OKLAHOMA HEALTH CARE AUTHORITY
REGULAR BOARD MEETING
March 17, 2021 at 3:00 P.M.
Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

# A G E N D A

This meeting will occur via videoconference, but certain parties, including CEO Corbett, Chairman Hupfeld, Member Boyd, Member Nuttle, and OHCA staff, will be present at the OHCA building at 4345 N. Lincoln Blvd., Oklahoma City, OK 73105. All other OHCA Board members will participate in the videoconference from a remote location.

Videoconference Participants

Jean Hausheer, M.D. – Zoom videoconference
Alex Yaffe – Zoom videoconference
Philip Kennedy – Zoom videoconference
Tanya Case – Zoom videoconference

Public access via Zoom:
https://okhca.zoom.us/webinar/register/WN_Rdb7OaNZQ3G3ioQLCmvN8A
Telephone: 1-669-900-6833 Webinar ID: 969 1352 2144

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

2. Consent Agenda……Stan Hupfeld, Chair

    a) Approval of the January 26, 2021 OHCA Board Meeting Minutes (Attachment "A")
    b) Discussion and vote regarding the Authority's ability to withstand the procurement decision made by the CEO based on the Authority's budget and available funds.
        i. Legal Services Contract (Attachment "B")
        ii. Consultant Contracts (Attachment "C")
        iii. Health Information Exchange (Attachment "D")

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

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

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

    a) Member Experience
    b) High Level Managed Care Implementation Update

6. Discussion of Report from the Legislative……..……Alex Yaffe
   Advisory Committee (Attachment "E") Chair, Legislative Advisory Committee

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

8. Discussion of Report from the……..……..……..……..Jean Hausheer, M.D.
   Administrative Rules Advisory Committee and Chair, Administrative Rules Advisory Committee
   Possible Action Regarding Agency Rulemaking (Attachment "F")

    a) Consideration and Vote on a Declaration of a Compelling Public Interest for the Promulgation of the Emergency Rule in Attachment "F" in Accordance with 75 O.S. § 253.

    b) Consideration and Vote on Agency Recommended Rulemaking Pursuant to Article I of the

Administrative Procedures Act. OHCA Requests the Adoption of the Following Emergency Rule (see Attachment "F"):

i. **APA WF # 21-04 Diabetes Self-Management Education and Support (DSMES) Services**

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

ii. **APA WF # 20-04 Electronic Visit Verification (EVV)**
iii. **APA WF # 20-13 Child Support Cooperation Exemption for Recipients of Indian Health Services**
iv. **APA WF # 20-14 Therapy Assistants and Clinical Fellows**
v. **APA WF # 20-15A Residential Substance Use Disorder (SUD) Treatment Coverage**
vi. **APA WF # 20-16 Opioid Treatment Program (OTP) and Medication-Assisted Treatment (MAT) Services**
vii. **APA WF # 20-19A Appeals Language Cleanup**
viii. **APA WF # 20-20 Pay-for-Performance (PFP) program**
ix. **APA WF # 20-21 Employment Services Offered through Developmental Disabilities Services**
x. **APA WF # 20-06C Durable Medical Equipment (DME) and Supplies Benefit Moved under the Scope of the Home Health Benefit**
xi. **APA WF # 20-15B Residential Substance Use Disorder (SUD) Treatment Coverage**
xii. **APA WF # 20-19B Appeals and Incorrect References Language Cleanup**
xiii. **APA WF # 20-27 Specialty PRTF Staffing and Admission Revisions**
xiv. **APA WF # 20-22 Programs of All Inclusive-Care for the Elderly (PACE)**
xv. **APA WF # 20-23 Developmental Disabilities Services (DDS)**
xvi. **APA WF # 20-24 A&B ADvantage Waiver**
xvii. **APA WF # 20-25 Peer Recovery Support Specialist (PRSS) Services in Indian Health Services, Tribal Programs and Urban Indian Clinics (I/T/Us)**
xviii. **APA WF # 20-29 Provider Refund to Member when Copayment is Over-Collected**
xix. **APA WF # 20-31 State Treasurer's Achieving a Better Life Experience (STABLE) Accounts**
xx. **APA WF # 20-33 Bariatric Surgery Revisions**
xxi. **APA WF # 20-34 Dental Revisions**
xxii. **APA WF # 20-36A Lodging, Meals, and SoonerRide**
xxiii. **APA WF # 20-36B Lodging, Meals, and SoonerRide**
xxiv. **APA WF # 20-37 Obstetrical (OB) Ultrasound**
xxv. **APA WF # 20-38 Clinical Trials**
xxvi. **APA WF # 20-39 Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Policy Revisions**
xxvii. **APA WF # 20-40 Medicaid-Funded Abortion Certification Requirements**
xxviii. **APA WF # 20-41 Sunsetting of Health Homes**

