Oklahoma Health Care Authority
MEDICAL ADVISORY COMMITTEE
November 7th, 2024
1:00 – 3:30 PM
Charles Ed McFall Board Room

AGENDA

Please access via zoom:
https://www.zoomgov.com/webinar/register/WN_LOW9ZB2LTyqRgsAc3qp50A
Telephone: 1-669-254-5252 Webinar ID: 160 297 4109

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

II. Action Item: Approval of Minutes of the September 12th, 2024: **Medical Advisory Committee Meeting**

III. Public Comments (2 minute limit)

IV. MAC Member Comments/Discussion

V. IMD Post Award Forum: **Melissa Miller, Senior Director, Behavioral Health Policy, and Planning**

VI. SoonerCare Choice Post Award Forum: **Heather Cox, Policy and Program Management**

VII. OHCA Updates: **Christina Foss, Chief of Staff**

VIII. SoonerSelect Medical Request to Change Service Provisions: **Paula Root, Chief Medical Officer**

IX. SoonerSelect Dental Request to Change Service Provisions for DentaQuest: **Bernard Rhone, Director of Dental Services**

X. Proposed Rule Changes: Presentation, Discussion, and Vote: **Kasie McCarty, Senior Director of Federal and State Authorities**

A. **APA WF # 24-14 Hospice Benefit Expansion**
B. **APA WF # 24-18 Third Party Liability (TPL) for School-based Services**
C. **APA WF # 24-19 Updating Abortion Policy**
D. **APA WF # 24-24 Medication Assisted Treatment (MAT) Clarification**
E. **APA WF # 24-25 Psychological Testing Limit Increase**
F. **APA WF #24-21 Certified Registered Nurse Anesthetists (CRNA) Equalization**
G. **APA WF # 24-13 Program of All-Inclusive Care for the Elderly (PACE) Licensure**
H. **APA WF # 24-34 Community Health**

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

XII. Future Meeting: **Chairman, Jason Rhynes, O.D.**

January 9, 2025
March 6, 2025
May 1, 2025
July 3, 2025, or July 10, 2025
September 4, 2025, or September 11, 2025
November 6, 2025

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

Oklahoma Health Care Authority
MEDICAL ADVISORY COMMITTEE
MINUTES of the September 12, 2024, Meeting
4345 N. Lincoln Blvd., Oklahoma City, OK 73105

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

Chairman, Dr. Jason Rhynes called the meeting to order at 1:02 PM.

Delegates present were: Mr. Nick Barton, Ms. Joni Bruce, Dr. Steven Crawford, Ms. Janet Cizek, Ms. Jennifer King, Ms. Melissa Miller, Dr. J. Daniel Post, Dr. Marny Dunlap and Dr. Jason Rhynes

Alternates present were: Ms. Miranda Hooper, and Ms. Buffy Heater providing a quorum.

***Delegates absent without an alternate were*:** Mr. Brett Coble, Dr. Arlen Foulks, Dr. Raymond Smith, and Dr. Whitney Yeates.

II. Approval of the May 2nd, 2024 Minutes

Medical Advisory Committee

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

III. Public Comments (2-minute limit):

Ms. Mariel Fernandez with The Council of Autism Service Providers spoke regarding APA WF# 23-24- Applied Behavioral Analysis policy revisions. She applauds OHCA for making changes to the policy. There are several revisions that demonstrate a significant step forward, however, there is also revisions that's violate the Federal Mental Health Parity and Addiction Equality Act. Such as Sections 317:30-5-313(a)(1), 317:30-5-313(b)(4) 313(b)(5). 317:30-5-314(a)(1)(b) and 314(2)(J), 317:30-5-314(b)(3) parts (b) and (L), as well as 317:30-5-315 parts 2,3, and 4. They appear more restrictive than ETSDP allows, and they differ from the generally accepted standard of care and best clinical practice. The US Department of Health and Human Services released a set of final rules for implementing. One area addressed in the new rules are the quantitative limits to treatment for autism, including parent training requirements, diagnostic requirements, and PA requirements. Unless OHCA has applied the same limits in this policy to distinguish all medical surgical benefits, we respectfully request that the MAC recommend the rules align.

Ms. Mallory Flecther with the Oklahoma Association for Behavior Analysts spoke regarding APA WF# 23-24- Applied Behavioral Analysis policy revisions. She also applauds OHCA for making changes to the policy and has some of the same concerns. Section 317:30-5-313(b) frequency and duration of services includes several restricted measures on services that don't align with this practice. An example being that the diagnostic severity level as well as specific symptoms determined by OHCA, when its necessary to access those certain level of benefits. We strongly recommend that the changes be made consistent with generally accepted standards of care, and that the members

treatment level, and treatment dosage be consistent with their identified symptoms that are presented during the assessment process for board certified behavior analyst. There are additional quantitative and non-quantitative treatment limits throughout the policy, that restrict access in a manner that's not equally restricted to medical surgical services. The policy also includes a PA limitation that may result in a lapse of coverage for members continuing treatment found in section 317:353-1512. Their last concern is revisions include the requirement for a parent caregiver to attend treatment for the child to access indicated clinically appropriate treatments in section 317:353-1323 and 6.

IV. MAC Member Comments/Discussion:

Ms. Bruce stated a concern with children going inpatient or to a residential treatment facility for mental health services, and being transferred to a school that covers that entity, and then goes back home to their homeschool where the child is not getting any kind of information from the facilities, such as a transition plan, which is required by Medicaid. Schools are frustrated from the lack of communication concerning the students as well.

V. Budget Update:

Tasha Black, Senior Director of Budget and Procurement

Ms. Black presented the FY 2025 Budget to the members. Stating that our budget is 11.1 million dollars. OHCA was appropriated 1.3 billion dollars, which is 46.8% increase over last year. Our medical program budget increased this year by 1.7% or $135,143,690. We factored in 2.2% for our traditional population, and 2.8% for our expansion for a total of $212 million. Our program initiatives, such as CRNA rate increase is currently going through the public process, and then we have our nursing facility trach add-on which adds up to $10 million. In summary the total program total is $135,143,690. For more detailed information, please see agenda item 5 in the MAC agenda.

VI. Quality Advisory Committee Update:

Folake Adedeji, Chief Quality Officer

Ms. Adedeji gave an overview of the Quality Advisory Committee (QAC). The committee was established by the Oklahoma Legislature in 2022 to provide an oversight and evaluate performances across all quality-related aspects of SoonerSelect. They will make recommendations to the OHCA administrators & Board on measures used by contracted entities. There is 19 members with a chair & vice-chair selected. Along with the QAC, there is 3 sub-committees: Data & Operational, Performance Improvements Projects (PIPs), and Primary Care Spend. The sub-committee consists of 6 QAC members, and 3 OHCA staff. They will define and evaluate what constitutes OHCA's primary

care spend and make recommendations for OHCA's final primary care spend algorithm. For more detailed information, please see agenda item 6 in the MAC agenda.

VII. SoonerSelect Update:

Sandra Puebla, Deputy State Medicaid Director

Ms. Puebla was unable to make the meeting and Director Rains presented on her behalf stating that as of September there are 579,800 members enrolled in SoonerSelect Medical, with 200,000 members attributed to each plan. There is about 19,840 members enrolled in SoonerSelect CSP. There are 627,009 members enrolled in SoonerSelect Dental, with 300,000 members attributed to each plan. As of September 2024, an aggregate total of $906,249,480 has been reimbursed since implementation of all the SoonerSelct programs, with over 490,000 members all having been served by a SoonerSelect plan. An aggregate total of $756,949,126 has been reimbursed since implementation of the SoonerSelect Medical/CSP programs. Finally, an aggregate total of $115,920,163 has been reimbursed since implementation of the SoonerSelect Dental program on February 1, 2024.

A. SoonerSelect Dental Updates:

Bernard Rhone, Director of Dental Services

Dr. Rhone presented the SoonerSelect Dental Contracted Entity (CE) requests to change service provisions stating the SoonerSelect contract at section 1.7: Covered Benefits and section 1.8: Dental Services Utilization management states that dental CEs may not impose prior authorization guidelines/criteria or utilization management practices that are more restrictive than OHCA with OHCA prior approval. In July DentaQuest submitted a formal request to OHCA for review and approval to change service provisions. OHCA subject matter experts (SMEs) reviewed the requests, evaluating them in comparison to OHCA historical processes and practices, standard business practice in markets, and available data to determine whether to approve the requests. The procedure codes are D7230 - removal of impacted tooth -partially bony. D7240 - removal of impacted tooth- completely bony. D7413 - excision of malignant lesion up to 1.25cm. finally, D7414 – excision of malignant lesion greater than 1.25 cm. For more detailed information, see agenda item 7a in the MAC agenda.

VIII. Medicaid Director Update:

Traylor Rains, State Medicaid Director

Director Rains stated that CMS put out a great opportunity for school-based services, which our team, along with the Department of Education have been working on. It's a conjunction with the road we are going down regarding expanding our school-based services array of services, to where its not just those services that are limited to an IEP or 504 work plans. This grant will bring in the

funds to build infrastructure to the state, to continue educating schools on how to provides these services appropriately. Were also working on a juvenile reentry plan. This is to provider services to children in custody of Juvenile Justice to get them transitional services 30 days prior to release. There is also an 1115 demonstration opportunity that focus on reentry services for adults.

A. Prior Authorization Requirements for Psychological Testing:
Paula Root, Chief Medical Officer

Dr. Root presented on Prior Authorization (PA) requirements for psychological testing discussing that during an OHCA compliance review for the Mental Health Parity and Addiction Equity Act (MHPAEA) it was noted that a PA for psychological/neuropsychological test was required for Behavioral Health providers, however no PA was required for medical services. As a result, OHCA will be adding a PA requirement for psychological testing codes 96130, 96139, and 96146 for medical providers effective 10/1/2024. A few requirements include a member who is experiencing difficulty in functioning with origins not clearly determined, and an evaluation has been recommended and/or requested by a physician, psychiatrist, psychologist, or a licensed mental health professional. For more detailed information, see item 8a in the MAC agenda.

