members and will be comprised of LBHPs or registered nurses (RNs).

(d) The SQR will include, but not be limited to, review of facility and clinical record documentation as well as observation and contact with members. The clinical record review will consist of those records of members present or listed as facility residents at the beginning of the visit as well as members on which claims have been filed with OHCA for acute or PRTF levels of care. The SQR

includes validation of compliance with policy, which must be met for the services to be compensable.

(e) Following the SQR, the SQR team will report its findings to the facility. The facility will be provided with written notification if the findings of the review have resulted in any deficiencies. A copy of the final report will be sent to the facility's accrediting agency, as well as the State Survey Agency and any licensing agencies.

(f) Deficiencies identified during the SQR may result in full or partial recoupment of paid claims. The determination of whether to assess full or partial recoupment shall be at the discretion of the OHCA based on the severity of the deficiencies.

(g) Any days during which the facility is determined to be out of compliance with Federal Conditions of Participation or in which a member does not meet medical necessity criteria will result in full recoupment. Full recoupment may also result from a facility's failure to provide requested documentation within the timeframes indicated on requests for such documents or if the SQR team is denied timely admittance to a facility and/or access to facility records during the on-site portion of the SQR.

(h) Items which may result in full or partial recoupment of paid claims shall include, but not be limited to:

(1) **Assessments and evaluations**. Assessments and evaluations must be completed, with dated signature(s), by qualified staff within the timeframes outlined in Oklahoma Administrative Code (OAC) 317:30-5-95.6 and 317:30-5-95.37.

(2) **Plan of care**. Plans of care must be completed, with all required dated signatures within the timeframes described in OAC 317:30-5-95.4 and 317:30-5-96.33.

(3) **Certification of need (CON).** CONs must be completed by the appropriate team and in the chart within the timeframes outlined in 42 C.F.R. §§ 441.152, 456.160, and 456.481.

(4) **Active treatment**. Treatment must be documented in the chart at the required frequency by appropriately qualified staff as described in OAC 317:30-5-95.5, 317:30-5-95.7, 317:30-5-95.8, 317:30-5-95.9, 317:30-5-95.10 and 317:30-5-95.34.

(5) **Documentation of services**. Services must be documented in accordance with OAC 317:30-5-95.5, 317:30-5-95.8, 317:30-5-95.10, 317:30-5-95.41 and 42 C.F.R. §§ 412.27(c)(4) and 482.61. Documentation with missing elements or documentation that does not clearly demonstrate the therapeutic appropriateness and benefit of the service may result in recoupment.

(6) **Staffing**. Staffing must meet the ratios described in OAC 317:30-5-95.24(b)-(d)& (h)and OAC 317:30-5-95.38 per unit/per shift; and credentialing requirements as outlined in OAC 317:30-5-95.8, 317:30-5-95.9, 317:30-5-95.35, 317:30-5-95.36, and 42 C.F.R. §§ 412.27(d), 441.153, 441.156, and 482.62.

(7) **Restraint/seclusion.** Orders for restraint and seclusion must be completely and thoroughly documented with all required

elements as described in OAC 317:30-5-95.39 and 42 C.F.R. § 482.13(e) & (f) and 42 C.F.R. Part 483. Documentation must support the appropriateness and necessity for the use of restraint/seclusion. For PRTFs, documentation must include evidence that staff and resident debriefings occurred as required by OAC 317:30-5-95.39 and 42 C.F.R. Part 483.

(i) If the review findings have resulted in a recoupment, the days and/or services involved will be reported in the notification.

(j) In the event that CMS recoups from OHCA an amount that exceeds the provider's liability for findings described in this Section, the provider will not be held harmless and will be required to reimburse OHCA the total federal amount identified by CMS and/or its designated audit contractor, limited to the amount of the original paid claim less any previously recouped amounts.

(k) Penalties of non-compensable days which are the result of the facility's failure to appropriately provide and document the services described herein, or adhere to applicable accreditation, certification, and/or state licensing standards, are not compensable or billable to the member or the member's family.

(l) Facilities that are determined to owe recoupment of paid claims will have the ability to request a reconsideration of the findings. Details and instructions on how to request a reconsideration will be part of the report documentation sent to the facility.

(m) Facilities that are determined by the SQR process to be out of compliance in significant areas will be required to submit a Corrective Action Plan (CAP) detailing steps being taken to bring performance in line with requirements. Facilities that are required to submit a CAP may be further assessed through a formal, targeted post-CAP review process.

**317:30-5-96.2. Payments definitions**

~~The following words and terms, when used in Sections OAC 317:30-5-96.3 through 317:30-5-96.7, shall have the following meaning, unless the context clearly indicates otherwise:~~

~~**"Allowable costs"** means costs necessary for the efficient delivery of member care.~~

~~**"Ancillary Services"** means the services for which charges are customarily made in addition to routine services. Ancillary services include, but are not limited to, physical therapy, speech therapy, laboratory, radiology and prescription drugs.~~

~~**"Border Status"** means a placement in a state that does not border Oklahoma but agrees to the same terms and conditions of instate or border facilities.~~

~~**"Developmentally disabled child"** means a child with deficits in adaptive behavior originating during the developmental period. This condition may exist concurrently with a significantly subaverage general intellectual functioning.~~

~~**"Eating Disorders Programs"** means acute or intensive residential behavioral, psychiatric and medical services provided in a discreet~~

~~unit to individuals experiencing an eating disorder.~~

~~**"Professional services"** means services of a physician, psychologist or dentist legally authorized to practice medicine and/or surgery by the state in which the function is performed.~~

~~**"Psychiatric Residential Treatment Facility (PRTF)"** means a non-hospital with an agreement to provide inpatient psychiatric services to individuals under the age of 21.~~

~~**"Routine Services"** means services that are considered routine in the freestanding PRTF setting. Routine services include, but are not limited to:~~

~~(A) room and board;~~
~~(B) treatment program components;~~
~~(C) psychiatric treatment;~~
~~(D) professional consultation;~~
~~(E) medical management;~~
~~(F) crisis intervention;~~
~~(G) transportation;~~
~~(H) rehabilitative services;~~
~~(I) case management;~~
~~(J) interpreter services (if applicable);~~
~~(K) routine health care for individuals in good physical health; and~~
~~(L) laboratory services for a substance abuse/detoxification program.~~

~~**"Specialty treatment program/specialty unit"** means acute or intensive residential behavioral, psychiatric and medical services that provide care to a population with a special need or issues such as developmentally disabled, intellectually disabled, autistic/Asperger's, eating disorders, sexual offenders, or reactive attachment disorders. These members require a higher level of care and staffing ratio than a standard PRTF and typically have multiple problems.~~

~~**"Treatment Program Components"** means therapies, activities of daily living and rehabilitative services furnished by physician/psychologist or other licensed mental health professionals.~~

~~**"Usual and customary charges"** refers to the uniform charges listed in a provider's established charge schedule which is in effect and applied consistently to most members and recognized for program reimbursement. To be considered "customary" for reimbursement, a provider's charges for like services must be imposed on most members regardless of the type of member treated or the party responsible for payment of such services.~~

The following words and terms, when used in OAC 317:30-5-96.3 through 317:30-5-96.7, shall have the following meaning, unless the context clearly indicates otherwise:

**"Add-on payment"** means an additional payment added to the per diem to recognize the increased cost of serving members with complex needs in a PRTF or Acute II.

**"Allowable costs"** means costs necessary for the efficient delivery of member care.

**"Ancillary services"** means the services for which charges are customarily made in addition to routine services. Ancillary services include, but are not limited to, physical therapy, speech therapy, laboratory, radiology, and prescription drugs.

**"Border status"** means a placement in a state that does not border Oklahoma. Reimbursement for out-of-state services is made in accordance with OAC 317:30-3-89 through 317:30-3-92 and the Oklahoma Medicaid State Plan.

**"Developmentally disabled child"** means a child with deficits in adaptive behavior originating during the developmental period. This condition may exist concurrently with a significantly subaverage general intellectual functioning.

**"Eating disorder programs"** means acute or intensive residential behavioral, psychiatric, and medical services provided in a discreet unit to individuals experiencing an eating disorder.

**"Professional services"** means services of a physician, psychologist, or dentist legally authorized to practice medicine and/or surgery by the state in which the function is performed.

**"Routine services"** means services that are considered routine in the Acute II and PRTF levels of care setting. Routine services include, but are not limited to:

(A) Room and board;
(B) Treatment program components;
(C) Psychiatric treatment;
(D) Professional consultation;
(E) Medical management;
(F) Crisis intervention;
(G) Transportation;
(H) Rehabilitative services;
(I) Case management;
(J) Interpreter services (if applicable);
(K) Routine health care for individuals in good physical health; and
(L) Laboratory services for a substance abuse/detoxification program.

**"Specialty treatment program/specialty unit"** means Acute or other intensive behavioral, psychiatric, and medical services that provide care to a population with special needs or issues such as developmentally disabled, intellectually disabled, autistic/Asperger's, eating disorders, sexual offenders, or reactive attachment disorders. These members require a higher level of care and staffing ratio than a standard PRTF and typically have multiple problems.

**"Treatment program components"** means therapies, activities of daily living, and rehabilitative services furnished by physician/psychologist or other licensed mental health professionals.

**"Usual and customary charges"** refers to the uniform charges listed in a provider's established charge schedule which is in effect and applied consistently to most members and recognized for program reimbursement. To be considered "customary" for reimbursement, a provider's charges for like services must be imposed on most members regardless of the type of member treated or the party responsible for payment of such services.

**317:30-5-96.3. Methods of payment**

~~(a) **Reimbursement.** Covered inpatient psychiatric and/or substance abuse services will be reimbursed using one of the following methodologies:~~

~~(1) Diagnosis Related Group (DRG);~~

~~(2) cost based; or~~

~~(3) a predetermined per diem payment.~~

~~(b) **Acute Level of Care.**~~

~~(1) Psychiatric units within general medical surgical hospitals and Critical Access hospitals. Payment will be made utilizing a DRG methodology. [See OAC 317:30-5-41(b)]. Psychiatric professional (physicians and psychologists) services provided in conjunction with the inpatient stay are separately payable from the DRG paid to the hospital;~~

~~(2) Freestanding Psychiatric Hospitals. A predetermined statewide per diem payment will be made for all facility services provided during the inpatient stay. Psychiatric professional (physicians and psychologists) services provided in conjunction with the inpatient stay are separately payable from the per diem paid to the hospital. Rates vary for public and private providers.~~

~~(c) **Residential Level of Care**~~

~~(1) **Instate Services.**~~

~~(A) Psychiatric Hospitals or Inpatient Psychiatric Programs. A pre-determined all-inclusive per diem payment will be made for routine, ancillary and professional services. Public facilities will be reimbursed using either the statewide or facility specific interim rates and settled to total allowable costs as determined by analyses of the cost reports (Form CMS 2552) filed with the OHCA.~~

~~(B) Psychiatric Residential Treatment Facilities. A pre-determined per diem payment will be made to private PRTFs with 16 beds or less for routine services. All other services are separately billable. A predetermined all-inclusive per diem payment will be made for routine, ancillary and professional services to private facilities with more than 16 beds. Public facilities will be reimbursed using either the statewide or facility specific interim rates and settled to total allowable costs as determined by analyses of the cost reports (Form 2552) filed with the OHCA.~~

~~(2) **Out-of-state services.**~~

~~(A) Border and "border status" placements. Facilities are reimbursed in the same manner as in-state hospitals or PRTFs.~~
~~(B) Out-of-state placements. In the event comparable services cannot be purchased from an Oklahoma facility and the current payment levels are insufficient to obtain access for the member, the OHCA may negotiate a predetermined, all-inclusive per diem rate for specialty programs/units. An incremental payment adjustment may be made for 1:1 staffing (if clinically appropriate and prior authorized). Payment may be up to, but no greater, than usual and customary charges. The 1:1 staffing adjustment is limited to 60 days annually.~~

~~(d) **Health Home Transitioning Services**. Health Home services for the provision of comprehensive transitional care to existing members are considered to be inpatient psychiatric services, when services exceed and do not duplicate ordinary inpatient discharge planning during the last 30 days of a covered acute or residential stay. Payment for Health Home transitioning services provided under arrangement with the inpatient provider will be directly reimbursed to the Health Home outside of the facility's per diem or DRG rate.~~

(a) **Reimbursement.**

(1) Covered inpatient psychiatric and/or substance use disorder services will be reimbursed using one (1) of the following methodologies:

(A) Diagnosis related group (DRG);

(B) Cost-based; or

(C) A predetermined per diem payment.

(2) For members twenty-one (21) to sixty-four (64) years of age, payment shall not be made to any inpatient psychiatric facility that qualifies as an IMD, except as provided by OAC 317:30-5-95.23 and 317:30-5-95.11.

(b) **Levels of care.**

(1) **Acute.**

(A) Payment will be made to psychiatric units within general medical surgical hospitals and critical access hospitals utilizing a DRG methodology. [See OAC 317:30-5-41]. Psychiatric professional (physicians and psychologists) services provided in conjunction with the inpatient stay are separately payable from the DRG paid to the hospital;

(B) Payment will be made to psychiatric hospitals utilizing a predetermined statewide per diem payment for all facility services provided during the inpatient stay. Psychiatric professional (physicians and psychologists) services provided in conjunction with the inpatient stay are separately payable from the per diem paid to the hospital. Rates vary for public and private providers.

(2) **Acute II.**

(A) Payment will be made to in-state psychiatric hospitals or inpatient psychiatric programs utilizing a predetermined all-inclusive per diem payment for routine, ancillary, and

professional services.

(B) Public facilities will be reimbursed using either the statewide or facility-specific interim rates and settled to total allowable costs as determined by analyses of the cost reports (Form CMS 2552) filed with the OHCA.

(3) **PRTFs.**

(A) A pre-determined per diem payment will be made to private PRTFs with sixteen (16) beds or less for routine services. All other services are separately billable.

(B) A predetermined all-inclusive per diem payment will be made for routine, ancillary, and professional services to private facilities with more than sixteen (16) beds.

(C) Public facilities will be reimbursed using either the statewide or facility-specific interim rates and settled to total allowable costs as determined by analyses of the cost reports (Form CMS 2552) filed with the OHCA.

(c) **Out-of-state services.**

(1) **Border and "border status" placements.** Facilities are reimbursed in the same manner as in-state hospitals or PRTFs. Refer to OAC 317:30-3-90 and 317:30-3-91.

(2) **Out-of-state placements.** In the event comparable services cannot be purchased from an Oklahoma facility and the current payment levels are insufficient to obtain access for the member, the OHCA may negotiate a predetermined, all-inclusive per diem rate for specialty programs/units. An incremental payment adjustment may be made for one (1): one (1) staffing (if clinically appropriate and prior authorized). Payment may be up to, but no greater, than usual and customary charges. The one (1): one (1) staffing adjustment is limited to sixty (60) days annually. Refer to OAC 317:30-3-90 and 317:30-3-91.

(d) **Add-on payments.**

(1) Additional payment shall only be made for services that have been prior authorized by OHCA or its designee and determined to be medically necessary. For medical necessity criteria applicable for the add-on payment(s), refer to the SoonerCare Medical Necessity Criteria Manual for Inpatient Behavioral Health Services found on the OHCA website.

(2) SoonerCare shall provide additional payment for the following services rendered in an Acute II and PRTF, as per the Oklahoma Medicaid State Plan.

(A) **Intensive treatment services (ITS) add-on.** Payment shall be made for members requiring intensive staffing supports.

(B) **Prospective complexity add-on.** Payment shall be made to recognize the increased cost of serving members with a mental health diagnosis complicated with non-verbal communication.

(C) **Specialty add-on.** Payment shall be made to recognize the increased cost of serving members with complex needs.

(e) **Services provided under arrangement.**

(1) **Health home transitioning services.**

(A) Services for the provision of comprehensive transitional care to existing members are considered to be inpatient psychiatric services, when services exceed and do not duplicate ordinary inpatient discharge planning during the last thirty (30) days of a covered acute or residential stay.

(B) Payment for health home transitioning services provided under arrangement with the inpatient provider will be directly reimbursed to the health home outside of the facility's per diem or DRG rate.

(2) **Case management transitioning services.**

(A) Services for the provision of case management transitioning services to existing members are considered to be inpatient psychiatric services, when services exceed and do not duplicate ordinary inpatient discharge planning during the last thirty (30) days of a covered acute or residential stay.

(B) Payment for case management transitioning services provided under arrangement with the inpatient provider will be directly reimbursed to a qualified community-based provider.

(3) **Evaluation and psychological testing by a licensed psychologist.**

(A) Services for the provision of evaluation and psychological testing by a licensed psychologist to existing members are considered to be inpatient psychiatric services, when services exceed and do not duplicate ordinary inpatient discharge planning during the last thirty (30) days of a covered acute or residential stay.

(B) Payment for evaluation and psychological testing by a licensed psychologist for services provided under arrangement with the inpatient provider will be directly reimbursed to a qualified provider in accordance with the Oklahoma Medicaid State Plan.

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

**SUBCHAPTER 15. PERSONAL CARE SERVICES**

**317:35-15-8.2. State Plan Personal Care Eligible Provider Exception**

The Oklahoma Department of Human Services (OKDHS) Aging Services (AS) may authorize a member's legal guardian to be eligible for SoonerCare (Medicaid) reimbursement when he or she is hired by a home care provider agency as a personal care service provider. Authorization for a legal guardian as a provider requires the criteria in (1) though (4) of this Section and monitoring provisions to be met.

(1) Authorization for a legal guardian to be the member's care provider may occur only when the member is offered a choice of providers and documentation demonstrates:

(A) Another provider is not available; or

(B) The member's needs are so extensive that the legal guardian providing the care is prohibited from obtaining employment.

(2) The service must:

(A) Fall under the State Plan Personal Care (SPPC) program guidelines;

(B) Be necessary to avoid institutionalization;

(C) Be a service and/or support specified in the person-centered service plan;

(D) Be provided by a person who meets provider qualifications;

(E) Be paid at a rate that does not exceed what would be paid to a provider of a similar service and does not exceed what is allowed by Medicaid (SoonerCare)for the payment of personal care or personal assistance services; and

(F) Not be an activity the legal guardian would ordinarily perform or is responsible to perform.

(3) The legal guardian service provider complies with:

(A) Providing no more that forty (40) hours of services in a seven (7) calendar day period;

(B) Planned work schedules that must be available in advance for the member's home care agency. Variations to the schedule must be noted and supplied to the home care agency two (2) weeks in advance unless the change is due to an emergency;

(C) Utilization of the Electronic Visit Verification System (EVV) also known as the Interactive Voice Response Authentication (IVRA) system; and

(D) Being identified and monitored by the home care agency.

(4) The home care agency is required to submit a request and obtain approval for eligible provider exceptions to OKDHS AS prior to employing a legal guardian as a member's personal care assistant (PCA). Eligible provider exceptions require the home care agency to:

(A) Provide monitoring and complete the Eligible Provider Exception Six Month Review document, when in the member's home completing the six-month Nurse Evaluation document in the Medicaid waiver information system; and

(B) Annually complete the Eligible Provider Exception Request and submit it with the annual Service Authorization Model (SAM) documentation no later than forty-five (45) calendar days prior to the previous eligible provider exception service authorization end date.