9. Discussion of Report from the Pharmacy Advisory Committee and Possible Action Regarding Drug Utilization Board Recommendations ……..……..Terry Cothran, D.Ph. Senior Director of Pharmacy Services

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

i. Blenrep (Belantamab Mafodotin-blmf), Darzalex® (Daratumumab), Darzalex Faspro™ (Daratumumab/Hyaluronidase-fihj), Empliciti® (Elotuzumab), Hemady™ (Dexamethasone 20mg Tablet), Ninlaro® (Ixazomib), Sarclisa® (Isatuximab-irfc), and Xpovio® (Selinexor)
ii. Lenvima® (Lenvatinib)

iii. AirDuo® Digihaler® (Fluticasone Propionate/Salmeterol), ArmonAir® Digihaler® (Fluticasone Propionate), and Breztri Aerosphere™ (Budesonide/Glycopyrrolate/Formoterol Fumarate)
iv. Enspryng™ (Satralizumab-mwge) and Uplizna™ (Inebilizumab-cdon)
v. Ortikos™ [Budesonide Extended-Release (ER) Capsule]
vi. Pizensy™ (Lactitol)
vii. Oriahnn™ (Elagolix/Estradiol/Norethindrone and Elagolix)
viii. Nexletol® (Bempedoic Acid) and Nexlizet™ (Bempedoic Acid/Ezetimibe)
ix. Durysta™ (Bimatoprost Implant)
x. Imcivree™ (Setmelanotide)

10. Discussion and Possible Action……Stan Hupfeld, Chair
Possible Executive Session as Recommended by the Director of Legal Services and Authorized by the Open Meeting Act, 25 O.S. § 307(B)(4) and (7), To Discuss Confidential Legal Matters, Including Pending State and Federal Litigation.

11. Adjournment……Stan Hupfeld, Chair

NEXT BOARD MEETING
May 19, 2021
Oklahoma Health Care Authority
Via Videoconference

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MINUTES OF A SPECIAL BOARD MEETING
OF THE HEALTH CARE AUTHORITY BOARD
January 26, 2021
Oklahoma Health Care Authority Boardroom
Oklahoma City, Oklahoma

Manner and Time of Notice of Meeting: A statutorily required public meeting notice was placed on the front door of the Oklahoma Health Care Authority on January 25, 2020 at 8:00 a.m. Advance public meeting notice was provided to the Oklahoma Secretary of State. In addition to the posting of the statutory public notice, the agency placed its agenda on its website on January 22, 2020 at 5:00 p.m.

Pursuant to a roll call of the members, a quorum was declared to be present, and Chairman Hupfeld called the meeting to order at 8:30 a.m.

BOARD MEMBERS PRESENT: Chairman Hupfeld, Vice-Chairman Yaffe, Member Boyd, Member Case, Member Curry, Member Hausheer, Member Kennedy, Member Nuttle, Member Shamblin

**ITEM 2 – PUBLIC COMMENT ON THIS MEETING'S AGENDA ITEMS BY ATTENDEES WHO GAVE 24-HOUR PRIOR WRITTEN NOTICE**

Stanley Hupfeld, OHCA Board Chairman

- Sandra Harrison, VP of Regulatory and Legal Affairs of the Oklahoma Hospital Association
- Victor Clay, President and Owner of Complete Care Medical
- Debra Billingsley, Executive Director of the Oklahoma Pharmacists Association
- Lynn Means, Executive Director of the Oklahoma Dental Association
- Dr. Woody Jenkins, Oklahoma State Medical Association
- Verna Foust, CEO of Red Rock Behavioral Health

**ITEM 3 / DISCUSSION AND POSSIBLE VOTE ON APPROVAL OF CONSENT AGENDA WHICH INCLUDES:**

Chairman Hupfeld suggested that items 3A and 3B be voted on as a group and items 3C.i and items 4A-C be voted on as a group.

a) Approval of the November 12, 2020 OHCA Board Meeting Minutes (Attachment "A")
b) Approval of State Plan Amendment Rate Committee Rates (Attachment "B")

MOTION: Member Hausheer moved for approval of item 3A-B listed in the Consent Agenda, as published. The motion was seconded by Member Curry.