IX. Proposed Rule Changes: Presentation, Discussion, and vote:
Kasie McCarty, Senior Director of Federal and State Authorities

Ms. McCarty was not able to attend the MAC. Ms. Heather Cox spoke on her behalf.

APA WF #24-22 High-acuity Tracheostomy Rate for Nursing Facilities — The Oklahoma Health Care Authority (OHCA) is proposing a new policy to establish an add-on rate for nursing facilities that serve tracheostomy patients who meet the high-acuity criteria. The rate will help to cover the high cost associated with this type of care and is being determined using existing cost data based on four components: direct care and allied staff costs, social and support staff costs, cost of drugs and medical supplies, and general and administrative costs.

Budget Impact: The estimated budget impact for SFY2025 will be an increase in the total amount of $1,557,225; with $498,468 in state share.

The rule change motion to approve as by Dr. Steve Crawford and seconded by Dr. J. Daniel Post and passes unanimously.

APA WF #24-23 Applied Behavioral Analysis Policy Revisions — The proposed emergency rule revisions update outdated ABA policies to ensure that services meet a standard level of quality for all applicable members. This includes updates to documentation requirements for Behavior Intervention Plans, critical incident reporting, family training requirements, and billing guidelines.

Additionally, these rules update the medical necessity criteria and describe various exclusions to treatment. Lastly, language is added to ensure ABA providers do not use restraint, except in extreme and documented circumstances.

Budget Impact: The proposed changes are budget neutral.

The rule change motion to approve as by Dr. Steve Crawford and seconded by Ms. Melissa Miller and passes unanimously.

APA WF #24-26 A&B Developmental Disabilities Services - The proposed revisions update Developmental Disabilities Services (DDS) policy to align with the DDS 1915(c) Home and Community Based Services (HCBS) waiver programs that were recently amended and approved by the Centers for Medicare and Medicaid Services (CMS), effective July 1, 2024. The proposed revisions add the diagnosis of Global Developmental Delay as an acceptable diagnosis for admission to a DDS HCBS waiver for individuals under 6 years of age and clarify that a diagnosis of intellectual disability (ID) is based on the criteria set forth by the Social Security Administration. Other revisions remove the requirement for authorization of community transition services to be issued for the date a member transitions into the community. Additionally, revisions add a new residential service for members in custody of Oklahoma Department of Human Services (OHS) and adult members with extensive behavioral support needs that cannot be safely met with currently available supports. Lastly, revisions permit legally responsible individuals to serve as Habilitation Training Specialists to individuals for whom they are legally responsible.

Budget Impact: The estimated budget for SFY 2025 will be an increase in the amount of $10,262,939; with $5,717,272 in state share.

The Agency is requesting the effective date to be or November 1, 2024, or upon receiving gubernatorial approval.

The rule change motion to approve as by Dr. J. Daniel Post and seconded by Dr. Marny Dunlap and passes unanimously.

APA WF #24-20 Pharmacists as Providers — House Bill 2322 from the 2022 legislative session directed the Oklahoma Health Care Authority to reimburse pharmacists for services rendered within their scope of practice at the same rate paid to other providers for provision of the same services. The proposed additions implement pharmacists' services as a covered benefit to SoonerCare members. The policy additions require pharmacists to be licensed by the Oklahoma State Board of Pharmacy, allows coverage of services within pharmacists' statutory scope of practice, and establishes a reimbursement methodology for pharmacists that is identical to that of physicians.

Further, the proposed changes add pharmacists' services to definition of an I/T/U facility encounter, allowing them to be reimbursed at the OMB rate.

Budget Impact: This budget impact is expected to be effectively budget neutral due to a shift in billing provider type; no net increase in utilization or cost is expected.

The rule change motion to approve as by Dr. Steve Crawford and seconded by Dr. J. Daniel Post and passes unanimously.

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

There was no new business addressed.

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

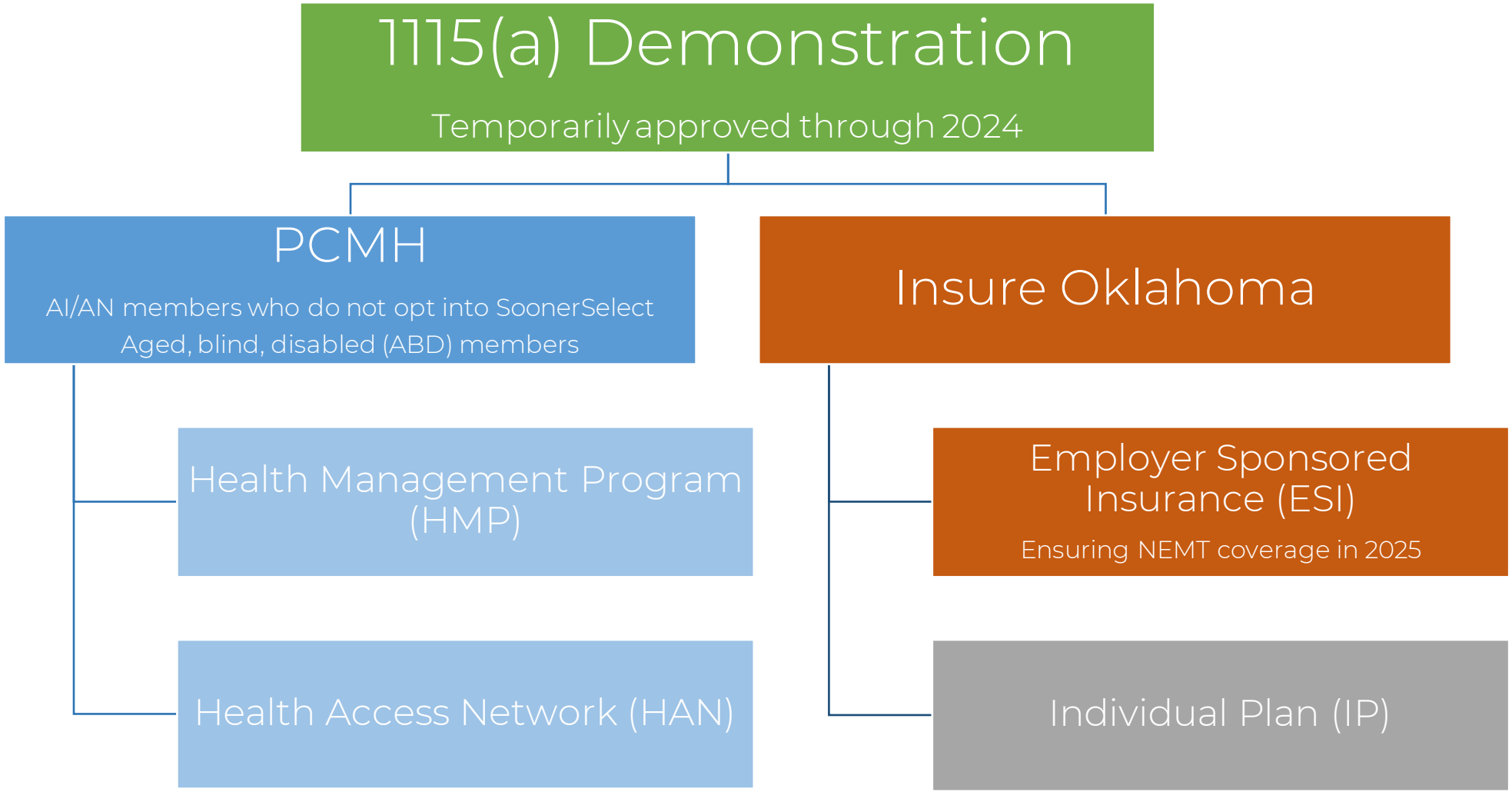
Chairman Rhynes asked for a motion to adjourn. Motion was provided by Dr. Steven Crawford and seconded by Ms. Melissa Miller, there was no dissent and the meeting adjourned at 2:47pm.

SOONERCARE CHOICE POST-AWARD FORUM

Heather Cox, Health Policy Director

November 7, 2024

SOONERCARE CHOICE



OKLAHOMA
Health Care Authority

Submit Questions/comments:

Federal.Authorities@okhca.org

GET IN TOUCH

4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

oklahoma.gov/ohca
mysoonercare.org

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

SoonerSelect Medical Contracted Entity (CE) Requests to Change Service Provisions

The SoonerSelect Medical Contract at Section 1.7: Covered Benefits and Section 1.8: Medical Management states that contracted entities (CEs) may not impose prior authorization guidelines/criteria or utilization management practices that are more restrictive than OHCA without OHCA prior approval.

On 9/24/2024 Oklahoma Complete Health and Oklahoma Complete Health Children's Specialty Program submitted a formal request to OHCA for review and approval to change service provisions.

OHCA subject matter experts (SMEs) reviewed the request, evaluating it in comparison to OHCA historical processes and practices, standard business practice in other markets, and available data to determine whether to approve the request.

OHCA decisions are noted in the table below:

SoonerSelect Medical Requests to Change Service Provisions				
CURRENT PRIOR AUTHORIZATION CRITERIA TOOL	**PROPOSED PRIOR AUTHORIZATION CRITERIA TOOL**	**REASON FOR PROPOSED CHANGE**	**ANTICIPATED IMPACT**	**OHCA DECISION**
Prior Authorization Criteria for MRI of Lumbar Spine or Spinal Canal				
Oklahoma Complete Health has used InterQual (A Change HealthCare Product) as criteria to determine the appropriateness of requests for Magnetic Resonance Imaging (MRI) of Lumbar Spine or Spinal Canal. InterQual requires either physical therapy or home exercises or activity modification for more than 4 weeks within the past year.	Oklahoma Complete Health proposes to change the PA tool from InterQual to Evolent Health (previously known as National Imaging Associates, Inc). Evolent requires at least 6 weeks of conservative therapy in the most recent 6 months.	The Choosing Wisely campaign was created in 2012 by the American Board of Internal Medicine Foundation. Through this campaign most specialty societies have created statements about the appropriateness of certain procedures, including MRI Imaging for low back pain. An MRI of the lumbar spine is always appropriate if a red flag is present	This request will lengthen the time of conservative treatment for lower back pain before imaging studies are considered appropriate from 4 to 6 weeks. The change is consistent with the Choosing Wisely campaign and the current recommendations of the American College of Radiology. The anticipated effect on participating providers should	APPROVED Item will be presented at the Nov. 7, 2024, MAC meeting.

