Rules Agenda
December 11, 2008

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

Page 2 A. Revising SoonerCare eligibility rules to allow time-limited coverage for Iraqis and Afghans with special immigrant status pursuant to Public Law 110-161 and 110-181. **(Reference APA WF # 08-44)**

Page 12 B. Revising ADvantage Waiver Services rules to add private duty nursing as a compensable service under the waiver program. **(Reference APA WF # 08-45)**

Page 28 C. Revising Outpatient Hospital and Free-Standing Ambulatory Surgery Center rules to reflect upcoming changes to the reimbursement methodology for outpatient surgery services. **(Reference APA WF # 08-47)**

Page 36 D. Revising Personal Care rules to transfer the responsibility for the authorization of service units and monitoring of service provisions from OKDHS nurses to agency provider nurses. **(Reference APA WF # 08-22)**

Page 56 E. Revising rules to require the use of the new Interactive Voice Response Authentication (IVRA) time and attendance system for providers of Personal Care and certain in-home ADvantage services. **(Reference APA WF # 08-29 A and B)**

Page 61 F. Revising Non-Emergency Transportation rules to remove specific reimbursement language from policy and refer to the state plan. **(Reference APA WF # 08-49)**

Page 63 G. Revising Dental rules to: (1) allow prior authorization for a second set of panoramic films taken within three years of the first set; (2) allow prior authorization for a second provider to correct poorly rendered restorative procedures by the original provider of services; and (3) restrict the application of ceramic based and cast metal crowns to natural teeth only. **(Reference APA WF # 08-41)**

Page 76 H. Revising grievance Procedures and Process rules to reflect current practice for provider appeals. **(Reference APA WF # 08-40)**

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

A. **CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY**
Subchapter 5. Eligibility and Countable Income
Part 3. Non-Medical Eligibility Requirements
OAC 317:35-5-25. [AMENDED]
(Reference APA WF # 08-44)

FINDING OF EMERGENCY: The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to comply with Public Laws 110-181 and 110-161 regarding SoonerCare eligibility treatment of Iraqis and Afghans with special immigrant status. These individuals with Special Immigrant status are Iraqis or Afghans who were employed by the U.S. military as translators or provided faithful and valuable service for or on behalf of the U.S. government for at least one year and have experienced or are likely to experience a serious threat as a consequence of that employment. Rule revisions are needed to assure that eligible individuals receive the SoonerCare benefits they are entitled to receive.

SUMMARY: SoonerCare rules regarding citizenship are revised to include Iraqis and Afghans with special immigrant status as qualified aliens. Iraqi and Afghan Special Immigrants are a relatively new category of special immigrants, created by Public Law 109-163. Each Federal fiscal year, a certain number of Iraqis and Afghans and their families who were employed by the U.S. military as translators and meet other requirements, may be granted Iraqi or Afghan Special Immigrant Status under section 101(a)(27) of the Immigration and Nationality Act (INA). Public Law 110-161 allows six months of eligibility for Afghan special immigrants and Public Law 110-181 allows eight months of eligibility for Iraqi special immigrants. All other eligibility requirements must be met in order to qualify for SoonerCare services during this time-limited period. After this time-limited period of eligibility, Iraqi and Afghan special immigrants will lose eligibility for SoonerCare services until they meet the 5-year bar or otherwise meet the citizenship or alien eligibility criteria.

BUDGET IMPACT: Agency staff has determined that the revisions are budget neutral to the agency.

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

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on November 20, 2008, and recommended Board approval.

PROPOSED EFFECTIVE DATE: February 1, 2009

AUTHORITY: The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Public Law 109-163; Public Law 110-181; Public Law 110-161

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
Eligibility rules are revised to allow time-limited coverage for Iraqis and Afghans with special immigrant status pursuant to Public Law 110-161 and 110-181.

CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME
PART 3. NON-MEDICAL ELIGIBILITY REQUIREMENTS

317:35-5-25. Citizenship/alien status and identity verification requirements

(a) **Citizenship/alien status and identity verification requirements.** Verification of citizenship/alien status and identity are required for all adults and children approved for Medicaid.

(1) The types of acceptable evidence that verify identity and citizenship include:

(A) United States (U.S.) Passport;

(B) Certificate of Naturalization issued by U.S. Citizenship & Immigration Services (USCIS) (Form N-550 or N-570);

(C) Certificate of Citizenship issued by USCIS (Form N-560 or N-561);

(D) Copy of the Medicare card or printout of a BENDEX or SDX screen showing receipt of Medicare benefits, Supplemental Security Income or disability benefits from the Social Security Administration; or

(E) Tribal membership card or Certificate of Degree of Indian Blood (CDIB) card, with a photograph of the individual~~, for Native Americans~~.

(2) The types of acceptable evidence that verify citizenship but require additional steps to obtain satisfactory evidence of identity are listed in subparagraphs (A) and (B). Subparagraph (A) lists the most reliable forms of verification and is to be used before using items listed in (B). Subparagraph (B) lists those verifications that are less reliable forms of verification and are used only when the items in (A) are not attainable.

(A) Most reliable forms of citizenship verification are:

(i) A U.S. public Birth Certificate showing birth in one of the 50 states, the District of Columbia, Puerto Rico (on or after 1/13/1941), Guam (on or after 4/10/1899), the U.S. Virgin Islands (on or after 1/17/1917), American Samoa, Swain's Island, or the Northern Mariana Islands after 11/4/1986;

(ii) A Report of Birth Abroad of a U.S. citizen issued by the Department of Homeland Security or a Certification of birth issued by the State Department (Form FS-240, FS-545 or DS-1350);

(iii) A U.S. Citizen ID Card (Form I-179 or I-197);

(iv) A Northern Mariana Identification Card (Form I-873) (Issued by the INS to a collectively naturalized citizen of the U.S. who was born in the Northern Mariana Islands before 11/3/1986);

(v) An American Indian Card issued by the Department of Homeland Security with the classification code "KIC" (Form I-872);

(vi) A Final Adoption Decree showing the child's name and U. S. place of birth;

(vii) Evidence of U.S. Civil Service employment before 6/1/1976;

(viii) An Official U.S. Military Record of Service showing a U.S. place of birth (for example a DD-214);

(ix) Tribal membership card or Certificate of Degree of Indian Blood (CDIB) card, without a photograph of the individual, for Native Americans;

(x) Oklahoma Voter Registration Card; or

(xi) Other acceptable documentation as approved by OHCA.

(B) Other less reliable forms of citizenship verification are:

(i) An extract of a hospital record on hospital letterhead established at the time of the person's birth that was created five years before the initial application date and that indicates a U.S. place of birth. For children under 16 the evidence must have been created near the time of birth or five years before the date of application;

(ii) Life, health, or other insurance record showing a U.S. place of birth that was created at least five years before the initial application date and that indicates a

U.S. place of birth;

(iii) Federal or State census record showing U.S. citizenship or a U.S. place of birth (generally for persons born 1900 through 1950). The census record must also show the applicant's/member's age; or

(iv) One of the following items that show a U.S. place of birth and was created at least five years before the application for Medicaid. This evidence must be one of the following and show a U.S. place of birth:

(I) Seneca Indian tribal census record;

(II) Bureau of Indian Affairs tribal census records of the Navajo Indians;

(III) U.S. State Vital Statistics official notification of birth registration;

(IV) An amended U.S. public birth record that is amended more than five years after the person's birth; or

(V) Statement signed by the physician or midwife who was in attendance at the time of birth.

(3) Acceptable evidence of identity that must accompany citizenship evidence listed in (A) and (B) of paragraph (2) of this subsection includes:

(A) A driver's license issued by a U.S. state or territory with either a photograph of the individual or other identifying information such as name, age, sex, race, height, weight, or eye color;

(B) A school identification card with a photograph of the individual;

(C) An identification card issued by Federal, state, or local government with the same information included on driver's licenses;

(D) A U.S. military card or draft record;

(E) A U.S. military dependent's identification card;

(F) A Native American Tribal document including Certificate of Degree of Indian Blood, or other U.S. American Indian/Alaska Native Tribal document with a photograph of the individual or other personal identifying information;

(G) A U.S. Coast Guard Merchant Mariner card;

(H) A state court order placing a child in custody as reported by the OKDHS;

(I) For children under 16, school records may include nursery or daycare records;

(J) If none of the verification items on the list are available, an affidavit may be used for children under 16. An affidavit is only acceptable if it is signed under penalty of perjury by a parent or guardian stating the date and place of the birth of the child and **cannot be used if an affidavit for citizenship was provided.**

(b) **Centralized Verification Unit.**

(1) When the applicant/member is unable to obtain citizenship verification, a reasonable opportunity is afforded the applicant/member to obtain the evidence as well as assistance in doing so. A reasonable opportunity is afforded the applicant/member before taking action affecting the individual's eligibility for Medicaid. The reasonable opportunity time frame usually consists of 60 days. In rare instances, the CVU may extend the time frame to a period not to exceed an additional 60 days.

(2) Additional methods of verification are available to the CVU. These methods are the least reliable forms of verification and should only be used as a last resort:

(A) Institutional admission papers from a nursing facility, skilled care facility or other institution. Admission papers generally show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth;

(B) Medical (clinic, doctor, or hospital) record created at least five years before the initial application date that indicates a U.S. place of birth. For children under 16, the document must have been created near the time of birth. Medical records generally show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth. An immunization record is not considered a medical record for purposes of establishing U.S. citizenship;

(C) Written affidavit. Affidavits are only used in rare circumstances. If the verification requirements need to be met through affidavits, the following rules apply:

(i) There must be at least two affidavits by two individuals who have personal knowledge of the event(s) establishing the applicant's/member's claim of citizenship;

(ii) At least one of the individuals making the affidavit cannot be related to the applicant/member;

(iii) In order for the affidavit to be acceptable the persons making them must be able to provide proof of their own citizenship and identity;

(iv) If the individual(s) making the affidavit has information which explains why evidence establishing the applicant's/member's claim or citizenship does not exist or cannot be readily obtained, the affidavit must contain this information as well;

(v) The State must obtain a separate affidavit from the applicant/member or other knowledgeable individual (guardian or representative) explaining why the evidence does not exist or cannot be obtained; and

(vi) The affidavits must be signed under penalty of perjury.

(c) **Alienage verification requirements**. Medicaid services are provided as listed to the defined groups as indicated in this subsection if they meet all other factors of eligibility.

(1) **Eligible aliens (qualified aliens).** The groups listed in the following subparagraphs are eligible for the full range of Medicaid services. A qualified alien is:

(A) an alien who was admitted to the United States and has resided in the United States for a period greater than five years from the date of entry and who was:

(i) lawfully admitted for permanent residence under the Immigration and Nationality Act;

(ii) paroled into the United States under Section 212(d)(5) of such Act for a period of at least one year;

(iii) granted conditional entry pursuant to Section 203(a)(7) of such Act as in effect prior to April 1, 1980; or

(iv) a battered spouse, battered child, or parent or child of a battered person with a petition under 204(a)(1)(A) or (B) or 244(a)(3) of the Immigration and Naturalization Act.

(B) an alien who was admitted to the United States and who was:

(i) granted asylum under Section 208 of such Act regardless of the date asylum is granted;

(ii) a refugee admitted to the United States under Section 207 of such Act regardless of the date admitted;

(iii) an alien with deportation withheld under Section 243(h) of such Act regardless of the date deportation was withheld;

(iv) a Cuban or Haitian entrant as defined in Section 501(e) of the Refugee Education Assistance Act of 1980, regardless of the date of entry;

(v) an alien who is a veteran as defined in 38 U.S.C. ' 101, with a discharge characterized as an honorable discharge and not on the grounds of alienage;

(vi) an alien who is on active duty, other than active duty for training, in the Armed Forces of the United States;

(vii) the spouse or unmarried dependent child of an individual described in (C) of this paragraph.

(viii) a victim of a severe form of trafficking pursuant to Section 107(b) of the Trafficking Victims Protection Act of 2000; or

(ix) admitted as an Amerasian immigrant.

(C) permanent residents who first entered the country under (B) of this paragraph and who later converted to lawful

permanent residence status.

(2) **Other aliens lawfully admitted for permanent residence (non-qualified aliens).** Non-qualified aliens are those individuals who were admitted to the United States and who do not meet any of the definitions in paragraph (1) of this subsection. Non-qualified aliens are ineligible for Medicaid for five years from the date of entry except that non-qualified aliens are eligible for emergency services only when the individual has a medical condition (including emergency labor and delivery) with acute symptoms which may result in placing his/her health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of body organ or part without immediate medical attention. The only exception is when a pregnant woman qualifies under the pregnancy related benefits covered under the Title XXI program because the newborn child will meet the citizenship requirement at birth.

(3) **Afghan Special Immigrants.** Afghan special immigrants, as defined in Public Law 110-161, who have special immigration status after December 26, 2007, are exempt from the five year period of ineligibility for SoonerCare services for a time-limited period. The time-limited exemption period for Afghan special immigrants is six months from the date of entry into the United States as a special immigrant or the date of conversion to special immigrant status. All other eligibility requirements must be met to qualify for SoonerCare services. If these individuals do not meet one of the categorical relationships, they may apply and be determined eligible for Refugee Medical Assistance. Once the six month exemption period ends, Afghan special immigrants are no longer exempt from the five year bar for SoonerCare services and are only eligible for services described in (2) of this subsection until the five year period ends. Afghan special immigrants are considered lawful permanent residents.

(4) **Iraqi Special Immigrants.** Iraqi special immigrants, as defined in Public Law 110-181, who have special immigration status after January 28, 2008, are exempt from the five year period of ineligibility for SoonerCare services for a time-limited period. The time-limited exemption period for Iraqi special immigrants is eight months from the date of entry into the United States as a special immigrant or the date of conversion to special immigrant status. All other eligibility requirements must be met to qualify for SoonerCare services. If these individuals do not meet one of the categorical relationships, they may apply and be determined eligible for Refugee Medical Assistance. Once the eight month exemption period ends, Iraqi special immigrants are no longer exempt from the five year bar for SoonerCare services and are only eligible

for services described in (2) of this subsection until the five year period ends. Iraqi special immigrants are considered lawful permanent residents.

~~(3)~~ (5) **Undocumented aliens.** Undocumented aliens who do not meet any of the definitions in (1)-(2) of this subsection are eligible for emergency services only when the individual has a medical condition (including emergency labor and delivery) with acute symptoms which may result in placing his/her health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of body organ or part without immediate medical attention. The only exception is when a pregnant woman qualifies under the pregnancy related benefits covered under the Title XXI program because the newborn child will meet the citizenship requirement at birth.