FOR THE MOTION: Chairman Hupfeld, Vice-Chairman Yaffe, Member Boyd, Member Case, Member Kennedy, Member Nuttle, Member Shamblin

Mr. Corbett provided a brief comment regarding the MCO related items being proposed in Item 4A-C. In his comment, Mr. Corbett stated that it is the authority of the Board to vote on the contracts dependent on OHCA's budget and availability of funds. He also added that, Aaron Morris, OHCA CFO, will provide an overview of how the not-to-exceed amount was determined through an actuarial process. Vice-Chairman Yaffe referenced title 63, section 5007, C as stating, "The Board shall have the power and duty to establish policies of the OHCA" and asked how Mr. Corbett feels the Governor can tell the Board how to establish policy. Mr. Corbett stated that policy versus strategic direction are different. The authority does lay with the Governor. Policy decisions have been discussed previously with regards to revisions within OHCA's current State Plan. As it relates to the decision of how to operate the organization, something like this rests with the Governor. Member Case stated she did not believe there was a consensus among the board and asked if an opinion of the Attorney General could be requested for as to what the authority of the board truly is. Mr. Corbett looked to counsel and recalled that there were authorities provided to the Board prior to the Governor being given the authorities, one of which gave the Board authority to make procurement decisions, those which were passed to him. Member Case clarified that she understands the procurement, however is unsure of what the role of the Board truly is. When asked if she had made a motion, Member Case stated she certainly could make it a motion.

Vice-Chairman Yaffe added that the statute previously mentioned does include the amendment that was put into effect on March 13, 2019 and moved that the Board seeks the guidance and official Attorney General opinion as to what the roles and responsibilities are of the Board, Member Case seconded that motion. Ms. Buettner stated that the motion is not something that could be voted on as it is not listed on the agenda. Vice-Chairman asked for authority as to why, to which Ms. Buettner stated that under the Open Meetings Act, OHCA is required to post any action items on the agenda. Vice-Chairman Yaffe asked that the Board move into Executive Session, to which Ms. Buettner stated the Executive Session is not on the agenda and cannot be voted on. Vice-Chairman Yaffe sought legal advice from the Board's counsel, Dawson Engle, who agreed with Ms. Buettner that it would be in violation of the Open Meetings Act. Member Nuttle agreed that the Board could seek an Attorney General opinion, but the purpose of the current motion is to determine a policy issue and asked how critical it was for the Board to vote on the MCO contracts. Mr. Corbett stated it is critical in ensuring implementation is on track. Chairman Hupfeld stated he fully accepts the motion to explore, with all appropriate parties, the role and authority of the Board, however there are items that requires action and asked the Board to move forward with the agenda.

Vice-Chairman Yaffe withdrew his motion to seek Attorney General opinion. Mr. Engle, recommended the Board not accept any further motion to seek Attorney General opinion as it is not on the agenda and suggested a special meeting be scheduled should the Board like to engage in further Attorney General discussions.

Mr. Morris provided an overview of Item 3C.i, Third Party Liability Expenditure of Funds Contract.

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| MOTION: | Member Case motioned to vote on item 3C.i as a separate item. The motion was seconded by Vice-Chairman Yaffe. |
| FOR THE MOTION: | Chairman Hupfeld, Member Boyd, Member Curry, Member Hausheer, Member Kennedy, Member Nuttle, Member Shamblin |

c) Discussion and vote regarding the Authority's ability to withstand the procurement decision made by the CEO based on the Authority's budget and available funds.
    i. Third Party Liability (Attachment "C")

Member Case requested to comment on the Third Party Liability contract. Member Case expressed her concern regarding the fact that the Board of Equalization has not met to certify expenditures for this year. Member Case stated that the fact that the funds for the Third Party Liability contract have not been certified by the Board of Equalization gives her pause constitutionally. Mr. Corbett reminded the Board that each contract has a not to exceed amount and all subject to appropriate financial availability, particularly appropriations from the legislature. To the extent that funding not be available, the contract would be terminated. Member Case wanted it noted that it gives a protester a cause for action against the OHCA Board. Because the issue of the authority of the OHCA has been brought to light, Vice-Chairman Yaffe does not believe that the board should vote in the affirmative or at all on any of the procurement items until further guidance from the Attorney General. Vice-Chairman Yaffe further stated that he will vote no this until further guidance from the Attorney General is received. Member Hausheer requested that Vice-Chairman Yaffe specify what items he plans to vote no on. Vice-Chairman Yaffe stated that with the questions raised statutorily of the Board's authority, procedurally, it does not make sense to vote on any procurement items until we have official word from the Attorney General on what the Board's authority is. He understands that there is currently a motion and a second to approve the Third Party Contract, but that the real question is does the board approve this? His vote will be "no" as it is not known whether the Board has authority to approve these contracts. Member Nuttle stated the Board does have authority to vote on this contract. The question of authority to the Attorney General is, "Does the Board have authority to question policy?" Member Shamblin asked if it would be appropriate, she would be willing to withdraw her vote and further asked if it is within a board members right to not vote on agenda items. Dawson Engle, Deputy General Counsel, stated that correct procedure would be a motion to table an item.