SoonerSelect Medical Requests to Change Service Provisions				
CURRENT PRIOR AUTHORIZATION CRITERIA TOOL	**PROPOSED PRIOR AUTHORIZATION CRITERIA TOOL**	**REASON FOR PROPOSED CHANGE**	**ANTICIPATED IMPACT**	**OHCA DECISION**
		within the patient's history or upon physical examination. The American College of Radiology issued a statement in 2022, which was published on the National Institutes of Health website. This statement says, "in general, imaging is considered for patients with approximately 6 weeks of non-surgical treatment where there has been little or no improvement in their low back pain."	be minimal since it is already consistent with the standard of care for practicing physicians.	

November 7, 2024 MAC
Proposed Rule Amendment Summary

These proposed **EMERGENCY** rules were previously presented at Tribal Consultation and were subject to at least a 15-day public comment period.

The Agency is requesting the effective date to be immediately upon receiving gubernatorial approval.

APA WF # 24-14 Hospice Benefit Expansion — The Oklahoma Health Care Authority (OHCA) proposes emergency revisions that are necessary to comply with newly amended state law. Currently, hospice coverage is limited to children, expansion adults, and the dual eligible population. In accordance with House bill (HB) 3980 of the 2024 legislative session, the proposed revisions will expand hospice coverage to include all full-benefit Medicaid members. Existing criteria and payment methodologies will be applied to any new populations.

Budget Impact: The estimated budget impact for SFY25 will be an increase in the total amount of $20,277.00; with $6,675.19 in state share. The estimated total cost for SFY26 is an increase of $40,554.00; with $13,350.38 in state share.

APA WF # 24-18 Third Party Liability (TPL) for School-based Services — The Oklahoma Health Care Authority (OHCA) proposes to permit an exception to current TPL rules so that Medicaid is the payor of first resort, or prior to federal IDEA funds, for Medicaid-covered services documented within a student's an Individualized Education Program (IEP) and (IFSP) in accordance with section 1903(c) of the Social Security Act. The Agency will then "pay and chase" to recoup the funds from the liable third party. Further, schools can still bill third party payors; however, it will not be required. This change aims to remove barriers for Local Education Agencies (LEA) to access Medicaid payment to support critical services for children with disabilities.

Budget Impact: The estimated total cost for SFY25 is $35,253; with $11,605 in state share. The estimated total cost for SFY26 is $70,507; with $23,533 in state share.

APA WF # 24-19 Updating Abortion Policy — The proposed revisions align OHCA policy with state law on abortion. Currently, policy includes that abortion services can be accessed in instances of rape, incest, and/or when the mother's life is in danger; however, the exceptions of rape and incest will be removed.

Budget Impact: Budget neutral.

APA WF # 24-24 Medication Assisted Treatment (MAT) Clarification — The proposed emergency rule revisions are a request from ODMHSAS to comply with recent federal rule changes at 42 CFR § 8.12. This rule change ensures that refusal of members to participate in treatment phases of therapy, rehabilitation, case management, and peer recovery support services as described in OAC 317:30-5-241.7(f) will not prohibit them from receiving medications from an Opioid Treatment Program.

Budget Impact: Budget neutral.

APA WF # 24-25 Psychological Testing Limit Increase — The proposed emergency rule revisions are a request from ODMHSAS to increase the initial limit on psychological testing hours from eight (8) to ten (10). This change will allow for an adequate initial baseline of testing hours for most testing instruments and ensure that members who require psychological testing have sufficient initial coverage. Providers may still request an additional six (6) hours for complex testing, bringing the total to sixteen (16) hours.

Budget Impact: The estimated budget impact for SFY25 will be an increase in the total amount of $113,838; with $24,463 in state share. The estimated total cost for SFY26 is an increase $227,676; with $48,927 in state share. The state share will be covered by ODMHSAS.

APA WF #24-21 Certified Registered Nurse Anesthetists (CRNA) Equalization — The OHCA proposes emergency rule revisions to increase access to care and help alleviate workforce shortages by increasing rates for CRNAs practicing within scope of practice, in collaboration with a physician or dentist licensed in this state. Reimbursement will be increased to 100% of the physician fee schedule, from the existing 80%. In situations when the CRNA is practicing under medical direction, reimbursement will remain consistent with established methodology within the Title XIX State Plan, which is 50% of the physician fee schedule.

Budget Impact: The estimated budget impact for SFY25 will be an increase in the total amount of $6,642,110; with $2,183,594 in state share. The estimated total cost for SFY26 is an increase of $7,970,533; with $2,750,817 in state share.

The Agency is requesting the effective date to be January 1, 2025, or upon receiving gubernatorial approval.

APA WF # 24-13 Program of All-Inclusive Care for the Elderly (PACE) Licensure Policy — The proposed rule changes remove the requirement that PACE providers be licensed as an adult day care and clarify some OHCA regulatory requirements of PACE providers. HB3238 of the 2024 legislative session, found in statute at 56 OS 1017.7, 63 OS 1-872, and 63 OS 1-1961, amends the Adult Day Care Act and the Home Care Act to exempt PACE organizations from the licensure requirements of adult day cares and home health organizations. It also assigns new regulatory authority to the OHCA to enforce federal PACE regulations (42 CFR Part 460), including but not limited to evaluation, monitoring, and oversight requirements. These rule changes will reduce the administrative burden on PACE providers and ensure OHCA expectations and requirements are clear.

Budget Impact: Budget neutral

APA WF # 24-34 Community Health Services — The proposed emergency rule changes are a request of Oklahoma State Department of Health (OSDH) to add coverage and reimbursement for Community Health Services provided within a public health clinic. These services are provided by a Community Health Worker (CHW) working at a county or a city-county health department and must be ordered by a physician. Services include screening and assessments, health education/coaching, and health system navigation. Eligible providers must obtain a certificate of completion of a C3 core competency-based training offered by OSDH or an affiliated local health

department and work and bill under a licensed provider. Eligible members must have a diagnosis of a chronic condition, unmet health-related social need, received a screening, or be pregnant to receive services.

Budget Impact: The estimated budget impact for SFY25 will be an increase in the total amount of $130,704; with $43,028 in state share. The estimated total cost for SFY26 is $871,360; with $285,980 in state share. The state share will be covered by OSDH.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 58. NON-HOSPITAL BASED HOSPICE

317:30-5-531. Coverage ~~for adults~~

(a) **Definition. "Hospice care"** means a comprehensive, holistic program of palliative and/or comfort care and support provided to the member and his/her family when a physician certifies that the member has a terminal illness and has a life expectancy of six (6) months or less.

(b) **Requirements.**

(1) Hospice services must be related to the palliation and management of the member's illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills.

(2) Hospice care is performed under the direction of a physician as per the member's plan of care in an approved hospital hospice facility, in-home hospice program, or nursing facility.

(c) **Eligibility.** Coverage for hospice services is provided to Medicaid eligible ~~expansion adults only~~members.

~~(1) Expansion adults defined by 42 Code of Federal Regulations § 435.119 who are age nineteen (19) or older and under sixty-five (65), at or below one hundred thirty-three percent (133%) of the federal poverty level (FPL), and who are not categorically related to the aged, blind, or disabled eligibility group are eligible for hospice services.~~

~~(2)~~(1) Hospice care eligibility requires physician certification that the member is terminally ill and includes a medical prognosis with a life expectancy of six (6) months or less if the illness runs its normal course. The terminal prognosis also must be supported by clinical documentation in the medical record. The certification must be completed by the member's attending physician or the Medical Director of an Interdisciplinary Group. Nurse practitioners serving as the attending physician may not certify the terminal illness; however, nurse practitioners may re-certify the terminal illness.

~~(3)~~(2) For information regarding hospice provision provided through waivers, refer to Oklahoma Administrative Code (OAC) 317:30-5-763, 317:30-5-1200, and 317:30-5-1202.

(d) **Covered services.** Hospice care services can include but are not limited to:

(1) Nursing care;

(2) Physician services (e.g., physicians employed or working under arrangements made with the hospice);

(3) Medical equipment and supplies;

(4) Drugs for symptom control and pain relief;

(5) Home health aide services;

(6) Personal care services;

(7) Physical, occupational and/or speech therapy;

(8) Medical social services;

(9) Dietary counseling; and

(10) Grief and bereavement counseling to the member and/or family are required but are not reimbursable.

(e) **Prior authorization.** All services must be prior authorized, and a written plan of care must be

established before services are rendered. For medical review purposes, all hospice services will be authenticated in accordance with OAC 317:30-3-30.

(f) **Service election.**

(1) For Medicaid eligible adults, the member or member's legal guardian or authorized representative must sign an election statement, choosing hospice care instead of routine medical care with the objective to treat and cure the member's terminal illness, and by doing so waives his or her right to other Medicaid benefits, except for care not related to the terminal illness and care provided by the attending physician.

(2) For Medicaid eligible children, hospice services are available without forgoing any other service to which the member is entitled under SoonerCare for curative treatment of the terminal illness.

~~(2)~~(3) Once the member, legal guardian, or member's authorized representative has elected hospice care, the hospice medical team assumes responsibility for the member's medical care for the terminal illness. Hospice providers are not responsible for curative treatments for members that elect such services while on hospice.

(g) **Service revocation.**

(1) Hospice care services may be revoked by the member, family, legal guardian, or authorized representative at any time.

(2) Upon revoking the election of Medicaid coverage of hospice care for a particular election period, the member resumes Medicaid coverage of ~~the~~any benefits waived when hospice care was elected.

(3) The member may at any time elect to receive hospice coverage for any other hospice election periods for which he or she is eligible.

(h) **Service frequency.** Hospice care services:

(1) Are available for an initial two (2) ninety-day (90-day) certification periods. After the two (2) initial ninety-day (90-day) periods, a member is allowed an unlimited number of sixty-day (60-day) certification periods during the remainder of the member's lifetime. Each certification period requires a new prior authorization.

(2) Require a hospice physician or nurse practitioner to have a face-to-face encounter with the member to determine if the member's terminal illness necessitates continuing hospice care services. The encounter should take place prior to the one hundred eightieth (180^{th}) day recertification and each subsequent recertification thereafter; and attest that such visit took place.