## SUBCHAPTER 17. ADVANTAGE WAIVER SERVICES

**317:35-17-1. Overview of long-term medical care services; relationship to Qualified Medicare Beneficiary Plus (QMBP), Specified Low-Income Medicare Beneficiary (SLMB), and other Medicaid (SoonerCare) services eligibility**

(a) Long-term medical care for the categorically needy includes:

(1) ~~care~~Care in a ~~nursing facility. Refer to~~long-term care facility per Oklahoma Administrative Code (OAC) 317:35-19;

(2) ~~care~~Care in a public or private intermediate care facility for the intellectually disabled~~. Refer to~~ (ICF/IID), per OAC 317:35-9;

(3) ~~care~~Care of persons ~~age 65 years and~~sixty-five (65) years of age and older in mental health hospitals~~. Refer to~~, per OAC 317:35-9;

(4) Home and ~~Community Based Services Waivers~~Community-Based waiver services for persons with intellectual disabilities~~. Refer to~~, per OAC 317:35-9;

(5) Personal Care services~~. Refer to~~, per OAC 317:35-15; and

(6) ~~the~~ Home and ~~Community Based Services Waiver (ADvantage Waiver)~~Community-Based waiver services (ADvantage waiver) for frail elderly, ~~(65 years of age or older),~~sixty-five (65) years of age and older; and a targeted group of adults with physical disabilities, ~~21 to 64~~twenty-one (21) to sixty-four (64) years of age and older, who do not have an intellectual disability or a cognitive impairment related to a developmental disability~~.~~ per OAC 317:35-17-3.

(b) When an individual is certified as eligible for SoonerCare coverage of long-term care, he or she is also eligible for other SoonerCare services. ADvantage ~~Waiver~~waiver members do not have a copayment for ADvantage services except for prescription drugs. For members residing in an ADvantage ~~Assisted Living~~

~~Center,~~assisted living center, any income beyond ~~150~~one-hundred and fifty percent (150%) of the federal benefit rate is available to defray the cost of the assisted living services received. The member is responsible for payment to the assisted living services center provider for days of service, from the first day of each full-month in which services were received, until the vendor pay obligation is met. When an individual is aged, blind, or disabled and is determined eligible for long-term care, a separate eligibility determination must be made for QMBP or SLMB benefits. An ADvantage program member may reside in a licensed assisted living services center only when the assisted living services center is a certified ADvantage assisted living services center provider from whom the member is receiving ADvantage assisted living services.

**317:35-17-3. ADvantage program services**

(a) The ADvantage program is a Medicaid Home and ~~Community Based Waiver~~Community-Based waiver used to finance non-institutional, long-term care services for the elderly and a targeted group of physically disabled adults when there is a reasonable expectation that within a ~~30-calendar~~thirty (30) calendar day period, the person's health, due to disease process or disability, would~~,~~ without appropriate services, deteriorate and require ~~nursing~~long-term care (LTC) facility care to arrest the deterioration. Individuals may not be enrolled in ADvantage for the sole purpose of enabling them to obtain Medicaid eligibility. Eligibility for ADvantage program services is contingent on an individual requiring one (1) or more of the services offered in the ~~Waiver~~waiver, at least monthly, ~~in order~~ to avoid institutionalization.

(b) The number of individuals who may receive ADvantage services is limited.

(1) To receive ADvantage program services, individuals must meet one of the ~~following~~ categories~~.~~ in (A) though (D) of this paragraph. He or she must:

(A) ~~be 65~~Be sixty-five (65) years of age and older; or

(B) ~~be 21 to 64~~Be twenty-one (21) to sixty-four (64) years of age, ~~when~~ physically disabled and not developmentally disabled~~ or when 21 to 64 years of age and not physically disabled, the person has a clinically documented, progressive degenerative disease process that responds to treatment and previously required hospital or nursing facility (NF) level of care services for treatment related to the condition; and requires ADvantage services to maintain the treatment regimen to prevent health deterioration~~; or

(C) ~~when~~When developmentally disabled, and ~~21 to 64~~twenty-

one (21) to sixty-four (64) years of age; and does not have an intellectual disability or a cognitive impairment related to the developmental disability~~.~~;

(D) Be twenty-one (21) to sixty-four (64) years of age, not physically disabled but has clinically documented, progressive, degenerative disease process that responds to treatment and previously required hospital or LTC facility level of care services to maintain the treatment regimen to prevent health deterioration.

(2) In addition, the individual must meet criteria in (A) through (C)~~.~~ of this paragraph. He or she must:

(A) ~~require~~Require ~~nursing~~long-term care facility level of care~~. Refer to~~, per Oklahoma Administrative Code (OAC) 317:35-17-2;

(B) ~~meet~~Meet service eligibility criteria~~. Refer to~~, per OAC 317:35-17-3(f); and

(C) ~~meet~~Meet program eligibility criteria~~. Refer to~~, per OAC 317:35-17-3(g).

(c) ADvantage members are eligible for limited types of living arrangements. The specific living arrangements are set forth ~~below.~~in (1) though (5) of this subsection.

(1) ADvantage program members are not eligible to receive services while residing in an unlicensed institutional living arrangement, such as a room and board home and/or facility; an institutional setting including, but not limited to, licensed facilities, such as a hospital, a ~~nursing~~LTC facility, licensed residential care facility, or licensed assisted living facility, unless the facility is an ADvantage ~~Assisted Living Center or in an unlicensed institutional living arrangement, such as a room and board home/facility.~~assisted living center.

(2) Additional living arrangements in which members may receive ADvantage services are the member's own home, apartment, or independent-living apartment, or a family or friend's home or apartment. A home/apartment unit is defined as a self-contained living space having a lockable entrance to the unit and including a bathroom and ~~food storage/preparation~~food storage and/or preparation amenities in addition to ~~bedroom/living~~bedroom and/or living space.

(3) ADvantage program members may receive services in a shelter or similar temporary-housing arrangement that may or may not meet the definition of ~~home/apartment,~~home and/or apartment in emergency situations, for a period not to exceed ~~60-calendar~~sixty (60) calendar days during which location and transition to permanent housing is sought.

(4) For ADvantage members who are full-time students, a dormitory room qualifies as an allowable living arrangement in which to receive ADvantage services ~~for the period during~~

~~which~~while the member is a student.

(5) Members may receive ADvantage respite services in a ~~nursing facility~~an LTC facility for a continuous period not to exceed ~~30-calendar~~thirty (30) calendar days.

(d) Home and ~~Community Based Waiver Services~~Community-Based waiver services are outside of the scope of Medicaid State Plan services. The Medicaid ~~Waiver~~waiver allows ~~OHCA~~the Oklahoma Health Care Authority (OHCA) to offer certain Home and ~~Community Based~~Community-Based services to an annually capped number of persons, who are categorically needy, ~~refer to DHS Form~~per Oklahoma Department of Human Services (OKDHS) Appendix C-1, Schedule VIII. B. 1., and without such services would be institutionalized. The estimated cost of providing an individual's care outside the ~~nursing facility~~LTC facility cannot exceed the annual cost of caring for that individual in ~~a nursing facility.~~an LTC facility. When determining the ADvantage service plan cost cap for an individual, the comparable SoonerCare cost to serve that individual in ~~a NF~~an LTC facility is estimated.

(e) Services provided through the ADvantage ~~Waiver~~waiver are:

(1) ~~case~~Case management;

(2) ~~respite;~~Respite;

(3) ~~adult~~Adult day health care;

(4) ~~environmental~~Environmental modifications;

(5) ~~specialized~~Specialized medical equipment and supplies;

(6) ~~physical,~~Physical, occupational, or speech therapy or consultation;

(7) ~~advanced supportive/restorative assistance;~~Advanced supportive and/or restorative assistance;

(8) ~~nursing;~~Nursing

(9) ~~skilled~~Skilled nursing;

(10) ~~home-delivered~~Home-delivered meals;

(11) ~~hospice~~Hospice care;

(12) ~~medically~~Medically necessary prescription drugs, within the limits of the ADvantage ~~Waiver;~~waiver;

(13) ~~personal~~Personal care, State Plan, or ADvantage personal care;

(14) A Personal Emergency Response System (PERS);

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

(16) Institution ~~Transition Services;~~

(17) ~~assisted~~Assisted living; and

(18) SoonerCare medical services for individuals, ~~21~~twenty-one (21) years of age and over, within the State Plan scope ~~of the State Plan~~.

(f) The ~~DHS~~OKDHS area nurse or nurse designee makes a determination of service eligibility prior to evaluating the Uniform Comprehensive Assessment Tool (UCAT) assessment for ~~nursing~~long-

term care facility level of care. The~~ following~~ criteria in (1) through (5) of this subsection are used to make the service eligibility determination~~:~~, which includes:

(1) ~~an~~An open ADvantage ~~Program Waiver~~program waiver slot, as authorized~~ by the Waiver document approved~~ by the Centers for Medicare and Medicaid Services (CMS), which is available to ensure federal participation in payment for services to the individual. When the Oklahoma Department of Human Services/Aging Services ~~(DHS/AS)~~(OKDHS/AS) determines all ~~ADvantage Waiver~~ slots are filled, the individual cannot be certified by ~~DHS~~OKDHS as eligible for ADvantage services~~, the individual's~~and his or her name is placed on a waiting list for entry when an open slot becomes available;

(2) ~~the individual is in the~~The ADvantage ~~targeted~~waiver-targeted service group. The target group ~~are~~is individuals, who:

(A) ~~are~~Are frail and ~~65~~sixty-five (65) years of age and older; or

(B) ~~have a physical disability,~~ are ~~between 21 and 64~~Twenty-one to sixty-four years of age~~,~~ and ~~do not have an intellectual disability or a cognitive impairment; or~~physically disabled; or

(C) ~~have developmental disability, are 21 and 64 years of age, and does~~When developmentally disabled, and are twenty-one (21) to sixty-four (64) years of age and do not have an intellectual disability or cognitive impairment related to the developmental disability; or

(D) Are twenty-one (21) to sixty-four (64) years of age, not physically disabled but have a clinically documented, progressive, degenerative disease process that responds to treatment and previously required hospital or long-term care facility level of care services to maintain the treatment regimen to prevent health deterioration. The individual must meet criteria, per OAC 317:35-174-3(b)(2)(A through C).

(3) ~~the~~An ineligible individual~~ is not eligible~~ because he or she poses a physical threat to himself or herself or others as supported by professional documentation~~:~~.

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

(5) ~~the~~An ineligible individual~~ is not eligible~~ when his or her living environment poses a physical threat to himself or herself or others as supported by professional documentation where applicable, and measures to correct hazardous conditions or assist ~~individuals~~the individual move are unsuccessful or not feasible.

(g) The State, as part of the ~~Waiver~~ADvantage waiver program approval authorization, ensures ~~Centers for Medicare and Medicaid Services (CMS)~~CMS that each member's health, safety, or welfare can be maintained in his or her home. When a member's identified needs cannot be met through provision of ADvantage program or Medicaid State Plan services and other formal or informal services are not in place or immediately available to meet those needs, the individual's health, safety, or welfare in ~~their~~his or her home cannot be ensured. The ADvantage Administration (AA) determines ADvantage program eligibility through the service plan approval process. An individual is deemed ineligible for the ADvantage program based on~~ the following~~ criteria~~:~~ (1) through (8) of this subsection.

(1) ~~the~~The individual's needs, as identified by UCAT and other professional assessments, cannot be met through ADvantage program services, Medicaid State Plan services, ~~and~~or other formal or informal services~~;~~.

(2) ~~one~~One (1) or more members of the individual's household pose a physical threat to~~ self~~themselves or others as supported by professional documentation~~;~~.

(3) ~~the~~The individual or other household members use threatening, intimidating, degrading, or use sexually inappropriate ~~language/innuendo~~language and/or innuendo or behavior towards service providers, either in the home or through other contact or communications, and significant efforts were attempted to correct such behavior, as supported by professional documentation or other credible documentation.

(4) ~~the~~The individual or the individual's authorized agent is uncooperative or refuses to participate in service development or service delivery and these actions result in unacceptable increases of risk to the individual's health, safety, or welfare in his or her home, as determined by the individual, the interdisciplinary team, or the AA~~;~~.

(5) ~~the~~The individual's living environment poses a physical threat to self or others as supported by professional documentation and measures to correct hazardous conditions or assist the person to move are unsuccessful or are not feasible~~;~~.

(6) ~~the~~The individual provides false or materially inaccurate information necessary to determine program eligibility or withholds information necessary to determine program eligibility~~;~~.

(7) ~~the~~The individual does not require at least one ADvantage service monthly~~; and~~.

(8) ~~the~~The individual, his or her family member(s), associate(s), or any other person(s) or circumstances as relates to care and coordination in ~~the individual's~~his or her living environment produces evidence of illegal drug activity

or substances used illegally as intoxicants. This includes:

(A) The use, possession, or distribution of illegal drugs;

(B) The abusive use of other drugs, such as medication prescribed by a doctor; ~~or~~

(C) The use of substances, such as inhalants including, but not limited to:

(i) ~~typewriter~~Typewriter correction fluid;

(ii) ~~air~~Air conditioning coolant;

(iii) ~~gasoline;~~Gasoline;

(iv) ~~propane;~~Propane

(v) ~~felt tip~~Felt-tip markers;

(vi) ~~spray~~Spray paint;

(vii) ~~air~~Air freshener;

(viii) ~~butane;~~Butane;

(ix) ~~cooking~~Cooking spray;

(x) ~~paint;~~Paint and

(xi) ~~glue;~~Glue;

(D) The observed intoxication, consumption or sensory indicators, such as smell of the use of ~~an~~any drug or intoxicant by the individual, family members, associates, or any other person(s) present at the time care is provided may be construed as evidence indicative of illegal drug activity or intoxication. This includes drug use or intoxicated activity that is menacing to the member or staff providing services;

(E) ~~the~~The observance of drug paraphernalia or any instrument used in the manufacturing, production, distribution, sale, or consumption of drugs or substances including, but not limited to:

(i) ~~smoking~~Smoking pipes used to consume substances other than tobacco;

(ii) ~~roach~~Roach clips containing marijuana cigarettes;

(iii) ~~needles~~Needles and other implements used for injecting drugs into the body;

(iv) ~~plastic~~Plastic bags or other containers used to package drugs;

(v) ~~miniature~~Miniature spoons used to prepare drugs; or

(vi) ~~kits~~Kits used in the production of synthetic controlled substances including descriptive materials that accompany the item, describing or depicting its use~~;~~.

(F) ~~instructions, oral~~Instructions, verbal or written, concerning the item or device including, but not limited to, the manner in which the object is labeled and displayed for sale;

(G) ~~the~~The typical use of such items in the community; and/or

(H) ~~testimony~~Testimony of an expert witness regarding use of

the item.

(h) ~~the~~The case manager provides the AA with professional documentation or other credible documentation to support the recommendation for redetermination of program eligibility. The service providers continue providing services according to the person-centered service plan as provider safety permits until the individual is removed from the ADvantage program. As a part of the procedures requesting redetermination of program eligibility, ~~DHS~~OKDHS AS provides technical assistance to the provider for transitioning the individual to other services~~, and~~.

(i) ~~individuals~~Individuals determined ineligible for ADvantage program services are notified in writing by ~~DHS~~OKDHS AS of the determination and of the right to appeal the decision.

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

**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 ~~(DHS)~~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~~ adult~~ member lives in a non-residential setting. SDS provides a member 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 ~~DHSDDS~~OKDHS DDS specifies may be directed by the member or representative using employer and budget authority.

(1) SDS may be directed by:

(A) ~~an~~An adult member, when the member has the ability to self-direct;

(B) ~~a~~A member's legal representative including a parent, spouse or legal guardian; or

(C) ~~a~~A non-legal representative freely chosen by the member or his or her legal representative.

(2) The person directing services must:

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

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

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

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

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

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

(G) ~~not~~Not serve as the ~~SDS-HTS~~Self-Directed (SD) Habilitation Training Specialist (HTS) for the member ~~her~~ whom he or she is directing services.

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

(1) The SDS budget. A plan of care 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 ~~Habilitation Training Specialist (HTS)~~HTS services. This amount is under the control and discretion of the member in accordance with this policy and the approved plan of care, and is the allocated amount that may be used to develop the SDS budget. The SDS budget details the specific plan for spending.

(A) The SDS budget is developed annually at the time of the annual plan development and updated as necessary by 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 criteria of service necessity, per ~~OAC~~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 services performed by a financial management services (FMS) subagent, background checks, ~~workers'compensation~~workers' compensation insurance, and the amount identified for ~~SD-HTS and SD-GS.~~SD-HTS and Self-directed goods and services (SD-GS).

(D) The SDS budget is added to the plan of care to replace any portion of traditional HTS services to be self-directed.

(2) The ~~SD-Habilitation Training Specialist (SD-HTS)~~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 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 ~~the~~ staff ~~are~~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 ~~policy,~~rule, family members include parents and siblings, ~~including~~ step- and ~~half-siblings~~half-parents and 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 SD-HTS must:

(A) ~~be 18~~Be eighteen (18) years of age;

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

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

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

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

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

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

(H) ~~not~~Not implement ~~restrictive or intrusive~~prohibited procedures, per OAC ~~340:100-5-57;~~340:100-5-58;

(I) ~~provide~~Provide 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 members of the group; and

(J) ~~not~~Not perform any job duties associated with other employment including on-call duties at the same time they are providing ~~SD-HTS~~SD-HTS services.

(3) ~~Self-directed goods and services (SD-GS).~~ SD-GS are incidental, non-routine goods and services that promote the member's self-care, daily living, adaptive functioning, general household ~~activity,~~activities, meal preparation, and leisure skills needed to reside successfully in the community and do not duplicate other services authorized in the member's plan of care. These ~~goods and services~~SD-GS must be included in the individual plan and approved SDS budget. SD-GS must meet the requirements listed in (A) through (F).

(A) The item or service is justified by a recommendation from a licensed professional.

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

(C) One (1) or more of the following additional criteria are met. The item or service would:

(i) ~~increase~~Increase the member's functioning related to the disability;

(ii) ~~increase~~Increase the member's safety in the home environment; or

(iii) ~~decrease~~Decrease dependence on other SoonerCare funded services.

(D) SD-GS may include, but are not limited to:

(i) ~~fitness~~Fitness items that can be purchased at retail stores;

(ii) ~~personal emergency monitoring systems;~~Short duration

camps lasting fourteen (14) consecutive calendar days or less;

(iii) ~~a~~A food catcher;

(iv) ~~a~~A specialized swing set;

(v) ~~toothettes~~Toothettes or an electric toothbrush;

(vi) ~~a~~A seat lift;

(vii) ~~weight~~Weight loss programs~~,~~ or gym memberships when:

~~(viii) gym memberships when:~~

(I) ~~there~~There is an identified need for weight loss or increased physical activity;

(II) ~~justified~~Justified by outcomes related to weight loss, increased physical activity or stamina; and

(III) ~~in~~In subsequent plan of care 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 not be used for:

(i) ~~co-payments~~Co-payments for medical services;

(ii) ~~over-the-counter~~Over-the-counter medications;

(iii) ~~items~~Items or treatments not approved by the Food and Drug Administration;

(iv) ~~homeopathic~~Homeopathic services;

(v) ~~services~~Services available through any other funding source, such as SoonerCare, Medicare, private insurance, the public school system, rehabilitation services, or natural supports;

(vi) ~~room~~Room and board including deposits, rent, and mortgage payments;

(vii) ~~personal~~Personal items and services not directly related to the member's disability;

(viii) ~~vacation~~Vacation expenses;

(ix) ~~insurance;~~Insurance;

(x) ~~vehicle~~Vehicle maintenance or other transportation related expense;

(xi) ~~costs~~Costs related to internet access;

(xii) ~~clothing;~~Clothing;

(xiii) ~~tickets~~Tickets and related costs to attend recreational events;

(xiv) ~~services,~~Services, goods, or supports provided to, or benefiting persons other than the member;

(xv) ~~experimental~~Experimental goods or services;

(xvi) ~~personal~~Personal trainers;

(xvii) ~~spa~~Spa treatments; or

(xviii) ~~goods~~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~~Enroll and complete the DDS-sanctioned self-direction training course ~~in self-direction.~~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 completed prior to the implementation of self-direction and covers:

(A) ~~staff~~Staff recruitment;

(B) ~~hiring~~Hiring of staff as an employer of record;

(C) ~~staff~~Staff orientation and instruction;

(D) ~~supervision of staff~~Staff supervision including scheduling and service provisions;

(E) ~~staff~~Staff evaluation;

(F) ~~staff~~Staff discharge;

(G) ~~philosophy~~Philosophy of self-direction;

(H) OHCA policy on self-direction;

(I) ~~individual~~Individual budgeting;

(J) ~~development~~Development of a self-directed support plan;

(K) ~~cultural~~Cultural diversity; and

(L) ~~rights,~~Rights, risks, and responsibilities~~;~~.