Member Shamblin and Member Curry both withdrew their motions to approve item 3C.i.

Member Case motioned to table item 3C.i, 4A, 4B, and 4C. The motion was seconded by Vice-Chairman Yaffe. Chairman Hupfeld looked to counsel to ensure Member Case's motion to table the items was a proper motion. Mr. Engle stated it was a proper motion, waiting on a second. Mr. Corbett reminded the board that the Board had previously taken action on these contracts and are currently in operation. As it relates to the board's ability to approve procurement decisions that he made subject to the availability of funds still stands. Member Nuttle stated that the Board has an obligation to vote to allow OHCA to function. Member Nuttle asked the Board, on this motion, to consider how they would vote if the objections to what the overall discussion to on whether the Board has the authority to question policy, and not use it as a protest vote to disrupt the business of the agency. Chairman Hupfeld asked Compliance Committee Chairman Kennedy to provide some

insight, as the contracts were brought to the Board, through the Compliance Advisory Committee. Chairman Kennedy stated it was the recommendation of the Compliance committee to the Board to approve the contracts. Member Hausheer asked the other Compliance Committee members to provide comment on their choice to vote to recommend the contracts to the Board for approval. Vice-Chairman Yaffe stated he did vote in the affirmative, however, since then there has been significant information that has risen that has given him pause. Regarding Item 3C.i, specifically, which expires on June 30, 2021, the issue still relates to the Board's authority. Vice-Chairman Yaffe stated he has heard the OHCA Board be called an Advisory Board, however he does not believe the Board is an advisory board. Member Boyd added that there are currently two issues on the table: 1: the authority of the Board that will not be solved today. He suggested the Board either vote and get an Attorney General opinion and if the opinion invalidates the vote, that's fine, if the opinion upholds the vote, that's fine as well. The second issue affects the operation on the agency. Member Hausheer wanted to note that she was not made aware that the Medical Advisory Committee was not in favor of these items until the day before the Board meeting. She requested that, in the future, the Board be notified ahead of time of these things. Chairman Hupfeld noted that he has been aware all along of what the role of the Board has been and continued with the call of roll for the motion that is on the table.

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| MOTION: | Member Case moved to table items 3C.i, 4A, 4B, 4C. The motion was seconded by Vice-Chairman Yaffe. |
| FOR THE MOTION: | Vice-Chairman Yaffe, Member Case, Member Curry, Member Hausheer |
| AGAINST THE MOTION: | Chairman Hupfeld, Member Boyd, Member Kennedy, Member Nuttle, Member Shamblin |

***The motion to table items 3C.i, 4A, 4B, 4C failed.**

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| MOTION: | Member Kennedy moved to approve item 3C.i as published. The motion was seconded by Member Boyd. |
| FOR THE MOTION: | Chairman Hupfeld, Member Boyd, Member Kennedy, Member Nuttle, Member Shamblin |
| AGAINST THE MOTION: | Vice-Chairman Yaffe, Member Case, Member Curry, Member Hausheer |

***The motion to approve item 3C.i passed**

**ITEM 4 / DISCUSSION AND VOTE REGARDING THE AUTHORITY'S ABILITY TO WITHSTAND THE PROCUREMENT DECISION MADE BY THE CEO BASED ON THE AUTHORITY'S BUDGET AND AVAILABLE FUNDS**

Aaron Morris, Chief Financial Officer

Mr. Morris provided an overview of the following Expenditure of Funds Contracts:

a. External Quality Review Contract (for more detailed information, see attachment "D" in the board packet)

There were no questions regarding this contract.