~~(4)~~ (6) **Ineligible aliens.**

(A) Ineligible aliens who do not fall into the categories in (1) and (2) of this subsection, yet have been lawfully admitted for temporary or specified periods of time include, but are not limited to: foreign students, visitors, foreign government representatives, crewmen, members of foreign media and temporary workers including agricultural contract workers. This group is ineligible for Medicaid, including emergency services, because of the temporary nature of their admission status. The only exception is when a pregnant woman qualifies under the pregnancy related benefits covered under the Title XXI program because the newborn child will meet the citizenship requirement at birth.

(B) These individuals are generally issued Form I-94, Arrival Departure Record, on which an expiration date is entered. This form is not the same Form I-94 that is issued to persons who have been paroled into the United States. Parolees carry a Form I-94 that is titled "Arrival-Departure Record - Parole Edition". Two other forms that do not give the individual "Immigrant" status are Form I-186, Nonresident Alien Mexican Border Crossing Card, and Form SW-434, Mexican Border Visitors Permit.

~~(5)~~ (7) **Preauthorization.** Preauthorization is required for payment of emergency medical services rendered to non-qualified and undocumented aliens. Persons determined as having lawful alien status must have the status verified through Systematic Alien Verification for Entitlements (SAVE).

(d) **Alienage.** A decision regarding eligibility cannot be made until the eligibility condition of citizenship and alienage is determined.

(1) **Immigrants.** Aliens lawfully admitted for permanent residence in the United States are classified as immigrants by the BCIS. These are individuals who entered this country with

the express intention of residing here permanently.

(2) **Parolees.** Under Section 212(d)(5) of the Immigration and Nationality Act, individuals can be paroled into the United States for an indefinite or temporary period at the discretion of the United States Attorney General. Individuals admitted as Parolees are considered to meet the "citizenship and alienage" requirement.

(3) **Refugees and Western Hemisphere aliens.** Under Section 203(a)(7) of the Immigration and Nationality Act, Refugees and Western Hemisphere aliens may be lawfully admitted to the United States if, because of persecution or fear of prosecution due to race, religion, or political opinion, they have fled from a Communist or Communist-dominated country or from the area of the Middle East; or if they are refugees from natural catastrophes. These entries meet the citizenship and alienage requirement. Western Hemisphere aliens will meet the citizenship requirement for Medicaid if they can provide either of the documents in subparagraphs (A) and (B) of this paragraph as proof of their alien status.

(A) Form I-94 endorsed "Voluntary Departure Granted-Employment Authorized", or

(B) The following court-ordered notice sent by BCIS to each of those individuals permitted to remain in the United States: "Due to a Court Order in Silva vs. Levi, 76 C4268 entered by District Judge John F. Grady in the District Court for the Northern District of Illinois, we are taking no action on your case. This means that you are permitted to remain in the United States without threat of deportation or expulsion until further notice. Your employment in the United States is authorized".

(4) **Special provisions relating to Kickapoo Indians.** Kickapoo Indians migrating between Mexico and the United States carry Form I-94, Arrival-Departure Record (Parole Edition). If Form I-94 carries the statement that the Kickapoo is "paroled pursuant to Section 212(d)(5) of the Immigration and Nationality Act" or that the "Kickapoo status is pending clarification of status by Congress" regardless of whether such statements are preprinted or handwritten and regardless of a specific mention of the "treaty", they meet the "citizenship and alienage" requirement. All Kickapoo Indians paroled in the United States must renew their paroled status each year at any local Immigration Office. There are other Kickapoos who have entered the United States from Mexico who carry Form I-151 or Form I-551, Alien Registration Receipt Cards. These individuals have the same status as other individuals who have been issued Form I-151 or Form I-551 and therefore, meet the citizenship and alienage requirements. Still other Kickapoos are classified as Mexican Nationals by the BCIS. They carry Form I-94, Arrival-

Departure Record, which has been issued as a visiting visa and does not make mention of the treaty. Such form does not meet the "citizenship and alienage" requirements but provides only the ineligible alien status described in (c)(4)(b) of this Section.

(5) **American Indians born in Canada.** An American Indian born in Canada, who has maintained residence in the United States since entry, is considered to be lawfully admitted for permanent residence if he/she is of at least one-half American Indian blood. This does not include the non-citizen whose membership in an Indian tribe or family is created by adoption, unless such person is of at least 50 percent or more Indian blood. The methods of documentation are birth or baptismal certificate issued on a reservation, tribal records, letter from the Canadian Department of Indian Affairs, or school records.

(6) **Permanent non-immigrants.** Marshall Islanders and individuals from the Republic of Palau and the Federated States of Micronesia are classified as permanent non-immigrants by BCIS. They are eligible for emergency services only.

B. **CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**
Subchapter 5. Individual Providers and Specialties
Part 85. ADvantage Program Waiver Services
OAC 317:30-5-763. [AMENDED]
(Reference APA WF # 08-45)

FINDING OF EMERGENCY: The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to add private duty nursing as a compensable service under the ADvantage waiver program. Without this addition, some ADvantage members will not be able to have their needs met in their homes and will require unnecessary and more costly nursing facility placement.

SUMMARY: ADvantage Waiver Services rules are revised to add private duty nursing as a compensable service in order to better meet ADvantage members= needs in the home. The ADvantage Waiver program offers an array of home and community-based services to eligible members as an alternative to nursing facility care. Services available to the member through ADvantage are intended to meet the need for care and assistance. Currently, the ADvantage program only offers skilled nursing services. Some members, however, require private duty nursing services to supplement family provided services. The provision of private duty nursing services will work to prevent or postpone the nursing facility placement of the member.

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

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

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on November 20, 2008, and recommended Board approval.

PROPOSED EFFECTIVE DATE: February 1, 2009

AUTHORITY: The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR 440.80

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
ADvantage Waiver Services rules are revised to add private duty nursing as a compensable service under the waiver program.

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

317:30-5-763. Description of services

Services included in the ADvantage Program are as follows:

(1) **Case Management.**

(A) Case Management services are services that assist a member in gaining access to medical, social, educational or other services, regardless of payment source of services, that may benefit the member in maintaining health and safety. Case managers initiate and oversee necessary assessments and reassessments to establish or reestablish waiver program eligibility. Case managers develop the member's comprehensive plan of care, listing only services which are necessary to prevent institutionalization of the member, as determined through assessments. Case managers initiate the addition of necessary services or deletion of unnecessary services, as dictated by the member's condition and available support. Case managers monitor the member's condition to ensure delivery and appropriateness of services and initiate plan of care reviews. If a member requires hospital or nursing facility services, the case manager assists the member in accessing institutional care and, as appropriate, periodically monitors the member's progress during the institutional stay and helps the member transition from institution to home by updating the service plan and preparing services to start on the date the member is discharged from the institution. Case Managers must meet ADvantage Program minimum requirements for qualification and training prior to providing services to ADvantage members. Prior to providing services to members receiving Consumer-Directed Personal Assistance Services and Supports (CD-PASS), Case Managers are required to receive training and demonstrate knowledge regarding CD-PASS service delivery model, "Independent Living Philosophy" and demonstrate competency in Person-centered planning.

(B) Providers may only claim time for billable Case

Management activities described as follows:

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

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

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

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

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

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

(2) **Respite.**

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

the member. Units of services are limited to the number of units approved on the plan of care.

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

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

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

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

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

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

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

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

(4) **Environmental Modifications.**

(A) Environmental Modifications are physical adaptations to the home, required by the member's plan of care, which are

necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home and without which, the member would require institutionalization. Adaptations or improvements to the home which are not of direct medical or remedial benefit to the waiver member are excluded.

(B) All services require prior authorization.

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

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

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

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

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

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

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

(A) Nursing services are services listed in the plan of care which are within the scope of the Oklahoma Nursing Practice Act and are provided by a registered professional nurse, or

licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State. Nursing services includes skilled nursing and/or private duty nursing. Skilled nursing is provided on an intermittent or part-time basis. Private duty nursing is individual and continuous care provided to a participant at home by licensed nurses. The provision of the nursing service will work to prevent or postpone the institutionalization of the member. ~~(A)~~ (B) ~~Skilled~~ Nursing services are services of a maintenance or preventive nature provided to members with stable, chronic conditions. These services are not intended to ~~be treatment for~~ treat an acute health condition and may not include services which would be reimbursable under either Medicaid or Medicare's Home Health Program. This service primarily provides nurse supervision to the Personal Care Assistant or to the Advanced Supportive/Restorative Assistance Aide~~, assessment of~~ and assesses the member's health and ~~assessment of~~ prescribed medical services to ensure that they meet the member's needs as specified in the plan of care. A skilled nursing assessment/evaluation on-site visit is made to each member for whom Advanced Supportive/Restorative Assistance services are authorized to evaluate the condition of the member and medical appropriateness of services. An assessment/evaluation visit report will be made to the ADvantage Program case manager in accordance with review schedule determined in consultation between the Case Manager and the Skilled Nurse, to report the member's condition or other significant information concerning each advanced supportive/restorative care member.

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

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

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

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

(I) ~~filling~~ preparing a one-week supply of insulin syringes for a blind diabetic who can safely self-

inject the medication but cannot fill his/her own syringe. This service would include monitoring the member's continued ability to self-administer the insulin;

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

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

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

(V) providing consultation and education to the member, member's family and/or other informal caregivers identified in the service plan, regarding the nature of the member~~=~~s chronic condition. Provide skills training (including return skills demonstration to establish competency) to the member, family and/or other informal caregivers as specified in the service plan for preventive and rehabilitative care procedures ~~to the member, family and/or other informal caregivers as specified in the service plan~~.

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

(8) **Home Delivered Meals.**

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

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

(9) **Occupational Therapy services.**

(A) Occupational Therapy services are those services that increase functional independence by enhancing the development of adaptive skills and performance capacities of members with physical disabilities and related psychological and cognitive impairments. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Treatment involves the therapeutic use of self-care, work and play activities and may include modification of the tasks or environment to enable the member to achieve maximum independence, prevent further disability, and maintain health. Under a physician's order, a licensed occupational therapist evaluates the member's rehabilitation potential and develops an appropriate written therapeutic regimen. The regimen utilizes paraprofessional occupational therapy assistant services, within the limits of their practice, working under the supervision of the licensed occupational therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

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

(10) **Physical Therapy services.**

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

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

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

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

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

(12) **Respiratory Therapy Services.**

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

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

(13) **Hospice Services**.

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

care must be developed by the hospice team in conjunction with the member's ADvantage case manager before hospice services are provided. The hospice services must be related to the palliation or management of the member's terminal illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills. ADvantage Hospice may be provided to the member in a Nursing Facility (NF) only when the member is placed in the NF for ADvantage Facility Based Extended Respite. Hospice provided as part of Facility Based Extended Respite may not be reimbursed for more than five days during any 30 day period. A member that is eligible for Medicare Hospice provided as a Medicare Part A benefit, is not eligible to receive ADvantage Hospice services.

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

(14) **ADvantage Personal Care.**

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

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

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

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

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

be eligible to receive PERS service, the member must meet all of the following service criteria:

(i) a recent history of falls as a result of an existing medical condition that prevents the individual from getting up from a fall unassisted;

(ii) lives alone and has no regular caregiver, paid or unpaid, and therefore is left alone for long periods of time;

(iii) demonstrates capability to comprehend the purpose of and activate the PERS;

(iv) has a health and safety plan detailing the interventions beyond the PERS to assure the member's health and safety in his/her home;

(v) has a disease management plan to implement medical and health interventions that reduce the possibility of falls by managing the member's underlying medical condition causing the falls; and,

(vi) the service avoids premature or unnecessary institutionalization of the member.

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

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

(A) Consumer-Directed Personal Assistance Services and Supports are Personal Services Assistance and Advanced Personal Services Assistance that enable an individual in need of assistance to reside in their home and in the community of their choosing rather than in an institution and to carry out functions of daily living, self care, and mobility. CD-PASS services are delivered as authorized on the service plan. The member employs the Personal Services Assistant (PSA) and/or the Advanced Personal Services Assistant (APSA) and is responsible, with assistance from ADvantage Program Administrative Financial Management Services (FMS), for ensuring that the employment complies with State and Federal Labor Law requirements. The member may designate an adult family member or friend, an individual who is not a PSA or APSA to the member, as an "authorized representative" to assist in executing these employer functions. The member:

(i) recruits, hires and, as necessary, discharges the PSA or APSA;

(ii) provides instruction and training to the PSA or APSA on tasks to be done and works with the Consumer Directed Agent/Case Manager to obtain ADvantage skilled nursing services assistance with training when necessary. Prior

to performing an Advanced Personal Services Assistance task for the first time, the APSA must demonstrate competency in the tasks in an on-the-job training session conducted by the member and the member must document the attendant's competency in performing each task in the ASPA's personnel file;

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

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

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

(B) The service Personal Services Assistance may include:

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

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

(I) bathing and personal hygiene;

(II) dressing and grooming;

(III) eating including meal preparation and cleanup;

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

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

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

Advanced Personal Services Assistance includes assistance with health maintenance activities that may include:

(i) routine personal care for persons with ostomies (including tracheotomies, gastrostomies and colostomies with well-healed stoma) and external, ~~in dwelling~~ indwelling, and suprapubic catheters which includes changing bags and soap and water hygiene around ostomy or catheter site;

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

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

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

(v) use lift for transfers;

(vi) manually assist with oral medications;

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

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

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

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

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

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

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

(iv) providing to the member, as needed, assistance with employer related cognitive tasks, decision-making and specialized skills that may include assistance with Individual Budget Allocation planning and support for making decisions including training and providing

reference material and consultation regarding employee management tasks such as recruiting, hiring, training and supervising the member's Personal Services Assistant or Advanced Personal Services Assistant; and

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

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

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

(17) **Institution Transition Services.**

(A) Institution Transition Services are those services that are necessary to enable an individual to leave the institution and receive necessary support through ADvantage waiver services in their home and/or in the community.

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

(i) Institution Transition Case Management services are prior authorized and billed per 15-minute unit of service

using the appropriate HCPC and modifier associated with the location of residence of the member served as described in OAC 317:30-5-763(1)(C).

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

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

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

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

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

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

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

C. **CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**
Subchapter 5. Individual Providers and Specialties
Part 3. Hospitals
OAC 317:30-5-42.14. [AMENDED]
Part 63. Ambulatory Surgical Centers
OAC 317:30-5-565. through 30-5-567. [AMENDED]
(Reference APA WF # 08-47)

FINDING OF EMERGENCY: The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to reflect a new payment methodology for outpatient hospitals and free-standing ambulatory surgical centers. This payment methodology will more closely align with Medicare=s. Without this change, contracted SoonerCare outpatient surgery providers will continue to suffer an administrative burden in filing claims and necessary provider follow-up. Systems updates will continue to be a manual, labor-intensive process subject to normal human error. The coordination of benefits between OHCA and other third party payers will continue to be difficult.