(2) ~~sign~~Sign an agreement with DDS;

(3) ~~agree~~Agree to utilize the services of a FMS subagent;

(4) ~~agree~~Agree to pay administrative costs for background checks, FMS subagent fee, and workers' compensation insurance from his or her SDS budget;

(5) ~~comply~~Comply with federal and state employment laws and ensure no employee works more than ~~40~~forty (40) hours per week in the capacity of an SD-HTS;

(6) ~~ensure~~Ensure that each employee is qualified to provide the services for which he or she is employed and that all billed services are actually provided;

(7) ~~ensure~~Ensure that each employee complies with all DDS training requirements per OAC 340:100-3-38 et seq.;

(8) ~~recruit,~~Recruit, hire, supervise, and discharge all employees providing self-directed services, when necessary;

(9) ~~verify~~Verify employee qualifications;

(10) ~~obtain~~Obtain background screenings on all employees providing SD-HTS services per OAC 340:100-3-39;

(11) ~~send~~Send progress reports per OAC 340:100-5-52.

(12) ~~participate~~Participate in the Individual Plan and SDS budget process;
(13) ~~immediately~~Immediately notify the case manager of any emergencies or changes in circumstances~~ or emergencies~~ that may require modification of the type or amount of services provided for in the member's Individual Plan or SDS budget;
(14) ~~wait~~Wait for approval of budget modifications before implementing changes;
(15) ~~comply~~Comply with DDS and OHCA administrative rules;
(16) ~~cooperate~~Cooperate with DDS monitoring requirements per OAC 340:100-3-27;
(17) ~~cooperate~~Cooperate with FMS subagent requirements to ensure accurate records and prompt payroll processing including:
(A) ~~reviewing~~Reviewing and signing employee time cards;
(B) ~~verifying~~Verifying the accuracy of hours worked; and
(C) ~~ensuring~~Ensuring the appropriate expenditure of funds;
(18) ~~complete~~Complete all required documents within established timeframes;
(19) ~~pay~~Pay for services incurred in excess of the budget amount;
(20) ~~pay~~Pay for services not identified and approved in the member's SDS budget;
(21) ~~pay~~Pay for services provided by an unqualified provider;
(22) ~~determine~~Determine staff duties, qualifications, and specify service delivery practices consistent with SD-HTS Waiver service specifications;
(23) ~~orient~~Orient and instruct staff in duties;
(24) ~~evaluate~~Evaluate staff performance;
(25) ~~identify~~Identify and train back-up staff, when required;
(26) ~~determine~~Determine amount paid for services within ~~Plan~~plan limits;
(27) ~~schedule~~Schedule staff and the provision of services;
(28) ~~ensure~~Ensure SD-HTS do not implement ~~restrictive or intrusive~~prohibited procedures per OAC ~~340:100-5-57;~~340:100-5-58; and
(29) ~~sign~~Sign an agreement with~~ DDS and~~ the SD-HTS.

(f) **~~Financial management services (FMS) subagent responsibilities.~~FMS.** The FMS subagent is an entity designated as an agent by DDS to act on behalf of members who have employer and budget authority for the purpose of managing payroll tasks for the member's employee(s) and for making payment of SD-GS as authorized in the member's ~~Plan.~~plan. FMS subagent duties include, but are not limited to:
(1) ~~compliance~~Compliance with all DDS and OHCA administrative rules and contract requirements;
(2) ~~compliance~~Compliance with DDS or OHCA random and targeted

audits ~~conducted by DDS or the OHCA~~;
(3) ~~provision of financial management support to the member by tracking~~Tracking individual expenditures and monitoring SDS budgets;
(4) ~~processing~~Processing the member's employee payroll, withholding, filing and paying of applicable federal, state, and local employment-related taxes and insurance;
(5) ~~collection~~Collection and process of employee's time sheets and making payment to member's employees;
(6) ~~processing~~Processing and payment of invoices for SD-GS as authorized in the member's SDS budget;
(7) ~~providing~~Providing each member with information that assists with the SDS budget management;
(8) ~~providing~~Providing reports to members/representatives, as well as monthly to DDS and to OHCA upon request;
(9) ~~providing~~Providing DDS and OHCA authorities access to individual member's accounts through a web-based program;
(10) ~~assisting~~Assisting members in verifying employee citizenship status;
(11) ~~maintaining~~Maintaining separate accounts for each member's SDS budget;
(12) ~~tracking~~Tracking and reporting member funds, balances, and disbursements;
(13) ~~receiving~~Receiving and disbursing funds for SDS payment per OHCA agreement; and
(14) ~~executing~~Executing and maintaining a contractual agreement between DDS and the SD-HTS (employee).

(g) **DDS case management responsibilities in support of SDS.**
(1) The case manager develops the member's ~~Plan~~plan per OAC 340:100-5-50 through 340:100-5-58;
(2) The DDS case manager meets with the member, member's representative, or legal guardian, when applicable, to discuss the ~~following~~Waiver service delivery options in ~~the HCBS Waiver:~~(A) and (B) of this paragraph:
(A) ~~traditional~~Traditional Waiver services; and
(B) ~~self-directed~~Self-Directed services including information regarding scope of choices, options, rights, risks, and responsibilities associated with self-direction.
(3) When the member chooses self-direction, the case manager:
(A) ~~discusses~~Discusses with member or representative the available ~~amountin~~amount in the budget;
(B) ~~assist~~Assists the member or representative with the development and modification of the SDS budget;
(C) ~~submits~~Submits request for SD-GS to the DDS director or designee for review and approval ~~prior to the case manager's approval of the SDS budget~~;
(D) ~~approves~~Develops the SDS budget and modifications;

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

(F) ~~provides the FMS subagent a copy of the member's authorized SDS budget and any modifications;~~

~~(G) monitors~~Monitors implementation of the ~~Plan~~plan per OAC 340:100-3-27;

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

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

~~(J) specifies additional employee qualifications in the Plan based on the member's needs and preferences when such qualifications are consistent with approved Waiver qualifications;~~

~~(K) specifies in the Plan how services are provided;~~

~~(L) refers potential SD-HTS providers to the FMS subagent for enrollment;~~

~~(M) assists in locating and securing services and other community resources that promote community integration and independence as provided in the member's Plan; and~~

~~(N)~~ (I) ~~ensures restrictive or intrusive~~Ensures prohibited procedures, per OAC ~~340:100-5-57~~340:100-5-58 are not implemented by the SD-HTS. If the Team determines restrictive or intrusive procedures are necessary~~, SD-HTS is not appropriate to meet the member's needs and traditional services must be used.~~ 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 without disruption at any time, provided traditional Waiver services are in place. Members or representatives may not choose the self-directed option again until the next annual planning meeting, with services resuming no earlier than the beginning of the next plan of care. A member desiring to file a complaint must follow procedures per OAC 340:2-5-61.

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

(1) Members may be involuntarily terminated from self-direction and offered traditional Waiver services when it has been determined by the DDS director or designee that any of the following exist:

(A) ~~immediate~~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~~Intentional misuse of funds following notification, assistance and support from DDS;

(C) ~~failure~~Failure to follow and implement policies of self-direction after receiving DDS technical assistance and guidance;

(D) ~~fraud;~~Fraud;

(E) ~~it is determined that restrictive or intrusive procedures are essential for safety; or~~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~~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, the case manager assists the member access needed and appropriate services through the traditional Waiver services option, ensuring 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 ~~Organized Health Care Delivery System,~~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 80. MOBILE AND/OR PORTAL DENTAL TREATMENT FACILITIES**

**317:30-5-706. Definitions**

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

**"Mobile and/or portable dental treatment facilities"** means the following, limited places of treatment, as authorized by the Oklahoma State Dental Act: group homes for juveniles; public and private schools; and mobile dental clinics. The rules in this Part expressly shall not apply to SoonerCare reimbursement of dental services provided at any other authorized place of service, including, but not limited to: "dental offices," as defined by 59 O.S. § 328.3; federal, tribal, state, or local public health facilities; federally qualified health centers; and hospitals or dental ambulatory surgery centers.

**"Individual provider"** means a dentist, dental hygienist, or dental assistant who provides dental services at a mobile and/or portable dental treatment facility.

**317:30-5-707. Eligible providers**

(a) In order for dental services provided at a mobile and/or portable dental treatment facility to be eligible for SoonerCare reimbursement, a dental group shall meet all applicable requirements set forth in the Oklahoma Board of Dentistry rules and the Oklahoma State Dental Act, including, but not limited to, all licensing and permitting requirements.

(1) All dentists and dental hygienists working at a mobile and/or portable dental treatment facility shall be currently licensed in good standing with the Oklahoma Board of Dentistry. All dental assistants working at a mobile and/or portable dental treatment facility shall be currently permitted by the Oklahoma Board of Dentistry.

(2) The license or permit (or a photocopy of the license or permit) of every individual provider shall be prominently displayed at the mobile and/or portable dental treatment facility, pursuant to 59 O.S. § 328.21.

(3) For services provided in a mobile dental clinic, the permit to operate the mobile dental clinic shall be prominently displayed in the mobile dental clinic vehicle, pursuant to 59 O.S. § 328.40a.

(b) In accordance with OAC 317:30-5-695.1, every dental group providing services at a mobile and/or portable dental treatment facility must be fully contracted with the OHCA as a dental group provider and must be fully contracted with OHCA as a mobile and/or portable dental treatment facility.
(c) Every individual dentist practicing at a mobile and/or portable dental treatment facility must be fully contracted with the OHCA as a dentist.
(d) Dental groups and individual providers providing dental services at a mobile and/or portable dental treatment facility shall comply with all state and federal Medicaid law, including, but not limited to, OHCA administrative rules, the Code of Federal Regulations, and the Oklahoma State Medicaid Plan.

**317:30-5-708. Parental consent requirements**

Individual providers at a mobile and/or portable dental treatment facility shall not perform any service on a minor without having obtained, prior to the provision of services, a signed, written consent from the minor's parent or legal guardian, that includes, at a minimum, the:

(1) Name of the dental group and/or dentist providing the dental services at the mobile and/or portable dental treatment facility;
(2) Permanent business mailing address of the dental group and/or dentist providing the dental services at the mobile and/or portable dental treatment facility;
(3) Business telephone number of the dental group and/or dentist providing the dental services at the mobile and/or portable dental treatment facility. This telephone number must be available for emergency calls;
(4) Full printed name of the child to receive services;
(5) Child's SoonerCare Member ID number; and
(6) An inquiry of whether the child has had dental care in the past twelve (12) months and if the child has a dental appointment scheduled with his/her regular dentist. If applicable, parent should list the name and address of the dentist and/or dental office where the care is provided.

**317:30-5-709. Coverage**

Payment is made only to contracted dental groups for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services provided to SoonerCare-eligible individuals under the age of twenty-one (21). All mobile and/or portable dental treatment facilities must have a SoonerCare-contracted, Oklahoma-licensed dentist onsite to supervise staff and provide certain services. Coverage for dental services provided to children/adolescents at

a mobile and/or portable dental treatment facility is limited to:

(1) One (1) fluoride application per member per twelve (12) months;

(2) One (1) dental assessment annually that is performed by a SoonerCare-contracted, Oklahoma-licensed dentist; and

(3) Dental sealants on tooth numbers 2, 3, 14, 15, 18, 19, 30, and 31. The Oklahoma Health Care Authority (OHCA) will not reimburse the application of dental sealants for a given OHCA member more than once every thirty-six (36) months, regardless of whether the services are provided at a mobile and/or portable dental treatment facility, or at some other authorized place of service.

**317:30-5-710. Post-care**

Each member receiving dental care at a mobile and/or portable dental treatment facility must receive an information sheet at the end of the visit. The information sheet must contain:

(1) The name of the dentist, dental hygienist, and/or dental assistant who provided the dental services at the mobile and/or portable dental treatment facility;

(2) A valid business telephone number and/or other emergency contact number for the dental group and/or dentist that provided the dental services at the mobile and/or portable dental treatment facility;

(3) A listing of the treatment rendered, including, when applicable, billing codes, fees, and tooth numbers;

(4) A description of any follow-up treatment that is needed or recommended; and

(5) Referrals to specialists or other dentists if the individual providers were unable to provide the necessary treatment, and additional care is needed.

**317:30-5-711. Billing**

Refer to Oklahoma Administrative Code (OAC) 317:30-5-704 through 317:30-5-705 for billing instructions and guidelines. Please note that for any dental service provided at a mobile and/or portable dental treatment facility that is billed to SoonerCare, the appropriate place of service must be identified on the claim.

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

**SUBCHAPTER 7. SOONERCARE**

**PART 1. GENERAL PROVISIONS**

**317:25-7-2. SoonerCare Choice: overview**

(a) The Oklahoma Health Care Authority (OHCA) operates a Primary Care Case Management (PCCM) system for SoonerCare Choice eligible members. PCCM is a managed care model in which each enrollee has a medical home with a primary care provider (PCP). Enrollees may select their own primary care provider or clinic as their PCP if that provider is enrolled with OHCA as a PCP and as a SoonerCare provider. ~~For those~~Those who do not choose a PCP, ~~they will~~may be assigned to one~~.~~ (1). Members may change PCPs at any time.

(b) The PCP is paid a monthly care coordination payment in accordance with the conditions in the PCP's SoonerCare Choice contract to provide or otherwise assure the delivery of medically-necessary preventive and primary care medical services, including securing referrals for specialty services and prior authorizations for an enrolled group of eligible members, with the exception of services described in subsection (c) of this Section for which authorization is not required. The PCP assists the member in gaining access to the health care system and monitors the member's condition, health care needs and service delivery.

(c) Services which do not require a referral from ~~the~~a PCP include preventive or primary care services rendered by another SoonerCare contracted provider~~,~~ such as: outpatient behavioral health ~~agency~~ services~~,~~; vision services for children~~,~~; dental services~~,~~; child abuse/sexual abuse examinations~~,~~; prenatal and obstetrical services~~,~~; family planning services~~,~~; emergency physician and hospital services~~,~~; ~~disease management services,~~chronic disease prevention and management programs and other care coordination programs; and services delivered to Native Americans at ~~IHS,~~Indian Health Service, tribal, or urban Indian clinics. Female members may access a SoonerCare women's health specialist without a referral for covered routine and preventive health care services. This is in addition to the enrollee's PCP if that source is not a woman's health specialist.

(d) SoonerCare Choice covered services delivered by ~~the~~a PCP are reimbursed at the SoonerCare fee schedule rate under the procedure code established for each individual service. ~~To the extent~~If services are provided or authorized by ~~the Primary Care Provider,~~ a PCP, the OHCA does not make SoonerCare Choice payments for services delivered outside the scope of coverage of the SoonerCare Choice program~~,~~; thus, a referral by ~~the~~a PCP does not guarantee payment.

(e) ~~The~~A PCP may charge a co-payment for services provided to SoonerCare members in accordance with ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-3-5(d).
(f) Members with chronic conditions may elect to enroll in a health management program to improve their health.
(g) PCPs may elect to participate in Health Access Networks pursuant to Subchapter 9 to improve access to care.
(h) PCPs may elect to participate in a Health Management Program pursuant to Subchapter 11 to improve access to care.

**317:25-7-3. Definitions**

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

**~~"Aged, Blind and Disabled"~~"Aged, Blind and Disabled (ABD)"** means the Medicaid covered populations under 42 ~~U.S.C.,~~United States Code (U.S.C.) Section 1396a (a)(10)(A)(i) and (F).

**"Board"** means the board designated by the Oklahoma legislature to establish policies and adopt and promulgate rules for the Oklahoma Health Care Authority.

~~**"CEO"** means the Chief Executive Officer of the Oklahoma Health Care Authority.~~

**"Custody"** means the custodial status, as reported by the Oklahoma Department of Human Services.

**"Medicaid"** means the medical assistance program authorized by 42 U.S.C., Section 1396a et seq. The program provides medical benefits for certain low-income persons. It is jointly administered by the federal and state governments.

**"Medicare"** means the program defined at 42 U.S.C. § 1395 et seq.

**"OHCA"** means the Oklahoma Health Care Authority.

**"OKDHS"** means the Oklahoma Department of Human Services.

**"PCCM"** means Primary Care Case Management.

~~**"PCP"** means Primary Care Provider, including a Provider or Physician Group.~~

**"Primary Care Case Management"** means a managed care health service delivery system in which health services are delivered and coordinated by Primary Care Providers.

**~~"Primary Care Provider"~~"Primary care provider (PCP)"** means a Primary Care Provider, including a provider or physician group, ~~a provider~~ under contract with the ~~Oklahoma Health Care Authority~~OHCA to provide primary care services and case management, including securing all medically-necessary referrals for specialty services and prior authorizations.

**"Provider or ~~Physician Group~~"physician group"** means a partnership, limited partnership, limited liability company, corporation or professional corporation, composed of doctors of medicine and/or doctors of osteopathy and/or advanced practice

registered nurses, and/or physician assistants who provide health care of the nature provided by independent practitioners and are permitted by state and federal law and regulations to receive SoonerCare provider payments.

**"SoonerCare"** means the Medicaid program administered by the ~~Oklahoma Health Care Authority.~~OHCA.

**"SoonerCare Choice"** means a comprehensive medical benefit plan featuring a medical home including a ~~Primary Care Provider~~PCP for each member.

**317:25-7-5. Primary care providers (PCPs)**

For provision of health care services, the OHCA contracts with qualified ~~Primary Care Providers.~~PCPs. All providers serving as PCPs must have a valid SoonerCare Fee-for-Service contract as well as an exercised SoonerCare Choice addendum. Additionally, all PCPs, excluding ~~Provider~~provider or ~~Physician Groups,~~physician groups must agree to accept a minimum capacity of patients~~,~~; provided, however, this does not guarantee PCPs a minimum patient volume. ~~Primary Care Providers~~PCPs are limited to:

(1) **Physicians.** Any physician licensed to practice medicine in the state in which he or she practices who is engaged in a general practice or in family medicine, general internal medicine or general pediatrics may serve as a PCP. ~~The Chief Executive Officer (CEO) of the OHCA may designate physicians to serve as PCPs who are licensed to practice medicine in the state in which they practice who are specialized in areas other than those described above. In making this determination, the CEO may consider such factors as the percentage of primary care services delivered in the physician's practice, the availability of primary care providers in the geographic area of the state in which the physician's practice is located, the extent to which the physician has historically provided services to SoonerCare members, and the physician's medical education and training.~~

(A) For physicians serving as SoonerCare Choice PCPs, the State caps the number of members per physician at ~~2,500.~~two thousand, five hundred (2,500) ~~However, the CEO in his/her discretion may increase this number in under served areas based on a determination that this higher cap is in conformance with usual and customary standards for the community.~~ If a physician practices at multiple sites, the capacity at each site is determined based on the number of hours per week the physician holds office hours, not to exceed one (1) FTE. Thus, the physician cannot exceed a maximum total capacity of ~~2500~~two thousand, five hundred (2,500) members.

(B) In areas of the ~~State~~state where cross-state utilization patterns have developed because of limited provider capacity

in the ~~State,~~state the ~~CEO~~OHCA may authorize contracts with out-of-state providers for PCP services. ~~Out-of-State~~Out-of-state PCPs are required to comply with all access standards imposed on Oklahoma physicians~~.~~, as well as Oklahoma Administrative Code (OAC) 317:30-3-89 through 317:30-3-92.