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| MOTION: | Member Kennedy moved to approve item 4A as published. The motion was seconded by Member Nuttle. |
| FOR THE MOTION: | Chairman Hupfeld, Member Boyd, Member Kennedy, Member Nuttle, Member Shamblin |
| AGAINST THE MOTION: | Vice-Chairman Yaffe, Member Case, Member Curry, Member Hausheer |

***The motion to approve item 4A passed.**

b. SoonerSelect/SoonerSelect Children (for detailed information, see attachment "E" in the board packet)

Mr. Morris provided an overview of the process leading up to seeking approval of this contract. OHCA hired a national firm to perform the analysis required for rate setting. The budget is established based on actuary analysis of historical program spending, utilization, and covered lives. The Zoom feed was lost during this portion of Mr. Morris' presentation. Staff were able to get the Zoom back up within minutes of losing feed. Member Hausheer asked if it was a fair assumption that the

agency, in general, has to make adjustments moving forward and if it is appropriate of the Board to contemplate that the legislature, at least, historically, has also made corrections along the way to which Mr. Morris answered yes, any changes to the contracts will require the Board to vote again on the contract. Member Case asked how can it assured that the funding can be available for the next fiscal year. Mr. Morris stated that OHCA manages the program be based on funding, so if OHCA were to receive an appropriation reduction that could not be self-funded, OHCA would have to take action to be able to budget for that. Mr. Corbett added that the Finance team monitors the budget closely. When asked about OHCA holding money, Mr. Morris stated OHCA reports all cash reserves to the legislature, OMES and the Compliance Committee. Member Nuttle added that it is not unusual to vote on a budget item like this. OHCA has carryover funds and contingency funds for the flu season that are substantial and subject to change in federal law that requires certain conditions in how we provide services in rural areas that cost more money. If there is a shortage of funds, there is a legislative process for emergency funding. Vice-Chairman Yaffe expressed his concern about the authority of the Board to take this action, resulting in his motion to table this item. He also added that he does not think OHCA, at this time, has the infrastructure in place to oversee the multi-billion dollar companies. Member Case asked what the reason was for rushing this contract. Mr. Corbett stated that this project will require a lot of work to implement. The process needs to get underway, it is an operation matter at this point. Member Shamblin asked if the Attorney General opinion comes back and says the Board had the authority to be involved, does that mean the Board should have voted on it last summer. Member Nuttle stated it is in fact separate. If the Attorney General rules this is a policy board, then it changes the whole process. In response to Member Shamblin, Member Case added that she believes the Board has relevant policy authority under section 5007, stating “the Board shall have the duty to establish policies of the Oklahoma Health Care Authority.”

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| MOTION: | Vice-Chairman Yaffe moved to table items 4B. The motion was seconded by Member Case. |
| FOR THE MOTION: | Vice-Chairman Yaffe, Member Boyd, Member Case, Member Curry |
| AGAINST THE MOTION: | Chairman Hupfeld, Member Boyd, Member Hausheer, Member Kennedy, Member Nuttle, Member Shamblin |

***The motion to table item 4B failed.**
Member Case requested clarification of Member Hausheer’s vote for the motion to table item 4B. Member Hausheer confirmed her “No” vote to table.

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| MOTION: | Member Kennedy moved to approve item 4B. The motion was seconded by Member Nuttle. |
| FOR THE MOTION: | Chairman Hupfeld, Member Boyd, Member Hausheer, Member Kennedy, Member Nuttle, Member Shamblin |
| AGAINST THE MOTION: | Vice-Chairman Yaffe, Member Case, Member Curry |

***The motion to approve item 4B passed.**

c. SoonerSelect/SoonerSelect Dental (for detailed information, see attachment “F” in the board packet)

Member Boyd asked for a commitment that the metrics, on both sides, be brought to the Board on a regular basis. Mr. Morris stated that designing recording templates is a big part of readiness activity.

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| MOTION: | Vice-Chairman Yaffe moved to table items 4C. The motion was seconded by Member Case. |
| FOR THE MOTION: | Vice-Chairman Yaffe, Member Case, Member Curry |
| AGAINST THE MOTION: | Chairman Hupfeld, Member Boyd, Member Hausheer, Member Kennedy, Member Nuttle, Member Shamblin |

***The motion to table item 4C failed.**

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| MOTION: | Member Kennedy moved to approve item 4C. The motion was seconded by Member Nuttle. |

FOR THE MOTION: Chairman Hupfeld, Member Boyd, Member Hausheer, Member Kennedy, Member Nuttle, Member Shamblin

AGAINST THE MOTION: Vice-Chairman Yaffe, Member Case, Member Curry

***The motion to approve item 4C passed.**

**ITEM 5 / CHIEF EXECUTIVE OFFICER'S REPORT**
Kevin Corbett, Chief Executive Officer

Mr. Corbett thanked the Board members for taking the time to attend this meeting in person. OHCA has weighed in on hospital capacity. OHCA's Policy team created the opportunity to have flexibility for creating capacity and other alternatives for discharge and admissions. The first being presumptive eligibility for long term care, outpatient fusion services for COVID therapeutics, and Hospital Care At Home.