SUMMARY: Agency rules are revised to reflect upcoming changes to the reimbursement methodology for outpatient surgery services. Currently, OHCA does not use the same methodology to process Ambulatory Surgical Center/Ambulatory Payment Classification (ASC/APC) claims as Medicare. OHCA currently pays for outpatient surgery under a Ahierarchical@ methodology that does not align with any other payer. This current methodology creates an administrative burden for facilities submitting claims and makes it difficult for OHCA to coordinate benefits with other payers. Beginning January 1, 2009, OHCA will no longer process outpatient surgery claims under a Ahierarchical@ payment methodology. This change in payment methodology will more closely align OHCA=s payment methodology with Medicare=s, thereby relieving the administrative burden on contracted SoonerCare outpatient surgery providers and facilitating the coordination of benefits between OHCA and other third party payers.

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

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

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee

considered the proposed rule revisions on November 20, 2008, and recommended Board approval.

PROPOSED EFFECTIVE DATE: Immediately upon Governor's approval.

AUTHORITY: The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR 440.20

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
Outpatient Hospital and Free-Standing Ambulatory Surgery Center rules are revised to reflect upcoming changes to the reimbursement methodology for outpatient surgery services.

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 3. HOSPITALS

317:30-5-42.14. Surgery and diagnostic services

~~(a) **Reimbursement.** Reimbursement is made for selected surgeries performed in an outpatient hospital. When an ambulatory surgery is performed in the inpatient hospital setting, the physician must provide exception rationale justifying the need for an inpatient setting to OHCA medical staff for review.~~

~~(b) **Ambulatory Surgery Center Groups.** The Medicare definition of covered Ambulatory Surgery Center (ASC) facility services includes services furnished on a outpatient basis in connection with a covered surgical procedure. This is a bundled payment that includes operating and recovery rooms, patient preparation areas, waiting rooms, and other areas used by the patient or offered for use to patients scheduled for surgical procedures. It includes all services and procedures in connection with covered procedures provided by facility personnel and others involved in patient care. These services do not include physician services, or other health services for which payment can be made under other OHCA medical program provisions (e.g., services of an independent laboratory located on the same site as the ASC, prosthetic devices other than intra ocular lenses (IOLs), anesthetist services, DME). (See OAC 317:30-5-565 for items separately billable.)~~

~~(c)~~ (a) **Ambulatory Patient Classification (APC) Groups.** ~~Certain surgical services filed with revenue code series 36X and 49X and that do not fall within an Ambulatory Patient Classification (ASC) group will pay a SoonerCare rate based on Medicare's APC groups.~~

~~This is not a bundled rate. Other lines on the claim may pay.~~ All outpatient hospital services paid under the Medicare Outpatient Prospective Payment System (OPPS) are classified into groups called Ambulatory Payment Classifications or APCs. Group services identified by Health Care Procedure Coding System (HCPCS) codes and descriptors within APC groups are the basis for setting payment rates under OPPS. Services in each APC are similar clinically and in terms of the resources they require. The payment rate calculated for an APC applies to all of the services assigned to the APC. Depending on the services provided, a hospital may receive a number of APC payments for the services furnished to a member on a single day.

(b) **Reimbursement.** Reimbursement is made for selected services performed in an outpatient hospital. Hospital outpatient services are paid on a rate-per-service basis that varies according to the Ambulatory Payment Classification (APC) group to which the services are assigned.

~~(d)~~ (c) **Multiple Surgeries.** ~~Multiple surgeries refers to more than one surgical procedure done on the same person on the same day. The multiple surgery rule provides that under certain circumstances the second and subsequent surgeries may be discounted.~~ Multiple procedures furnished during the same visit are discounted. The full amount is paid for the procedure with the highest payment group. Fifty percent is paid for any other surgical procedure(s) performed at the same time if the procedure is subject to discounting based on the status indicator established by Medicare.

(d) **Status indicators**. Status indicators identify whether the service described by a HCPCS code is paid under the OPPS and if so, whether payment is made separately or packaged and if payment is subject to discounting. SoonerCare follows Medicare's guidelines for packaged/bundled service costs.

(e) **Minor procedures.** Minor procedures that are normally performed in a physician's office are not covered in the outpatient hospital unless medically necessary.

(f) **Ambulatory Surgery.** When an ambulatory surgery is performed in the inpatient hospital setting, the physician must provide exception rationale justifying the need for an inpatient setting to OHCA medical staff for review.

~~(f)~~(g) **Dental Procedures.** ~~Dental services are routinely rendered in the dental office, unless the situation requires that the dental service be performed in the outpatient hospital setting. However, services are not covered in the outpatient hospital setting for the convenience of the dentist or member. Dental procedures are not covered as Medicare ASC procedures.~~ Routine dental procedures that are normally performed in a dentist's office are not covered in an outpatient hospital setting unless medically necessary as determined by OHCA. For OHCA payment purposes, the ~~ASC~~ APC list

has been expanded to cover ~~these~~ dental services for adults in an ICF/MR and all children.

(1) Non-emergency routine dental that is provided in an outpatient hospital setting is covered under the following circumstances:

(A) The child has a medical history of uncontrolled bleeding or other medical condition which renders in-office treatment impossible.

(B) The child has uncontrollable behavior in the dental office even with premedication.

(C) The child needs extensive dental procedures or oral surgery procedures.

(2) Non-emergency routine dental that is provided in an outpatient hospital setting is covered for children and/or adults who are residents in ICFs/MR only under the following circumstances ~~for children or adults who are residents in ICFs/MR~~:

~~(1)~~ (A) A concurrent hazardous medical condition exists;

~~(2)~~ (B) The nature of the procedure requires hospitalization or;

~~(3)~~ (C) Other factors (e.g. behavioral problems due to mental impairment) necessitate hospitalization.

~~(g) **Special Procedures**. Certain procedures rendered in a designated area of a licensed hospital dedicated to specific procedures (i.e, Cardiac Catheterization Lab, etc.) are covered and are not paid at a bundled rate. When multiple APC procedures are performed in the same visit, payment will be the rate of the procedure in the highest payment group.~~

PART 63. AMBULATORY SURGICAL CENTERS

317:30-5-565. Eligible providers

~~All eligible ambulatory surgical center providers must be certified by Medicare and have a current contract with the Oklahoma Health Care Authority. (1) **Definition of ambulatory surgical center.**~~ An ambulatory surgical center (ASC) is a distinct entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients~~, and which enters into an agreement with HCFA to do so~~. All eligible ambulatory surgical center providers must be certified by Medicare and have a current contract with the Oklahoma Health Care Authority. ~~An ASC may be either independent (i.e., not part of a provider of services or any other facility), or may be operated by a hospital (i.e., under the common ownership, licensure or control of a hospital). If an ASC is the latter type it has the option of being covered and certified under Medicare as an ASC, or of being covered as an outpatient hospital facility. In order to be covered as an ASC operated by a hospital,~~

~~a facility must:~~

~~(A) elect to do so, and continue to be so covered unless HCFA determines there is good cause to do otherwise;~~

~~(B) be a separately identifiable entity, physically, administratively, and financially independent and distinct from other operations of the hospital; and~~

~~(C) meet all the requirements with regard to health and safety, and agree to the assignment, coverage and reimbursement rules applied to independent ASC's.~~

~~(2) **Federal requirements.** In order to be eligible to enter into an agreement with HCFA to be covered as an ASC, a facility must be surveyed and certified as complying with the conditions for coverage for ASC's in 42 CFR 416.39-49.~~

317:30-5-566. ~~Outpatient surgery~~ Ambulatory Surgery Center services

(a) ~~The covered facility services are defined as those services furnished by an Ambulatory Surgical Center (ASC) or Outpatient Hospital Facility (OHF) in connection with a covered surgical procedure.~~ **Reimbursement**. Reimbursement is made for selected services based on the Medicare approved list of covered services that can be performed at an ASC. Ambulatory surgery center services are paid on a rate-per-service basis that varies according to the Health Care Procedure Coding System (HCPCS) codes. Separate payments may be made to the ASC for covered ancillary services. To be considered a covered ancillary service for which separate payment is made, the items and services must be provided integral to covered surgical procedures, that is, immediately before, during, or immediately after the covered surgical procedure.

~~(1) **Services included in the facility reimbursement rates are:**~~

~~(A) Nursing, technicians, and other related services. These include all services in connection with covered procedures furnished by nurses and technical personnel who are employees of the facility. In addition to the nursing staff, this category would include orderlies and others involved in patient care.~~

~~(B) Use by the member of the facility. This category includes operating and recovery rooms, patient preparation areas, waiting rooms, and other areas used by the patient or offered for use by the patient's relatives in connection with surgical services.~~

~~(C) Drugs, biologicals, surgical dressings, supplies, splints, casts, appliances and equipment. This category includes all supplies and equipment commonly furnished by the facility in connection with surgical procedures including any drugs and biologicals administered while the member is in the facility. Surgical dressings, other supplies, splints, and casts include only those furnished by the facility at the~~

~~time of surgery. Additional supplies and materials furnished later would generally be furnished as incident to a physician's service and not as a facility service. Supplies include those required for both the member and facility personnel, i.e., gowns, masks, drapes, hoses, scalpels, etc., whether disposable or reusable.~~

~~(D) Diagnostic or therapeutic items and services directly related to the surgical procedures. Payment to the facility includes items and services furnished by facility staff in connection with covered surgical procedures. These diagnostic tests include but are not limited to tests such as urinalysis, blood hemoglobin or hematocrit, CBC and fasting blood sugar, etc.~~

~~(E) Administrative, recordkeeping and housekeeping items and services. These include the general administrative functions necessary to run the facility, such as scheduling, cleaning, utilities, rent, etc.~~

~~(F) Blood, blood plasma, platelets, etc. Under normal circumstances, blood and blood fractions furnished during the course of the procedure will be included in the payment for the facility charge. In cases of patients with congenital or acquired blood disorders, additional payment can be made within the scope of the Authority's Medical Programs.~~

~~(G) Materials for anesthesia. These include the anesthetic and any materials necessary for its administration.~~

~~(2)~~ **~~Services not included in facility reimbursement rates are:~~**

~~(A) Physicians' services. This category includes most services performed in the facility which are not considered facility services. The term physicians' services includes any pre/post-operative services, such as office visits, consultations, diagnostic tests, removal of stitches, changing of dressings, or other services which the individual physician usually includes in a set global fee for a given surgical procedure.~~

~~(B) The sale, lease or rental of durable medical equipment (DME) to members for use in their homes. If the facility furnishes items of DME to members it should be treated as a DME supplier and this requires a separate contract and separate claim form. Coverage of DME is limited to the scope of the Authority's Medical Programs.~~

~~(C) Prosthetic devices. Non-implantable Prosthetic devices, whether implanted, inserted, or otherwise applied by covered surgical procedures are not included in the facility payment. One of the more common prostheses is intra ocular lenses (IOL's). These should be billed as a separate line item.~~

~~(D) Ambulance services. If the facility furnishes ambulance services, they are covered separately as ambulance services if otherwise compensable under the Authority's Medical~~

~~Programs. This requires a separate contract and a separate claim form.~~

~~(E) Leg, arm, back and neck braces. These items are not included in the facility payment. Payment is limited to the scope of the Authority's Medical Programs.~~

~~(F) Artificial legs, arms and eyes. This equipment is not considered part of a facility service and is not included in the facility payment rate. Payment is limited to the scope of the Authority's Medical Programs.~~

~~(G) Services of an independent laboratory. Payment for laboratory services is limited to the scope of the Authority's Medical Programs.~~

~~(H) Reimbursement - facility services. The facility services are reimbursed according to the group in which the surgical procedure is listed. If more than one surgical procedure is performed at the same setting, the second and subsequent surgeries may be discounted. Reimbursement will be made at a state-wide payment rate based on Medicare's established groups as adapted for SoonerCare.~~

(b) **Multiple surgeries**. Multiple procedures furnished during the same visit are discounted. The full amount is paid for the procedure with the highest payment rate. Fifty percent is paid for any other procedure(s) performed at the same time if the procedure is subject to discounting based on the discount indicator established by Medicare.

(c) **Payment indicators**. Payment indicators identify whether the service described by a HCPCS code is paid under the ASC methodology and if so, whether payment is made separately or packaged. SoonerCare follows Medicare's guidelines for packaged/bundled service costs.

(d) **Minor procedures.** Minor procedures that are normally performed in a physician's office are not covered in an ambulatory surgery center unless medically necessary and they are on the Medicare list for procedures approved to be performed in an ASC.

(e) **Dental Procedures**. For OHCA payment purposes, the ASC list has been expanded to cover dental services for adults in an ICF/MR and all children.

(1) Non-emergency routine dental that is provided in an ambulatory surgery center is covered for children under the following circumstances:

(A) The child has a medical history of uncontrolled bleeding or other medical condition renders in-office treatment impossible.

(B) The child has uncontrollable behavior in the dental office even with premedication.

(C) The child needs extensive dental procedures or oral surgery procedures.

(2) Non-emergency routine dental that is provided in an ambulatory surgical center is covered for children and/or adults who are residents in ICFs/MR only under the following circumstances:

(A) A concurrent hazardous medical condition exists;

(B) The nature of the procedure requires hospitalization or;

(C) Other factors (e.g. behavioral problems due to mental impairment) necessitate hospitalization.

317:30-5-567. Coverage by category

Payment is made for ambulatory surgical center services as set forth in this Section.

(1) **Children.** Payment is made for children for medically necessary surgical procedures which are included on the Medicare's ~~List of Covered Surgical Procedures~~ list of covered ASC surgical procedures and dental procedures in certain circumstances.

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

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

(2) **Adults.** Payment is made for adults for medically necessary surgical procedures which are included on Medicare's ~~the List of Covered Surgical Procedures~~ list of covered ASC surgical procedures.

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

D. **CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY**
Subchapter 15. Personal Care Services
OAC 317:35-15-1. through 35-15-10. [AMENDED]
OAC 317:35-15-11. [REVOKED]
OAC 317:35-15-15. [AMENDED]
(Reference APA WF # 08-22)

FINDING OF EMERGENCY: The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to transfer responsibilities for the authorization of service units and monitoring of service provisions from the Oklahoma Department of Human Services (OKDHS) nurses to agency provider nurses. The Aging Division of OKDHS requested these revisions in order to eliminate a duplication of responsibilities by the OKDHS nurses and nurses employed by the agencies who provide Personal Care services to eligible SoonerCare members. Furthermore, the OKDHS nurses will have additional time available to complete their other work activities.

SUMMARY: Personal Care rules are revised to transfer the responsibilities for the authorization of service units and monitoring of service provisions from the OKDHS nurses to Personal Care agency nurses. Personal Care services are provided to SoonerCare members to help them carry out activities of daily living, such as bathing, grooming, meal preparation, and laundry. Medical need for Personal Care services is determined by the OKDHS nurse using the Uniform Comprehensive Assessment Tool (UCAT) criteria and professional judgment. Due in part to the current nurse shortage, the OKDHS Aging Division has requested these revisions to remove the current duplication of responsibilities by their nurses and Personal Care agency nurses. The OKDHS nurses will still determine the level of care and maintain oversight of the units of Personal Care services authorized for all SoonerCare members. Also, they will have more time to attend to their other responsibilities including mandatory visits to nursing facilities in order to determine medical need for long term care for SoonerCare applicants. Other revisions update terminology, forms, and procedures.