(2) **Advanced Practice Registered Nurses~~.~~ (APRNs).** ~~Advanced Practice Nurses~~APRNs who have prescriptive authority may serve as PCPs for the Primary Care Case Management delivery system if licensed to practice in the state in which he or she practices. ~~Advanced Practice Nurses~~APRNs who have prescriptive authority may serve as PCPs for a maximum number of ~~1,250~~one thousand, two hundred and fifty (1,250) members. ~~However, the CEO in his/her discretion may increase this number.~~

(3) **Physician Assistants~~.~~ (PAs).** ~~Physician Assistants~~PAs may serve as PCPs if licensed to practice in the state in which he or she practices. ~~Physician Assistants~~PAs may serve as PCPs for a maximum number of ~~1,250~~one thousand, two hundred and fifty (1,250) members. ~~However, the CEO in his/her discretion may increase this number.~~

(4) **Indian Health Service (IHS) Facilities and Federally Qualified Health Center (FQHC) provider groups~~.~~ and Rural Health Clinics (RHC).**

(A) ~~Indian Health Service~~IHS facilities whose professional staff meet the general requirements in paragraphs (1) through (3) of this Section and the provider participation requirements at OAC 317:30-5-1088 may serve as PCPs.

(B) ~~Federally Qualified Health Centers~~FQHCs whose professional staff meet the general requirements in paragraphs (1) through (3) of this Section and the provider participation requirements in OAC 317:30-5-660.2 may serve as PCPs.

(C) RHCs whose professional staff meet the general requirements in paragraphs (1) through (3) of this Section and the provider participation requirements in OAC 317:30-5-355 may serve as PCPs.

(5) **Provider or physician group capacity and enrollment.**

(A) Provider or physician groups must agree to accept a minimum enrollment capacity and may not exceed ~~2,500~~two thousand, five hundred (2,500) members per physician participating in the provider group.

(B) If licensed ~~physician assistants~~PAs or ~~advanced practice nurses~~APRNs are members of a group, the capacity may be increased by ~~1,250~~one thousand, two hundred and fifty (1,250) members if the provider is available full-time.

(C) Provider or physician groups must designate a medical director to serve as the primary contact with OHCA.

## PART 3. ENROLLMENT CRITERIA

### 317:25-7-10. Enrollment with a Primary Care Provider (PCP)

(a) All SoonerCare Choice members described in ~~OAC~~Oklahoma Administrative Code (OAC) 317:25-7-12 may enroll with a PCP. SoonerCare Choice applicants have the opportunity to select a PCP during the application process. Enrollment with a PCP may begin any day of the month.

(1) The OHCA offers all members the opportunity to choose a PCP from a directory which lists available PCPs.

(2) When a notice of PCP enrollment is sent to a member, the member is advised of the right to change ~~the~~a PCP at any time.

(b) Members may receive services from ~~the~~a PCP or from a provider to which the member has been referred by ~~the~~a PCP. Notwithstanding this provision, subject to limitations which may be placed on services by the OHCA, members may ~~self refer~~self-refer for preventive or primary care services rendered by another SoonerCare contracted provider, outpatient behavioral health ~~agency~~ services, vision services for children, dental services, child abuse/sexual abuse examinations, prenatal and obstetrical services, family planning services, services delivered to Native Americans at ~~IHS,~~Indian Health Service, tribal, or urban Indian clinics, chronic disease prevention and management programs and other care coordination programs, and emergency physician and hospital services.

### 317:25-7-13. Enrollment ineligibility

Members in certain categories are excluded from participation in the SoonerCare Choice program. All other members ~~are~~may be enrolled in the SoonerCare Choice program and subject to the provisions of this Subchapter. Members excluded from participation in SoonerCare Choice include:

(1) Individuals receiving services in a ~~nursing~~long-term care facility, in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), or through a Home and Community Based Waiver~~.~~;

~~(2) Individuals privately enrolled in an HMO.~~

~~(3) Individuals who would be traveling more than 45 miles or an average of 45 minutes to obtain primary care services.~~

~~(4)~~ (2) Individuals in the former foster care children's group ~~(see OAC 317:35-5-2).~~[see Oklahoma Administrative Code (OAC) 317:35-5-2];

~~(5)~~ (3) Individuals ~~who are eligible for SoonerCare solely due to presumptive eligibility.~~in benefit programs with limited scope, such as Tuberculosis, Family Planning, or pregnancy only;

~~(6)~~ (4) Non-qualified or ineligible aliens~~.~~;

~~(7)~~ (5) Children in subsidized adoptions~~.~~;

~~(8)~~ (6) Individuals who are dually-eligible for SoonerCare and

Medicare~~.~~;
~~(9)~~(7) Individuals who are in an Institution for Mental Disease (IMD)~~.~~; and/or
~~(10)~~(8) Individuals who have other ~~primary medical insurance.~~creditable coverage.

## PART 5. ENROLLMENT PROCESS

### 317:25-7-25. Member enrollment process

(a) SoonerCare eligible individuals whose eligibility is based on one (1) of the aid categories~~ included in the program as~~ defined in ~~OAC~~Oklahoma Administrative Code (OAC) 317:25-7-12~~ must~~are eligible to enroll with a ~~PCP.~~primary care physician (PCP). Parents or guardians will choose on behalf of minor members in the household. Families with more than one (1) enrollee may choose a different PCP for each family member.
(b) Until the effective date of enrollment with a PCP, services for a newborn are reimbursed at a fee-for-service rate. Upon eligibility determination, newborns may enroll with a PCP who is in general practice, family practice, or general pediatrics. Enrollment materials will advise the parent or guardian of the right to change ~~the~~a PCP after the effective date of enrollment.
(c) A description of the PCCM program and the PCP directory ~~is provided by the OHCA to OKDHS for distribution to OKDHS county offices.~~are available on the Oklahoma Health Care Authority's (OHCA) website.
(d) For purposes of determining the member's choice of PCP, the most recent PCP selection received by the OHCA determines the PCP with which the member is enrolled~~ with~~, as long as capacity is available. If capacity is not available or the member does not choose, the member is assigned according to the assignment mechanism as defined by the OHCA. A member who is eligible for SoonerCare Choice but is not assigned, may request enrollment with a PCP by contacting the SoonerCare Helpline~~.~~ or through the member's mySoonerCare.org account, if applicable.
(e) PCPs may not refuse an assignment, seek to disenroll a member, or otherwise discriminate against a member on the basis of age, sex, race, physical or mental disability, national origin, or type of illness or condition, unless that condition can be better treated by another provider type, except that ~~IHS,~~Indian Health Service, tribal or urban Indian programs may provide services to ~~Native American IHS~~ members consistent with federal law.

### 317:25-7-26. Automatic re-enrollment

SoonerCare members who become disenrolled from a PCP solely by virtue of becoming temporarily ~~(for 365 days or less)~~[for three hundred and sixty-five (365) days or less] ineligible for SoonerCare services, ~~are automatically~~may be re-enrolled with

their previously-selected PCP, subject to capacity. The member is notified of the ~~automatic re-enrollment~~enrollment and any right to disenroll from that PCP~~.~~ or change to another PCP.

**317:25-7-27. Changing ~~PCPs~~Primary care providers (PCPs)**

(a) The ~~OHCA~~Oklahoma Health Care Authority (OHCA) is responsible for changing a member's enrollment from one (1) PCP to another:

(1) ~~without~~Without cause upon the member's request; or

(2) ~~upon~~Upon demonstration of good cause. For purposes of this paragraph, good cause means:

(A) ~~those~~Those members who are habitually non-compliant with the documented medical directions of the provider; or

(B) ~~those~~Those members who pose a threat to employees, or other patients of the PCP; or

(C) ~~as~~As a result of a grievance determination by the OHCA; or

(D) ~~in~~In those cases where reliable documentation demonstrates that the physician-patient relationship has so deteriorated that continued service would be detrimental to the member, the provider or both; or

(E) ~~the~~The member's illness or condition would be better treated by another type of provider; or

(3) when the state imposes an intermediate sanction.

(b) A written request by the PCP to change the enrollment of a member is acted upon by the OHCA within ~~30~~thirty (30) days of its receipt. The decision to change PCPs for cause is made at the discretion of the OHCA, subject to appeals policies delineated at ~~OAC~~Oklahoma Administrative Code 317:2-1. The effective date of change is set so as to avoid the issue of abandonment.

(c) In the event a SoonerCare PCP contract is terminated by OHCA for any reason, or the PCP terminates participation in the SoonerCare Choice program ~~the CEO may, at his or her discretion, assign members to a participating PCP when it is determined to be in the best interests of the member whose PCP has terminated.~~the panel members formerly aligned with the terminating PCP shall be enrolled with a different PCP.

**317:25-7-28. Disenrolling a member from SoonerCare Choice**

(a) The ~~OHCA~~Oklahoma Health Care Authority (OHCA) may disenroll a member from SoonerCare Choice if:

(1) ~~the~~The member is no longer eligible for SoonerCare Choice services;

(2) ~~the~~The member ~~has been~~is incarcerated;

(3) ~~the~~The member dies;

(4) ~~disenrollment~~Disenrollment is determined to be necessary by the OHCA;

(5) ~~the~~The status of the member changes, rendering him/her ineligible for SoonerCare;

(6) ~~the~~The member is authorized to receive services in a nursing facility, in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or through a Home and Community Based Waiver;

(7) ~~the~~The member becomes dually-eligible for SoonerCare and Medicare; or

(8) ~~the~~The member becomes covered under other ~~primary medical insurance.~~creditable coverage.

(b) The OHCA may disenroll the member at any time if the member is disenrolled for good cause, as it is defined in ~~OAC~~Oklahoma Administrative Code (OAC) 317:25-7-27. The OHCA will inform the PCP of any disenrollments from his or her member roster.

(c) OHCA may disenroll a member upon the PCP's request as described in (1) through (5) of this subsection.

(1) ~~The~~A ~~PCP~~primary care provider (PCP) may file a written request asking OHCA to take action, including, but not limited to, disenrolling a member when the member:

(A) ~~is~~Is physically or verbally abusive to office staff, providers, and/or other patients;

(B) ~~is~~Is habitually non-compliant with the documented medical directions of ~~the~~a PCP; or

(C) ~~regularly~~Regularly fails to arrive for scheduled appointments without cancelling and the PCP has made all reasonable efforts to accommodate the member.

(2) The request from ~~the~~a PCP for disenrollment of a member must include ~~one of~~one (1) or more of the following:

(A) ~~documentation~~Documentation of the difficulty encountered with the member, including the nature, extent, and frequency of abusive or harmful behavior, violence, and/or inability to treat or engage the member;

(B) ~~identification~~Identification and documentation of unique religious or cultural issues that may be ~~effecting~~affecting ~~the~~a PCP's ability to provide treatment effectively to the member; or

(C) ~~documentation~~Documentation of special assistance or intervention offered.

(3) ~~The~~A PCP may not request disenrollment because of a change in the member's health status, the member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from the member's special needs except when the member's enrollment with ~~the~~a PCP seriously impairs his/her ability to furnish services to this member or other members.

(4) ~~The~~A PCP must document efforts taken to inform the member orally or in writing of any actions that have interfered with the effective provision of covered services, as well as efforts to explain what actions or language of the member are acceptable and unacceptable and the consequences of unacceptable behavior,

including disenrollment from ~~the~~a PCP.
(5) The OHCA will give written notice of the disenrollment request to the member.

## PART 7. COORDINATION AND CONTINUITY OF CARE

### 317:25-7-29. Screening, diagnosis and preventive benefits [REVOKED]

~~(a) The PCP is responsible for coordinating or delivering preventive and primary care services which are medically necessary to all SoonerCare members enrolled with him/her..~~
~~(b) School and health department clinics may conduct EPSDT screening examinations on children who have not been screened by their PCP pursuant to the EPSDT periodicity schedule. If it is ascertained that a child is not current, the school or health department clinic must first contact the PCP and attempt to set up an appointment for the child within three weeks. If the PCP cannot meet this condition, the clinic will be permitted to conduct the screen and bill fee-for-service.~~
~~(1) The school or health department clinic must submit a claim for reimbursement, as well as documentation that:~~
~~(A) the PCP was contacted and an examination could not be conducted by the PCP within the specified guidelines; and~~
~~(B) the PCP has forwarded information for the patient file regarding the diagnosis, services rendered and need for follow-up. This documentation must be returned to the child's record for verification that PCPs have first been contacted and that school and health department clinics are providing PCPs with the information necessary to ensure continuity of care.~~
~~(2) The school-based clinic or health department must conduct the screening examination within three weeks from the date the determination was made that the PCP could not conduct the exam within the specified guidelines.~~

### 317:25-7-30. Obtaining SoonerCare Choice services

(a) Medical services which are not the responsibility of the ~~PCP~~primary care provider (PCP) to authorize under the care coordination component of SoonerCare~~,~~ Choice, as described in ~~OAC~~Oklahoma Administrative Code (OAC) 317:25-7-10(b), are obtained in the same manner as under the regular SoonerCare fee-for-service program.
(b) ~~Authorization for out-of-state transportation for primary care and specialty care is determined by the OHCA Medical Director.~~For policy regarding out-of-state transportation for primary and specialty care, refer to OAC 317:30-3-89 through 317:30-3-92.
(c) An American Indian/Alaska Native (AI/AN) eligible SoonerCare member may choose a PCP from the provider directory, including the

~~IHS,~~Indian Health Service (IHS), tribal and ~~Urban~~urban Indian clinics that participate as SoonerCare PCPs. ~~The member needs to have the Certified Degree of Indian Blood information in order to enroll.~~ An ~~American Indian~~AI/AN member in SoonerCare may enroll with a PCP who is not an IHS, tribal, or urban Indian clinic and still use the IHS, tribal, or urban Indian clinic for medical care. A referral from ~~the~~a PCP is needed for services that the clinic cannot provide, except for self-referred services.
(d) If an IHS, tribal, or urban Indian clinic is unable to deliver a service to a SoonerCare enrollee and must refer the member for the service to a non-IHS, tribal, or urban Indian clinic, SoonerCare reimbursement is made only to the specialist when the service ~~is~~has been referred by ~~the~~a PCP, unless PCP authorization is not required under OAC ~~317:25-7-10(b).~~317:25-7-2 (c).
(e) ~~The~~A PCP is not obligated to provide emergency services and is not responsible for authorization or approval for payment for members seen in the emergency room. ~~The~~A PCP may not require members to seek prior authorization (PA) for emergency services. However, ~~the~~a PCP may provide emergency care in an emergency setting, within his/her legal scope of practice.
(f) ~~Some outpatient procedures require prior authorization. The PCP is responsible for obtaining a list before an outpatient procedure is done.~~A PA is required for some medical procedures, equipment, medications, and specialty services. The PCP and/or requesting provider are responsible for submitting the PA request to SoonerCare. The member and requesting provider will be notified of SoonerCare's decision to authorize the requested services. A PA is not a guarantee of payment.

## PART 9. REIMBURSEMENT

### 317:25-7-40. SoonerCare Choice reimbursement

(a) **Care coordination component.** Participating ~~PCPs~~primary care providers (PCPs) are paid a monthly care coordination payment to assure the delivery of medically-necessary preventive and primary care medical services, including referrals for specialty services for an enrolled group of eligible members. The PCP assists the member in gaining access to the health care system and monitors the member's condition, health care needs and service delivery.
(b) **Visit-based fee-for-service component.** SoonerCare Choice covered services provided by ~~the~~a PCP are reimbursed at the SoonerCare fee schedule rate under the procedure code established for each individual service. To the extent services are authorized by ~~the~~a PCP, the ~~OHCA~~Oklahoma Health Care Authority (OHCA) does not make SoonerCare Choice payments for services delivered outside the scope of coverage of the SoonerCare Choice program~~, thus~~. In other words, a referral by ~~the~~a PCP does not guarantee payment.
(c) **Incentive program component.** Subject to the availability of

funds, OHCA will develop a bonus payment program to encourage coordination of services, to reward improvement in health outcome and promote efficiency.

(d) **SoonerCare networks.** For every PCP who participates in an OHCA approved ~~health care access network,~~Health Access Network, a per-member-per-month payment is established by OHCA and paid to the network.

## SUBCHAPTER 9. HEALTH ACCESS NETWORKS

### 317:25-9-1. Purpose

The purpose of this Subchapter is to describe the rules governing the Health Access Networks ~~(HAN's)~~(HANs) participating in the statewide SoonerCare program. The rules provide assurances that ~~Health Access Networks~~HANs will work with providers to coordinate and improve the quality of care for SoonerCare members. ~~The use of Health Access Networks is a limited pilot program with the purpose of enhancing the development of comprehensive medical homes for Oklahoma SoonerCare Choice members.~~

### 317:25-9-2. Requirements

~~(a) HAN's~~Health Access Networks (HANs) are non-profit, administrative entities that work with providers to coordinate and improve the quality of care for SoonerCare members. The HAN must:

(1) ~~be~~Be organized for the purpose of restructuring and improving the access, quality, and continuity of care to SoonerCare members;

(2) ~~offer patients~~Facilitate members' access to all levels of care, including primary, outpatient, specialty, certain ancillary services, and acute inpatient care, within a community or across a broad spectrum of providers across a service region or the ~~State;~~state through improved access to specialty care, telehealth, and expended quality improvement strategies;

~~(3) submit an application to the OHCA as specified in (c) of this Section;~~

~~(4) offer core components of electronic medical records, improved access to specialty care, telemedicine, and expanded quality improvement strategies;~~

~~(5) have an organized and systematic quality improvement process, including the identification of measurable performance targets; and~~

~~(6)~~(3) ~~offer~~Offer care management/care coordination to persons ~~in the HANs. This includes care management for specified members with complex health care needs as approved by OHCA. The HAN will not provide care management services to HMP members in the HAN, as these members will receive care management from HMP health coaches or from the OHCA internal Chronic Care Unit.~~with complex health care needs as specified in the state-HAN provider agreement.

~~(b) Networks must meet at least two of the following:~~

~~(1) have a formal affiliation agreement/partnership at the community-level with traditional and non-traditional providers;~~
~~(2) have a formal program to promote public health principles, community development, and local educational programs to address the challenges of rural and underserved populations; and~~
~~(3) have 501(c)3 or not-for-profit status.~~

~~(c) In order to qualify to participate as a SoonerCare contracted HAN's, the network must submit an application to the OHCA that details how the network plans to:~~
~~(1) reduce costs associated with the provision of health care services to SoonerCare, uninsured and underinsured individuals;~~
~~(2) improve access to, and the availability of, health care services provided to individuals served by the health access network;~~
~~(3) enhance the quality and coordination of health care services provided to such individuals through mutually defined quality improvement initiatives;~~
~~(4) improve the health status of communities served by the health access network;~~
~~(5) reduce health disparities in such communities;~~
~~(6) identify all PCPs, specialty providers, and other provider types affiliated with the health access network.~~

~~(d) The application to participate as a SoonerCare contracted HAN's will be accepted and approved at the sole discretion of OHCA with implementation initiated after completion of a readiness review by OHCA staff and approval by OHCA's Medical Advisory Taskforce (MAT).~~

**317:25-9-3. Reimbursement**

(a) In order to be eligible for payment, ~~HAN's~~Health Access Networks (HANs) must have on file with ~~OHCA,~~the Oklahoma Health Care Authority (OHCA) an approved Provider Agreement. Through this agreement, the HAN assures that OHCA's requirements are met and assures compliance with all applicable ~~Federal~~federal and ~~State~~state regulations. ~~These agreements are renewed annually with each provider.~~

(b) The HAN will be reimbursed a per member per month (PMPM) rate based on the number of member months paid to the PCPs affiliated with the HAN. OHCA reserves the right to limit reimbursement based on availability of funds.