COVID and COVID Relief process continues at $900 billion, about $265 million in federal funds to the state for testing, contact tracing and vaccine administration, due to the enhanced FMAP. The public Health Emergency has been extended through April 2021, which allows an extension on the enhanced FMAP through this fiscal year.

Regulatory environment: OHCA recognizes the changes of federal partners, however those that we interact with on day to day basis are still at CMS. OHCA is working to maintain current relationships and create new working relationships.

Expansion: OHCA's budget hearing with the Senate was scheduled January 25th and the budget hearing with the House is scheduled January 26th. Mr. Corbett extended an invitation to attend to the Board. One of the significant budget items is expansion, $164 million of our $210 million total request. OHCA has worked with House and Senate leadership on what might be available: SoonerCare 2.0 still being an on the table and SHOPP increases for assessments. Other state agencies could also see the benefit of expansion through members served.

MCO Update: The current process has been underway since June 2020. OHCA received 7 requests for the medical RFP and 3 for the dental RFP. The contract process has ceased and the readiness process has begun and will go for 90-days. Mr. Corbett guarantees full transparency throughout the entire process. Accountability will also be part of OHCA's internal processes. When asked when the bids will be awarded, Mr. Corbett stated the bid will be awarded by the end of the week.

Mr. Corbett highlighted the Operation Metrics. For more detailed information, see the last item in the board packet.

HIE: Award has been made and Carter Kimble has been named the Director. More information can be provided after the protest. Member Hausheer requested that the Board be notified of when the protest is complete.

**Mr. Corbett stated that OHCA will make a request to the Attorney General for an opinion on the authority of the board, subject to his availability.**

**ITEM 6 / CHIEF OF STAFF'S REPORT**
Ellen Buettner, Chief of Staff

Ms. Buettner provided an operational update. OHCA is continuing conversations with Sec. Budd and OMES on opportunities for co-location with other state agencies or moving to a smaller location. In regards to the health and wellbeing of staff, only 48 cases of COVID have been reported, 12 of whom were in the building. OHCA is also working with the Department of Health to have OHCA volunteers at vaccine pods.

Employee Development: OHCA participated in and scored a 60% engagement rate in the Energage survey. As a result of that score, OHCA was named one of the top places to work in Oklahoma. Two other culture driver initiatives that OHCA is working on are: Consensus Performance Evaluations and Succession Planning. The intent of these exercises are to enhance discussions about career goals. Ms. Buettner also highlighted the go-live of OHCA's new public website. OHCA Communications has partnered with DMH and OSDH for interagency town halls for all of the agency's employees.

**ITEM 7 / CHIEF OPERATING OFFICER'S REPORT**
Melody Anthony, Chief Operating Officer/State Medicaid Director

Ms. Anthony provided an update on the MCO timeline. At this time, the plan is to submit the RFPs, rates, and amendments to the feds in February. The feds have until August to work with OHCA prior to MCO implementation. Tribes will be given the option to opt-in or out of Managed Care at fee-for-service.

**ITEM 7A / EXPANSION UPDATE**
Melody Anthony, Chief Operating Officer/State Medicaid Director

Ms. Anthony provided a brief Expansion Update, which included information on pre and post expansion coverage, SPA Approvals, and Operational Readiness. For more detailed information, see attachment G in the board packet.

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

Committee Chair Yaffe provided comments on the upcoming legislative session. COVID will be a large part of session. There is a lot of work that needs to be done, now that the MCO contracts have been approved by the Board. Ms. Foss provided a request bill overview, including Third Party Liability, Medical Advisory Committee, CEO Appeals Process, and Shared Savings for Tribal partners. Pro Tem Treat and Floor Leader Echols have both filed legislation to extend the temporary changes to the Open Meeting Act and stated they would be a priority this session. Ms. Foss also stated that the Board could watch the recording for the Senate budget hearing at any time. Routine updates will continue to be sent to the Board.