BUDGET IMPACT: Agency staff has determined that the revisions are budget neutral to the agency.

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

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on November 20, 2008, and recommended Board approval.

PROPOSED EFFECTIVE DATE: February 1, 2009

AUTHORITY: The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR Section 440.167

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
Personal Care rules are revised to transfer the service authorization and monitoring of service provisions from the Oklahoma Department of Human Service nurses to nurses that are employed by the agencies who provide Personal Care Services.

CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
SUBCHAPTER 15. PERSONAL CARE SERVICES

317:35-15-1. Overview of long-term medical care services; relationship to ~~QMB~~ QMBP, SLMB and other ~~Medicaid service~~ SoonerCare services and eligibility ~~and spenddown calculation~~

Long-term medical care for the categorically needy includes care in a nursing facility (refer to OAC 317:35-19), public and private intermediate care facility for the mentally retarded (refer to OAC 317:35-9), persons age 65 years or older in mental health hospitals (refer to OAC 317:35-9), Home and Community Based Waiver Services for the Mentally Retarded (refer to OAC 317:35-9), Home and Community Based Waiver Services for the ADvantage program (refer to OAC 317:35-17), and Personal Care services (refer to this subchapter). Personal Care provides services in the member's own home. Any time an individual is certified as eligible for ~~Medicaid~~ SoonerCare coverage of long-term care, the individual is also eligible for other ~~Medicaid~~ SoonerCare services. Another application ~~or spenddown computation~~ is not required. ~~Spenddown is applied to the first long-term care claim filed.~~ Any time an aged, blind or disabled individual is determined eligible for long-term care, a separate determination must be made to see if eligibility conditions as a Qualified Medicare Beneficiary (QMB) or Specified

Low-Income Medicare Beneficiary (SLMB) are met. Another application for QMB or SLMB benefits is not required. ~~Any spenddown computed for long-term care is not applicable to QMB coverage.~~

317:35-15-2. Personal Care services

(a) Personal Care is assistance to an individual in carrying out activities of daily living, such as bathing, grooming and toileting, or in carrying out instrumental activities of daily living, such as preparing meals and doing laundry or errands directly related to the member's personal care needs, to assure personal health and safety of the individual or to prevent or minimize physical health regression or deterioration. The Personal Care service requires a skilled nursing assessment of need, development of a care plan to meet identified personal care needs, care plan oversight and periodic re-assessment and updating, if necessary, of the care plan. Personal Care services do not include technical services such as, tracheal suctioning, bladder catheterization, colostomy irrigation, and operation of equipment of a technical nature.

(b) Personal Care services support informal care being provided in the member's home. A rented apartment, room or shelter shared with others is considered "the member's home". A facility which meets the definition of a nursing facility, room and board, licensed residential care facility, group home, rest home or a specialized home as set forth in O.S. Title 63, Section 1-819 et seq., Section 1-899.1 et seq., and Section 1-1902 et seq., and/or in any other typed of settings prohibited under applicable federal or state statutes, rules, regulations, or other written instruments that have the effect of law is not considered the "the member's home" for delivery of SoonerCare Personal Care Program services.

(c) Personal Care services may be provided by an individual employed by the member referred to as a Personal Care Assistant (PCA) or by a qualified employee of a home care agency that is certified to provide ~~PC~~ Personal Care services and contracted with the OHCA to provide ~~PC~~ Personal Care services. OKDHS must determine a PCA to be qualified to provide ~~PC~~ Personal Care services before they can provide services.

317:35-15-3. Application for Personal Care~~; forms~~

(a) **Requests for Personal Care.** A request for Personal Care is made to the local ~~DHS~~ OKDHS office. A written financial application is not required for an individual who has an active ~~Medicaid~~ SoonerCare case. A financial application for Personal Care consists of the Medical Assistance Application form. The form is signed by the ~~client~~ applicant, parent, spouse, guardian or someone else acting on the ~~client's~~ applicant's behalf. All conditions of financial eligibility must be verified and documented in the case record. When current information already available in

the local office establishes eligibility, the information may be used by recording source and date of information. If the applicant also wishes to apply for a State Supplemental Payment, either the applicant or his/her guardian must sign the application form.

(b) **Date of application**.

(1) The date of application is:

(A) the date the applicant or someone acting on his/her behalf signs the application in the county office;

(B) the date the application is stamped into the county office when the application is initiated outside the county office; or,

(C) the date when the request for ~~Medicaid~~ SoonerCare is made orally and the financial application form is signed later.

(2) An exception to paragraph (1) of this subsection would occur when ~~DHS~~ OKDHS has contracts with certain providers to take applications and obtain documentation. After the documentation is obtained, the contract provider forwards the application and documentation to the ~~DHS~~ OKDHS county office of the ~~client's~~ applicant's county of residence for ~~Medicaid~~ SoonerCare eligibility determination. The application date is the date the ~~client~~ applicant signed the application form for the provider.

(c) **Eligibility status.** Financial and medical eligibility must be established before services can be initiated.

317:35-15-4. Determination of medical eligibility for Personal Care

(a) **Eligibility**. The OKDHS area nurse, or designee, utilizes the UCAT criteria and professional judgment in determining medical eligibility and level of care. To be eligible for Personal Care services, the individual must:

(1) have adequate informal supports that contribute to care, or decision making ability as documented on the UCAT, to remain in his/her home without risk to his/her health, safety, and well-being:

(A) the individual must have the decision making ability to respond appropriately to situations that jeopardize his/her health and safety or available supports that compensate for his/her lack of ability as documented on the UCAT, or

(B) the individual who has his/her decision making ability, but lacks the physical capacity to respond appropriately to situations that jeopardize health and safety and has been informed by the ~~LTC~~ OKDHS nurse of potential risks and consequences may be eligible;

(2) require a ~~care~~ plan of care involving the planning and administration of services delivered under the supervision of professional personnel;

(3) have a physical impairment or combination of physical and mental impairments. An individual who poses a threat to self or

others as supported by professional documentation may not be approved for Personal Care services;

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

(5) lack the ability to meet personal care needs without additional supervision or assistance, or to communicate needs to others; and

(6) require assistance, not of a technical nature, to prevent or minimize physical health regression and deterioration.

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

(1) **"ADL"** means the activities of daily living. Activities of daily living are activities that reflect the ~~client's~~ member's ability to perform self-care tasks essential for sustaining health and safety such as:

(A) bathing,

(B) eating,

(C) dressing,

(D) grooming,

(E) transferring (includes getting in and out of a tub, bed to chair, etc.),

(F) mobility,

(G) toileting, and

(H) bowel/bladder control.

(2) **"ADLs score of three or greater"** means the ~~client~~ member cannot do one ADL at all or needs some help with two ADLs.

(3) **"ADLs score is two"** means the ~~client~~ member needs some help with one ADL.

(4) **"Client support very low need"** means the ~~client's~~ member's UCAT Client Support score is zero which indicates in the UCAT assessor's clinical judgment, formal and informal sources are sufficient for present level of ~~client~~ member need in most functional areas.

(5) **"Client support low need"** means the member's UCAT Client Support score is 5 which indicates in the UCAT assessor's clinical judgment, support from formal and informal sources are nearly sufficient for present level of ~~client~~ member need in most functional areas.

(6) **"Client support moderate need"** means the UCAT Client Support score is 15, which indicates in the UCAT assessor's clinical judgment formal and informal support is available, but overall, it is inadequate, changing, fragile or otherwise problematic.

(7) **"Client support high need"** means the ~~client's~~ member's UCAT Client Support score is 25 ~~and~~ which indicates in the UCAT

assessor's clinical judgment, formal and informal supports are not sufficient as there is very little or no support available to meet a high degree of ~~client~~ member need.
(8) **"Community Services Worker"** means any person employed by or under contract with a community services provider who provides, for compensation or as a volunteer, health-related services, training, or supportive assistance to frail elderly, disabled person(s), or person(s) with developmental disabilities, and who is not a licensed health professional.
(9) **"Community Services Worker Registry"** means a registry established by the Oklahoma Department of Human Services, as required by Section 1025.1 et seq. of Title 56 of the Oklahoma Statutes, to list community services workers against whom a final investigative finding of abuse, neglect, or exploitation, as defined in Section 10-103 of Title 43A of the Oklahoma Statutes, involving a frail elderly, disabled person(s) or person(s) with developmental disabilities has been made by ~~DHS~~ OKDHS or an administrative law judge, amended in 2002 to include the listing of ~~Medicaid~~ SoonerCare personal care assistants providing personal care services.
(10) **"Instrumental activities of daily living"** means those activities that reflect the member's ability to perform household chores and tasks within the community essential for sustaining health and safety such as:
(A) shopping,
(B) cooking,
(C) cleaning,
(D) managing money,
(E) using a telephone,
(F) doing laundry,
(G) taking medication, and
(H) accessing transportation.
~~(10)~~ (11) "**IADL**" means the instrumental activities of daily living.
~~(11)~~ (12) "**IADLs score is at least six**" means the ~~client~~ member needs some help with at least three IADLs or cannot do two IADLs at all.
~~(12)~~ (13) "**IADLs score of eight or greater**" means the ~~client~~ member needs some help with four IADLs or the ~~client~~ member cannot do two IADLs at all and needs some help with one other IADLs.
~~(13) "**Instrumental activities of daily living**" means those activities that reflect the client's ability to perform household chores and tasks within the community essential for sustaining health and safety such as:~~
~~(A) shopping,~~
~~(B) cooking,~~

~~(C) cleaning,~~
~~(D) managing money,~~
~~(E) using a telephone,~~
~~(F) doing laundry,~~
~~(G) taking medication, and~~
~~(H) accessing transportation.~~

(14) **"~~Medicaid~~ SoonerCare personal care services provider"** means a program, corporation, or individual who provides services under the state's ~~Medicaid~~ SoonerCare personal care program or ADvantage Waiver to individuals who are elderly or who have a physical disability.

(15) **"MSQ"** means the mental status questionnaire.

(16) **"MSQ moderate risk range"** means a total weighted score of seven or more which indicates an orientation-memory-concentration impairment or a memory impairment.

(17) **"Nutrition moderate risk"** means the total weighted UCAT Nutrition score is 8 or more which indicates poor appetite or weight loss combined with special diet requirements, medications or difficulties in eating.

(18) **"Social resources score is eight or more"** means the ~~client~~ member lives alone or has no informal support when sick or needs assistance, or has little or no contact with others.

(c) **Medical eligibility minimum criteria for Personal Care.** The medical eligibility minimum criteria for Personal Care is the minimum UCAT score criteria which a ~~client~~ member must meet for medical eligibility for personal care and are:

(1) functional ADLs score is a five or greater; or IADLs score of eight or greater; or Nutrition score is eight or greater; or the MSQ score is seven or greater; or the ADLs score is three and IADLs score is at least six, and

(2) Client Support is moderate risk; or Client Support score is five~~ or more~~ and the Social Resources score is eight or more.

(d) **Medical eligibility determination**. Medical eligibility for Personal Care is determined by the Oklahoma Department of Human Services. The medical decision for Personal Care~~, the care plan and service plan approval for Personal Care~~ is made by the ~~DHS~~ OKDHS area nurse, or designee, utilizing the Uniform Comprehensive Assessment Tool (UCAT).

(1) When Personal Care services are requested, the local office is responsible for completing the UCAT, Part III.

(2) Categorical relationship must be established for determination of eligibility for Personal Care. If categorical relationship to Aid to the Disabled has not already been established but there is an extremely emergent need for Personal Care and current medical information is not available, the local office authorizes a medical examination. When authorization is necessary, the county director issues the Authorization for

Examination, ~~DHS~~ OKDHS form ~~ABCDM-16~~ 08MA016E, and the Report of Physician's Examination, ~~DHS~~ OKDHS form ~~ABCDM-80~~ 08MA02E, to a licensed medical or osteopathic physician (refer to OAC 317:30-5-1). The physician cannot be in a medical facility intern, residency, or fellowship program or in the full time employment of the Veterans Administration, Public Health Service or other agency. The OKDHS county ~~social~~ worker submits the information to the Level of Care Evaluation Unit (LOCEU) to request a determination of eligibility for categorical relationship. LOCEU renders a decision on categorical relationship using the same definition used by SSA. A follow-up is required by the ~~DHS social~~ OKDHS county worker with the Social Security Administration (SSA) to be sure that SSA's disability decision agrees with the decision of LOCEU.

(3) Approved contract agencies may complete the UCAT Part I for intake and screening and forward the form to the county office.

(4) When ~~DHS~~ the OKDHS county office does not receive a UCAT from the AA, a UCAT I is initiated by the DHS county staff upon receipt of the referral.

(5) The ~~DHS Long Term Care (LTC)~~ OKDHS nurse completes the ~~UCAT III~~ assessment visit within 10 working days of receipt of the referral for Personal Care from the ~~social~~ OKDHS county worker or receipt of the UCAT I ~~and II~~ (Intake and Screening) request for Personal Care for the ~~client~~ member who is ~~Medicaid~~ SoonerCare eligible at the time of the request. The ~~LTC~~ OKDHS nurse completes the assessment visit within 20 working days of the ~~Medicaid~~ SoonerCare application for the ~~client~~ applicant who has not been determined financially ~~Medicaid~~ SoonerCare eligible at the time of the request. The ~~DHS social~~ OKDHS county worker is responsible for contacting the ~~individual~~ applicant within three working days from the date of the receipt of the request for services to initiate the financial eligibility process. If the UCAT Part I ~~or II~~ indicates the request is from an individual who resides at home and an immediate response is required to ensure the health and safety of the ~~client~~ person (emergency situation) or to avoid institutional placement, the UCAT Part III assessment visit has top priority for scheduling.

(6) During the assessment visit, the ~~LTC~~ OKDHS nurse completes the UCAT III and reviews with the member rights to privacy, fair hearing and provider choice. The OKDHS nurse informs the ~~client~~ member of medical eligibility criteria and provides information about the different ~~DHS~~ OKDHS long-term care service options. The OKDHS nurse documents on the UCAT III whether the ~~client~~ member wants to be considered for nursing facility level of care services or if the ~~client~~ member is applying for a specific service program. If based upon the information obtained during the assessment, the OKDHS nurse determines ~~that~~ the ~~client~~ member may be at risk for health and safety, an immediate

referral is made to Adult Protective Services (APS) ~~staff are notified immediately~~. The referral is documented on the UCAT.