## SUBCHAPTER 11. HEALTH MANAGEMENT PROGRAM

**317:25-11-1. Purpose**

The purpose of this Subchapter is to describe the rules governing the Health Management Program (HMP) participating in the statewide SoonerCare program. The rules provide assurances that the HMP will work with providers to coordinate and improve the quality of care for SoonerCare members.

**317:25-11-2. Requirements**

(a) The Health Management Program (HMP) is a voluntary program offered statewide and serves SoonerCare Choice members ages four (4) through sixty-three (63) with or at risk for chronic illness who are at the highest risk for adverse outcome and increased health care expenditures.
(b) HMP services are grounded in motivational interviewing and evidence-based guidelines. The HMP services are designed by the HMP vendor and approved by the Oklahoma Health Care Authority (OHCA). The HMP vendor's activities may include services delivered directly to SoonerCare Choice members or activities in connection with health care providers that are designed to benefit SoonerCare Choice members. HMP activities/services can include:

(1) Health coaching;
(2) Practice facilitation;
(3) Health navigation;
(4) Performance improvement projects; and
(5) Transition of care assistance.

**317:25-11-3. Reimbursement**

The Health Management Program (HMP) vendor must have an approved Provider Agreement on file. Through this agreement, the HMP assures that the Oklahoma Health Care Authority's requirements are met and assures compliance with all applicable federal and state regulations. HMPs are not a service delivery system.

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**
**CHAPTER 45. INSURE OKLAHOMA**

**SUBCHAPTER 9. INSURE OKLAHOMA ESI EMPLOYEE ELIGIBILITY**

**317:45-9-1.1 Certification of newborn child deemed eligible**

(a) A newborn child is deemed eligible on the date of birth for SoonerCare benefits when the child is born to a member of Insure Oklahoma Employer Sponsored Insurance (ESI) and the annual gross household income does not exceed SoonerCare requirements. The newborn child is deemed eligible for SoonerCare benefits through the last day of the month the child attains the age of one (1) year.

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

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

(1) Loses Oklahoma residence; or

(2) Expires.

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

**SUBCHAPTER 11. INSURE OKLAHOMA IP**

**PART 1. INDIVIDUAL PLAN PROVIDERS**

**317:45-11-2. Insure Oklahoma ~~IP~~Individual Plan (IP) provider payments**

Payment for covered benefits rendered to Insure Oklahoma IP members is made to contracted Insure Oklahoma IP healthcare providers for medical and surgical services within the scope of OHCA's medical programs, provided the services are medically necessary as defined in Oklahoma Administrative Code 317:30-3-1(f).

(1) Coverage of certain services requires prior authorization and may be based on a determination made by a medical consultant in individual circumstances; and

~~(2) The decision to charge a co-payment for a missed visit is at the provider's discretion;~~

~~(3)~~(2) The provider may collect the member's co-payment in addition to the SoonerCare reimbursement for services provided~~; and~~.

~~(4) The provider may refuse to see members based on their inability to pay their co-payment.~~

## PART 5. INSURE OKLAHOMA IP MEMBER ELIGIBILITY

**317:45-11-21.1. Certification of newborn child deemed eligible**

(a) A newborn child is deemed eligible on the date of birth for SoonerCare benefits when the child is born to a member of Insure Oklahoma Individual Plan (IP) and the annual gross household income does not exceed SoonerCare requirements. The newborn child is deemed eligible for SoonerCare benefits through the last day of the month the child attains the age of one (1) year.

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

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

(1) Loses Oklahoma residence; or

(2) Expires.

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

**317:45-11-22. ~~PCP~~Primary Care Physician (PCP) choices**

(a) The applicant ~~(and dependents if also applying for Insure Oklahoma IP) is~~and any covered dependent(s) are required to select a valid PCP.

(b) ~~If a valid PCP is selected by the applicant or dependents and they are not enrolled with the first PCP choice, they are enrolled with the next available PCP choice. The applicant is notified in writing why their initial choice was not selected.~~The applicant and any covered dependent(s) must make a PCP selection though their mysoonercare.org account.

(c) After initial enrollment in Insure Oklahoma ~~IP,~~Individual Plan the applicant ~~or dependents can~~any covered dependent(s) may change their PCP selection through their mysoonercare.org account or by calling the Insure Oklahoma helpline.

(d) To ensure members have access to their Patient Centered Medical Home, Insure Oklahoma staff may facilitate enrollment as applicable.

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

**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**

**PART 8. REHABILITATION HOSPITALS**

**317:30-5-111. Coverage for adults**

For persons ~~21~~twenty-one (21) years of age or older, payment is made to hospitals for inpatient services as described in this section.

(1) All general inpatient hospital services which are not provided under the Diagnosis Related Group (DRG) payment methodology for all persons ~~21~~twenty-one (21) years of age or older is limited to ~~24~~ninety (90) days per person per state fiscal year (July 1 through June 30). The ~~24~~ninety (90) day limitation applies to both hospital and physician services. No exceptions or extensions will be made to the ~~24~~ninety (90) day inpatient services limitation.

(2) All inpatient stays are subject to post-payment utilization review by the ~~OHCA's~~Oklahoma Health Care Authority's (OHCA) designated Quality Improvement Organization (QIO). These reviews are based on severity of illness and intensity of treatment.

(A) It is the policy and intent of OHCA to allow hospitals and physicians the opportunity to present any and all documentation available to support the medical necessity of an admission and/or extended stay of a SoonerCare member. If the QIO, upon their initial review determines the admission should be denied, a notice is issued to the facility and the attending physician advising them of the decision. This notice also advises that a reconsideration request may be submitted within the specified time frame on the notice and consistent with the Medicare guidelines. Additional information submitted with the reconsideration request is reviewed by the QIO that utilizes an independent physician advisor. If the denial decision is upheld through this review of additional information, the QIO sends written notification of the denial decision to the hospital, attending physician and the OHCA. Once the OHCA has been notified, the overpayment is processed as per the final denial determination.

(B) If the hospital or attending physician did not request reconsideration from the QIO, the QIO informs OHCA there has been no request for reconsideration and as a result their initial denial decision is final. OHCA, in turn, processes the overpayment as per the denial notice sent to the OHCA by the QIO.

(C) If an OHCA, or its designated agent, review results in denial and the denial is upheld throughout the appeal process

and refund from the hospital and physician is required, the member cannot be billed for the denied services.

(3) If a hospital or physician believes that a hospital admission or continued stay is not medically necessary and thus not compensable but the member insists on treatment, the member should be informed that he/she will be personally responsible for all charges. If a claim is filed and paid and the service is later denied, the patient is not responsible.

(4) Payment is made to a participating hospital for hospital based physician's services. The hospital must have a Hospital-Based Physician's contract with OHCA for this method of billing.

(5) Outpatient services for adults are covered as listed in ~~OAC~~Oklahoma Administrative Code 317:30-5-42.1.

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

**SUBCHAPTER 1. GENERAL PROVISIONS**

**317:30-1-3. Description of rules**

How to use this Chapter. This Chapter contains basic information concerning the ~~Oklahoma Title XIX Medical Assistance~~SoonerCare Program ~~(Medicaid)~~. It is intended for use by all providers of medical and health related services participating in the program.

(1) The Chapter contains Sections dealing with ~~the organization, administration and financing of the program, recipient eligibility,~~provider policies, coverage of medical and health services, and other general program policies and procedures applicable to all providers. ~~Rules and procedures applicable to particular provider groups and billing instructions are distributed to providers according to the type of services rendered.~~

(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 ~~do much to eliminate~~reduce misunderstandings concerning the coverage~~, status~~and reimbursement of SoonerCare services~~, recipient eligibility and proper billing procedures all of which can result in delays in payment, incorrect payment or denial of payment~~and the Agency's expectations of providers. As users of the rules in this Chapter, OHCA also solicits suggestions and comments from providers.

**317:30-1-4. Definitions**

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

**"Adult"** means an individual twenty-one (21) years of age or older, unless otherwise specified by statute, regulation, and/or policy adopted by the Oklahoma Health Care Authority (OHCA). For eligibility criteria policy for children and adults, please refer to Oklahoma Administrative Code (OAC) 317:35-5-2.

**"Child"** means an individual under twenty-one (21) years of age, unless otherwise specified by statute, regulation, and/or policy adopted by the OHCA. For eligibility criteria policy for children and adults, please refer to OAC 317:35-5-2.

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

**SUBCHAPTER 1. GENERAL PROVISIONS**

**317:35-1-2. Definitions**

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

**"Acute Care Hospital"** means an institution that meets the requirements ~~of 42 CFR, Section 440.10 and~~defined in Section (§) 440.10 of Title 42 of the Code of Federal Regulations (C.F.R.) and:

(A) is maintained primarily for the care and treatment of patients with disorders other than mental diseases;

(B) is formally licensed or formally approved as a hospital by an officially designated authority for state standard setting; and

(C) meets the requirements for participation in Medicare as a hospital.

**"Adult"** means an individual twenty-one (21) years of age or older, unless otherwise specified by statute, regulation, and/or policy adopted by the Oklahoma Health Care Authority (OHCA). For eligibility criteria policy for children and adults, please refer to Oklahoma Administrative Code (OAC) 317:35-5-2.

**"ADvantage Administration (AA)"** means the Oklahoma Department of Human Services ~~(OKDHS)~~(DHS) which performs certain administrative functions related to the ADvantage Waiver.

**"Aged"** means an individual whose age is established as ~~65~~sixty-five (65) years or older.

**"Agency partner"** means an agency or organization contracted with the OHCA that will assist those applying for services.

**"Aid to Families with Dependent Children (AFDC)"** means the group of low income families with children described in Section 1931 of the Social Security Act. The Personal Responsibility and Work Opportunity Act of 1996 established the new eligibility group of low income families with children and linked eligibility income and resource standards and methodologies and the requirement for deprivation for the new group to the State plan for ~~Aid to Families with Dependent Children~~AFDC in effect on July 16, 1996. Oklahoma has elected to be less restrictive for all SoonerCare members related to AFDC. Effective January 1, 2014, children covered under Section 1931 are related to the children's group, and adults covered under Section 1931 are related to the parent and caretaker relative group. The Modified Adjusted Gross Income (MAGI) methodology is used to determine eligibility for these groups.

**"Area nurse"** means a registered nurse in the ~~OKDHS~~DHS Aging Services Division, designated according to geographic areas who evaluates the ~~UCAT~~Uniform Comprehensive Assessment Tool (UCAT) and determines medical eligibility for Personal Care, ADvantage Waiver, and Nursing Facility services. The area nurse also approves care plan and service plan implementation for Personal Care services.

**"Area nurse designee"** means a registered nurse selected by the area nurse who evaluates the UCAT and determines medical eligibility for Personal Care, ADvantage Waiver, and Nursing Facility services.

**"Authority"** means the ~~Oklahoma Health Care Authority (OHCA)~~OHCA.

**"Blind"** means an individual who has central visual acuity of 20/200 or less in the better eye with the use of a correcting lens.

**"Board"** means the ~~Oklahoma Health Care Authority~~OHCA Board.

**"Buy-in"** means the procedure whereby the OHCA pays the member's Medicare premium.

(A) **"Part A Buy-in"** means the procedure whereby the OHCA pays the Medicare Part A premium for individuals determined eligible as Qualified Medicare Beneficiaries Plus (QMBP) who are enrolled in Part A and are not eligible for premium free enrollment as explained under Medicare Part A. This also includes individuals determined to be eligible as Qualified Disabled and Working Individuals (QDWI).

(B) **"Part B Buy-in"** means the procedure whereby the OHCA pays the Medicare Part B premium for categorically needy individuals who are eligible for Part B Medicare. This includes individuals who receive TANF or the State Supplemental Payment to the Aged, Blind or Disabled, and those determined to be Qualified Medicare Beneficiary Plus (QMBP), Specified Low Income Medicare Beneficiaries (SLMB) or Qualifying Individual-1 (QI-1). Also included are individuals who continue to be categorically needy under the PICKLE amendment and those who retain eligibility after becoming employed.

**"Caretaker relative"** means a person other than the biological or adoptive parent with whom the child resides who meets the specified degree of relationship within the fifth degree of kinship.

**"Case management"** means the activities performed for members to assist them in accessing services, advocacy and problem solving related to service delivery.

**"Categorically needy"** means that income and, when applicable, resources are within the standards for the category to which the individual is related.

**"Categorically related" or "related"** means the individual meets

basic eligibility requirements for an eligibility group.

**"Certification period"** means the period of eligibility extending from the effective date of certification to the date of termination of eligibility or the date of the next periodic redetermination of eligibility.

**"Child"** means an individual under twenty-one (21) years of age, unless otherwise specified by statute, regulation, and/or policy adopted by the OHCA. For eligibility criteria policy for children and adults, please refer to OAC 317:35-5-2.

**"County"** means the Oklahoma ~~Department of Human Services~~DHS' office or offices located in each county within the State.

**"Custody"** means the custodial status, as reported by ~~the Oklahoma Department of Human Services~~DHS.

**"Deductible/Coinsurance"** means the payment that must be made by or on behalf of an individual eligible for Medicare before Medicare payment is made. The coinsurance is that part of the allowable medical expense not met by Medicare, which must be paid by or on behalf of an individual after the deductible has been met.

(A) For Medicare Part A (Hospital Insurance), the deductible relates to benefits for inpatient services while the patient is in a hospital or nursing facility. After the deductible is met, Medicare pays the remainder of the allowable cost.

(B) For Medicare Part B (Medical Insurance), the deductible is an annual payment that must be made before Medicare payment for medical services. After the deductible is met, Medicare pays ~~80%~~eighty percent (80%) of the allowable charge. The remaining ~~20%~~twenty percent (20%) is the coinsurance.

**"Disabled"** means an individual who is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or which has lasted (or can be expected to last) for a continuous period of not less than ~~12~~twelve (12) months.

**"Disabled child"** means for purposes of Medicaid Recovery a child of any age who is blind, or permanently and totally disabled according to standards set by the Social Security Administration.

**"Estate"** means all real and personal property and other assets included in the member's estate as defined in Title 58 of the Oklahoma Statutes.

**"Gatekeeping"** means the performance of a comprehensive assessment by the ~~OKDHS~~DHS nurse utilizing the ~~Uniform Comprehensive Assessment Tool (UCAT)~~UCAT for the determination of Medical eligibility, care plan development, and the determination of Level of Care for Personal Care, ADvantage Waiver and Nursing Facility services.

**"Ineligible Spouse"** means an individual who is not eligible for

~~SSI~~Supplemental Security Income (SSI) but is the husband or wife of someone who is receiving SSI.

**"Local office"** means the Oklahoma ~~Department of Human Services~~DHS' office or offices located in each county within the State.

**"LOCEU"** means the Oklahoma Health Care Authority's Level of Care Evaluation Unit.

**"MAGI eligibility group"** means an eligibility group whose financial eligibility is determined through the Modified Adjusted Gross Income (MAGI) methodology. The groups subject to MAGI are defined in ~~42 CFR 435.603~~42 C.F.R. § 436.603 and listed in OAC 317:35-6-1.

**"Modified Adjusted Gross Income (MAGI)"** means the financial eligibility determination methodology established by the Patient Protection and Affordable Care Act (PPACA) in 2009.

**"Medicare"** means the federally funded health insurance program also known as Title XVIII of the Social Security Act. It consists of four (4) separate programs. Part A is Hospital Insurance, Part B is Medical Insurance, Part C is Medicare Advantage Plans, and Part D is Prescription Drug Coverage.

(A) **"Part A Medicare"** means Hospital Insurance that covers services for inpatient services while the patient is in a hospital or nursing facility. Premium free enrollment is provided for all persons receiving OASDI or Railroad Retirement income who are age ~~65~~sixty-five (65) or older and for those under age ~~65~~sixty-five (65) who have been receiving disability benefits under these programs for at least ~~24~~twenty-four (24) months.

(i) Persons with end stage renal disease who require dialysis treatment or a kidney transplant may also be covered.

(ii) Those who do not receive OASDI or Railroad Retirement income must be age ~~65~~sixty-five (65) or over and pay a large premium for this coverage. Under Authority rules, these individuals are not required to enroll for Part A to be eligible for SoonerCare benefits as categorically needy. They must, however, enroll for Medicare Part B. Individuals eligible as a QMBP or as a ~~Qualified Disabled and Working Individual (QDWI)~~QDWI under Medicaid are required to enroll for Medicare Part A. The Authority will pay Part A premiums for QMBP individuals who do not qualify for premium free Part A and for all QDWI's.

(B) **"Part B Medicare"** means Supplemental Medical Insurance that covers physician and related medical services other than inpatient or nursing facility care. Individuals eligible to enroll in Medicare Part B are required to do so under OHCA policy. A monthly premium is required to keep

this coverage in effect.

**"Minor child"** means a child under the age of ~~18~~eighteen (18).

**"Nursing Care"** for the purpose of Medicaid Recovery is care received in a nursing facility, an intermediate care facility for individuals with intellectual disabilities (ICF/IIDs) or other medical institution providing nursing and convalescent care, on a continuing basis, by professional personnel who are responsible to the institution for professional medical services.

**"OCSS"** means the Oklahoma ~~Department of Human Services~~DHS' Oklahoma Child Support Services (formerly Child Support Enforcement Division).

**"OHCA"** means the Oklahoma Health Care Authority.

**"OHCA Eligibility Unit"** means the group within the ~~Oklahoma Health Care Authority~~OHCA that assists with the eligibility determination process.

~~**"OKDHS"**~~**"DHS"** means the Oklahoma Department of Human Services.

**"~~OK~~DHS nurse"** means a registered nurse in the ~~OK~~DHS Aging Services Division who meets the certification requirements for UCAT Assessor and case manager, and who conducts the uniform assessment of individuals utilizing the ~~Uniform Comprehensive Assessment Tool (UCAT)~~UCAT for the purpose of medical eligibility determination. The ~~OK~~DHS nurse also develops care plans and service plans for Personal Care services based on the UCAT.

**"Qualified Disabled and Working Individual (QDWI)"** means individuals who have lost their Title II OASDI benefits due to excess earnings, but have been allowed to retain Medicare coverage.

**"Qualified Medicare Beneficiary Plus (QMBP)"** means certain aged, blind or disabled individuals who may or may not be enrolled in Medicare Part A, meet the Medicaid QMBP income and resource standards and meet all other Medicaid eligibility requirements.

**"Qualifying Individual"** means certain aged, blind or disabled individuals who are enrolled in Medicare Part A, meet the Medicaid Qualifying Individual income and resource standards and meet all other Medicaid eligibility requirements.

**"Qualifying Individual-1"** means a Qualified Individual who meets the Qualifying Individual-1 income and resource standards.

**"Reasonably compatible"** means that there is no significant discrepancy between information declared by a member or applicant and other information available to the agency. More specific policies and procedures for determining whether a declaration is reasonably compatible are detailed in Oklahoma's Verification Plan.

**"Recipient lock-in"** means when a member is restricted to one primary physician and/or one pharmacy. It occurs when the OHCA determines that a SoonerCare member has used multiple physicians and/or pharmacies in an excessive manner over a ~~12-month~~twelve (12) month period.

**"Scope"** means the covered medical services for which payment is made to providers on behalf of eligible individuals. The Oklahoma Health Care Authority Provider Manual (OAC 317:30) contains information on covered medical services.

**"Specified Low Income Medicare Beneficiaries (SLMB)"** means individuals who, except for income, meet all of the eligibility requirements for QMBP eligibility and are enrolled in Medicare Part A.

**"TEFRA"** means the Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97-248). TEFRA provides coverage to certain disabled children living in the home who would qualify for SoonerCare if residents of nursing facilities, ICF/IIDs, or inpatient acute care hospital stays are expected to last not less than ~~60~~sixty (60) days.