(i) **Documentation.** Initial documentation requirements for requesting services, documentation requirements for continuation of services, and the full hospice guidelines can be found at OHCA's website, https://oklahoma.gov/ohca.

(j) **Reimbursement.**

(1) SoonerCare shall provide hospice care reimbursement:

(A) For each day that an individual is under the care of a hospice, the hospice will be reimbursed an amount applicable to the level, type and intensity of the services furnished to the individual for that day in accordance with the Oklahoma Medicaid State Plan.

(B) For independent physician direct services in accordance with the Oklahoma Medicaid State Plan.

(2) Through the Oklahoma Medicaid State Plan, the OHCA established payment amounts for the following categories:

(A) **Routine hospice care.** Member is at home and not receiving hospice continuous

care.

(B) **Continuous home care.** Member is not in an inpatient facility and receives hospice on a continuous basis at home; primarily consisting of nursing care to achieve palliation and management of acute medical symptoms during a brief period of crisis only as necessary to maintain the terminally ill patient at home. If less skilled care is needed on a continuous basis to enable the person to remain at home, this is covered as routine hospice care.

(C) **Inpatient respite care.** Member receives care in an approved inpatient facility on a short-term basis for respite.

(D) **General inpatient care.** Member receives general inpatient care in an inpatient facility for pain control or acute or chronic symptom management that cannot be managed at home.

(E) **Nursing facility (NF)/intermediate care facilities for individuals with intellectual disabilities (ICF/IID) care**. Member receives hospice care in a NF or ICF/IID. Hospice nursing facility or ICF/IID room and board per diem rates are reimbursed to the in-home hospice provider at a rate equal to ~~95%~~ninety-five percent (95%) of the skilled nursing facility rate. The hospice provider is responsible for passing the room and board payment through to the NF or ICF/IID. If Medicare is the primary payer of hospice benefits, OHCA will only reimburse the hospice provider for coinsurance and deductible amounts per the Oklahoma Medicaid State Plan and will continue to pay the room and board to the nursing facility.

(F) **Service intensity add-on**. Member receives care by a registered nurse (RN) or social worker when provided in the last seven (7) days of his/her life.

(G) **Other general reimbursement items.**

(i) **Date of discharge**. For the day of discharge from an inpatient unit, the appropriate home care rate is to be paid unless the patient dies as an inpatient. When the patient is discharged as deceased, the inpatient rate, either general or respite, is to be paid for the discharge date.

(ii) **Inpatient day cap**. Payments to a hospice for inpatient care must be limited according to the number of days of inpatient care furnished to Medicaid patients. During the twelve-month (12-month) period beginning October 1 of each year and ending September 30, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) may not exceed twenty percent (20%) of the aggregate total number of days of hospice care provided to all Medicaid recipients during that same period. This limitation is applied once each year, at the end of the hospices' cap period.

(iii) **Obligation of continuing care**. After the member's Medicare hospice benefit expires, the patient's Medicaid hospice benefits do not expire. The hospice must continue to provide the recipient's care until the patient expires or until the member revokes the election of hospice care.

317:30-5-532. Coverage for children [REVOKED]

~~Hospice is palliative and/or comfort care provided to the member and his/her family when a physician certifies that the member has a terminal illness and has a life expectancy of six months or less. A hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional and spiritual stresses which are experienced during the final stages~~

~~of illness and death. Hospice services must be related to the palliation and management of the member's illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills.~~

~~(1) Payment is made for home based hospice services for terminally ill individuals with a life expectancy of six months or less when the member and/or family has elected hospice benefits. Hospice services are available to eligible members without forgoing any other service to which the member is entitled under SoonerCare for curative treatment of the terminal illness. Once the member has elected hospice care, the hospice medical team assumes responsibility for the member's medical care for the terminal illness in the home environment. Hospice providers are not responsible for curative treatments for members that elect such services while on hospice. Hospice care includes nursing care, physician services, medical equipment and supplies, drugs for symptom control and pain relief, home health aide and personal care, physical, occupational and/or speech therapy, medical social services, dietary counseling and grief and bereavement counseling to the member and/or family. Services must be prior authorized.~~

~~(2) Hospice care is available for two 90-day periods and an unlimited number of 60-day periods during the remainder of the member's lifetime. Beginning January 1, 2011, a hospice physician or nurse practitioner must have a face to face encounter with the member to determine if the member's terminal illness necessitates continuing hospice care services. The encounter must take place prior to the 180th day recertification and each subsequent recertification thereafter; and attests that such visit took place. The member and/or the family may voluntarily terminate hospice services. Hospice services must be reasonable and necessary for the palliation or management of a terminal illness or related conditions. A certification that the individual is terminally ill must be completed by the member's attending physician or the Medical Director of an Interdisciplinary Group. Nurse practitioners serving as the attending physician may not certify the terminal illness; however, effective January 1, 2011, nurse practitioners may re-certify the terminal illness.~~

~~(3) Services must be prior authorized. A written plan of care must be established before services are provided. The plan of care should be submitted with the prior authorization request.~~

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-24. Third party liability

As the Medicaid Agency, the Oklahoma Health Care Authority (OHCA) is the payer of last resort, with few exceptions. When other resources are available, those resources must first be utilized. Exceptions to this policy are those receiving medical treatment through Indian Health Services, eligible students on an Individualized Education Program (IEP) or Individual Family Service Plan (IFSP) receiving school-based services and those eligible for the Crime Victims Compensation Act. Guidance for third party liability under the Insure Oklahoma program is found in Oklahoma Administrative Code (OAC) 317:45, Insure Oklahoma.

(1) If a member has coverage by an absent parent's insurance program or any other policy holder, that insurance resource must be used prior to filing a SoonerCare claim. This includes Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO) and any other insuring arrangements that provide a member access to healthcare. Members must comply with all requirements of their primary insurance as well as SoonerCare requirements in order to take advantage of both coverages. For example, a member must comply with the network restrictions of both the primary and SoonerCare plans. If the member does not comply with the requirements of the primary plan, he/she will be responsible for the charges incurred. The state's authorization that an item or service is as covered under the state plan, or a waiver of such plan, shall meet the prior authorization requirements of the primary insurer. If the provider is aware of private insurance or liability, a claim must first be filed with that source. When private insurance information is known to the OHCA, the eligibility verification system will reflect that information. If payment is denied by the primary insurance, except as stated above, the provider must attach the Explanation of Benefits (EOB), stating the reason for the denial, to the claim submitted to the Fiscal Agent. When payment is received from another source, that payment amount must be reflected on the claim form.

(2) It is possible that other resources are available but are unknown to OHCA. Providers will routinely question SoonerCare members to determine whether any other resources are available. In some instances, coverage may not be obvious, for example, the member may be covered by a policy on which he/she is not the subscriber (e.g., a child whose absent parent maintains medical and hospital coverage).

(3) If the provider receives payment from another source after OHCA has made payment, it is necessary that the provider reimburse OHCA for the SoonerCare payment. The provider may retain the primary insurance payment, if any, that represents payment for services that are not covered services under SoonerCare. By accepting the OHCA's payment, the provider agrees to accept it as payment in full and, therefore, cannot retain any portion of other resource money as payment for reduced charges on covered services. Other than SoonerCare copayments, a provider cannot bill a member for any unpaid portion of the bill or for a claim that is not paid because of provider administrative error. If, after reimbursing OHCA and retaining a portion of the other payment in satisfaction of any non-covered services there is money remaining, it must be refunded to the member.

(4) If a member is covered by a private health insurance policy or plan, he/she is required to inform medical providers of the coverage, including:

(A) provision of applicable policy numbers;

(B) assignment payments to medical providers;

(C) provision of information to OHCA of any coverage changes; and

(D) release of money received from a health insurance plan to the provider if the provider has not already received payment or to the OHCA if the provider has already been paid by the OHCA.

(5) Members are responsible for notifying their providers of the intent to make application for SoonerCare coverage and of any retroactive eligibility determinations. Members may be responsible for any financial liability if they fail to notify the provider of the eligibility determinations and as a result, the provider is unable to secure payment from OHCA.

(6) Members must present evidence of any other health insurance coverage to a medical provider each time services are requested. Members may be responsible for any financial liability if they fail to furnish the necessary information before the receipt of services and as a result, the provider is unable to secure payment from OHCA.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 3. HOSPITALS

317:30-5-50. Abortions

~~(a) Payment is made only for abortions in those instances where the abortion is necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed, or where the pregnancy is the result of an act of rape or incest. SoonerCare coverage for abortions to terminate pregnancies that are the result of rape or incest are considered to be medically necessary services and federal financial participation is available specifically for these services.~~

~~(1) For abortions necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, the physician must complete the Certification for Medicaid Funded Abortion and certify in writing that the abortion is being performed due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed. The patient's name and address must be included in the certification and the certification must be signed and dated by the physician. The certification must be attached to the claim.~~

~~(2) For abortions in cases of rape or incest, there are two requirements for the payment of a claim. First, the physician must fully complete the Certification for Medicaid Funded Abortion. Second, the patient must have made a police report or counselor's report of the rape or incest. In cases where an official report of the rape or incest is not available, the physician must certify in writing and provide documentation that in his or her professional opinion, the patient was unable, for physical or psychological reasons, to comply with the requirement. The statement explains the reason the rape or incest was not reported. The patient's name and address must be included in the certification and the certification must be signed and dated by the physician and the patient. In cases where a physician provides certification and documentation of a patient's inability to file a report, the Oklahoma Health Care Authority (OHCA) will perform a prepayment review of all records to ensure there is sufficient documentation to support the physician's certification.~~

~~(b) The OHCA performs a look-behind procedure for abortion claims paid from SoonerCare funds. This procedure will require that this Agency obtain the complete medical records for abortions paid under SoonerCare. On a post payment basis, this Authority will obtain the complete medical records on all claims paid for abortions.~~

~~(c) Claims for spontaneous abortions, including Dilation and Curettage do not require certification. The following situations also do not require certification:~~

~~(1) If the physician has not induced the abortion, counseled or otherwise collaborated in inducing the abortion, and~~

~~(2) If the process has irreversibly commenced at the point of the physician's medical intervention.~~

~~(d) Claims for the diagnosis incomplete abortion require medical review. The appropriate diagnosis codes should be used indicating spontaneous abortion, etc.; otherwise the procedure will be denied.~~

(a) Payment of abortion related services is made only in those instances where there is no detectable heartbeat of the fetus, or if, in reasonable medical judgment, the SoonerCare member has a complicating condition that necessitates termination of the pregnancy to avert serious risk of substantial and irreversible physical impairment of a major bodily function, not including psychological or emotional conditions, or death.