~~(A) The LTC nurse uses the Personal Care service plan form to develop an individual plan of care. The plan of care and service plan, including the amount and frequency of DHS Personal Care services, is based on the client's needs as determined by the UCAT III assessment.~~

~~(B)~~ (A) If the ~~client's~~ member's needs cannot be met by ~~DHS~~ Personal Care ~~and Home Health~~ services alone, the ~~LTC~~ OKDHS nurse informs the ~~client~~ member of the other ~~DHS Long Term Care (LTC)~~ community long term care service options. The ~~LTC~~ OKDHS nurse assists the ~~client~~ member in accessing service options selected by the ~~client~~ member in addition to, or in place of, Personal Care services.

~~(C)~~ (B) If multiple household members are applying for ~~DHS~~ SoonerCare Personal Care services, the UCAT assessment is done for all the ~~client~~ household members at the same time. ~~Individual care plans and service plans are discussed and developed with the group of clients who appear eligible so service delivery can be coordinated to achieve the most efficient use of resources. The number of units of service allocated to each individual is distributed between family members to assure that the absence of one family member does not adversely affect the family member(s) remaining in the home.~~

~~(D) If the length of time from the date the initial assessment information was obtained to the date the assessment is submitted to the area nurse, or designee, exceeds 60 days, the assessment must be updated as necessary including a new signature and date. A new UCAT and assessment visit is required if the length of time exceeds 90 days.~~

(C) The OKDHS nurse informs the member of the qualified agencies in their local area available to provide services and obtains the member's primary and secondary choice of agencies. If the member or family declines to choose a primary personal care service agency, the OKDHS nurse selects an agency from a list of all available agencies, using a round-robin system. The OKDHS nurse documents the name of the selected personal care service agency.

(7) The ~~LTC~~ OKDHS nurse ~~scores~~ completes the UCAT III~~. Within five~~ within three working days of the assessment visit~~, the nurse forwards the UCAT and the completed Personal Care plan and service plan forms~~ and sends it to the OKDHS area nurse, or designee, for medical eligibility determination. Personal care service eligibility is established as of the date that both medical eligibility is approved and financial eligibility is

established. ~~The client's Personal Care service plan and care plan include:~~

(A) ~~goals and tasks;~~ If the length of time from the date the initial assessment to the date of service eligibility determination exceeds 60 days, the assessment must be updated as necessary including a new signature and date. A new UCAT and assessment visit is required if the length of time exceeds 90 days.

(B) ~~the number of authorized Personal Care units (hours) per month;~~ Upon establishment of Personal Care service eligibility, the OKDHS nurse contacts the member's preferred personal care service agency, or if necessary, the secondary agency or the agency selected by the rotation system.

(C) ~~frequency of service visits;~~ Within one working day of agency acceptance, the OKDHS nurse forwards the referral to the personal care service agency for Service Authorization Model (SAM) packet development. [Refer to OAC 317:35-15-8(a)]. The date the referral is forwarded is the certification effective date.

~~(D) the effective date for services; and~~

~~(E) the certification period for the care plan and service plan.~~

(8) Following the development of the Service Authorization Model (SAM) packet by the personal care service agency, and within three working days of receipt of the packet from the agency, the OKDHS nurse reviews the packet to ensure agreement with the plan. Once agreement is established, the packet is forwarded to the OKDHS area nurse or designees for review.

~~(8)~~ (9) Within 10 working days of receiving the ~~UCAT, care plan, and service plan~~ Service Authorization Model (SAM) packet from the ~~LTC~~ OKDHS nurse, the OKDHS area nurse, or designee, ~~determines medical eligibility for Personal Care services,~~ certifies or denies the ~~care plan and service plan~~ Service Authorization Model (SAM) packet ~~and enters the medical decision on MEDATS~~. If there is certification, the OKDHS area nurse enters into the system the units authorized. ~~Denied service and care plans~~ Service Authorization Model (SAM) packets that fail to meet authorization are returned to the ~~LTC~~ OKDHS nurse for revision or further justification by the personal care service agency. ~~The LTC nurse revises and re-submits the denied service and care plans to the area nurse, or designee, within five working days of receipt of the returned documents.~~

~~(9)~~ (10) The OKDHS area nurse, or designee, ~~determines the medical certification period for the plan of care and service plan which is the same as the certification period for the medical eligibility decision [see OAC 317:35-15-7(b)]~~ assigns a medical certification period of not more than 36 months. The

service plan certification period under the Service Authorization Model (SAM) is for a period of 12 month.

(11) Once the OKDHS nurse is notified of the service plan authorization, and within one working day, forwards copies of the certified Personal Care Service Plan [OKDHS form 02AG031E (AG-6)] to the agency.

(12) The OKDHS nurse notifies the OKDHS county worker in writing of the service and the number of authorized personal care service units including the start and end dates. The OKDHS county worker opens the service authorization. These steps are automated via ELDERS. Once the authorization is opened, five Service Authorization Model (SAM) visits by a skilled nurse are automatically authorized.

317:35-15-5. General financial eligibility requirements for Personal Care

Financial eligibility for Personal Care is determined using the rules on income and resources according to the category to which the individual is related. (See OAC 317:35-10 for individuals categorically related to AFDC, and OAC 317:35-7-36 for those categorically related to ABD.) ~~(1)~~ Income~~,~~ and resources ~~and expenses~~ are evaluated on a monthly basis for all individuals requesting payment for Personal Care who are categorically related to ABD; maximum countable monthly income and resource standards for individuals related to ABD are found on OKDHS form 08AX001E (Appendix C-1), Schedule VI (QMBP program standards).

~~(2) The maintenance standards on the DHS Appendix C-1, Schedule II. A. are used to evaluate income and resources when an individual requests Personal Care with income and resources that exceed the categorically needy standards. Any vendor copayment for Personal Care is deducted from the claim prior to payment.~~

317:35-15-6. Determining financial eligibility of categorically needy individuals

Financial eligibility for Personal Care for categorically needy individuals is determined as follows:

(1) **Financial eligibility/categorically related to AFDC**. In determining income for the individual related to AFDC, all family income is considered. (See OAC 317:35-5-45 for Exceptions to AFDC rules.) The "family", for purposes of determining need, includes the following persons if living together (or if living apart but there has been no break in the family relationship):

(A) spouse; and

(B) parent(s) and minor children of their own.

(i) For adults, to be categorically needy, the net income must be less than the categorically needy standard as

shown on the ~~DHS~~ OKDHS form 08AX001E (Appendix C-1), Schedule X.

(ii) For individuals under 19, to be categorically needy, the net income must be equal to or less than the categorically needy standard as shown on the ~~DHS~~ OKDHS form 08AX001E (Appendix C-1), Schedule I. A.

(2) **Financial eligibility/categorically related to ABD**. In determining income and resources for the individual related to ABD, the "family" includes the individual and spouse, if any. To be categorically needy, the countable income must be less than the categorically needy standard as shown on the ~~DHS~~ OKDHS form 08AX001E (Appendix C-1), Schedule ~~VIII. A~~ VI (QMBP standard). If an individual and spouse cease to live together for reasons other than institutionalization or receipt of the ADvantage waiver or HCBW/MR services, income and resources are considered available to each other through the month in which they are separated. Mutual consideration ceases with the month after the month in which the separation occurs. Any amounts which are actually contributed to the spouse after the mutual consideration has ended are considered.

(3) **Determining financial eligibility for Personal Care**. For individuals determined categorically needy for Personal Care, ~~excess income is not applied to~~ the member will not pay a vendor payment for Personal Care services.

317:35-15-7. Certification for Personal Care

(a) ~~**Application date.**~~ The first month of the Personal Care certification period must be the first month the ~~client~~ member was determined eligible for Personal Care, both financially and medically.

(1) As soon as eligibility or ineligibility for Personal Care is established, the local office updates the computer form and the appropriate notice is computer generated. Notice information is retained on the notice file for county use.

(2) An applicant approved for Personal Care under ~~Medicaid~~ SoonerCare as categorically needy is mailed a Medical Identification Card.

(b) ~~**Certification period for Personal Care.**~~ A medical certification period of not more than 36 months is assigned for an individual categorically related to ABD who is approved for Personal Care. The certification period for Personal Care is based on the UCAT evaluation and clinical ~~judgement~~ judgment of the OKDHS area nurse or designee. When the individual determined eligible for Personal Care is categorically related to AFDC, a medical certification period of not more than 36 months is assigned.

317:35-15-8. Agency Personal Care ~~service management~~ Service Authorization and Monitoring

~~(a) At the time of assessment, the OKDHS nurse informs the member of the qualified agencies in their local area available to provide services and obtains the member's primary and secondary choice of agencies. If the member or family declines to choose a primary PC service agency, the OKDHS nurse selects an agency from a list of all local available agencies, using a round-robin system. The OKDHS nurse documents the name of the selected PC service agency.~~

~~(b) After medical and financial eligibility are established, OKDHS contacts the member's preferred PC service agency or, if necessary, the secondary agency or the agency selected by the rotation system. The OKDHS nurse forwards the referral to the PC services agency and establishes an initial PC skilled nursing service authorization for assessment and care plan development. Within one working day, OKDHS notifies the PC service agency and member of eligibility approval and also the authorization for PC skilled nursing for assessment and care plan development. The agency, prior to placing a PCA in the member's home, initiates an OSBI background check, checks the OKDHS Community Services Worker Registry in accordance with Section 1025.2 of Title 56 of the Oklahoma Statutes, and, as appropriate, checks the Certified Nurse Aid Registry.~~

~~(c)~~ (a) Within ten working days of receipt of the ~~member's PC eligibility approval,~~ referral for Personal Care services, the ~~PC services agency skilled nurse~~ Personal Care Assessment/Service Planning Nurse completes ~~an in-home assessment of~~ a Service Authorization Model (SAM) visit in the home to assess the member's ~~PC~~ Personal Care service needs, ~~develops a care plan~~ completes a Service Authorization Model (SAM) packet based on the member's needs and submits the ~~plan~~ packet to the OKDHS nurse. The member's ~~PC services care plan includes PC services goals and tasks, the number of authorized PC service units per month, frequency of PC service visits, the begin date for PC services, and the care plan end date which is no more than one year from the plan begin date. If more than one person in the household has been authorized to receive PC services, all household members' care plans are discussed and developed with the eligible members so service delivery can be coordinated to achieve the most efficient use of resources. The number of units of PC service authorized for each individual is distributed between all eligible family members to assure that the absence of one family member does not adversely affect the family member(s) remaining in the home.~~ Service Authorization Model (SAM) packet includes:

(1) State Plan Personal Care Progress Notes (OKDHS form 02AG044E);

(2) Personal Care Planning Schedule [OKDHS form 02AG030E (AG-5)];

(3) Personal Care Plan [OKDHS form 02AG029E (AG-4)]; and

(4) Personal Care Service Plan [02AG031E (AG-6)].

(b) If more than one person in the household has been referred to receive Personal Care services, all household members' Service Authorization Model (SAM) packets are discussed and developed with the eligible members so service delivery can be coordinated to achieve the most efficient use of resources. The number of units of Personal Care service authorized for each individual is distributed between all eligible family members to assure that the absence of one family member does not adversely affect the family member(s) remaining in the home.

~~(d) Within three working days of receipt of the care plan from the PC services agency, the OKDHS nurse reviews and approves or denies the care plan and notifies the agency. The OKDHS nurse may also reduce the number of units requested by the PC services agency and then approve the care plan. When the OKDHS nurse denies a plan or approves a plan with fewer authorized units than the submitted plan, OKDHS consults with the PC services agency prior to denying the care plan or approving the care plan with reduced units.~~

(c) The Personal Care service agency receives a certified Service Plan [OKDHS form 02AG031E (AG-6)] from OKDHS as authorization to begin services. The agency delivers a copy of the care plan and service plan to the member upon initiating services.

~~(e)~~ (d) Prior to placing a ~~PC~~ Personal Care attendant in the member's home or other service-delivery setting, an OSBI background check, OKDHS Community Service Worker Registry check in accordance with Section 1025.2 of Title 56 of the Oklahoma Statutes, and as appropriate, the Certified Nurse Aide Registry Check must be completed.

~~(f)~~ (e) The ~~PC service skilled nurse~~ Personal Care Assessment/Service Planning Nurse monitors their member's ~~care~~ plan of care.

(1) The ~~PC~~ Personal Care service provider agency contacts the member within ~~5~~ five calendar days of receipt of the approved ~~care plan~~ Service Plan [OKDHS form 02AG031E (AG-6)] in order to make sure that services have been implemented and the needs of the member are being met.

(2) The ~~PC services agency nurse~~ Personal Care Assessment/Service Planning Nurse makes a Service Authorization Model (SAM) home visit at least every 180 days to assess the member's satisfaction with their care and to evaluate the ~~care plan~~ Service Authorization Model (SAM) packet for adequacy of goals and units authorized. Whenever a home visit is made, the ~~PC services agency nurse~~ Personal Care Assessment/Service Planning Nurse documents their findings in the ~~personal care services progress notes~~ State Plan Personal Care Progress Notes (OKDHS form 02AG044E). The personal care agency forwards a copy of the Progress Notes to the OKDHS nurse for review. The monitoring visit may be conducted by an LPN. If an LPN or

social worker conducts the monitoring visit, an RN must co-sign the progress notes.

(3) Requests by the ~~PC~~ Personal Care service agency to change the number of units authorized in the ~~care plan~~ Service Authorization Model (SAM) packet are submitted to OKDHS and are approved or denied by the OKDHS area nurse, or designee prior to implementation of the changed number of units.

(4) Annually, or more frequently if the member's needs change, the ~~PC services agency nurse~~ Personal Care Assessment/Service Planning Nurse re-assesses member's need and develops a new ~~care plan~~ Service Authorization Model (SAM) eligibility packet to meet personal care needs. ~~If the member's need does not change, the agency nurse may re-authorize the member's existing plan.~~

~~(g) When the PC services agency returns the member's care plan containing a service start date to OKDHS, the OKDHS nurse notifies the OKDHS county social worker in writing of the service and number of authorized PC service units and the start and end date of PC service authorization.~~

(5) If the member is unstaffed, the Personal Care service agency communicates with the member and makes efforts to restaff. If the member is unstaffed for 30 calendar days, the agency notifies the OKDHS nurse on an OKDHS form 02AG032E (AG-7), Provider Communication Form. The OKDHS nurse contacts the member and if the member chooses, initiates a transfer of the member to another Personal Care service agency that can provide staff.

317:35-15-8.1. Agency Personal Care services; billing, and ~~issue~~ problem resolution

The ~~Administrative Agent~~ ADvantage Administration (AA) certifies qualified ~~PC~~ Personal Care service agencies and facilitates the execution of the agencies' SoonerCare contracts on behalf of OHCA. OHCA will check the list of providers that have been barred from ~~Medicare/Medicaid~~ Medicare/SoonerCare participation to ensure that the ~~PC~~ Personal Care services agency is not listed.