**"Worker"** means the OHCA or OKDHS worker responsible for assisting in eligibility determinations.

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

**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**

**PART 62. PRIVATE DUTY NURSING**

**317:30-5-555. ~~Eligible providers~~Private Duty Nursing (PDN)**

~~(a) An organization who desires to be paid by SoonerCare for private duty nursing must meet the following requirements prior to providing services to eligible SoonerCare members:~~

~~(1) an executed contract with OHCA, and~~

~~(2) the organization must meet the requirements of OAC 317:30-5-545 or it must be licensed by the State Health Department as a Home Care Agency.~~

~~(b) The provider of services within the organization must be a licensed practical nurse or a registered nurse.~~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)].

**317:30-5-556. ~~Definitions~~Eligible providers**

~~Private duty nursing is medically necessary care provided on a regular basis by a Licensed Practical Nurse or Registered Nurse in~~

~~the member's primary residence or to assist outside the home during transport to medical appointments and emergency room visits in lieu of transport by ambulance.~~(a) A home health agency that desires to be reimbursed by SoonerCare for private duty nursing (PDN) must meet the following requirements prior to providing services to eligible SoonerCare members:

(1) The agency must be fully contracted with OHCA as a provider; and,

(2) The agency must meet the requirements of Oklahoma Administrative Code (OAC) 317:30-5-545, and it must be licensed by the Oklahoma State Health Department (OSDH) as a home care agency.

(b) The provider of PDN services, within the agency, must be a licensed practical nurse or a registered nurse who is currently licensed and in good standing in the state in which services are provided.

**317:30-5-558. Private duty nursing (PDN) coverage limitations**

The following ~~regulations~~provisions apply to all ~~private duty nursing~~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 ~~Nursing~~home health agency before requesting prior authorization and must be updated at least annually and signed by the physician;

(3) A telephonic interview and/or personal visit by an OHCA care management nurse is required prior to the authorization for services;

(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 ~~is limited to~~must be counted in and cannot exceed~~assisting during transport to medical appointments and emergency room visits in lieu of transport by ambulance and is limited to~~ the number of hours requested on the treatment plan and approved by OHCA.

(6) ~~Private duty nursing~~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 ~~Private Duty Nursing~~PDN services if all health and safety issues cannot be met in the ~~home~~ 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) ~~Private duty nursing~~PDN is not authorized in excess of sixteen~~16~~ (16) hours per day ~~except immediately following a hospital stay or the temporary incapacitation of the primary caregiver. Under these two exceptions, care in excess of 16 hours is authorized for a period up to 30 days. As expressed in this subsection, incapacity means an involuntary ability to provide care~~. 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.

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

**SUBCHAPTER 3. GENERAL PROVIDER POLICIES**

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

**317:30-3-65. Early and Periodic Screening, ~~Diagnosis~~Diagnostic and Treatment (EPSDT) program/Child-health Services**

Payment is made to eligible providers for Early and Periodic Screening, ~~Diagnosis~~Diagnostic and Treatment (EPSDT) services on behalf of eligible individuals under the age of ~~21~~twenty-one (21).

(1) The EPSDT program is a comprehensive child-health program, designed to ensure the availability of, and access to, required health care resources and help parents and guardians of Medicaid-eligible children and adolescents use these resources. An effective EPSDT program assures that health problems are diagnosed and treated early before they become more complex and their treatment more costly. The physician plays a significant role in educating parents and guardians about all services available through the EPSDT program. The receipt of an identified EPSDT screening makes the member eligible for all necessary follow-up care that is within the scope of the SoonerCare program. Early and Periodic Screening, ~~Diagnosis~~Diagnostic and Treatment (EPSDT) covers services, supplies, or equipment that are determined to be medically necessary for a child or adolescent, and which are included within the categories of mandatory and optional services in Section 1905(a) of Title XIX, regardless of whether such services, supplies, or equipment are listed as covered in ~~Oklahoma's State Plan~~Oklahoma's Medicaid State Plan.

(2) Federal regulations also require that the State set standards and protocols for each component of EPSDT services. The standards must provide for services at intervals which meet reasonable standards of medical and dental practice. The standards must also provide for EPSDT services at other intervals as medically necessary to determine the existence of certain physical or behavioral health illnesses or conditions.

(3) SoonerCare providers who perform EPSDT screenings must assure that the screenings they provide meet the minimum standards established by the Oklahoma Health Care Authority in order to be reimbursed at the level established for EPSDT services.

(4) An EPSDT screening is considered a comprehensive examination. A provider billing SoonerCare for an EPSDT screen may not bill any other Evaluation and Management Current

Procedure Terminology (CPT) code for that patient on that same day. It is expected that the screening provider will perform necessary treatment as part of the screening charge. However, there may be other additional diagnostic procedures or treatments not normally considered part of a comprehensive examination, including diagnostic tests and administration of immunizations, required at the time of screening. Additional diagnostic procedures or treatments may be billed independently from the screening. Some services as set out in this section may require prior authorization.

(5) For an EPSDT screening to be considered a completed reimbursable service, providers must perform, and document, all required components of the screening examination. Documentation of screening services performed must be retained for future review.

(6) All comprehensive screenings provided to individuals under age ~~21~~twenty-one (21) must be filed on HCFA-1500 using the appropriate preventive medicine procedure code or an appropriate Evaluation and Management code from the Current Procedural Terminology Manual (CPT) accompanied by the appropriate "V" diagnosis code.

(7) For EPSDT services in a school-based setting that are provided pursuant to an IEP, please refer to Part 103, Qualified Schools As Providers Of Health-Related Services, in Oklahoma Administrative Code 317:30-5-1020 through 317:30-5-1028.

## SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

## PART 103. QUALIFIED SCHOOLS AS PROVIDERS OF HEALTH-RELATED SERVICES

### 317:30-5-1022. Periodicity schedule [REVOKED]

~~(a) The SoonerCare program has adopted the recommendations of the American Academy of Pediatrics' Bright Futures' periodicity schedule for services.~~

~~(b) Children and adolescents enrolled in SoonerCare are referred to their SoonerCare provider for services. In cases where the SoonerCare provider authorizes the school to perform the screen or fails to schedule an appointment within three (3) weeks and a request has been made and documented by the school, the school may then furnish the Early and Periodic Screening, Diagnosis and Treatment child-health screening and bill it as a fee-for-service activity. Results of the child-health screening are forwarded to the member's SoonerCare provider.~~

### 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, of Oklahoma Administrative Code at 317:30-3-65 through 317:30-3-63.12. Payment is made for the following compensable services rendered by qualified school providers:

~~(1) **Child-health screening.** An initial screening may be requested by an eligible member at any time and must be provided without regard to whether the member's age coincides with the established periodicity schedule. Coordination referral is made to the SoonerCare provider to assure at a minimum, that periodic screens are scheduled and provided in accordance with the periodicity schedule following the initial screening. Child-health screening must adhere to the following requirements:~~

~~(A) Children and adolescents enrolled in SoonerCare must be referred to their SoonerCare provider for child-health screenings. In cases where the SoonerCare provider authorizes the school to perform this screen or fails to schedule an appointment within three (3) weeks and a request has been made and documented by the school, the school may then furnish the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) child-health screening. Written notification must be mailed to the SoonerCare member's primary care provider (PCP) prior to the school's intent to furnish and bill for the screen. Results of this screening must be forwarded to the member's SoonerCare provider.~~

~~(B) Child-health screenings must be provided by a state-licensed physician (M.D. or D.O.), state-licensed nurse practitioner with prescriptive authority, or state-licensed physician assistant. Screening services must include the following:~~

~~(i) Comprehensive health and developmental history, including assessment of both physical and mental health development;~~

~~(ii) Comprehensive unclothed physical exam;~~

~~(iii) Appropriate immunizations according to the age and health history;~~

~~(iv) Laboratory test, including blood level assessment; and~~

~~(v) Health education, including anticipatory guidance.~~

~~(C) Mass screenings for any school-based service are not billable to SoonerCare, nor are screenings that are performed as a child or adolescent find activity pursuant to an Individuals with Disabilities Education Act (IDEA) requirement. There must be a documented referral in place that indicates the child or adolescent has an individualized~~

~~need that warrants a screening to be performed.~~

~~(2) **Child-health encounter.** The child-health encounter may include a diagnosis and treatment encounter, a follow-up health encounter, or a home visit. A child-health encounter may include any of the following services:~~

~~(A) vision;~~

~~(B) hearing;~~

~~(C) dental;~~

~~(D) a health history;~~

~~(E) physical examination;~~

~~(F) developmental assessment;~~

~~(G) nutrition assessment and counseling;~~

~~(H) social assessment and counseling;~~

~~(I) genetic evaluation and counseling;~~

~~(J) indicated laboratory and screening tests;~~

~~(K) screening for appropriate immunizations; or~~

~~(L) health counseling and treatment of childhood illness and conditions.~~

~~(3)~~(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 who:

(i) ~~holds~~Holds a Certificate of Clinical Competence from the American Speech-Language-Hearing Association (ASHA); or

(ii) ~~has~~Has completed the equivalent educational requirements and work experience necessary for the certificate; or

(iii) ~~has~~Has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

(B) **Audiometry test.** Audiometric test (Immittance [Impedance] audiometry or tympanometry) includes bilateral assessment of middle ear status and reflex studies (when appropriate) provided by a state-licensed audiologist who:

(i) ~~holds~~Holds a Certificate of Clinical Competence from ASHA; or

(ii) ~~has~~Has completed the equivalent educational requirements and work experience necessary for the certificate; or

(iii) ~~has~~Has completed the academic program and is acquiring supervised work experience to qualify for the

certificate.

(C) **Ear impression (for earmold).** Ear impression (for earmold) includes taking an impression of a member's ear and providing a finished earmold ~~which is~~, to be used with the member's hearing aid as provided by a state-licensed audiologist who:

(i) ~~holds~~Holds a Certificate of Clinical Competence from the ASHA; or

(ii) ~~has~~Has completed the equivalent educational requirements and work experience necessary for the certificate; or

(iii) ~~has~~Has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

(D) **Vision screening.** Vision screening in schools includes application of tests and examinations to identify visual defects or vision disorders. The vision screening may be performed by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) under the supervision of an RN~~, or state-certified vision impairment teacher~~. The service can be billed when a SoonerCare member has an individualized documented concern that warrants a screening. A vision examination must be provided by a state-licensed Doctor of Optometry (O.D.) or licensed physician specializing in ophthalmology (M.D. or D.O.). This vision examination, at a minimum, includes diagnosis and treatment for defects in vision.

(E) **Speech-language evaluation.** Speech-language evaluation is for the purpose of identification of children or adolescents with speech or language disorders and the diagnosis and appraisal of specific speech and language services. Speech-language evaluations must be provided by state-licensed speech-language pathologist who:

(i) ~~holds~~Holds a Certificate of Clinical Competence from the ASHA; or

(ii) ~~has~~Has completed the equivalent educational requirements and work experience necessary for the certificate; or

(iii) ~~has~~Has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

(F) **Physical therapy evaluation.** Physical therapy evaluation includes evaluating the student's ability to move throughout the school and to participate in classroom activities and the identification of movement dysfunction and related functional problems ~~and must be provided by a state-licensed physical therapist~~. It must be provided by a state-licensed

physical therapist. Physical therapy evaluations must adhere to guidelines found at OAC 317:30-5-291.

(G) **Occupational therapy evaluation.** Occupational therapy evaluation services include determining what therapeutic services, assistive technology, and environmental modifications a student requires for participation in the special education program and must be provided by a state-licensed occupational therapist.

(H) ~~**Psychological evaluation and testing.** Psychological evaluation and testing are for the purpose of diagnosing and determining if emotional, behavioral, neurological, or developmental issues are affecting academic performance and for determining recommended treatment protocol. Evaluation/testing for the sole purpose of academic placement (e.g. diagnosis of learning disorders) is not a compensable service. Psychological evaluation and testing must be provided by state-licensed, board-certified psychologist or school psychologist certified by Oklahoma State Department of Education (OSDE).~~**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).

~~(4)~~(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 ~~Individualized Education Program (IEP)~~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, ~~Master's Degree Audiologist~~master's degree audiologist who:

(I) ~~holds~~Holds a Certificate of Clinical Competence from the ASHA; or

(II) ~~has~~Has completed the equivalent educational requirements and work experience necessary for the certificate; or

(III) ~~has~~Has completed the academic program and is acquiring supervised work experience to qualify for the certificate;

(ii) ~~state-licensed~~State-licensed, ~~Master's Degree Speech-Language Pathologist~~master's degree speech-language pathologist who:

(I) ~~holds~~Holds a Certificate of Clinical Competence from the ASHA; or

(II) ~~has~~Has completed the equivalent educational requirements and work experience necessary for the certificate; or

(III) ~~has~~Has completed the academic program and is acquiring supervised work experience to qualify for the certificate; and

~~(iii) state-certified deaf education teacher;~~

~~(iv)~~ (iii) ~~certified~~Certified orientation and mobility specialists; and

~~(v) state-certified vision impairment teachers.~~

(B) **Speech-language therapy services.** Speech-language therapy services include provisions of speech and language services for the habilitation or prevention of communicative disorders. Speech-language therapy services must be provided by or under the direct guidance and supervision of a state-licensed ~~Speech-Language Pathologist~~speech-language pathologist within the scope of his or her practice under state law who:

(i) ~~holds~~Holds a Certificate of Clinical Competence from the ASHA; or

(ii) ~~has~~Has completed the equivalent educational requirements and work experience necessary for the certificate; or

(iii) ~~has~~Has completed the academic program and is acquiring supervised work experience to qualify for the certificate; or

(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 state-licensed physical therapist; services may also be provided by a ~~Physical Therapy Assistant~~physical therapy assistant who has been authorized by the Board of Examiners working under the supervision of a licensed ~~Physical Therapist~~physical therapist. The licensed ~~Physical Therapist~~physical therapist may not supervise more than ~~three Physical Therapy Assistants~~three (3) physical therapy assistants.

(D) **Occupational therapy services.** Occupational therapy may include provision of services to improve, develop, or restore impaired ability to function independently. Occupational therapy services must be provided by or under the direct guidance and supervision of a state-licensed ~~Occupational Therapist~~occupational therapist; services may also be provided by an ~~Occupational Therapy Assistant~~occupational therapy assistant who has been authorized by the Board of Examiners, working under the supervision of a licensed ~~Occupational Therapist~~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) **~~Psychotherapy~~Counseling services.** ~~Psychotherapy services are the provision of counseling for children and parents.~~ All services must be for the direct benefit of the member. ~~Psychotherapy~~Counseling services must be provided by a state-licensed ~~Social Worker~~social worker, a state-licensed ~~Professional Counselor~~professional counselor, a state-licensed ~~Psychologist~~psychologist or ~~School Psychologist certified by the OSDE~~SDE-certified school psychologist, a state-licensed ~~Marriage and Family Therapist~~marriage and family therapist, or a state-licensed ~~Behavioral Practitioner~~behavioral health practitioner, or under Board supervision to be licensed in one (1) of the above-stated areas.

(G) **Assistive technology.** Assistive technology ~~are~~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) ~~state-licensed, Speech-Language Pathologist~~State-licensed speech-language pathologist who:

(I) ~~holds~~Holds a Certificate of Clinical Competence from the ASHA; or

(II) ~~has~~Has completed the equivalent educational requirements and work experience necessary for the certificate; or

(III) ~~has~~Has completed the academic program and is acquiring supervised work experience to qualify for the certificate;

(ii) ~~state-licensed Physical Therapist~~State-licensed physical therapist; or

(iii) ~~state-licensed Occupational Therapist~~State-licensed occupational therapist.

(H) **Personal care.** Provision of personal care services (PCS) allow students with disabilities to safely attend school~~; includes, but is not limited to, assistance with toileting, oral feeding, positioning, hygiene, and riding the school bus, to handle medical or physical emergencies~~. 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~~/assistants~~ that have completed training approved or provided by ~~OSDE~~SDE, or ~~Personal Care Assistants~~personal care assistants, including LPNs, who have completed on-the-job training specific to their duties. ~~Personal Care services do~~PCS does not include behavioral monitoring. Paraprofessionals are not allowed to administer medication, nor are they allowed to assist with or provide therapy services to SoonerCare members. Tube feeding of any type may only be reimbursed if provided by a RN or LPN. Catheter insertion and Catheter/Ostomy care may only be reimbursed when done by a RN or LPN. All PCS must be prior authorized.

(I) **Therapeutic behavioral services (TBS).** ~~Therapeutic behavioral services are interventions to modify the non-adaptive behavior necessary to improve the student's ability to function in the community as identified on the plan of care. Medical necessity must be identified and documented through assessment and annual evaluations/re-evaluations. Services encompass behavioral management, redirection, and assistance in acquiring, retaining, improving, and generalizing socialization, communication and adaptive~~

~~skills.~~ 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~~ behavioral health school aide (BHSA) who has a high school diploma or equivalent and has successfully completed ~~the paraprofessional~~ training approved by the ~~OSDE and a training curriculum in behavioral interventions for pervasive developmental disorders as recognized by OHCA.~~SDE, and in collaboration with the Oklahoma Department of Mental Health and Substance Abuse Services, along with corresponding continuing education. BHSA must be supervised by a bachelor's level individual with a special education certification. BHSA must have CPR and First Aid certification. Six (6) additional hours of related continuing education are required per year.

~~(J) **Immunization.** Immunizations must be coordinated with the PCP for children and adolescents enrolled in SoonerCare. An administration fee, only, can be paid for immunizations provided by the schools.~~

(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.

**317:30-5-1024. Periodic screening examination [REVOKED]**

~~At a minimum, referrals to ***SoonerCare*** providers for periodic screening must be completed and provided in accordance with the periodicity schedule following the initial screening.~~

**317:30-5-1025. Interperiodic screening examination [REVOKED]**

~~Interperiodic screenings must be provided when medically necessary to determine the existence of suspected physical or mental illnesses or conditions. They may include physical, mental or dental conditions. The determination of whether an interperiodic screen is medically necessary may be made by a health, developmental or educational professional who comes into contact with the child outside of the formal health care system. Children enrolled in SoonerCare are referred to their SoonerCare~~

~~provider for these services. In cases where the SoonerCare provider authorizes the School to perform the screen or fails to schedule an appointment within three weeks and a request has been made and documented by the School, the School may then furnish the EPSDT child health screening and bill it as a fee-for-services activity. Results of this interperiodic screening are forwarded to the child's SoonerCare provider.~~

**317:30-5-1026. Reporting of suspected ~~child~~ abuse/neglect**

~~Instances of child abuse and/or neglect discovered through screenings and regular examinations are to be reported in accordance with State law. Section 7103 of Title 10 of the Oklahoma Statutes mandates reporting suspected abuse or neglect to the Oklahoma Department of Human Services. Section 7104 of Title 10 of the Oklahoma Statutes further requires reporting of criminally injurious conduct to the nearest law enforcement agency.~~Instances of child abuse and/or neglect are to be reported in accordance with state law, including, but not limited to, 10A Oklahoma Statute (O.S.) § 1-2-101 and 43A O.S. § 10-104. Any person suspecting child abuse or neglect shall immediately report it to the Oklahoma Department of Human Services (OKDHS) hotline, at 1-800-522-3511; any person suspecting abuse, neglect, or exploitation of a vulnerable adult shall immediately report it to the local DHS County Office, municipal or county law enforcement authorities, or, if the report occurs after normal business hours, the OKDHS hotline. Health care professionals who are requested to report incidents of domestic abuse by adult victims with legal capacity shall promptly make a report to the nearest law enforcement agency, per 22 O.S. § 58.

**317:30-5-1027. Billing**

~~(a)~~ Each service has a specified unit of service (unit) for billing purposes which represents the actual time spent providing a direct service. Direct service must be face-to face with the child. There is no reimbursement for time reviewing/completing paperwork and/or documentation related to the service or for staff travel to/from the site of service, unless otherwise specified.