**ITEM 9 / DISCUSSION OF REPORT FROM THE COMPLIANCE ADVISORY COMMITTEE**
Phil Kennedy, Chair of the Compliance Advisory Committee

Committee Chair Kennedy reported on the December 9th and January 13th Compliance Committee Meetings. On December 9, 2020, the Committee met to discuss the SFY 22 budget request. He highlighted items from the report including: annualizations, increase in FMAP bringing in about $26 million in federal funds, and the decrease in CHIP funding of about $5 million. When combined, the total net comes to about $20 million. Increased utilization is about 2.6% across the board with a total cost of $100 million, with $28.8 million of that being state dollars. Medicare A and B are estimated to be an increase of about $4.7 million, of that $1.5 million in state dollars. With the MCO Premium Tax, there is an upfront cost for the first year that OHCA will pay, receive the matching federal funds, and then the MCO will pay the full amount of the tax. This will allow the state to receive as estimated net gain of almost $40 million in federal funds. Total expansion cost will be about $1.3 billion, of which $164 million will be state share. He also discussed some new initiatives, including Adult Dental Benefits which will total about $6.87 million, of which $16.7 is the state share. Alternative Treatment for Pain Management has a total budget of $32.6, of which $7.6 will be the state share. In total, the SFY 2022 budget increase is estimated at $1.6 billion, of which $210 million will be state share. Member Case asked, in regards to the MCO premium tax, if the law will need to be changed as to where the money will go. OHCA received an informal opinion from the Attorney General's office, stating that the amount can find its way back to OHCA.

On January 13, 2021, the Committee met to discuss OHCA's current finances. Committee Chairman Kennedy provided an overview of OHCA's finances through November 2020. OHCA's variance is $59.8. Revisions to the budget will be made. The plan was to make the revisions on December 16, 2020, however there are some administrative changes that need to be made. The increases were funded with prior year one-time funds. The federal funds revenue variance is due to program expenditure variance and the program expenditure variance is due to estimated expenditure increase related to increased enrollment that has not been realized. Most program lines are seeing significant variances for this reason. Drug Rebates are under budget by $9.7 million through November, but will be over budget in December. November financials show other state agency receivables of $35.8 million, much of which is due to timing and billing cycles. DHS is caught up and all invoices are less than 30-days. DMH is also caught up with a positive balance. The tobacco tax fund, which is used to fund Insure Oklahoma, has large cash balance of $19 million, of which $17 million is from the prior year.

Drug rebate claiming: OHCA is looking at new methodology of returning drug rebate revenue to the federal government, which will achieve additional federal revenue in SFY 2021. OHCA believes that revenue to be $10-$17 million depending on how many years OHCA can go back.

**ITEM 10i-vii / DISCUSSION OF REPORT FROM THE ADMINISTRATIVE RULES ADVISORY COMMITTEE AND POSSIBLE ACTION REGARDING AGENCY RULEMAKING**
Jean Hausheer, M.D., Chair of Administrative Rules Advisory Committee

a) Consideration and Vote of the Agency Recommended Rulemaking Pursuant to Article I of the Administrative Procedures Act. OHCA Requests the Adoption of the Following Permanent Rules (see attachment "H")

i. **APA WF # 20-01 High-Investment Drugs Carve-Out —** ADDING agency rules at ***OAC 317:30-5-42.20 and 317:30-5-47.6*** and AMENDING ***OAC 317:30-3-31, 317:30-5-42.1, and 317:30-5-47***
ii. **APA WF # 20-02 Retroactive Eligibility —** AMENDING agency rules at ***OAC 317:35-6-60*** and ADDING agency rules at ***OAC 317:35-6-60.2***
iii. **APA WF # 20-03 Treatment of Lottery or Gambling Winnings for Income Eligibility —** AMENDING agency rules at ***OAC 317:35-6-51*** and ADDING agency rules at ***OAC 317:35-6-55***
iv. **APA WF # 20-05 Continuation of Services Pending Appeals —** ADDING agency rules at ***OAC 317:2-1-2.6***
v. **APA WF # 20-06B Durable Medical Equipment (DME) and Supplies Benefit Moved under the Scope of the Home Health Benefit —** AMENDING agency rules at ***OAC 317:35-18-6***
vi. **APA WF # 20-06D Durable Medical Equipment (DME) and Supplies Benefit Moved under the Scope of the Home Health Benefit —** AMENDING agency rules at ***OAC 317:50-1-14***
vii. **APA WF # 20-11 Medicare Part C (Medicare Advantage) —** AMENDING agency rules at ***OAC 317:30-3-25***

MOTION: Member Case moved for approval of Item 10i-vii as published. The motion was seconded by Member Curry.