(1) **Payment for Personal Care.** Payment for ~~PC~~ Personal Care services is generally made for care in the member's "own home". In addition to an owned or rented home, a rented apartment, room or shelter shared with others is considered to be the member's "own home". A facility that meets the definition of a nursing facility, room and board, licensed residential care facility, licensed assisted living facility, group home, rest home or a specialized home as set forth in O.S. Title 63, Section 1-819 et seq., Section 1-890.1 et seq., and Section 1-1902 et seq., and/or in any other type of settings prohibited under applicable federal or state statutes, rules, regulations, or other written instruments that have the effect of law is not a setting that qualifies as the member's "own home" for delivery

of ~~PC~~ Personal Care services through SoonerCare. With prior approval of the OKDHS area nurse, ~~PC~~ Personal Care services may be provided in an educational or employment setting to assist the member in achieving vocational goals identified on the care plan.

(A) **Use of Personal Care service agency**. To provide ~~PC~~ Personal Care services, an agency must be licensed by the Oklahoma State Department of Health, meet certification standards identified by OKDHS ~~or the AA~~, and possess a current SoonerCare contract.

(B) **Reimbursement**. Personal Care services payment on behalf of a member is made according to the type of service and number of units of ~~PC~~ Personal Care services authorized in the ~~care plan~~ Service Authorization Model (SAM) packet.

(i) The amount paid to ~~PC~~ Personal Care services providers for each unit of service is according to the established SoonerCare rates for the ~~PC~~ Personal Care services. Only authorized units contained ~~on~~ in each eligible member's individual ~~care plan~~ Service Authorization Model (SAM) packet are eligible for reimbursement. Providers serving more than one ~~PC~~ Personal Care service member residing in the same residence will assure that the members' ~~care plans~~ Service Authorization Model (SAM) packets combine units in the most efficient manner possible to meet the needs of all eligible persons in the residence.

(ii) Payment for ~~PC~~ Personal Care services is for tasks performed in accordance with OAC 317:30-5-951 only when listed on an authorized ~~care~~ plan of care. Payment for ~~PC~~ Personal Care skilled nursing service is made on behalf of the member for assessment/evaluation and associated service planning per assessment/service planning visit by the ~~provider agency personal care skilled nurse~~ Personal Care Assessment/Service Planning Nurse.

(2) **Issue resolution.**

(A) If the member is dissatisfied with the ~~PC~~ Personal Care services provider agency or the assigned PCA, and has exhausted attempts to work with the ~~PC~~ Personal Care services agency's grievance process without resolution, the member may contact the OKDHS nurse to attempt to resolve the issues. The member has the right to appeal to the OHCA in accordance with OAC 317:2-1-2. For members receiving ADvantage services, the member or family should contact their case manager for the problem resolution. If the problem remains unresolved, the member or family should contact the Consumer Inquiry System (CIS). Providers are required to provide the CIS contact number to every member. The ADvantage Program member also has the right to appeal to the OHCA in accordance with OAC 317:2.

(B) When a problem with performance of the Personal Care attendant is identified, agency staff will conduct a counseling conference with the member and/or the attendant as appropriate. Agency staff will counsel the attendant regarding problems with his/her performance.

317:35-15-9. Redetermination of financial eligibility for Personal Care

~~(a)~~ The ~~social~~ OKDHS county worker must complete a redetermination of financial eligibility before the end of the certification period. A notice is generated only if there is a change which affects the client's financial ~~responsibility~~ eligibility.

~~(b) The area nurse, or designee, must complete a redetermination of medical eligibility before the end of the long-term care medical certification period.~~

317:35-15-10. Redetermination of medical eligibility for Personal Care services

(a) **Medical eligibility redetermination.** The OKDHS area nurse, or designee, must complete a redetermination of medical eligibility before the end of the long-term care medical certification period.

~~(a)~~ (b) **Recertification**. The OKDHS nurse re-assesses the ~~PC~~ Personal Care services member for medical re-certification based on the member's needs and level ~~or~~ of caregiver support required, using the UCAT at least every 36 months. During this re-certification assessment, the OKDHS nurse informs the member of the state's other SoonerCare long-term care options. The OKDHS nurse submits the re-assessment~~,~~ to the OKDHS area nurse, or designee, for re-certification. ~~Recertification documents are~~ Documentation is sent to the OKDHS area nurse, or designee, no later than the tenth day of the month in which the certification expires. When the OKDHS area nurse, or designee determines medical eligibility for ~~PC~~ Personal Care services, a re-certification review date is entered on the system.

~~(b)~~ (c) **Change in ~~service plan and care plan~~ amount of units or tasks within Personal Care service for ~~State Plan PC~~ Personal Care service members.** ~~Upon notification by the PC service agency of the member's need for a change in the amount of PC service required, the OKDHS nurse initiates the process to increase or decrease the approved units of service on the member's care plan. Based on the documentation provided by the PC service agency to OKDHS, the area nurse or designee approves or denies the care plan changes within three working days of receipt of the request. A copy of the signed care plan is included in the case record. The social worker updates the service authorization system after they are notified of the increase or decrease.~~ When the Personal Care services agency

determines a need for a change in the amount of units or tasks within the Personal Care service, a new Personal Care Service Authorization Model (SAM) packet is completed and submitted to OKDHS. The change is approved or denied by the OKDHS area nurse, or designee prior to implementation.

~~(c)~~ (d) **Voluntary closure of ~~State Plan PC~~ Personal Care services**. If a member decides Personal Care services are no longer needed to meet his/her needs, a medical decision is not needed. The member and the OKDHS nurse or ~~social~~ OKDHS county worker completes and signs OKDHS form 02AG038E, AG-17, Voluntary Action of Personal Care Case Closure form.

~~(d)~~ (e) **Resuming ~~State Plan PC~~ Personal Care services.** If a member approved for Personal Care services has been without ~~PC~~ Personal Care services for less than 90 days but still has a current ~~PC~~ Personal Care services medical and SoonerCare financial eligibility approval, ~~PC~~ Personal Care services may be resumed using the member's previously approved ~~care plan~~ Service Authorization Model (SAM) packet. The ~~PC~~ Personal Care service agency submits a ~~PC~~ Personal Care services skilled nursing re-assessment of need within ten working days of the resumed plan start date using the State Plan Personal Care Progress Notes, OKDHS form 02AG044E. If the member's needs dictate, the ~~PC~~ Personal Care services agency may submit a request for a change in authorized ~~PC~~ Personal Care services units with ~~the re-assessment for authorization review by~~ a Service Authorization Model (SAM) packet to OKDHS.

~~(e)~~ (f) **Financial ineligibility**. Anytime OKDHS determines a ~~PC~~ Personal Care services member does not meet the SoonerCare financial eligibility criteria, the local OKDHS office notifies the member, ~~PC~~ Personal Care service provider, and the OKDHS nurse of financial ineligibility.

~~(f)~~ (g) **Closure due to medical ineligibility**. If the local OKDHS office is notified through the system that a member is no longer medically eligible for Personal Care, the ~~social~~ OKDHS county worker notifies the member of the decision. The OKDHS nurse notifies the ~~PC~~ Personal Care service agency.

~~(g)~~ (h) **Termination of State Plan Personal Care Services**.

(1) Personal Care services may be discontinued if:

(A) the member poses a threat to self or others as supported by professional documentation; or

(B) other members of the household or persons who routinely visit the household who, as supported by professional documentation, pose a threat of harm or injury to the member or other household visitors; or

(C) the member or family member fails to cooperate with Personal Care service delivery or to comply with OHCA or OKDHS rules as supported by professional documentation; or

(D) the member's health or safety is at risk as ~~documented on the UCAT~~ supported by professional documentation; or

(E) additional services, either "formal" (i.e., paid by ~~Medicaid~~ SoonerCare or some other funding source) or "informal" (i.e., unpaid) are provided in the home eliminating the need for SoonerCare Personal Care services.

(2) The member refuses to select and/or accept the services of a ~~PC~~ Personal Care service agency or PCA for 90 consecutive days as supported by professional documentation.

(3) For persons receiving ~~State Plan PC~~ Personal Care services, the ~~PC~~ Personal Care services agency submits documentation with the recommendation to discontinue services to OKDHS. The OKDHS nurse reviews the documentation and submits it to the OKDHS Area Nurse for determination. The OKDHS nurse notifies the member and the Personal Care service agency or PCA, and the local OKDHS county ~~social~~ worker of the decision to terminate services. ~~The social worker closes the authorization on the OKDHS system which sends~~ The member is sent an official closure notice ~~to the member~~ informing them of their appropriate member rights to appeal the decision to discontinue services.

317:35-15-11. Case transfer between categories [REVOKED]

~~If it becomes necessary to transfer a Medicaid Personal Care case from one category to another because of change of age, income, or marital status, a new application is not required. If someone other than the client or guardian signed the original application form and the transfer is to a money payment case, an application with the member's signature is required. The new case is certified retaining the original certification date and redetermination date, using the appropriate code for transfer from the old category and the appropriate effective date which coincides with the closure of the previous case category. Members and appropriate medical contractors are notified of the new case number and category by computer generated notice.~~

317:35-15-15. Referral for social services

In many situations, adults who are receiving medical services through ~~Medicaid~~ SoonerCare need social services. The ~~LTC~~ OKDHS nurse may make referrals for social services to the OKDHS worker in the local office. In addition to these referrals, a request for social services may be initiated by a ~~client~~ member or by another individual acting upon behalf of a ~~client~~ member.

(1) The OKDHS county worker is responsible for providing the indicated services or for referral to the appropriate resource outside the Department if the services are not available within the Department.

(2) Among the services provided by the OKDHS worker are:

(A) Services that will enable individuals to attain and/or maintain as good physical and mental health as possible;
(B) Services to assist patients who are receiving care outside their own homes in planning for and returning to their own homes or to other alternate care;
(C) Services to encourage the development and maintenance of family and community interest and ties;
(D) Services to promote maximum independence in the management of their own affairs;
(E) Protective services, including evaluation of need for and arranging for guardianship; and
(F) Appropriate family planning services, which include assisting the family in acquiring means to responsible parenthood. Services are offered in making the necessary referral and follow-up.

E. **CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**
Subchapter 5. Individual Providers and Specialties
Part 85. ADvantage Program Waiver Services
OAC 317:30-5-764. [AMENDED]
Part 95. Agency Personal Care Services
OAC 317:30-5-953. [AMENDED]
Chapter 35. Medical Assistance for Adults and Children-Eligibility
Subchapter 15. Personal Care Services
OAC 317:35-15-14. [AMENDED]
Subchapter 17. ADvantage Waiver Services
OAC 317:35-17-22. [AMENDED]
(Reference APA WF # 08-29 A & B)

FINDING OF EMERGENCY: The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to require that the provision of Personal Care and certain other in-home ADvantage services to SoonerCare members be documented using the Interactive Voice Response Authentication (IVRA) time and attendance system. The new electronic IVRA system will replace the current system of manual time documentation and therefore increase the efficiency of processing claims while reducing the error rate caused by duplication of records, resulting in a substantial savings of SoonerCare dollars over time.

SUMMARY: Rules are revised to require the use of the new Interactive Voice Response Authentication (IVRA) system to document time and attendance for all Personal Care and certain in-home ADvantage services provided to SoonerCare members. Currently, claims for Personal Care and associated in-home ADvantage services represent the highest volume of claim records processed through the Medicaid Management Information System. In-home services are necessarily provided in the individual homes of persons with physical and cognitive disabilities. The verification of service delivery is typically a paper time sheet signed by the member receiving services with a high potential for errors. Additionally, a paper based time and attendance system which requires transcription of time units from paper to computer is both inefficient and affords many opportunities for inadvertent errors.

BUDGET IMPACT: Agency staff has determined that the revisions will be budget neutral for the agency.

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

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on November 20, 2008, and recommended Board approval.

PROPOSED EFFECTIVE DATE: February 1, 2009

AUTHORITY: The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR 440.167

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
Rules are revised to require the utilization of the Interactive Voice Response Authentication (IVRA) system for documentation of certain in-home services provided to members.

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

317:30-5-764. Reimbursement
(a) Rates for waiver services are set in accordance with the rate setting process by the ~~Committee for Rates and Standards~~ State Plan Amendment Rate Committee (SPARC) and approved by the Oklahoma Health Care Authority Board.
(1) The rate for NF Respite is set equivalent to the rate for routine level of care nursing facility services that require providers having equivalent qualifications;
(2) The rate for daily units for Adult Day Health Care are set equivalent to the rate established by the Oklahoma Department of Human Services for the equivalent services provided for the OKDHS Adult Day Service Program that require providers having equivalent qualifications;
(3) The rate for units of Home-Delivered Meals are set equivalent to the rate established by the Oklahoma Department of Human Services for the equivalent services provided for the OKDHS Home-Delivered Meals Program that require providers having equivalent qualifications;
(4) The rates for units of ADvantage Personal Care and In-Home Respite are set equivalent to State Plan Agency Personal Care

unit rate which require providers having equivalent qualifications;

(5) The rates for Advanced Supportive/Restorative Assistance is set equivalent to 1.077 of the State Plan Agency Personal Care unit rate;

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

(A) The individual Budget Allocation (IBA) expenditure Accounts Determination constrains total Medicaid reimbursement for CD-PASS services to be less than expenditures for equivalent services using agency providers.

(B) The PSA and APSA service unit rates are calculated by the ~~AA~~ OKDHS/ASD during the CD-PASS service eligibility determination process. The ~~AA~~ OKDHS/ASD sets the PSA and APSA unit rates at a level that is not less than 80 percent and not more than 95 percent of the comparable Agency Personal Care (for PSA) or Advanced Supportive/Restorative (for APSA) service rate. The allocation of portions of the PSA and/or APSA rate to cover salary, mandatory taxes, and optional benefits (including Worker's Compensation insurance, if available) is determined individually for each member using the CD-PASS Individualized Budget Allocation Expenditure Accounts Determination Process.

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

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

(1) service;

(2) service provider;

(3) units authorized; and

(4) begin and end dates of service authorization.

(c) Service time for Personal Care, Nursing, Advanced Supportive/Restorative Assistance, In-Home Respite, CD-PASS

Personal Services Assistance, and Advanced Personal Services Assistance is documented solely through the use of the Interactive Voice Response Authentication (IVRA) system. Providers are required to use the IVRA system after access to the system is made available by OKDHS. The IVRA system provides alternate backup solutions should the automated system be unavailable. In the event of IVRA backup system failure, the provider will document time in accordance with their agency backup plan. The agency=s backup procedures are only permitted when the IVRA system is unavailable.