(1) Most units of service are time-based, meaning that the service must be of a minimum duration in order to be billed. A unit of service that is time-based is continuous minutes; the time cannot be aggregated throughout the day.

(2) There are no minimum time requirements for evaluation services, for which the unit of service is generally a completed evaluation. The only exception is the ~~Psychological Evaluation~~evaluation and testing (OAC 317:30-5-1023(b)(1)(H), which is billed in hourly increments.

~~(b) The following units of service are billed on the appropriate~~

~~claim form:~~

~~(1) Service: Child Health Screening; Unit: Completed comprehensive screening.~~

~~(2) Service: Interperiodic Child Health Screening; Unit: Completed interperiodic screening.~~

~~(3) Service: Child Health Encounter; Unit: per encounter; limited to 3 encounters per day.~~

~~(4) Service: Individual Treatment Encounter; Unit: 15 minutes, unless otherwise specified.~~

~~(A) Hearing and Vision Services.~~

~~(B) Speech Language Therapy; Unit: per session, limited to one per day.~~

~~(C) Physical Therapy.~~

~~(D) Occupational Therapy.~~

~~(E) Nursing Services; Unit: up to 15 minutes; maximum 32 units per day.~~

~~(F) Psychotherapy Services; maximum 8 units per day.~~

~~(C) Assistive Technology.~~

~~(H) Therapeutic Behavioral Services.~~

~~(5) Service: Group Treatment Encounter; no more than 5 members per group, Unit: 15 minutes, unless otherwise specified. A daily log/list must be maintained and must identify the SoonerCare participants for each group therapy session.~~

~~(A) Hearing and Vision Services.~~

~~(B) Speech Language Therapy; Unit: per session, limited to one per day.~~

~~(C) Physical Therapy.~~

~~(D) Occupational Therapy.~~

~~(E) Psychotherapy Services; maximum 8 units per day.~~

~~(6) Service: Administration only, Immunization; Unit: one administration.~~

~~(7) Service: Hearing Evaluation; Unit: Completed Evaluation.~~

~~(8) Service: Hearing Aid Evaluation; Unit: Completed Evaluation.~~

~~(9) Service: Audiometric Test (Impedance); Unit: Completed Test (Both Ears).~~

~~(10) Service: Tympanometry and acoustic reflexes.~~

~~(11) Service: Ear Impression Mold; Unit: 2 molds (one per ear).~~

~~(12) Service: Vision Screening; Unit: one examination, by state licensed O.D., M.D., or D.O.~~

~~(13) Service: Speech Language Evaluation; Unit: one evaluation.~~

~~(14) Service: Physical Therapy Evaluation; Unit: one evaluation.~~

~~(15) Service: Occupational Therapy Evaluation; Unit: one evaluation.~~

~~(16) Service: Psychological Evaluation and Testing; Unit: one hour.~~

~~(17) Service: Personal Care Services; Unit: 10 minutes, 32 units daily.~~
~~(18) Service: Nursing Assessment/Evaluation (Acute episodic care); Unit: one assessment/evaluation, 18 yearly.~~
~~(19) Service: Psychological Evaluation and Testing; Unit: per hour of psychologist time, 8 hours yearly.~~

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

**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**

**PART 79. DENTISTS**

**317:30-5-695. Eligible dental providers and definitions**

(a) Eligible dental providers in Oklahoma's SoonerCare program are:

(1) ~~individuals~~Individuals licensed as dentists under Title 59 of Oklahoma Statutes (O.S.), Sections (§§) 328.21, 328.22, and 328.23 (licensed dentists, specialty dentists and out of state dentists);

(2) ~~individuals~~Individuals issued permits as dental interns under 59 O.S. § 328.26;

(3) ~~individuals~~Individuals who are third and fourth year dental students at an accredited Oklahoma dental college; and

(4) ~~any~~Any individual issued a license in another state as a dentist.

(b) All eligible providers must be in good standing with regard to their license. Any revocation or suspension status of a provider referenced in subsection (a) above renders the provider ineligible for payment or subject to recoupment under SoonerCare.

(c) Eligible providers must document and sign records of services rendered in accordance with guidelines found at Oklahoma Administrative Code (OAC) 317:30-3-15.

(d) The American Dental Association's version of Code on Dental Procedures and Nomenclature (CDT) is used by the Oklahoma Health Care Authority (OHCA) to communicate information related to codes, and procedures for administration. Definitions, nomenclature, and descriptors as listed in the CDT will apply, with the exception of more specific definitions or limitations set forth.

(1) **"Decay"** means carious lesions in a tooth; decomposition and/or dissolution of the calcified and organic components of the tooth structure.

~~(2) **"Emergency Dental Care"** means, but is not limited to, the immediate service that must be provided to relieve the member from pain due to an acute infection, swelling, trismus or trauma.~~

~~(3) **"Emergency Extraction"** means, but is not limited to, an extraction of a tooth due to presence of pathology, trauma, severe periodontal involvement, significant caries or to relieve pain or infection.~~

(2) **"Medically necessary oral healthcare"** means treatment deemed necessary by a physician or dentist when a patient's medical condition or treatment is or will be likely complicated by an untreated oral health problem.

(3) **"Medically necessary extractions"** means, but is not limited to, an extraction of a tooth that has met medically necessary

criteria due to the presence of pathology, trauma, severe periodontal involvement, significant caries, pain or infection.

(4) **"Images"** means radiographs and diagnostic imaging that are part of the clinical record. Images should only be taken for clinical reasons as determined by the dentist and must be of diagnostic quality, properly identified, and dated.

(5) **"Palliative ~~Treatment"~~treatment"** means action that relieves pain but is not curative. Palliative ~~Treatment~~treatment is an all-inclusive service. No other codes are reimbursable on the same date of service.

(6) **"Radiographic ~~Caries"~~caries"** means dissolution of the calcified and organic components of tooth tissue that has penetrated the enamel and is approaching the dentinoenamel junction.

(7) **"Unbundling"** means billing separately for several individual procedures that are included within one (1) CDT or Current Procedural Terminology (CPT) code.

(8) **"Upcoding"** means reporting a more complex and/or higher cost procedure than actually performed.

**317:30-5-696. Coverage by category**

Payment is made for dental services as set forth in this Section.

(1) **Adults.**

(A) Dental coverage for adults is limited to:

(i) ~~Emergency~~Medically necessary extractions, as defined in Oklahoma Administrative Code (OAC) 317:30-5-695. Tooth extraction must have medical need documented;

(ii) ~~limited~~Limited oral examinations and medically necessary images, as defined in OAC 317:30-5-695, associated with the ~~emergency~~ extraction or with a clinical presentation with reasonable expectation that an ~~emergency~~ extraction will be needed;

(iii) Smoking and ~~Tobacco Use Cessation Counseling~~tobacco use cessation counseling; and

(iv) ~~medical~~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.

(B) Payment is made for dental care for adults residing in private ~~Intermediate Care Facilities for Individuals with Intellectual Disabilities~~intermediate care facilities for individuals with intellectual disabilities (ICF/IID) and who have been approved for ICF/IID level of care, similar to the scope of services available to individuals under age twenty-one (21).

(C) Limited dental services are available for members who meet all medical criteria, but need dental clearance to obtain organ transplant approval. Providers must obtain prior

authorization before delivery of dental service, with the exception of evaluation and extractions. All requests must be filed on the currently approved American Dental Association (ADA) form and must include diagnostic images, six-point periodontal charting, narratives and comprehensive treatment plans. The ~~OHCA~~Oklahoma Health Care Authority (OHCA) will notify the provider of determination using OHCA Prior Authorization Request Decision form. Prior authorized services must be billed exactly as they appear on the prior authorization request. The following dental services are available:

(i) ~~comprehensive~~Comprehensive oral evaluation~~,~~;

(ii) ~~two image bitewings,~~Two (2) bitewing images;

(iii) ~~prophylaxis~~Prophylaxis~~,~~;

(iv) ~~fluoride~~Flouride application~~,~~;

(v) ~~limited~~Limited restorative procedures~~,~~; and

(vi) ~~periodontal~~Periodontal scaling/root planing.

(2) **Home and community-based services (HCBS) waiver for the intellectually disabled.** All providers participating in the HCBS must have a separate contract with the OHCA to provide services under the HCBS. Dental services are defined in each waiver and must be prior authorized.

(3) **Children.** The OHCA Dental Program provides the basic medically necessary treatment. 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. 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.** This procedure should precede any images, and chart documentation must include image interpretations, caries risk assessment and both medical and dental health history of member. The comprehensive treatment plan should be the final ~~results~~result of this procedure.

(B) **Periodic oral evaluation.** This procedure may be provided for a member of record ~~if not seen by the dentist for more than~~once every six (6) months. An examination should precede any images, and chart documentation must include image interpretations, caries risk assessment, and both medical and dental health history of member. The comprehensive treatment plan should be the final ~~results~~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 include member history, prior images, caries risk assessment, the six-point periodontal charting, and both dental and general health needs of the member. The referring dentist is responsible for providing properly identified images of acceptable quality with a referral, if that provider chooses to expose and submit for reimbursement prior to referral. 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)~~ [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 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.

~~(F)~~ (G) **Dental prophylaxis.** This procedure is provided once every ~~184~~one hundred eighty-four (184) days along with topical application of fluoride.

~~(G)~~ (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~~The child is five (5) years of age or under;

(II) ~~70~~Seventy percent (70%) or more of the root structure remains; or

(III) ~~the~~The procedure is provided more than twelve (12) months prior to normal exfoliation.

(ii) Stainless steel crowns are treatment of choice for:

(I) ~~primary~~Primary teeth treated with pulpal therapy, if the above conditions exist;

(II) ~~primary~~Primary teeth where three (3) surfaces of extensive decay exist; or

(III) ~~primary~~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.

~~(H)~~ (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~~Posterior permanent teeth that have completed endodontic therapy if three (3) or more surfaces of tooth is destroyed;

(II) ~~posterior~~Posterior permanent teeth that have three (3) or more surfaces of extensive decay; or

(III) ~~where~~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.

~~(I)~~ (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 ~~70~~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 ~~70~~seventy percent (70%) or more of root structure is remaining.

~~(J)~~(K) **Endodontics.** Payment is made for the services provided in accordance with the following:

(i) This procedure is allowed when there are no other missing anterior teeth in the same arch requiring replacement.

(ii) The provider documents history of member's improved oral hygiene and flossing ability in records.

(iii) Prior authorization is required for members who have a treatment plan requiring more than two (2) anterior and/or ~~two (2)~~any posterior root canals.

(iv) Pre and post-operative periapical images must be available for review.

(v) Pulpal debridement may be performed for the relief of pain while waiting for the decision from the OHCA.

(vi) Providers are responsible for any follow-up treatment required due to a failed root canal therapy for twenty-four (24) month post completion.

(vii) Endodontically treated teeth should be restored to limited occlusal function and all contours should be replaced. These teeth are not automatically approved for any type of crown.

~~(K)~~(L) **Space maintainers.** Certain limitations apply with regard to this procedure. Providers are responsible for recementation of any maintainer placed by them for six (6) months post insertion.

(i) **Band and loop type space maintenance.** This procedure must be provided in accordance with the following guidelines:

(I) This procedure is compensable for all primary molars where permanent successor is missing or where succedaneous tooth is more than 5mm 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 should 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)~~ (M) **Analgesia.** Analgesia services are reimbursable in accordance with the following:

(i) **Inhalation of nitrous oxide.** Use of nitrous oxide is compensable for four (4) occurrences per year and is not separately reimbursable, if provided on the same date by the same provider 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 by the same provider 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)~~ (N) **Pulp caps.** Indirect and direct pulp cap must be ADA accepted calcium hydroxide or ~~Mineral Trioxide Aggregate~~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)~~(O) **Protective restorations.** This restoration includes removal of decay, if present, and is reimbursable for the same tooth on the same date of service with a direct or indirect pulp cap, if needed. Permanent restoration of the tooth is allowed after sixty (60) days unless the tooth becomes symptomatic and requires pain relieving treatment.

~~(O)~~(P) **Smoking and ~~Tobacco Use Cessation Counseling~~tobacco use cessation counseling.** Smoking and ~~Tobacco Use Cessation Counseling~~tobacco use cessation counseling is covered when performed utilizing the five (5) intervention steps of asking the member to describe his/her smoking, advising the member to quit, assessing the willingness of the member to quit, assisting with referrals and plans to quit, and arranging for follow-up. Up to eight (8) sessions are covered per year per individual who has documented tobacco use. It is a covered service when provided by physicians, physician assistants, nurse practitioners, certified nurse midwives, ~~Oklahoma State Health Department and FQHC nursing, and Maternal/Child Health Licensed Clinical Social Workers with a certification as a Tobacco Treatment Specialist Certification (CTTS) staff in addition to other appropriate services rendered~~Oklahoma State Health Department (OSDH) and Federally Qualified Health Center (FQHC) nurses, and maternal/child health licensed clinical social workers with a Tobacco Treatment Specialist Certification (TTS-C). Chart documentation must include a separate note that addresses the 5A's, separate signature, and the member specific information addressed in the five (5) steps and the time spent by the practitioner performing the counseling. Anything under three (3) minutes is considered part of a routine visit.

~~(P)~~(Q) **Diagnostic casts and/or oral/facial images.** Diagnostic casts ~~or~~and/or oral/facial images may be requested by OHCA or representatives of OHCA. If cast ~~or~~and/or images are received they will be considered supporting documentation and may be used to make a determination for authorization of services. Submitted documentation used to base a decision will not be returned. Providers will be reimbursed for either the study model or images.

(i) Documentation of photographic images must be kept in the client's medical record and medical necessity identified on the submitted electronic or paper claim.

(ii) Oral/facial photographic images are allowed under the following conditions:

(I) When radiographic images do not adequately support the necessity for requested treatment.

(II) When photo images better support medical necessity for the requested treatment rather than diagnostic models.

(III) If a comprehensive orthodontic workup has not been performed.

(iii) For photographic images, the oral/facial portfolio must include a view of the complete lower arch, complete upper arch, and left and right maximum intercuspation of teeth.

(I) Maximum intercuspation refers to the occlusal position of the mandible in which the cusps of the teeth of both arches fully interpose themselves with the cusps of the teeth of the opposing arch.

(II) Intercuspation defines both the anterior-posterior and lateral relationships of the mandible and the maxilla, as well as the superior-inferior relationship known as the vertical dimension of occlusion.

(iv) Study models or photographic images not in compliance with the above described diagnostic guidelines will not be compensable. The provider may be allowed to resubmit new images that adhere to the diagnostic guidelines. If the provider does not provide appropriate documentation, the request for treatment will be denied.

**317:30-5-698. Services requiring prior authorization**

(a) Providers must have prior authorization for certain specified services before delivery of that service, unless the service is provided on an emergency basis [See ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-5-695(d)(2)]. Requests for dental services requiring prior authorization must be accompanied by sufficient documentation. ~~Images with an indication of the left side of member, six point periodontal charting and copy of the comprehensive treatment plans are required.~~

(b) Requests for prior authorization are filed on the currently approved ~~ADA~~American Dental Association (ADA) form. ~~OHCA notifies the provider on the determination of prior authorization using OHCA Prior Authorization Request Decision form.~~ 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 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) Listed below are examples of services requiring prior authorization for members under ~~21~~twenty-one (21) and eligible ~~ICF/IID~~intermediate care facilities for individuals with

intellectual disabilities (ICF/IID) residents. 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 submitted with film mounts and each film or print~~ 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 current ADA form requesting all treatments requiring prior authorization. The images, digital media, photographs, or printouts must be of sufficient quality to clearly demonstrate for the reviewer, the pathology which is the basis for the authorization request. If radiographs are not taken, provider must include in narrative sufficient information to confirm diagnosis and treatment plan.

(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 oral hygiene and flossing ability in the member's records. Pulpal debridement may be performed for the relief of pain while waiting for the decision from the ~~OHCA~~Oklahoma Health Care Authority (OHCA) on request for endodontics.

(A) **Anterior endodontics.** Prior authorization is required for members who have a treatment plan requiring more than two (2) anterior root canals. All rampant, active caries ~~must~~should be removed prior to requesting anterior endodontics. Payment is made for services provided in accordance with the following:

(i) Permanent teeth only~~.~~;

(ii) Accepted ADA materials must be used~~.~~;

(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 ~~24~~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~~.~~; and

(vi) An endodontic procedure may not be approved if the tooth requires a post and core to retain a crown.

(B) **Posterior endodontics.** The guidelines for this procedure are as follows:

(i) The provider must document the member's oral hygiene and flossing ability in the member's records.

(ii) Teeth that require pre-fabricated post and cores to retain a restoration due to lack of natural tooth

structure should not be treatment planned for root canal therapy.

(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 ~~24~~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 there is a poor crown to root ratio or weakened root furcation area. Approval of second molars is contingent upon proof of medical necessity.

(vi) Only ADA accepted materials are acceptable under the OHCA policy.

(vii) Posterior endodontic procedure may not be approved if the tooth requires a post and core in order to present adequate structure to retain a crown.

(viii) Endodontics will not be considered if:

(I) ~~an~~An opposing tooth has super erupted;

(II) ~~loss~~Loss of tooth space is one third or greater;

(III) ~~opposing~~Opposing second molars are involved unless prior authorized; ~~or~~

(IV) ~~the~~The member has multiple teeth failing due to previous inadequate root canal therapy or follow-up; or

(V) ~~all~~All rampant, active caries must be removed prior to requesting posterior endodontics.

(ix) 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 ~~16~~sixteen (16) years of age or older and adults residing in private ~~Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)~~ICF/IID and who have been approved for ~~(ICF/IID)~~ICF/IID level of care. 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~~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 ~~(A)~~(iv) ~~of this paragraph~~ should 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. Non authorized restorative codes may be used if available.

(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) The provider must document the member's oral hygiene and flossing ability in the member's records including improved oral hygiene for at least twelve (12) months.

~~(F)~~(G) Provider is responsible for replacement or repair of all crowns if failure is caused by poor laboratory processes or procedure by provider for ~~48~~forty-eight (48) months post insertion.

(3) **Cast frame partial dentures.** 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 ~~16~~sixteen (16) through ~~20~~twenty (20) years of age. Provider must indicate which teeth will be replaced. Members must have improved oral hygiene documented for at least ~~12~~twelve (12) months in the provider's records and submitted with prior authorization request to be considered. Provider is responsible for any needed follow up for a period of two (2) years post insertion.

(4) **Acrylic partial.** This appliance is the treatment of choice for replacement of three (3) or more missing teeth in the same arch for members ~~12~~twelve (12) through ~~16~~sixteen (16) years of age. Provider must indicate tooth numbers to be replaced. This appliance includes all necessary clasps and rests.

(5) **Occlusal guard.** Narrative of medical necessity must be sent with prior authorization. Model should not be made or sent unless requested.

(6) **Fixed cast non-precious metal or porcelain/metal bridges.** Only members ~~17~~seventeen (17) through ~~20~~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 ~~18~~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.

(7) **Periodontal scaling and root planing.** Procedure is designed for the removal of calculus or tissue that is contaminated and ~~requires~~may require anesthesia and some soft tissue removal. This procedure requires that each tooth have three (3) or more of the six point measurements five (5) millimeters or greater, ~~or~~and have multiple areas of image supported bone loss, subgingival calculus and must involve two (2) or more teeth per quadrant for consideration. ~~This procedure is not allowed on members under the age 12.~~ This procedure is not allowed in conjunction with any other periodontal surgery.

**317:30-5-700. Orthodontic services**

(a) In order to be eligible for SoonerCare ~~Orthodontic~~orthodontic services, members must be referred through a primary care dentist using the DEN-2 form found on the Oklahoma Health Care Authority (OHCA) website; a member can receive a referral from a primary care dentist to the orthodontist only after meeting the following:

(1) ~~the~~The member has had a caries free initial visit; or

(2) ~~has~~Has all decayed areas restored and has remained caries free for twelve 12 months; and

(3) ~~has~~Has demonstrated competency in maintaining an appropriate level of oral hygiene.