(b) For abortions necessary to avert death or irreversible physical impairment of a major bodily function, the physician, must complete the Certification for Medicaid Funded Abortion and certify in writing that the abortion is being performed to avert death or irreversible physical impairment of a major bodily function. The patient's name and address must be included in the certification and the certification must be signed and dated by the physician. The certification must be attached to the claim.

(c) Prior to, or post payment, OHCA may perform a review of abortion related services. These reviews will require that the Agency obtain the applicable medical records.

(d) Claims for services related to fetal demise, including dilation and curettage, do not require the Certification for Medicaid Funded Abortion.

(e) The appropriate diagnosis codes should be used; otherwise, the procedure(s) will be denied.

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CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 69. CERTIFIED REGISTERED NURSE ANESTHETISTS

317:30-5-607. Billing instructions

The CRNA is responsible for entering the correct anesthesia procedure code on the appropriate claim form. Anesthesia codes from the Physicians' Current Procedural Terminology or Medicare assigned codes should be used.

(1) Payment is made only for the major procedure during an operative session.

(2) All anesthesia procedure codes must have a modifier. Without the modifier, the claim will be denied. Payment to the CRNA is ~~limited to 80%~~made at 100% of the physician allowable for anesthesia services ~~without medical direction~~in collaboration with a physician licensed in this state using modifier QZ and 50% of the physician allowable when services are provided under the medical direction of an anesthesiologist using modifier QX.

(3) Certain codes in the Medicine section of the CPT are used to identify extraordinary anesthesia services. Additional payment can be made when applicable for extremes of age, total body hypothermia and controlled hypertension.

(4) All other qualifying circumstances, i.e., physical status, emergency, etc., have been structured into the total allowable for the procedure.

(5) Hypothermia total body or regional is not covered unless medical necessity is documented and approved through review by the Authority's Medical Consultants.

(6) Payment for placement of central venous catheter, injection of anesthesia substance or similar procedures will be made only when the procedure is distinctly separate from the anesthesia procedure.

317:30-5-611. Payment methodology

Payment to the CRNA is limited to 80%made at 100% of the physician allowable for anesthesia services performed ~~without medical direction~~in collaboration with a physician licensed in this state and 50% of the physician allowable when services are provided under the medical direction of a licensed physician.

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PART 21. OUTPATIENT BEHAVIORAL HEALTH AGENCY SERVICES

317:30-5-241.7. Medication-assisted treatment (MAT) services for eligible individuals with opioid use disorder (OUD)

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

(1) **"Medication-assisted treatment (MAT)"** means an evidence-based practice approved by the Food and Drug Administration (FDA) to treat opioid use disorder, including methadone and all biological products licensed under federal law for such purpose. MAT also includes the provision of counseling and behavioral therapy.

(2) **"Office-based opioid treatment (OBOT)"** means a fully contracted SoonerCare provider that renders MAT services in OBOT settings. OBOT providers must have capacity to provide all drugs approved by the FDA for the treatment of opioid use disorder, directly or by referral, including for maintenance, detoxification, overdose reversal, and relapse prevention, and appropriate counseling and other appropriate ancillary services.

(3) **"Opioid treatment program (OTP)"** means a program or provider:

(A) Registered under federal law;

(B) Certified by the Substance Abuse and Mental Health Services Administration (SAMHSA);

(C) Certified by ODMHSAS, unless deemed an exempted entity as defined by federal law;

(D) Registered by the Drug Enforcement Agency (DEA);

(E) Registered by the Oklahoma Bureau of Narcotics and Dangerous Drugs (OBNDD); and

(F) Engaged in opioid treatment of individuals by use of an opioid agonist treatment medication, including methadone.

(4) **"Opioid use disorder (OUD)"** means a cluster of cognitive, behavioral, and physiological symptoms in which the individual continues use of opioids despite significant opioid-induced problems.

(5) **"Phase I"** means the first ninety (90) days of treatment.

(6) **"Phase II"** means the second ninety (90) days of treatment.

(7) **"Phase III"** means the third ninety (90) days of treatment.

(8) **"Phase IV"** means the last ninety (90) days of the first year of treatment.

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

(10) **"Phase VI"** means the phase of treatment for members who have been receiving continuous treatment for more than two (2) years.

(b) **Coverage**. The SoonerCare program provides coverage of medically necessary MAT services in OTPs, including but not limited to, methadone treatment, to eligible individuals with OUD. An OTP must have the capacity to provide the full range of services included in the definition of MAT and must document both medication dosing and supporting behavioral health services, including

but not limited to, individual, family and group therapy and rehabilitation services. MAT services and/or medications may also be provided in OBOT settings per OAC 317:30-5-9(b)(16).

(c) **OTP requirements.** Every OTP provider shall:

(1) Have a current contract with the OHCA as an OTP provider;

(2) Hold a certification as an OTP from ODMHSAS, unless deemed an exempted entity as defined by federal law;

(3) Hold a certification from the Substance Abuse and Mental Health Services Administration (SAMHSA);

(4) Be appropriately accredited by a SAMHSA-approved accreditation organization;

(5) Be registered with the DEA and the OBNDD; and

(6) Meet all state and federal opioid treatment standards, including all requirements within OAC 450:70.

(d) **Individual OTP providers.** OTP providers include a:

(1) MAT provider who is a physician, physician's assistant (PA), or advanced practice registered nurse (APRN) who may prescribe, dispense, and administer medications in accordance with state and federal law and the Oklahoma Medicaid State Plan.

(2) OTP behavioral health services practitioner who is a practitioner that meets the qualifications in OAC 317:30-5-240.3, except for family support and training providers, qualified behavioral therapy aide providers, multi-systemic therapy providers, and case manager I providers, for the provision of outpatient behavioral health services.

(e) **Intake and assessment**. OTPs shall conduct intake and assessment procedures in accordance with OAC 450:70-3-5 through OAC 450:70-3-7.

(f) **Service phases.** In accordance with OAC 450:70-6-17.2 through OAC 450:70-6-17.8, the OTP shall have structured phases of treatment and rehabilitation to support member progress and to establish requirements regarding member attendance and service participation. The OTP shall utilize ASAM criteria to determine the appropriate level of care during each phase of treatment. Refusal of members to participate in treatment services as prescribed in 317:30-5-241.7(f)(1) through 317:30-5-241.7(f)(5) shall not preclude them from receiving medications from the OTP. The OTP shall document refusal of treatment services in the clinical record. Treatment requirements for each phase shall include, but not limited to, the following:

(1) During phase I, the member shall participate in a minimum of four (4) treatment sessions per month. Available services shall include, but not be limited to, therapy, rehabilitation, case management, and peer recovery support services.

(2) During phase II, the member shall participate in at least two (2) treatment sessions per month. Available services shall include, but not be limited to, therapy, rehabilitation, case management, and peer recovery support services.

(3) During phase III, phase IV and phase V, the member shall participate in at least one (1) treatment session per month. Available services shall include, but not be limited to, therapy, rehabilitation, case management, and peer recovery support services.

(4) During phase VI, the LBHP, licensure candidate or certified alcohol and drug counselor (CADC) determines the frequency of therapy or rehabilitation service sessions with input from the member.

(5) If an OTP is providing MAT medications to members receiving residential substance use disorder services, the required minimum services for the OTP may be delivered by the residential substance use disorder provider. The OTP provider shall document the provision of these services and the provider delivering such services in the member's service plan.

(g) **Service plans**. In accordance with OAC 450:70-3-8, a service plan shall be completed for each member upon completion of the admission evaluation. The service plan shall be based on the patient's presenting problems or diagnosis, intake assessment, biopsychosocial assessment, and expectations of their recovery.

(1) **Service plan development.** Service plans shall be completed by an LBHP or licensure candidate. Service plans, including updates, must include dated signatures of the person served [if age fourteen (14) or older], the parent/guardian (if required by law), and the LBHP or licensure candidate. If a minor is eligible to self-consent to treatment pursuant to state law, a parent/guardian signature is not required. Service plans completed by a licensure candidate must be co-signed and dated by a fully-licensed LBHP. Signatures must be obtained after the service plan is completed.

(2) **Service plan content.** Service plans shall address, but not limited to, the following:

(A) Presenting problems or diagnosis;
(B) Strengths, needs, abilities, and preferences of the member;
(C) Goals for treatment with specific, measurable, attainable, realistic and time-limited;
(D) Type and frequency of services to be provided;
(E) Dated signature of primary service provider;
(F) Description of member's involvement in, and responses to, the service plan and his or her signature and date;
(G) Individualized discharge criteria or maintenance;
(H) Projected length of treatment;
(I) Measurable long and short term treatment goals;
(J) Primary and supportive services to be utilized with the patient;
(K) Type and frequency of therapeutic activities in which patient will participate;
(L) Documentation of the member's participation in the development of the plan; and
(M) Staff who will be responsible for the member's treatment.

(3) **Service plan updates.** Service plan updates shall be completed by an LBHP or licensure candidate. Service updates completed by a licensure candidate must be co-signed and dated by a fully-licensed LBHP. Service plan review and updates shall occur no less than every six (6) months and shall occur more frequently if required based upon the service phase or certain circumstances:

(A) Change in goals and objectives based upon member's documented progress, or identification of any new problem(s);
(B) Change in primary therapist or rehabilitation service provider assignment;
(C) Change in frequency and types of services provided;
(D) Critical incident reports; and/or
(E) Sentinel events.

(4) **Service plan timeframes.** Service plans shall be completed by the fourth visit after admission.

(h) **Progress notes.** Progress notes shall be completed in accordance with OAC 317:30-5-248(3).