PART 95. AGENCY PERSONAL CARE SERVICES

317:30-5-953. Billing

A billing unit of service for ~~personal care~~ Personal Care skilled nursing service equals a visit. A billing unit of service for ~~personal care~~ Personal Care services provided by a PC service agency is 15 minutes of PC services delivery. Billing procedures for Personal Care services are contained in the OKMMIS Billing and Procedure Manual. Service time for Personal Care and Nursing is documented solely through the Interactive Voice Response Authentication (IVRA) system after access to the system is made available by OKDHS. The IVRA system provides alternate backup solutions should the automated system be unavailable. In the event of IVRA backup system failure, the provider will document time in accordance with their agency backup plan. The agency=s backup procedures are only permitted when the IVRA system is unavailable.

CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
SUBCHAPTER 15. PERSONAL CARE SERVICES

317:35-15-14. Billing procedures for Personal Care

Billing procedures for Personal Care Services are contained in the OKMMIS Billing and Procedure Manual. Questions regarding billing procedures that cannot be resolved through a study of the manual are referred to the OHCA. Contractors for Personal Care bill on ~~HCFA-1500~~ CMS-1500. The OKDHS county office ~~provide~~ provides instructions to an individual PCA for completion of the claim at the time of the contractor orientation. Each Personal Care contractor submits a claim for each ~~client~~ member. The contractor prepares claims for services provided and submits the claims to the fiscal agent who is responsible for assuring that the claims have been properly completed. All Personal Care contractors must have a unique provider number. New contractors will be mailed the provider number after they have been placed on the claims processing contractor's provider file. Service time of Personal Care and Nursing is documented solely through the Interactive Voice

Response Authentication (IVRA) system after access to the system is made available by OKDHS. The IVRA system provides alternate backup solutions should the automated system be unavailable. In the event of IVRA backup system failure, the provider will document time in accordance with their agency backup plan. The agency=s backup procedures are only permitted when the IVRA system is unavailable.

SUBCHAPTER 17. ADVANTAGE WAIVER SERVICES

317:35-17-22. Billing procedures for ADvantage services

(a) Billing procedures for long-term care medical services are contained in the Provider Manuals. Questions regarding billing procedures which cannot be resolved through a study of these manuals should be referred to the OHCA.

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

(1) service;
(2) service provider;
(3) units authorized; and
(4) begin and end dates of service authorization.

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

(d) Service time of Personal Care, Nursing, Advanced Supportive/ Restorative Assistance, In-Home Respite, CD-PASS Personal Services Assistance and Advanced Personal Services Assistance is reimbursed solely through the Interactive Voice Response Authentication (IVRA) system. Providers are required to use the IVRA system after access to the system is made available by OKDHS. The IVRA system provides alternate backup solutions should the automated system be unavailable. In the event of IVRA backup system failure, the provider will document time in accordance with their agency backup plan. The agency=s backup procedures are only permitted when the IVRA system is unavailable.

F. **CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**
Subchapter 5. Individual Providers and Specialties
Part 32. SoonerRide Non-Emergency Transportation
OAC 317:30-5-326. [AMENDED]
(Reference APA WF #08-49)

FINDING OF EMERGENCY: The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions which would remove specific reimbursement language from the SoonerRide Non-Emergency Transportation (NET) rules and instead refer only to the reimbursement methodology found in the Oklahoma Title XIX State Plan. Language in the current SoonerRide rule only addresses reimbursement under a capitated methodology and is silent as to reimbursement at a fee for service mileage rate for those members eligible for NET but not included in the NET capitation roster, as is outlined in the State Plan Amendment. This discrepancy could lead to a potential Payment Error Rate Measurement (PERM) error if OHCA rules are not brought in line with current practices and Oklahoma Title XIX State Plan requirements.

SUMMARY: Agency rules are revised in order to remove specific reimbursement language from the Non-Emergency Transportation rules and instead refer only to the reimbursement methodology found in the Oklahoma Title XIX State Plan. This revision will bring OHCA rules in line with current OHCA practice and Oklahoma Title XIX State Plan requirements thereby avoiding a potential PERM error.

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

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

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on November 20, 2008, and recommended Board approval.

PROPOSED EFFECTIVE DATE: Immediately upon Governor=s approval.

AUTHORITY: The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act and Sections 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR 440.170

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
Non-Emergency Transportation (NET) rules are revised to remove specific reimbursement language and instead refer only to the reimbursement methodology found in the Oklahoma Title XIX State Plan

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

317:30-5-326. Provider eligibility

The Oklahoma Health Care Authority (OHCA) is responsible for assuring that necessary transportation is available to all eligible SoonerCare members who are in need of SoonerCare medical services in accordance with 42 CFR 431.53. The agency contracts with a broker to provide statewide curb to curb coverage for non-emergency transportation under the SoonerRide program. The broker provides the most appropriate and least costly mode of transportation necessary to meet the individual needs of SoonerCare members. Payment for covered services to the broker ~~is reimbursed under capitated methodology based on per member per month~~ is made pursuant to the methodology described in the Oklahoma Title XIX State Plan. The agency contracts directly with ambulance and air providers for all other transportation needs for eligible members not approved by SoonerRide.

G. **CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**
Subchapter 5. Individual Providers and Specialties
Part 79. Dentists
OAC 317:30-5-696. [AMENDED]
OAC 317:30-5-698 through OAC 317:30-5-699. [AMENDED]
(**Reference APA WF 08-41)**

FINDING OF EMERGENCY: The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to allow a second set of panoramic x-rays within 36 months of the first set for detection and treatment of oral disease. Additionally, the rule is revised to allow for corrective treatment of restorative services by a different dental provider than the original provider of poorly rendered services. SoonerCare members are at risk for increased health complications without proper diagnosis and treatment of oral disease.

SUMMARY: Dental rules are revised to allow, with prior authorization, panoramic x-rays more than once every 36 months, for the detection and treatment of oral disease. The request for authorization must be submitted with a detailed medical need narrative and will not be prior authorized without sufficient justification. A second set of panoramic x-rays allow providers, discovering preliminary evidence of oral disease to treat and eliminate the pathology. Rules are also revised to allow the OHCA Dental Director to prior authorize the correction of poorly rendered or insufficient treatment of restorative procedures by a different provider than the original provider of sub-standard treatment. Lastly, rules are revised to restrict the application of ceramic based and cast metal based crowns to natural teeth only.

BUDGET IMPACT: Agency staff has determined that the revisions will have a minimal budget impact.

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

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on November 20, 2008, and recommended Board approval.

PROPOSED EFFECTIVE DATE: February 1, 2009

AUTHORITY: The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR 440.100

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
Dental rules are revised to: (1) allow prior authorize for a second set of panoramic x-rays within three years of the first set; (2) allow prior authorization for correction of poorly rendered dental procedures by a different provider than the provider of sub-standard treatment; (3) and limit the application of crowns to natural teeth only.

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 79. DENTISTS

317:30-5-696. Coverage by category

Payment is made for dental services as set forth in this Section.

(1) **Adults.**

(A) Dental coverage for adults is limited to:

(i) emergency extractions;

(ii) Smoking and Tobacco Use Cessation Counseling; and

(iii) medical and surgical services performed by a dentist, to the extent such services may be performed under State law either by a doctor of dental surgery or dental medicine, when those services would be covered if performed by a physician.

(B) Payment is made for dental care for adults residing in private Intermediate Care Facilities for the Mentally Retarded (ICF/MR) and who have been approved for ICF/MR level of care, similar to the scope of services available to individuals under age 21.

(C) Pregnant women are covered under a limited dental benefit plan (Refer to (a)(4) of this Section).

(2) **Home and community based waiver services (HCBWS) for the mentally retarded.** All providers participating in the HCBWS must have a separate contract with the OHCA to provide services under the HCBWS. 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 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.

(A) **Comprehensive oral evaluation.** Evaluation must be performed and recorded for each new patient, or established patient not seen for more than 18 months. This procedure is allowed once each 18 month period.

(B) **Periodic oral evaluation.** This procedure may be provided for a member of record if she or he has not been seen for more than six months.

(C) **Emergency examination/limited oral evaluation.** This procedure is not compensable within two months of a periodic oral examination or if the member is involved in active treatment unless trauma or acute infection is the presenting complaint.

(D) **Oral hygiene instructions.** This service is limited to once every 12 months. The designated dental staff instructs the member or the responsible adult (if the child is under five years of age) in proper tooth brushing and flossing by actual demonstration and provides proper verbal and/or written diet information. This service also includes dispensing a new tooth brush, and may include disclosing tablets and dental floss.

(E) **Radiographs (x-rays).** To be SoonerCare compensable, x-rays must be of diagnostic quality and medically necessary. A clinical examination must precede any radiographs, and chart documentation must include patient history, prior radiographs, caries risk assessment and both dental and general health needs of the patient. The referring dentist is responsible for providing properly identified x-rays of acceptable quality with a referral, if that provider chooses to expose and submit for reimbursement prior to referral. Panoramic films are allowable once in a three year period and must be of diagnostic quality. Panoramic films are only compensable when chart documentation clearly indicates the test is being performed to rule out or evaluate non-caries related pathology. Prior authorization and a detailed medical need narrative are required for additional panoramic films taken within three years of the original set.

(F) **Dental sealants.** Tooth numbers 2, 3, 14, 15, 18, 19, 30 and 31 must be caries free on all surfaces to be eligible for this service. This service is available through 18.0 years of age and is compensable only once per lifetime. Replacement of sealants is not a covered service under the SoonerCare program.

(G) **Dental prophylaxis.** This procedure is provided once every 184 days including topical application of fluoride.

(H) **Composite restorations.**

(i) This procedure is compensable for primary incisors as follows:
(I) tooth numbers O and P to age 4.0 years;
(II) tooth numbers E and F to age 6.0 years;
(III) tooth numbers N and Q to 5.0 years; and
(IV) tooth numbers D and G to 6.0 years.
(ii) The procedure is also allowed for use in all vital and successfully treated non-vital permanent anterior teeth.
(iii) Class I and II composite restorations are allowed in posterior teeth; however, the OHCA has certain restrictions for the use of this restorative material. (See OAC 317:30-5-699).

(I) **Amalgam.** Amalgam restorations are allowed in:
(i) posterior primary teeth when:
(I) 50 percent or more root structure is remaining;
(II) the teeth have no mobility; or
(III) the procedure is provided more than 12 months prior to normal exfoliation.
(ii) any permanent tooth, determined as medically necessary by the treating dentist.

(J) **Stainless steel crowns.** The use of stainless steel crowns is allowed as follows:
(i) Stainless steel crowns are allowed if the child is five years of age or under, and 70 percent or more of the root structure remains or the tooth is not expected to exfoliate within the next 12 months.
(ii) Stainless steel crowns are treatment of choice for:
(I) primary teeth with pulpotomies or pulpectomies, if the above conditions exist;
(II) primary teeth where three surfaces of extensive decay exist; or
(III) primary teeth where cuspal occlusion is lost due to decay or accident.
(iii) Stainless steel crowns are the treatment of choice on posterior permanent teeth that have completed endodontic therapy, if more than three surfaces of extensive decay exist or where cuspal occlusion are lost due to decay prior to age 16.0 years.
(iv) Preoperative periapical x-rays must be available for review, if requested.
(v) Placement of a stainless steel crown includes all related follow up service for a period of two years. No other prosthetic procedure 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.

(K) **Pulpotomies and pulpectomies.**

(i) Therapeutic pulpotomies are allowable for molars and teeth numbers listed below. Pre and post operative periapical x-rays must be available for review, if requested.

(I) Primary molars having at least 70 percent or more of their root structure remaining or more than 12 months prior to normal exfoliation;

(II) Tooth numbers O and P before age 5.0 years;

(III) Tooth numbers E and F before 6.0 years;

(IV) Tooth numbers N and Q before 5.0 years; and

(V) Tooth numbers D and G before 6.0 years.

(ii) Pulpectomies are allowed for primary teeth if exfoliation of the teeth is not expected to occur for at least one year or if 70 percent or more of root structure is remaining.

(L) **Anterior root canals.** Payment is made for the services provided in accordance with the following:

(i) This procedure is done for permanent teeth when there are no other missing anterior teeth in the same arch requiring replacement.

(ii) Acceptable ADA filling materials must be used.

(iii) Preauthorization is required if the member's treatment plan involves more than four anterior root canals.

(iv) Teeth with less than 50 percent of clinical crown should not be treatment-planned for root canal therapy.

(v) Pre and post operative periapical x-rays must be available for review.

(vi) Pulpotomy may be performed for the relief of pain while waiting for the decision from the OHCA.

(vii) Providers are responsible for any follow-up treatment required due to a failed root canal therapy for 24 month post completion.

(viii) Endodontic 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.

(ix) If there are three or more missing teeth in the arch that requires replacement, root therapy will not be allowed.

(M) **Space maintainers.** Certain limitations apply with regard to this procedure. Providers are responsible for recementation of any maintainer placed by them for six 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 or where the successor tooth would not normally erupt in the next 12 months.

(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 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 x-rays must be available for review.

(ii) **Lingual arch bar.** Payment is made for the services provided in accordance with the following:

(I) Lingual arch bar is used where multiple missing teeth exist in the same arch.

(II) The requirements are the same as for band and loop space maintainer.

(III) Multiple missing upper anterior primary incisors may be replaced with the appliance to age 6.0 years to prevent abnormal swallowing habits.

(IV) Pre and post operative x-rays must be available.

(iii) **Interim partial dentures.** This service is for anterior permanent tooth replacement or if the member is missing three or more posterior teeth to age 16.0 years of age.

(N) **Analgesia.** Use of nitrous oxide is compensable for four occurrences per year.

(O) **Pulp caps (direct).** ADA accepted CAOH containing material must be used.

~~(P) **Occlusal guard.** Narrative of clinical findings must be sent with prior authorization request.~~

~~(Q)~~(P) **Sedative treatment.** ADA acceptable materials must be used for temporary restoration. This restoration is used for very deep cavities to allow the tooth an adequate chance to heal itself or an attempt to prevent the need for root canal therapy. This restoration, when properly used, is intended to relieve pain and may include a direct or indirect pulp cap. The combination of a pulp cap and sedative fill is the only restorative procedure allowed per tooth per day. Subsequent restoration of the tooth is allowed after a minimum of 30 days.

~~(R)~~(Q) **History and physical.** Payment is made for services for the purpose of admitting a patient to a hospital for dental treatment.

~~(S)~~(R) **Local anesthesia.** This procedure is included in the fee for all services.

~~(T)~~(S) **Smoking and Tobacco Use Cessation Counseling.** Smoking and Tobacco Use Cessation Counseling is covered when performed utilizing the five intervention steps of asking the patient to describe his/her smoking, advising the patient to quit, assessing the willingness of the patient to quit, assisting with referrals and plans to quit, and arranging for follow-up. Up to eight 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, nurse midwives, and Oklahoma State Health Department and FQHC nursing staff in addition to other appropriate services rendered. Chart documentation must include a separate note, separate signature, and the patient specific information addressed in the five steps and the time spent by the practitioner performing the counseling. Anything under three minutes is considered part of a routine visit.