(b) Member with cleft palate can be referred directly by their treating physician without a dental referral and are exempt from above requirements.

(c) The ~~Oklahoma~~ SoonerCare Orthodontic Program limits orthodontic services to handicapping malocclusions determined to be severe enough to warrant medically necessary treatment. The orthodontic provider has the ability to determine if members may qualify with a visual screening. Diagnostic record accumulation and/or submission should only occur for members with high potential for acceptance. These orthodontic services include the following:

(1) ~~a~~A handicapping malocclusion, as measured on the ~~Handicapping Labio-Lingual Deviation Index (HLD)~~Oklahoma Health Care Authority (OHCA) Handicapping Labio-Lingual Deviation Index of Malocclusion (DEN-6) form, with a minimum score of ~~30~~thirty (30);

(2) ~~any~~Any classification secondary to cleft palate or other maxillofacial deformity;

(3) ~~if~~If a single tooth or anterior crossbite is the only medical need finding, service will be limited to interceptive treatment;

(4) ~~fixed~~Fixed appliances only; and

(5) ~~permanent~~Permanent dentition with the exception of cleft defects.

(d) Reimbursement for ~~Orthodontic~~orthodontic services is limited to:

(1) Orthodontists, or

(2) General or Pediatric dental practitioners who have completed at least ~~200~~two-hundred (200) certified hours of continuing

education in the field of orthodontics practice and submit for review at least ~~25~~twenty-five successfully completed comprehensive cases. Of these ~~25~~twenty-five comprehensive cases, ten or more must be extraction cases. An applicant for this certification must practice in an OHCA deemed under-served area. The comprehensive cases submitted should be of a complexity consistent with type of handicapping malocclusion likely to be treated in the SoonerCare program.

(A) Cases submitted must include at least one (1) of each of the following types:

(i) ~~deep~~Deep overbite where multiple teeth are impinging upon the soft tissue of the palate;

(ii) ~~impacted~~Impacted canine or molar requiring surgical exposure;

(iii) ~~bilateral~~Bilateral posterior crossbite requiring fixed rapid palatal expansion; and

(iv) ~~skeletal~~Skeletal class II or III requiring orthognathic surgery.

(B) As with all dental or orthodontia treatment performed and reimbursed by SoonerCare, all pre and post orthodontic records must be available for review.

(C) The OHCA requires all general dentists providing comprehensive orthodontic care to submit a copy of the Oklahoma Board of Dentistry continuing education report and verification that at least ~~20~~twenty (20) continuing education hours in the field of orthodontics has been completed per reporting period. All verification reports must be submitted to OHCA Dental ~~unit~~Unit every three (3) years, no later than August 30. In addition, verification of adequate progress for all active orthodontic cases will be reviewed by the OHCA Dental Unit upon completion of ~~24~~twenty-four (24) months of therapy.

(e) The following limitations apply to orthodontic services:

(1) Cosmetic orthodontic services are not a covered benefit of the SoonerCare ~~Program~~program and no requests should be submitted;

(2) All orthodontic procedures require prior authorization for payment;

(3) Prior authorization for orthodontic treatment is not a notification of the member's eligibility and does not guarantee payment. Payment for authorized services depends on the member's eligibility at the beginning of each treatment year. Treatment year is determined by date of banding; and

(4) The member must be SoonerCare-eligible and under ~~18~~eighteen (18) years of age at the time the request for prior authorization for treatment is received by the OHCA. Services cannot be added or approved after eligibility has expired. It is the orthodontist's responsibility to verify that the member has current SoonerCare eligibility and the date of birth indicates the member is under age ~~18~~eighteen (18).

(f) Orthodontic services are an elective procedure. The orthodontist must interview the prospective member as to his/her understanding of and willingness to cooperate fully in a lengthy treatment program.
(g) The interview information is unavailable to OHCA except through the provider's recommendation of treatment. The interview process for OHCA members is equivalent to that of private pay patients.
(h) Providers are not obligated to accept a member when it appears that the member will not cooperate in the orthodontic hygiene treatment program, does not return to the general dentist for preventive visits or is not willing to keep eligibility for SoonerCare current.

**317:30-5-700.1. Orthodontic prior authorization**

(a) The following records and documentation, plainly labeled with the member's full name, recipient identification number (RID), and the orthodontist's name are required for prior authorization of orthodontic services and must be submitted to the Dental Unit of the ~~OHCA~~Oklahoma Health Care Authority (OHCA) Dental Program when the member has a total score of not less than ~~30~~thirty (30) points or meets other eligibility criteria in paragraph (d).

(1) Completed currently approved ~~ADA~~American Dental Association (ADA) dental claim form;

(2) Complete and scored Handicapping Labio-Lingual ~~Deviations~~Deviation (HDL) Index with Diagnosis of Angle's classification;

(3) Detailed description of any oral maxillofacial anomaly;

(4) Estimated length of treatment;

(5) Intraoral photographs showing teeth in centric occlusion and/or photographs of trimmed anatomically occluded diagnostic casts. A lingual view of casts may be included to verify impinging overbites;

(6) Cephalometric images with tracing, and panoramic film, with a request for prior authorization of comprehensive orthodontic treatment;

(7) Completed OHCA caries risk assessment form;

~~(7)~~(8) If diagnosed as a surgical case, submit an oral surgeon's written opinion that orthognathic surgery is indicated and the surgeon is willing to provide this service; and

~~(8)~~(9) Additional pertinent information as determined necessary by the orthodontist or as requested by the OHCA.

(b) All images and required documentation must be submitted in one (1) package. OHCA is not responsible for lost or damaged materials.
(c) All records and documentation submitted in a request for prior authorization for orthodontic treatment are reviewed by the OHCA ~~Orthodontic Consultant~~orthodontic consultant for compensability and length of treatment. Any documentation on which a decision is made will not be returned.
(d) Some children not receiving a minimum score of ~~30~~thirty (30) on the ~~Handicapping Labio-Lingual Deviation Index (HLD)~~HDL Index may

have other conditions to be considered. In the event an orthodontist believes there are other medical, social, or emotional conditions impacting the general health of the child, he/she refers to the conditions listed on the Early and Periodic Screening, ~~Diagnosis~~Diagnostic and Treatment (EPSDT) exception section found on the HLD. The following guidelines and restrictions apply to other conditions:

(1) Other medical, social, or emotional conditions are limited to those conditions that affect the medical, social or emotional function of the child~~.~~;

(2) Other medical, social, or emotional conditions are not scored if the sole condition sought to be improved is the cosmetic appearance of the child~~.~~;

(3) Such other medical, social, or emotional conditions must be demonstrated by objective evidence such as supported documentation outside the child's immediate family (e.g., a child's teacher, primary care physician, behavioral health provider, school counselor)~~.~~;

(4) Objective evidence must be submitted with the HLD~~.~~;

(5) When such other medical, social, or emotional conditions are reflected on the HLD, the OHCA ~~Orthodontic Consultant~~orthodontic consultant must review the data and use his or her professional judgment to score the value of the conditions~~.~~; and

(6) The OHCA ~~Orthodontic Consultant~~orthodontic consultant may consult with and utilize the opinion of the orthodontist who completes the form.

(e) If it is determined that the malocclusion is not severe enough to warrant medically necessary orthodontic services or the member's age precludes approval, a computer generated notice is issued to the provider and member with notice of the denial, the reason for the denial, and appeal rights ~~(see OAC 317:2-1 for grievance procedures and process)~~[see Oklahoma Administrative Code (OAC) 317:2-1 for grievance procedures and processes].

(f) Orthodontic treatment and payment for the services are approved within the scope of the SoonerCare program. If orthodontic treatment is approved, a computer generated notice is issued authorizing the first year of treatment.

(1) Approval of orthodontic treatment is given in accordance with the following:

(A) Authorization for the first year begins on the date of banding and includes the placement of appliances, arch wires, and a minimum of six (6) adjustments. It is expected that orthodontic members be seen every four (4) to eight (8) weeks for the duration of active treatment.

(B) Subsequent adjustments will be authorized in one (1) year intervals and the treating orthodontist must provide a comprehensive progress report at the ~~24~~twenty-four (24) month interval.

(C) All approved treatment is included on the original prior authorization and will include the total payment for that

treatment year.

(2) Claim and payment are made as follows:

(A) Payment for comprehensive treatment includes the banding, wires, adjustments as well as all ancillary services, including the removal of appliances, and the construction and placing of retainers.

(B) Payment is not made for comprehensive treatment beyond ~~36~~thirty-six (36) months.

(g) If the member moves from the geographic area or shows a need to change their provider, then the provider who received the yearly payment is financially responsible until completion of that member's orthodontic treatment for the current year.

(h) If the provider who received yearly payment does not agree to be financially responsible, then the ~~Oklahoma Health Care Authority will~~OHCA may recoup funds paid for the member's orthodontic treatment.

(i) All orthodontic services are subject to post-utilization review. This review may include a request by the OHCA to submit medical documentation necessary to complete the review. After review is completed, these materials are returned to the orthodontist.

(j) Study models or oral/facial images must be diagnostic and meet the following requirements:

(1) Study models must be properly poured and adequately trimmed without large voids or positive bubbles present.

(2) Centric occlusion must be clearly indicated by pencil lines on the study models, making it possible to occlude the teeth on the models in centric occlusion.

(3) 3-D model images are preferred.

(4) All measurements are made or judged on the basis of greater than or more than the minimal criteria. Measurement, counting, recording, or consideration is performed only on teeth that have erupted and may be seen on the study models.

(5) For photographic images, the oral/facial portfolio must show a view of the complete lower arch, complete upper arch, and left and right maximum intercuspation of teeth.

(A) Maximum intercuspation refers to the occlusal position of the mandible in which the cusps of the teeth of both arches fully interpose themselves with the cusps of the teeth of the opposing arch.

(B) Intercuspation defines both the anterior-posterior and lateral relationships of the mandible and the maxilla, as well as the superior-inferior relationship known as the vertical dimension of occlusion.

**317:30-5-704. Billing instructions**

(a) **HCPCS Codes.** The Oklahoma Health Care Authority (OHCA) utilizes the Medicare Level II ~~HCPCS Codes~~Healthcare Common

Procedure Coding System (HCPCS) codes. All claim submissions must be in compliance with this coding system.
(b) **Prior authorization.** Where applicable, the appropriate arch, quadrant, or tooth surface and tooth number must be included on the claim. Diagnosis codes are requested to be listed in box 34 of ~~ADA~~the current American Dental Association (ADA) dental claim form ~~2012~~. For mailed prior authorizations, a completed HCA-13D form is required.
(c) **Images.** Any type of film or prints submitted will not be returned. All images must be dated, mounted and have patient's name, recipient identification number (RID), provider name and provider number.

**317:30-5-705. Billing**

Billing for dental services may be submitted on the currently approved version of the American Dental Association (ADA) claim form. Diagnosis codes are requested to be listed in box 34 of the current ADA dental claim form ~~2012~~. Electronic submission must be made on the HIPPA compliant Form 837D.

**Oklahoma Health Care Authority Board Meeting – Drug Summary**

Drug Utilization Review Board Meeting – February 2020

| Recommendation/ Vote | Drug | Used for | Cost* | Notes |
|---|---|---|---|---|
| 1 | Duaklir® Pressair® | • Chronic Obstructive Pulmonary Disease (COPD) | • $11,940.00 per year | • Cheaper alternatives available |
| 2 | Scensesse®<br><br>Givlaari™ | • Erythropoietic Protoporphyria (EPP)<br><br>• Acute Hepatic Porphyria (AHP) | • NA<br><br>• $39,000 per month | • Increase pain free light exposure<br><br>• Decreases neurotoxic intermediates associated with attacks and other disease manifestations |
| 3 | Ultomiris® | • Paroxysmal Nocturnal Hemoglobinuria (PNH) | • $70,445.10 per 8 weeks | • Prevents blood clots from forming in small blood vessels |
| 4 | Korlym® | • Cushing's Syndrome | • $59,8880 per 30 days | • Hyperglycemia secondary to hypercortisolism of Cushing's |
| 5 | Ruzurgi® | • Lambert-Eaton Myasthenic Syndrome (LEMS) | • $19,200 per 30 days | • |

*Costs do not reflect rebated prices or net costs. Costs based on National Average Drug Acquisition Costs (NADAC) or Wholesale Acquisition Costs (WAC) if NADAC unavailable. N/A = not available at the time of publication.

## Recommendation 1: Vote to Prior Authorize Duaklir® Pressair®

The Drug Utilization Review Board recommends the prior authorization of Duaklir® Pressair® with the following criteria:

**Duaklir® Pressair® (Aclidinium Bromide/Formoterol Fumarate) Approval Criteria:**

1. Member must be 18 years of age or older; and
2. An FDA approved diagnosis of chronic obstructive pulmonary disease (COPD); and
3. A patient-specific, clinically significant reason why the member cannot use Tier-1 long-acting beta$_2$ agonist (LABA) and long-acting muscarinic antagonist (LAMA) individual components must be provided.

## Recommendation 2: Vote to Prior Authorize Scensesse® and Givlaari™

The Drug Utilization Review Board recommends the prior authorization of Scensesse® and Givlaari™ with the following criteria:

**Scenesse® (Afamelanotide) Approval Criteria:**

1. An FDA approved indication to increase pain-free light exposure in adult patients with a history of phototoxic reactions from erythropoietic protoporphyria (EPP); and
   a. The diagnosis of EPP must be confirmed by genetic testing; and
2. Member must be 18 years of age or older; and
3. Scenesse® must be administered by a health care professional who is proficient in the subcutaneous (subQ) implantation procedure and has completed the training program provided by the manufacturer prior to administration of the Scenesse® implant; and
   a. Scenesse® must be shipped via cold chain supply shipping and delivery to the health care setting where the member is scheduled to receive the implant administration; and
   b. Scenesse® must be stored under refrigeration (36 to 46°F) and protected from light prior to implantation; and
4. The Scenesse® implant should be inserted using an SFM Implantation Cannula or other implantation device that has been determined by the manufacturer to be suitable for implantation of Scenesse®; and
5. The prescriber must agree that the member will be monitored by a health care provider for at least 30 minutes after the implant administration; and
6. The prescriber must agree that the member will have a full body skin examination performed at least twice yearly while the member is being treated with Scenesse® to monitor pre-existing and new skin pigmentary lesions; and
7. Documentation that member will maintain sun and light protection measures during treatment with Scenesse® to prevent phototoxic reactions related to EPP; and
8. A quantity limit of 1 implant per 60 days will apply. Initial approvals will be for 2 implants for the duration of 4 months. Further approval may be granted if the prescriber documents that the member is responding well to treatment as indicated by increased tolerance of sunlight (i.e., less phototoxic reactions).

**Givlaari™ (Givosiran) Approval Criteria:**

1. An FDA approved diagnosis of acute hepatic porphyria (AHP) confirmed by:

   a. Genetic testing; or
   b. Elevated urinary porphobilinogen (PBG) and signs/symptoms of AHP; and
2. Member must be 18 years of age or older; and
3. Givlaari™ must be administered in a health care setting by a health care professional prepared to manage anaphylaxis; and
   a. Givlaari™ must be shipped to the health care setting where the member is scheduled to receive treatment; and
4. The prescriber must agree to monitor liver function tests prior to initiating treatment with Givlaari™, every month during the first 6 months of treatment, and as clinically indicated thereafter; and
5. The prescriber must agree to monitor renal function during treatment with Givlaari™ as clinically indicated; and
6. Member must not be taking sensitive CYP1A2 or CYP2D6 substrates (e.g., caffeine, dextromethorphan, duloxetine, amitriptyline, olanzapine, fluoxetine, paroxetine, hydrocodone, tramadol) concomitantly with Givlaari™; and
7. The member's recent weight must be provided on the prior authorization request in order to authorize the appropriate amount of drug required according to package labeling; and
8. Initial approvals will be for the duration of 6 months. Further approval may be granted if the prescriber documents that the member is responding well to treatment as indicated by less porphyria attacks and that the members does not have elevated transaminase levels.

## Recommendation 3: Vote to Prior Authorize Ultomiris®

The Drug Utilization Review Board recommends the prior authorization of Ultomiris® with the following criteria:

**Ultomiris® (Ravulizumab) Approval Criteria [Paroxysmal Nocturnal Hemoglobinuria Diagnosis]:**

1. Member must have an established diagnosis of paroxysmal nocturnal hemoglobinuria via international classification of disease (ICD) coding in member's medical claims history; and
2. An age restriction of 18 years and older will apply.

**Ultomiris® (Ravulizumab) Approval Criteria [Atypical Hemolytic Uremic Syndrome (aHUS) Diagnosis]:**

1. Member must have a documented diagnosis of aHUS.

## Recommendation 4: Vote to Prior Authorize Korlym®

The Drug Utilization Review Board recommends the prior authorization of Korlym® with the following criteria:

**Korlym® (Mifepristone) Approval Criteria:**

1. An FDA approved indication to control hyperglycemia secondary to hypercortisolism in adult patients with endogenous Cushing's syndrome who have type 2 diabetes mellitus (T2DM) or glucose intolerance; and
2. Member must have failed surgery intended to correct the cause of endogenous Cushing's syndrome or not be a candidate for surgery that is expected to correct the cause of endogenous Cushing's syndrome; and
3. Member must be 18 years of age or older; and
4. Korlym® must be prescribed by, or in consultation with, an endocrinologist (or be an advanced care practitioner with a supervising physician who is an endocrinologist); and
5. Female members must not be pregnant and must have a negative pregnancy test prior to initiation of therapy; and
6. Female members of reproductive potential must use a non-hormonal medically acceptable method of contraception (unless member has had a surgical sterilization) during treatment with Korlym® and for at least 1 month after discontinuing treatment; and
7. Member must not have any contraindications to taking Korlym® including the following:
    a. Taking drugs metabolized by CYP3A such as simvastatin, lovastatin, and CYP3A substrates with narrow therapeutic ranges, such as cyclosporine, dihydroergotamine, ergotamine, fentanyl, pimozide, quinidine, sirolimus, and tacrolimus; and
    b. Receiving systemic corticosteroids for lifesaving purposes (e.g., immunosuppression after organ transplantation); and
    c. Female members must not have a history of unexplained vaginal bleeding or endometrial hyperplasia with atypia or endometrial carcinoma; and
    d. Known hypersensitivity to mifepristone or to any of the product components; and
8. Authorizations will be for the duration of 12 months; and
9. Reauthorization may be granted if the prescriber documents the member is responding well to treatment.

## Recommendation 5: Vote to Prior Authorize Ruzurgi®

The Drug Utilization Review Board recommends the prior authorization of Korlym® with the following criteria:

**Ruzurgi® (Amifampridine) Approval Criteria:**

1. An FDA approved diagnosis of Lambert-Eaton myasthenic syndrome (LEMS); and
2. LEMS diagnosis must be confirmed by 1 of the following:
    a. A high titer anti-P/Q-type voltage-gated calcium channel (VGCC) antibody assay; or
    b. A confirmatory electrodiagnostic study [e.g., repetitive nerve stimulation (RNS), needle electromyography (EMG), single-fiber electromyography (SFEMG)]; and
3. The requested medication must be prescribed by, or in consultation with, a neurologist or oncologist; and
4. Member must not have a history of seizures or be taking medications that lower the seizure threshold (e.g., bupropion, tramadol, amphetamines, theophylline); and

5. A quantity limit of 300 tablets per 30 days will apply; and
6. Initial approvals will be for 6 months. Continued authorization will require the prescriber to indicate that the member is responding well to treatment and continues to require treatment with the requested medication.