(i) **Discharge planning.** All members shall be assessed for biopsychosocial appropriateness of discharge from each level of care using ASAM criteria that includes a list of symptoms for all six (6) dimensions and each of the levels of care, to determine a clinically appropriate placement in the least restrictive level of care. This organized process involves a professional determination by an LBHP or licensure candidate for appropriate placement to a specific level of care based on the following symptoms and situations:

(1) Acute intoxication and/or withdrawal potential;
(2) Biomedical conditions and complications;
(3) Emotional, behavioral or cognitive conditions and complications;
(4) Readiness to change;
(5) Relapse, continued use or continued problem potential; and
(6) Recovery/living environment.

(j) **Service exclusions.** The following services are excluded from coverage:

(1) Components that are not provided to or exclusively for the treatment of the eligible individual;
(2) Services or components of services of which the basic nature is to supplant housekeeping or basic services for the convenience of a person receiving covered services;
(3) Telephone calls or other electronic contacts (not inclusive of telehealth);
(4) Field trips, social, or physical exercise activity groups;

(k) **Reimbursement.** To be eligible for payment, OTPs shall:

(1) Have an approved provider agreement on file with the OHCA. Through this agreement, the OTP assures that they are in compliance with all applicable federal and state Medicaid law and regulations, including, but not limited to, OHCA administrative rules, ODMHSAS administrative rules, and the Oklahoma Medicaid State Plan.
(2) Obtain prior authorization for applicable drugs and services by the OHCA or its designated agent before the service is rendered by an eligible provider. Without prior authorization for applicable drugs and services, payment is not authorized.
(3) Record the National Drug Code (NDC) number for each drug used in every encounter at the time of billing.
(4) Be reimbursed pursuant to the methodology described in the Oklahoma Medicaid State Plan.

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SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 21. OUTPATIENT BEHAVIORAL HEALTH SERVICES

317:30-5-241.1 Screening, assessment and service plan

All providers must comply with the requirements as set forth in this Section.

(1) **Screening.**

(A) **Definition.** Screening is for the purpose of determining whether the member meets basic medical necessity and need for further behavioral health (BH) assessment and possible treatment services.

(B) **Qualified professional.** Screenings can be performed by any credentialed staff members as listed under OAC 317:30-5-240.3.

(C) **Target population and limitations.** Screening is compensable on behalf of a member who is seeking services for the first time from the contracted agency. This service is not compensable if the member has previously received or is currently receiving services from the agency, unless there has been a gap in service of more than six (6) months. To qualify for reimbursement, the screening tools used must be evidence-based or otherwise approved by Oklahoma Health Care Authority (OHCA) and Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) and appropriate for the age and/or developmental stage of the member.

(2) **Assessment.**

(A) **Definition.** Gathering and assessment of historical and current bio-psycho-social information which includes face-to-face contact with the person and/or the person's family or other person(s) resulting in a written summary report, diagnosis and recommendations. All agencies must assess the medical necessity of each individual to determine the appropriate level of care.

(B) **Qualified practitioners.** This service is performed by a licensed behavioral health professional (LBHP) or licensure candidate.

(C) **Target population and limitations.** The BH assessment is compensable on behalf of a member who is seeking services for the first time from the contracted agency. This service is not compensable if the member has previously received or is currently receiving services from the agency, unless there has been a gap in service of more than six (6) months and it has been more than one (1) year since the previous assessment.

(D) **Documentation requirements.** The assessment must include all elements and tools required by the OHCA. In the case of children under the age of eighteen (18), it is performed with the direct, active face-to-face participation of the parent or guardian. The child's level of participation is based on age, developmental and clinical appropriateness. The assessment must include at least one DSM diagnosis from the most recent DSM edition or diagnostic impression. The information in the assessment must contain but is not limited to the following:

(i) Behavioral, including substance use, abuse, and dependence;

(ii) Emotional, including issues related to past or current trauma;

(iii) Physical;

(iv) Social and recreational;
(v) Vocational;
(vi) Date of the assessment sessions as well as start and stop times; and
(vii) Signature of parent or guardian participating in face-to-face assessment. Signatures are required for members over the age of fourteen (14). Signature and credentials of the practitioner who performed the face-to-face behavioral assessment. The signatures may be included in a signature page applicable to both the assessment and treatment plan if the signature page clearly indicates that the signatories consent and approve of both.

(3) **Behavioral Health Services Plan Development.**

(A) **Definition.** The Behavioral Health Service Plan is developed based on information obtained in the assessment and includes the evaluation of all pertinent information by the practitioners and the member, including a discharge plan. It is a process whereby an individualized plan is developed that addresses the member's strengths, functional assets, weaknesses or liabilities, treatment goals, objectives and methodologies that are specific and time limited, and defines the services to be performed by the practitioners and others who comprise the treatment team. Behavioral Health Service Plan Development is performed with the direct active participation of the member and a member support person or advocate if requested by the member. In the case of children under the age of eighteen (18), it is performed with the participation of the parent or guardian and the child as age and developmentally appropriate, and must address school and educational concerns and assisting the family in caring for the child in the least restrictive level of care. For adults, it is focused on recovery and achieving maximum community interaction and involvement including goals for employment, independent living, volunteer work, or training. A Service Plan Development, Low Complexity is required every six (6) months and must include an update to the bio-psychosocial assessment and re-evaluation of diagnosis.

(B) **Qualified practitioners.** This service is performed by an LBHP or licensure candidate.

(C) **Time requirements.** Service Plan updates must be conducted face-to-face and are required every six (6) months during active treatment. However, updates can be conducted whenever it is clinically needed as determined by the qualified practitioner and member, but are only compensable twice in one (1) year.

(D) **Documentation requirements.** Comprehensive and integrated service plan content must address the following:

(i) member strengths, needs, abilities, and preferences (SNAP);
(ii) identified presenting challenges, problems, needs and diagnosis;
(iii) specific goals for the member;
(iv) objectives that are specific, attainable, realistic, and time-limited;
(v) each type of service and estimated frequency to be received;
(vi) the practitioner(s) name and credentials that will be providing and responsible for each service;
(vii) any needed referrals for service;
(viii) specific discharge criteria;
(ix) description of the member's involvement in, and responses to, the service plan, and his/her signature and date;

(x) service plans are not valid until all signatures are present [signatures are required from the member, if fourteen (14) or over], the parent/guardian [if younger than eighteen (18) or otherwise applicable], and the primary LBHP or licensure candidate. The signatures may be included in a signature page applicable to both the assessment and treatment plan if the signature page clearly indicates that the signatories consent and approve of both; and

(xi) all changes in a service plan must be documented in either a scheduled six (6) month service plan update (low complexity) or within the existing service plan through an amendment until time for the update (low complexity). Any changes to the existing service plan must, prior to implementation, be signed and dated by the member [if fourteen (14) or over], the parent/guardian [if younger than eighteen (18) or otherwise applicable], and the lead LBHP or licensure candidate.

(xii) Amendment of an existing service plan to revise or add goals, objectives, service provider, service type, and service frequency, may be completed prior to the scheduled six (6) month review/update. A plan amendment must be documented through an addendum to the service plan, dated and signed prior to the implementation, by the member [if fourteen (14) or over], the parent/guardian [if younger than eighteen (18) or otherwise applicable], and the lead LBHP or licensure candidate. A temporary change of service provider may be documented in the progress note for the service provided, rather than an amendment.

(xiii) Behavioral health service plan development, low complexity, must address the following:

(I) update to the bio-psychosocial assessment, re-evaluation of diagnosis service plan goals and/ or objectives;

(II) progress, or lack of, on previous service plan goals and/or objectives;

(III) a statement documenting a review of the current service plan and an explanation if no changes are to be made to the service plan;

(IV) change in goals and/or objectives (including target dates) based upon member's progress or identification of new need, challenges and problems;

(V) change in frequency and/or type of services provided;

(VI) change in practitioner(s) who will be responsible for providing services on the plan;

(VII) change in discharge criteria;

(VIII) description of the member's involvement in, and responses to, the service plan, and his/her signature and date; and

(IX) service plan updates (low complexity) are not valid until all signatures are present. The required signatures are: from the member [if fourteen (14) or over], the parent/guardian [if younger than eighteen (18) or otherwise applicable], and the primary LBHP or licensure candidate.

(E) **Service limitations:**

(i) Behavioral Health Service Plan Development, Moderate Complexity (i.e., pre-admission procedure code group) is limited to one (1) per member, per provider, unless more than one (1) year has passed between services, in which case, one can be requested and performed, if authorized by OHCA or its designated agent.

(ii) Behavioral Health Service Plan Development, Low Complexity: Service Plan updates are required every six (6) months during active treatment. Updates, however,

can be conducted whenever clinically needed as determined by the provider and member, but are only reimbursable twice in one (1) year. The date of service is when the service plan is complete and the date the last required signature is obtained. Services should always be age, developmentally, and clinically appropriate.

(4) **Assessment/Evaluation testing.**

(A) **Definition.** Assessment/Evaluation testing is provided by a clinician utilizing tests selected from currently accepted assessment test batteries. Test results must be reflected in the Service Plan. The medical record must clearly document the need for the testing and what the testing is expected to achieve.

(B) **Qualified practitioners.** Assessment/Evaluation testing will be provided by a psychologist, certified psychometrist, psychological technician of a psychologist, an LBHP or licensure candidate. For assessments conducted in a school setting, the Oklahoma State Department of Education (OSDE) requires that a licensed supervisor sign the assessment. Each qualified professional must have a current contract with the OHCA.

(C) **Documentation requirements.** All psychological services must be documented in the member's record. All assessment, testing, and treatment services/units billed must include the following:

(i) date;

(ii) start and stop time for each session/unit billed and physical location where service was provided;

(iii) signature of the provider;

(iv) credentials of provider;

(v) specific problem(s), goals and/or objectives addressed;

(vi) methods used to address problem(s), goals and objectives;

(vii) progress made toward goals and objectives;

(viii) patient response to the session or intervention; and

(ix) any new problem(s), goals and/or objectives identified during the session.