(4) **Pregnant Women.** Dental coverage for this special population is provided regardless of age.

(A) Proof of pregnancy is required (Refer to OAC 317:35-5-6).

(B) Coverage is limited to a time period beginning at the diagnosis of pregnancy and ending upon 60 days post partum.

(C) In addition to dental services for adults, other services available include:

(i) Comprehensive oral evaluation must be performed and recorded for each new client, or established client not seen for more than 24 months;

(ii) Periodic oral evaluation as defined in OAC 317:30-5-696(a)(3)(B);

(iii) Emergency examinations/limited oral evaluation. This procedure is not allowed within two months of an oral examination by the same provider for the same client, or if the client is under active treatment;

(iv) Oral hygiene instructions as defined in OAC 317:30-5-696(a)(3)(E);

(v) Radiographs as defined in OAC 317:30-5-696(a)(3)(F);

(vi) Dental prophylaxis as defined in OAC 317:30-5-696(a)(3)(H);

(vii) Composite restorations:

(I) Any permanent tooth that has an opened lesion that is a food trap will be deemed medically necessary for

this program and will be allowed for all anterior teeth.

(II) Class I posterior composite resin restorations are allowed in posterior teeth that qualify;

(viii) Amalgam. Any permanent tooth that has an opened lesion that is a food trap will be deemed as medically necessary and will be allowed; and

(ix) Analgesia. Use of nitrous oxide is compensable for four occurrences.

(D) Services requiring prior authorization (Refer to OAC 317:30-5-698).

(E) Periodontal scaling and root planing. Required that 50% or more of six point measurements be 4 millimeters or greater. This procedure is designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins and microorganism and requires anesthesia and some soft tissue removal.

(5) **Individuals eligible for Part B of Medicare.**

(A) Payment is made based on the member's coinsurance and deductibles.

(B) Services which have been denied by Medicare as noncompensable should be filed directly with the OHCA with a copy of the Medicare EOB indicating the reason for denial.

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. Emergency dental care is immediate service that must be provided to relieve the member from pain due to an acute infection, swelling, trismus or trauma. Requests for dental services requiring prior authorization must be accompanied by sufficient documentation. Study models (where indicated), x-rays, six point periodontal charting, comprehensive treatment plan and narrative may be requested. If the quality of the supporting material is such that a determination of authorization cannot be made, the material is returned to the provider. Any new documentation must be provided at the provider's expense.

(b) Requests for prior authorization are filed on the currently approved 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 and eligible ICF/MR residents. Minimum required records to be submitted with each request are right and left mounted bitewing x-rays and periapical films of tooth/teeth involved or the edentulous areas if not visible in the bitewings. X-rays must be mounted so that they are viewed from the front of the member. If required x-rays sent are copies, each film or print must be of good, readable quality and identified as to left and right sides. The film must clearly show the requested service area of interest. X-rays must be identified with member name, date, member ID number, provider name, and provider number. X-rays must be placed together in an envelope and stapled to the submission form. If radiographs are not taken, provider must include in narrative sufficient information to confirm diagnosis and treatment plan.

(1) Endodontics. Pulpotomy may be performed for the relief of pain while waiting for the decision from the OHCA on request for endodontics. A permanent restoration is not billable to the OHCA when performing pulpotomy or pulpal debridement on a permanent tooth.

(A) Anterior root canals. This procedure is for members whom, by the provider's documentation, have a treatment plan requiring more than four anterior root canals and/or posterior endodontics. Payment is made for services provided in accordance with the following:

(i) Permanent teeth numbered 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26 and 27 are eligible for therapy if there are no other missing teeth in the same arch requiring replacement, unless numbers 6, 11, 22, or 27 are abutments for prosthesis.

(ii) Accepted ADA filling must be used.

(iii) Pre and post operative periapical x-rays must be available for review.

(iv) Providers are responsible for any follow-up treatment required by a failed endodontically treated tooth within 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.

(vi) An endodontic procedure may not be approved if the tooth requires a post and core in order to present adequate structure to retain a crown.

(vii) If there are three or more missing teeth in the arch that requires replacement, root therapy will not be allowed.

(B) Posterior endodontics. The guidelines for this procedure are as follows:

(i) The provider documents that the member has improved oral hygiene and flossing ability in this member's records.
(ii) Teeth that would require pre-fabricated post and cores to minimally retain a crown due to lack of natural tooth structure should not be treatment planned for root canal therapy.
(iii) Pre and post operative periapical x-rays must be available for review.
(iv) Providers are responsible for any follow-up treatment required by a failed endodontically treated tooth within 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.
(vi) Only ADA accepted filling materials are acceptable under the OHCA policy.
(vii) Posterior endodontic procedure is limited to a maximum of five teeth. A request 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) there are missing teeth in the same arch requiring replacement;
(II) an opposing tooth has super erupted;
(III) loss of tooth space is one third or greater;
(IV) opposing second molars are involved; or
(V) the member has multiple teeth failing due to previous inadequate root canal therapy.
(ix) Endodontically treated teeth must be restored to limited occlusal function and all contours must be replaced. These teeth will not be approved for a crown if it appears the apex is not adequately sealed.
(x) a single failing root canal is determined not medically necessary for re-treatment.

(2) Cast metal crowns or ceramic-based crowns. ~~This procedure is~~ These procedures are compensable for restoration of natural teeth for members who are 16 years of age or older and adults residing in private Intermediate Care Facilities for the Mentally Retarded (ICF/MR) and who have been approved for (ICF/MR) level of care. Certain criteria and limitations apply.
(A) The following conditions must exist for approval of this procedure.
(i) The tooth must be fractured or decayed to such an extent to prevent proper cuspal or incisal function.
(ii) The clinical crown is destroyed by the above elements by one-half or more.

(iii) Endodontically treated teeth must have three or more surfaces restored or lost due to carious activity to be considered.

(B) The conditions listed in (A)(i) through (A)(iii) of this paragraph should be clearly visible on the submitted x-rays when a request is made for any type of crown.

(C) Routine build-up(s) for authorized crowns are included in the fee for the crown.

(D) A crown will not be approved if adequate tooth structure does not remain to establish cleanable margins, poor crown to root ratio, or the tooth appears to retain insufficient amounts of natural tooth structure. Cast dowel cores are not allowed.

(E) Preformed post(s) and core build-up(s) are not routinely provided with crowns for endodontically treated teeth.

(F) Ceramic-metal based crowns will be considered only for tooth numbers 4 through 13 and 21 through 28.

(G) Full cast metal crowns are treatment of choice for all posterior teeth.

(H) Provider is responsible for replacement or repair of cast crowns for 48 months post insertion.

(3) Cast frame partial dentures. This appliance is the treatment of choice for replacement of three or more missing permanent teeth in the same arch for members 16 through 20 years of age. Provider must indicate tooth number to be replaced and teeth to be clasped.

(4) Acrylic partial. This appliance is the treatment of choice for replacement of missing anterior permanent teeth or three or more missing teeth in the same arch for members 12 through 16 years of age and adults residing in private Intermediate Care Facilities for the Mentally Retarded (ICF/MR) and who have been approved for ICF/MR level of care. Provider must indicate tooth numbers to be replaced and teeth to be clasped. This appliance includes all necessary clasps and rests.

(5) Occlusal guard. Narrative of clinical findings must be sent with prior authorization request.

~~(5)~~ (6) Fixed cast non-precious metal or porcelain/metal bridges. Only members 17 through 20 years of age where the bite relationship precludes the use of an acrylic or cast frame partial denture are considered. Study models with narrative are required to substantiate need for fixed bridge(s). Members must have excellent oral hygiene documented in the requesting provider's records.

~~(6)~~ (7) Periodontal scaling and root planing. This procedure requires that 50% or more of the six point measurements be four millimeters or greater and must involve two or more teeth per quadrant for consideration. This procedure is allowed on members 12 to 20 years of age and requires anesthesia and some

soft tissue removal. The procedure is not allowed in conjunction with any other periodontal surgery. Allowance may be made for submission of required authorization data post treatment if the member has a medical or emotional problem that requires sedation.

~~(7)~~ (8) Additional prophylaxis. The OHCA recognizes that certain physical conditions require more than two prophylaxes. The following conditions may qualify a member for one additional prophylaxis per year:

(A) dilantin hyperplasia;
(B) cerebral palsy;
(C) mental retardation;
(D) juvenile periodontitis.

317:30-5-699. Restorations

(a) **Use of posterior composite resins.** Payment is not made for certain restorative services when posterior composite resins are used in restorations involving:

(1) replacement of any occlusal cusp;
(2) sub-gingival margins; and
(3) a restoration replacing more than 50 percent of the dentin.

(b) **Utilization parameters.** The Oklahoma Health Care Authority utilization parameters allow only one permanent restorative service to be provided per tooth per 12 months. Providers must document use of rubber dam isolation in daily treatment progress notes. The provider is responsible for follow-up or any required replacement of a failed restoration. Fees paid for the original restorative services may be recouped if any additional treatments are required on the same tooth by a different provider within 12 months due to defective restoration or recurrent decay. If it is determined by the Dental Director that a member has received poorly rendered or insufficient treatment from a provider, the Dental Director may prior authorize corrective procedures by a second provider.

(c) **Coverage for dental restorations.** Services for dental restorations are covered as follows:

(1) If the mesial occlusal pit and the distal occlusal pit on an upper molar tooth are restored at the same appointment, this is a one surface restoration.
(2) If any two separate surfaces on a posterior tooth are restored at the same appointment, it is a two surface restoration.
(3) If any three separate surfaces on a posterior tooth are restored at the same appointment, it is a three surface restoration.
(4) If the mesial, distal, facial and/or lingual of an upper anterior tooth is restored at the same appointment, this is a four surface restoration.

(5) If any two separate surfaces on an anterior tooth are restored at the same appointment, it is a two surface restoration.

(6) If any three separate surfaces on an anterior tooth are restored at the same appointment, it is a three surface restoration.

(7) An incisal angle restoration is defined as one of the angles formed by the junction of the incisal and the mesial or distal surface of an anterior tooth. If any of these surfaces are restored at the same appointment, even if separate, it is considered as a single incisal angle restoration.

(8) When four or more separate surfaces on a posterior tooth are restored at the same appointment it is a four surface restoration.

(9) Wide embrasure cavity preparations do not become extra surfaces unless at least one half of cusp or surface is involved in the restoration. An MODFL restoration would have to include the mesial-occlusal-distal surfaces as well as either the buccal groove pit or buccal surface or at least one half the surface of one of the buccal cusps. The same logic applies for the lingual surface.

(d) **Sedative restorations.** Sedative restorations include removal of decay, if present, and direct or indirect pulp cap, if needed. These two codes are the only codes that may be used for the same tooth on the same date of service. Permanent restoration of the tooth is allowed after 30 days unless the tooth becomes symptomatic and requires pain relieving treatment.

(e) **Pulp caps.** Indirect and direct pulp cap must be ADA accepted materials, not a cavity liner. Utilization of these codes are verified on a post payment review.

H. **CHAPTER 2. GRIEVANCE PROCEDURES AND PROCESS**
OAC 317:2-1-7. [AMENDED]
(Reference APA WF # 08-40)

FINDING OF EMERGENCY: The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to revise policy which incorrectly states that the provider appeal is forwarded to the SURS unit or Program Integrity Audit/Review unit after it has been docketed. Currently, agency=s practices are an appeal is forwarded to the Legal Services Division after it has been docketed. The revision is needed to reflect accurate agency practices and to ensure provider appeals are forwarded to the correct division without unnecessary delays.

SUMMARY: Agency rules are revised to ensure policy is consistent with the agency=s practices. Currently, agency=s practices are an appeal is forwarded to the Legal Services Division after it has been docketed. The revision is needed to reflect accurate agency practices and to ensure provider appeals are forwarded to the correct division without unnecessay delays.

BUDGET IMPACT: Agency staff has determined that the revisions are budget neutral to the agency.

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

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on November 20, 2008, and recommended Board approval.

PROPOSED EFFECTIVE DATE: Immediately upon Governor's approval.

AUTHORITY: The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 C.F.R. Section 435.902; 42 C.F.R. Section 435.930

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:

Agency rules are revised to ensure policy regarding provider appeals is consistent with the agency=s practices.

CHAPTER 2. GRIEVANCE PROCEDURES AND PROCESS

317:2-1-7. Surveillance, Utilization and Review System (SURS) and Program Integrity Audits/Reviews appeals

SURS and Program Integrity Audits/Reviews appeals are made to the State Medicaid Director.

(1) If a provider disagrees with a decision of the ~~Surveillance, Utilization and Review System Unit (SURS)~~ SURS or Program Integrity Audit/Review which has determined that the provider has received an overpayment, the provider may appeal, within 20 days of the date of that decision to the State Medicaid Director.

(2) The appeal from the SURS or Program Integrity Audit/Review decision will be commenced by the receipt of a letter from the appellant provider. The letter must set out with specificity, the overpayment decision to which the provider objects along with the grounds for appeal. The letter should explain in detail, the factual and/or legal basis for disagreement with the allegedly erroneous decision. The letter ~~will~~ should also include all relevant exhibits the provider believes necessary to decide the appeal.

(3) Upon ~~the~~ receipt of the appeal by the docket clerk, the matter will be docketed for the next meeting of the ~~MAC~~ Medical Advisory Committee (MAC). Any appeal received less than four weeks before a scheduled MAC meeting will be set for the following MAC meeting.

(4) The appeal will be forwarded to the ~~SURS unit or Program Integrity Audit/Review unit~~ OHCA Legal Services Division by the docket clerk for distribution to the members of the subcommittee and for preparation of the OHCA's case. A subcommittee of the MAC will be formed and render a recommendation to the State Medicaid Director.

(5) At the discretion of the MAC, witnesses may be called and information may be solicited from any party by letter, telephonic communication, fax, or other means. The subcommittee may request that members of the Authority be present during their consideration of the appeal. Members of the Authority's Legal Division may be asked to answer legal questions regarding the appeal.

(6) The subcommittee will issue a recommendation regarding the appeal, in writing, within 30 days of the hearing. An exception to the 30 day rule will apply in cases where the subcommittee sets the case over until its next scheduled meeting in order to gather additional evidence. The written recommendation will list the members of the subcommittee who participated in the

decision. In cases where an appeal must be continued, the subcommittee will issue a letter within 30 days of the initial hearing to inform the appellant of the continuance.
(7) The recommendation, after being formalized, will be sent to the docket clerk for review by the State Medicaid Director. The State Medicaid Director will issue a decision regarding the appeal within 60 days of the docket clerk's receipt of the recommendation from the MAC. The decision will be issued to the appellant or his/her authorized agent.
(8) If the provider is dissatisfied with the Medicaid Director's decision, it may be appealed to the CEO under OAC 317:2-1-13.