(D) **Service Limitations.** Testing for a child younger than three (3) must be medically necessary and meet established child [zero (0) to thirty-six (36) months of age] criteria as set forth in the Prior Authorization Manual. Evaluation and testing is clinically appropriate and allowable when an accurate diagnosis and determination of treatment needs is needed. ~~Eight (8)~~Ten (10) hours/units of testing per patient over the age of three (3), per provider is allowed every twelve (12) months. There may be instances when further testing is appropriate based on established medical necessity criteria found in the Prior Authorization Manual. Justification for additional testing beyond allowed amount as specified in this Section must be clearly explained and documented in the medical record. Testing units must be billed on the date the actual testing, interpretation, scoring, and reporting are performed. A maximum of twelve (12) hours of therapy and testing, per day per rendering provider are allowed. A child who is being treated in an acute inpatient setting can receive separate psychological services by a physician or psychologist as the inpatient per diem is for "non-physician" services only. A child receiving residential level treatment in either a therapeutic foster care home, or group home may not receive additional individual, group or family counseling or psychological testing unless allowed by the OHCA or its designated agent. Psychologists employed in state and federal agencies, who are not permitted to engage in private practice, cannot be reimbursed for services as an individually contracted provider. For assessment conducted in a school

setting the OSDE requires that a licensed supervisor sign the assessment. For individuals who qualify for Part B of Medicare, payment is made utilizing the SoonerCare allowable for comparable services. Payment is made to physicians, LBHPs or psychologists with a license to practice in the state where the services is performed or to practitioners who have completed education requirements and are under current board approved supervision to become licensed.

317:30-5-276. Coverage by category

(a) **Outpatient Behavioral Health Services.** Outpatient behavioral health services are covered as set forth in this Section, when provided in accordance with a documented individualized service plan medical record, developed to treat the identified behavioral health and/or substance use disorder(s), unless specified otherwise.

(1) All services are to be for the goal of improvement of functioning, independence, or wellbeing of the member. The services and treatment plans are to be recovery focused, trauma and co-occurring specific. The member must be able to actively participate in the treatment. Active participation means that the member must have sufficient cognitive abilities, communication skills, and short-term memory to derive a reasonable benefit from the treatment.

(2) In order to be reimbursed for services, providers must submit a completed Customer Data Core (CDC) to OHCA or its designated agent. The CDC must be reviewed, updated and resubmitted by the provider every six months. Reimbursement is made only for services provided while a current CDC is on file with OHCA or its designated agent. For further information and instructions regarding the CDC, refer to the Prior Authorization Manual.

(3) Some outpatient behavioral health services may require authorization. For information regarding services requiring authorization and the process for obtaining them, refer to the Prior Authorization Manual. Authorization of services is not a guarantee of payment. The provider is responsible for ensuring that the eligibility, medical necessity, procedural, coding, claims submission, and all other state and federal requirements are met. OHCA does retain the final administrative review over both authorization and review of services as required by 42 Code of Code of Federal Regulations 431.10.

(b) **Children.** Coverage for children includes the following services:

(1) Bio-Psycho-Social Assessments. Psychiatric Diagnostic Interview Examination (PDIE) initial assessment or Level of Care Assessment. The interview and assessment is defined as a face-to-face interaction with the member. Psychiatric diagnostic interview examination includes a history, mental status, and a disposition, and may include communication with family or other sources, ordering and medical interpretation of laboratory or other medical diagnostic studies. Only one (1) PDIE is allowable per provider per member. If there has been a break in service over a six (6) month period, then an additional unit of PDIE can be prior authorized by OHCA, or their designated agent.

(2) Psychotherapy in an outpatient setting including an office, clinic, or other confidential setting. The services may be performed at the residence of the member if it is demonstrated that it is clinically beneficial, or if the member is unable to go to a clinic or office. Psychotherapy is defined as a ~~one-to-one~~one-to-one treatment using a widely accepted modality or treatment framework suited to the individual's age, developmental abilities and diagnosis. It may include specialized techniques such as biofeedback or hypnosis.

Psychotherapy is considered to involve "interactive complexity" when there are communication factors during a visit that complicate delivery of the psychotherapy by the psychologist. Sessions typically involve members who have other individuals legally responsible for their care (i.e., minors or adults with guardians); members who request others to be involved in their care during the session (i.e., adults accompanied by one or more participating family members or interpreter or language translator); or members that require involvement of other third parties (i.e., child welfare, juvenile justice, parole/probation officers, schools, etc.). Psychotherapy should only be reported as involving interactive complexity when at least one (1) of the following communication factors is present:

(A) The need to manage maladaptive communication (i.e., related to high anxiety, high reactivity, repeated questions, or disagreement) among participants that complicate delivery of care.

(B) Caregiver emotions/behavior that interfere with implementation of the treatment plan.

(C) Evidence/disclosure of a sentinel event and mandated report to a third party (i.e., abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other visit participants.

(D) Use of play equipment, physical devices, interpreter or translator to overcome barriers to therapeutic interaction with a patient who is not fluent in the same language or who has not developed or lost expressive or receptive language skills to use or understand typical language.

(3) Family Psychotherapy is performed in an outpatient setting limited to an office, clinic, or other confidential setting. Family therapy is a face-to-face interaction between a therapist and the patient/family to facilitate emotional, psychological or behavioral changes and promote communication and understanding. Family therapy must be provided for the benefit of the member as a specifically identified component of an individual treatment plan.

(4) Group and/or Interactive Group psychotherapy in an outpatient setting must be performed in the psychologist's office, clinic, or other confidential setting. Group therapy is a ~~face-to face~~face-to-face interaction between a therapist and two or more unrelated patients (though there may be siblings in the same group, just not siblings only) to facilitate emotional, psychological, or behavioral changes. All group therapy records must indicate group size. Maximum total group size is six (6) patients for children four years of age up to the age of 18. Groups can include up to eight (8) individuals for members ~~18-20~~eighteen through twenty (18-20) years of age. Group therapy must be provided for the benefit of the member four (4) years of age or older as a specifically identified component of an individual treatment plan. Multi-family group therapy size is limited to eight family units.

(5) Assessment/Evaluation and testing is provided by a psychological technician of a psychologist or a LBHP utilizing tests selected from currently accepted assessment test batteries. For assessments conducted in a school setting, the Oklahoma State Department of Education requires that a licensed supervisor sign the assessment. ~~Eight~~Ten (10) hours/units of testing per patient (over the age of three), per provider is allowed every ~~12~~twelve (12) months. There may be instances when further testing is appropriate based on established medical necessity criteria found in the Prior Authorization Manual. Test results must be reflected in the service plan or medical record. The service must clearly document the need for the testing and what the testing is expected to achieve. Testing for a child younger than three must be medically necessary and meet established criteria as set forth in the Prior Authorization Manual. Justification for additional testing beyond allowed amount as specified

in this section must be clearly explained and documented in the medical record. Testing units must be billed on the date the testing, interpretation, scoring, and/or reporting was performed and supported by documentation.

(6) Health and Behavior codes - behavioral health services are available only to chronically and severely medically ill members.

(7) Crisis intervention services for the purpose of stabilization and hospital diversion as clinically appropriate.

(8) Payment for therapy services provided by a psychologist to any one member is limited to eight sessions/units per month. A maximum of twelve (12) sessions/units of therapy and testing services per day per provider are allowed. A maximum of ~~thirty five~~thirty-five (35) hours of therapy per week per provider are allowed. The weekly service hour limitation will be calculated using a rolling four (4) week average.

(9) A child may receive psychological testing and evaluation services as separately reimbursable services.

(10) A child receiving Residential Behavioral Management in a foster home, also known as therapeutic foster care, or a child receiving Residential Behavioral Management in a group home, also known as therapeutic group home, may not receive individual, group or family counseling or unless allowed by the OHCA or its designated agent.

(c) **Adults.** Coverage for adults is the same as for children. For group therapy, groups can include up to eight individuals for adult members ~~18~~eighteen (18) years of age and older.

(d) **Home and Community Based Waiver Services for the Intellectually Disabled.** All providers participating in the Home and Community Based Waiver Services program for people with intellectual and developmental disabilities must have a separate contract with this Authority to provide services under this program. All services are specified in the individual's plan of care.

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

(f) **Nursing Facilities.** Services provided to members residing in nursing facilities may not be billed to SoonerCare.

317:30-5-281. Coverage by Category

(a) **Outpatient Behavioral Health Services.** Outpatient behavioral health services are covered as set forth in this Section, and when provided in accordance with a documented individualized service plan and/or medical record, developed to treat the identified behavioral health and/or substance use disorder(s), unless specified otherwise**.**

(1) All services are to be for the goal of improvement of functioning, independence, or wellbeing of the member. The services and treatment plans are to be recovery focused, trauma and co-occurring specific. The member must be able to actively participate in the treatment. Active participation means that the member must have sufficient cognitive abilities, communication skills, and short-term memory to derive a reasonable benefit from the treatment.

(2) In order to be reimbursed for services, providers must submit a completed Customer Data Core (CDC) to OHCA or its designated agent. The CDC must be reviewed, updated and resubmitted by the provider every six (6) months. Reimbursement is made only for services provided while a current CDC is on file with OHCA or its designated agent. For further information and instructions regarding the CDC, refer to the Prior Authorization Manual.

(3) Some outpatient behavioral health services may require authorization. For information regarding services requiring authorization and the process for obtaining them, refer to the Prior Authorization Manual. Authorization of services is not a guarantee of payment. The provider is responsible for ensuring that the eligibility, medical necessity, procedural, coding, claims submission, and all other state and federal requirements are met. OHCA does retain the final administrative review over both authorization and review of services as required by 42 CFR 431.10.

(b) **Adults.** Outpatient behavioral health coverage for adults rendered by a LBHP is limited to bio-psycho-social assessments when required by OHCA as part of a preoperative prior authorization protocol for organ transplant or bariatric surgical procedures.

(1) The interview and assessment is defined as a face-to-face interaction with the member. Assessment includes a history, mental status, full bio-psycho-social evaluation, a disposition, communications with family or other sources, review of laboratory or other pertinent medical information, and medical/clinical consultations as necessary. The pre-op evaluation should aim to assess the member's psychological well-being, ability to make informed decisions, and willingness to participate actively in postoperative treatment.

(2) For bariatric preoperative assessments, issues to address include, but are not limited to: depression, self-esteem, stress management, coping skills, binge eating, change in eating habits, other eating disorders, change in social roles, changes associated with return to work/school, body image, sexual function, lifestyle issues, personality factors that may affect treatment and recovery, alcohol or substance use disorders, ability to make lasting behavior changes, and need for further support and counseling.

(c) **Children.** Coverage for children includes the following services:

(1) Bio-psycho-social and level of care assessments.

(A) The interview and assessment is defined as a face-to-face interaction with the member. Assessment includes a history, mental status, full bio-psycho-social evaluation, a disposition, communications with family or other sources, review of laboratory or other pertinent medical information, and medical/clinical consultations as necessary.

(B) Assessments for children's level of care determination of medical necessity must follow a specified assessment process through OHCA or their designated agent. Only one assessment is allowable per provider per member. If there has been a break in service over a six (6) month period, or the assessment is conducted for the purpose of determining a child's need for inpatient psychiatric admission, then an additional unit can be authorized by OHCA, or their designated agent.

(2) Psychotherapy in an outpatient setting including an office, clinic, or other confidential setting. The services may be performed at the residence of the member if it is demonstrated that it is clinically beneficial, or if the member is unable to go to a clinic or office. Individual psychotherapy is defined as a one to one treatment using a widely accepted modality or treatment framework suited to the individual's age, developmental abilities and diagnosis. It may include specialized techniques such as biofeedback or hypnosis. Psychotherapy is considered to involve "interactive complexity" when there are communication factors during a visit that complicate delivery of the psychotherapy by the LBHP. Sessions typically involve members who have other individuals legally responsible for their care (i.e., minors or adults with guardians); members who request others to be involved in their care during the session (i.e., adults accompanied by one or more participating family members or interpreter or language translator); or members that require involvement of other third parties (i.e., child

welfare, juvenile justice, parole/probation officers, schools, etc.). Psychotherapy should only be reported as involving interactive complexity when at least one of the following communication factors is present:

(A) The need to manage maladaptive communication (i.e., related to high anxiety, high reactivity, repeated questions, or disagreement) among participants that complicate delivery of care.

(B) Caregiver emotions/behavior that interfere with implementation of the treatment plan.

(C) Evidence/disclosure of a sentinel event and mandated report to a third party (i.e., abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other visit participants.

(D) Use of play equipment, physical devices, interpreter or translator to overcome barriers to therapeutic interaction with a patient who is not fluent in the same language or who has not developed or lost expressive or receptive language skills to use or understand typical language.

(3) Family Psychotherapy is performed in an outpatient setting limited to an office, clinic, or other confidential setting. Family therapy is a face-to-face interaction between a therapist and the patient/family to facilitate emotional, psychological or behavioral changes and promote communication and understanding. Family therapy must be provided for the benefit of the member as a specifically identified component of an individual treatment plan.

(4) Group and/or Interactive Group psychotherapy in an outpatient setting must be performed in an office, clinic, or other confidential setting. Group therapy is a face-to-face interaction between a therapist and two or more unrelated patients (though there may be siblings in the same group, just not siblings only) to facilitate emotional, psychological, or behavioral changes. All group therapy records must indicate group size. Maximum total group size is six (6) for ages four (4) up to eighteen (18). Groups with 18-20 year olds can include eight (8) individuals. Group therapy must be provided for the benefit of the member as a specifically identified component of an individual treatment plan. Multi-family group therapy size is limited to eight (8) family units.

(5) Assessment/evaluation and testing is provided by a psychologist, certified psychometrist, psychological technician of a psychologist or a LBHP utilizing tests selected from currently accepted assessment test batteries. For assessments conducted in a school setting, the Oklahoma State Department of Education requires that a licensed supervisor sign the assessment. ~~Eight (8)~~Ten (10) hours/units of testing per patient over the age of three (3), per provider is allowed every twelve (12) months. There may be instances when further testing is appropriate based on established medical necessity criteria found in the Prior Authorization Manual. Justification for additional testing beyond allowed amount as specified in this section must be clearly explained and documented in the medical record. Test results must be reflected in the service plan or medical record. The service plan must clearly document the need for the testing and what the testing is expected to achieve. Testing units must be billed on the date the testing, interpretation, scoring, and/or reporting was performed and supported by documentation.

(6) Crisis intervention services for the purpose of stabilization and hospitalization diversion as clinically appropriate.

(7) Payment for therapy services provided by a LBHP to any one member is limited to four (4) sessions/units per month. A maximum of twelve (12) sessions/units of therapy and testing services per day per provider are allowed. A maximum of thirty-five (35) hours of therapy per

week per provider are allowed. The weekly service hour limitation will be calculated using a rolling four (4) week average. Case Management services are considered an integral component of the behavioral health services listed above.

(8) A child receiving residential behavioral management in a foster home, also known as therapeutic foster care, or a child receiving residential behavioral management in a group home, also known as therapeutic group home, may not receive individual, group or family counseling or testing unless allowed by the OHCA or their designated agent.

(d) **Home and Community Based Waiver Services for the Intellectually Disabled.** All providers participating in the Home and Community Based Waiver Services for the intellectually disabled program must have a separate contract with this Authority to provide services under this program. All services are specified in the individual's plan of care.

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

(f) **Nursing Facilities.** Services provided to members residing in nursing facilities may not be billed to SoonerCare**.**

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

SUBCHAPTER 18. PROGRAMS FOR THE ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

317:35-18-4. Provider regulations

(a) The provider must comply with provisions of this Subchapter, ~~and~~ the regulations in 42 CFR, Part 460~~.~~, and all applicable local, state, and federal regulations. The provider must comply with all evaluation, monitoring, oversight, and other activities of the State Administering Agency (OHCA) as described in 42 CFR, Part 460.

~~(b) The provider agency must be licensed by the State of Oklahoma as an adult day care center.~~

~~(c) The provider must meet all applicable local, state, and federal regulations.~~

~~(d)~~(b) The provider must maintain an inquiry log of all individuals requesting Programs of All-Inclusive Care for the Elderly (PACE) services. This log will be available to the OHCA at all times. The log must include:

(1) type of contact;
(2) date of contact;
(3) name and phone number of the individual requesting services;
(4) name and address of the potential participant; and
(5) date of enrollment, or reason for denial if the individual is not enrolled.

(c) Pursuant to 42 CFR 460.70, any entity contracted by the provider to render PACE benefits must comply with the provisions of this Subchapter, the regulations in 42 CFR Part 460, and any other local, state, and federal regulations applicable to the provider.

(d) OHCA reserves the right to deny a provider's application for a new or renewed contract or terminate a contract with a provider as described in OAC 317:30-3-19.3 and OAC 317:30-3-19.5.

(e) PACE programs are license-exempt only when they provide services exclusively to PACE participants.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 112. PUBLIC HEALTH CLINIC SERVICES

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

CHD/CCHD service limitations are:

(1) Child-guidance services (refer to Oklahoma Administrative Code (OAC) 317:30-5-1023).

(2) Dental services (refer to OAC 317:30-3-65.4(7) for specific coverage).

(3) Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, including blood lead testing and follow-up services (refer to OAC 317:30-3-65 through 317:30-3-65.12 for specific coverage).

(4) Environmental investigations.

(5) Family planning and SoonerPlan family planning services (refer to OAC 317:30-5-12 for specific coverage guidelines).

(6) Immunizations (adult and child).

(7) Blood lead testing (refer to OAC 317:30-3-65.4 for specific coverage).

(8) Newborn hearing screening.

(9) Newborn metabolic screening.

(10) Maternity services (refer to OAC 317:30-5-22 for specific coverage).

(11) Public health nursing services.

(12) Tuberculosis case management and directly observed therapy.

(13) Laboratory services.

(14) Targeted case management.

(15) Community health services.

317:30-5-1162. Community Health Services

(a) **Overview.** Community Health Services are a preventive health service to prevent disease, disability and other health conditions or their progression; to prolong life; and/or to promote physical and mental health and efficiency. Community Health Services are furnished by community health workers (CHW). CHWs are trusted members of a community who help address chronic conditions, preventive health care needs, and health-related social needs.

(b) **Covered Services.** Community Health Services include:

(1) Health education and coaching, in individual or group settings, consistent with established or recognized healthcare standards, to promote beneficiaries' awareness of and engagement in health care and other related services as well as chronic disease self-management methods; including care planning, setting goals, and creating action plans to address barriers to engaging in care and/or self-management of chronic conditions;

(2) Screening and assessment to uncover the need for services;

(3) Health system navigation and health-related social resource coordination to assist beneficiaries with access to appropriate health care and other related community resources; care coordination services include engaging with beneficiaries and interdisciplinary care

teams as a part of a team-based, person-centered approach to support and advocate for physical and mental health including during time-limited episodes of instability.

(c) **Member Eligibility.** In order to receive CHW services, a beneficiary must have services ordered by a physician or other licensed practitioner and must have at least one of the following:

(1) Diagnosis of one or more chronic health conditions including behavioral health conditions;

(2) Self-reported/suspected or documented unmet health-related social need;

(3) Received a screening; and/or

(4) Pregnancy.

(d) **Provider Eligibility.** In order to provide CHW services, an individual shall, in addition to the requirements set forth in 317:30-5-1152:

(1) Be at least eighteen (18) years of age, a legal United States resident, and a resident of Oklahoma;

(2) Be contracted with the State Medicaid Agency or its designee;

(3) Pass a background check;

(4) Obtain a certificate of completion of a C3 core competency-based Community Health Worker training offered by the Oklahoma State Department of Health, Tulsa City County Health Department, and/or Oklahoma City County Health Department; or have two thousand (2,000) documented hours of paid, volunteer, or lived experience;

(5) Have lived experience that aligns with the community being served; and

(6) Work and bill under a licensed provider.

(e) **Limitations.** The following limits exist for community health services.

(1) Individuals may not receive more than two (2) hours or four (4) units per member per day.

(2) Monthly service limits are not to exceed twelve (12) hours or twenty-four (24) units.

(3) Hour limits are constant, regardless of whether services are administered in an individual or group setting.

(4) A visit may consist of multiple units of service on the same date; the time for units of service is added together and rounded up only once per visit.