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

**ITEM 11i-v / DISCUSSION OF REPORT FROM THE PHARMACY ADVISORY COMMITTEE AND POSSIBLE ACTION REGARDING DRUG UTILIZATION BOARD RECOMMENDATIONS**

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

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

i. Mycapssa® (octreotide)
ii. Zejula® (niraparib)
iii. Trikafta® (elexacaftor/tezacaftor/ivacaftor and ivacaftor)
iv. Evrysdi™ (risdiplam)
v. Cystadrops® (cysteamine 0.37% ophthalmic solution) and Cystaran™ (cysteamine 0.44% ophthalmic solution)

MOTION: Member Hausheer moved for approval of Item 11i-v as published. The motion was seconded by Member Boyd.

FOR THE MOTION: Chairman Hupfeld, Vice-Chairman Yaffe, Member Case, Member Curry, Member Kennedy, Member Nuttle, Member Shamblin

**ITEM 12 / ADJOURNMENT**

MOTION: Member Hausheer moved for approval for adjournment. The motion was seconded by Member Boyd.

FOR THE MOTION: Chairman Hupfeld, Vice-Chairman Yaffe, Member Case, Member Curry, Member Kennedy, Member Nuttle, Member Shamblin

Meeting adjourned at 11:17 a.m., 1/26/2021

NEXT BOARD MEETING
March 17, 2021
Oklahoma Health Care Authority
4345 N. Lincoln Blvd
Oklahoma City, OK 73105

*Martina Ordonez*
*Board Secretary*

*Minutes Approved: _____*

*Initials:_____*

**SUBMITTED TO THE C.E.O. AND BOARD ON MARCH 17, 2021**
**Discussion and vote regarding the Authority's ability to withstand the procurement decision made by the CEO based on the Authority's budget and available funds**

**BACKGROUND**

| | |
|---|---|
| **Services** | **Legal Services Contract** |
| **Purpose and Scope** | Review OHCA's draft RFPs and other relevant documents for the following:<br>• Compliance with state and federal legal requirements;<br>• Mitigation of risk with OHCA's transition to managed care. |
| **Procurement Method** | Direct Purchase Order |
| **Award** | Single Contractor |
| **New Contract Term** | Contract effective date October 1, 2020 through June 30, 2021, with no options to renew. |

**BUDGET**

| | |
|---|---|
| **Total Contract Not-to-Exceed Requested for Approval.** | $200,000.00 |
| **50% Federal Match Costs within the Total Contract Not-to-Exceed; 50% State Match** | $100,000.00 at 50%<br>$100,000.00 at 50% |

**RECOMMENDATION**

The Authority affirms its ability to withstand the procurement decision made by the CEO based on the budget and available funds. Board approval is requested for a total not-to-exceed of $200,000.00 for legal services described above.

**Additional Information**

| |
|---|
| **Contract Term, Including all Optional Renewal Years**<br>(Oklahoma law limits State Agencies from encumbering funds for more than a single State Fiscal Year. As a result, all State of Oklahoma contracts are entered into for an initial year period with subsequent optional renewal years. Every OHCA professional services contract includes standard contract termination language, including immediate, 30 day for cause, 60 day without cause, and non-renewal terminations.) |
| **Total Contract Not-to-Exceed Requested for Approval.**<br>(Actual not-to-exceed amounts are established by the competitive bid process. If the not-to-exceed amount exceeds the amount previously approved by $125,000.00 or more, the contract increase shall require additional Board approval.) |
| **Federal Match Percentage(s)**<br>(CMS authorizes Federal Match based upon specific criteria, for example, a single Information Technology contract may qualify for 50% administrative match, 75% operational match, and 90% implementation match.) |

**SUBMITTED TO THE C.E.O. AND BOARD ON MARCH 17, 2021**
**Discussion and vote regarding the Authority's ability to withstand the procurement decision made by the CEO based on the Authority's budget and available funds**

| | |
|---|---|
| **Services** | **Consultant Contract** |
| **Purpose and Scope** | OHCA is requesting an increase to the Consultant Contract. The awarded contract is currently with four contractors to provide consulting services on various policy, contracting, audit and rate-setting issues. The contractor performs comprehensive analysis, feasibility, determinations of budget impact, and evaluation of current and potential OHCA initiatives and programs.<br><br>The current environment requires more data-driven decision making and independent evaluation of performance and costs, therefore resulting in a greater need for these services.<br><br>• Analyze impact of policy changes on cost, access and quality of services<br>• Develop state plan amendments or waivers as needed<br>• Evaluate OHCA programs and recommend improvements<br>• Provide financial services including budget neutrality calculations, cost impacts, program feasibility, return on investment, and rate setting for new or existing services<br>• Assess data vulnerability and provide gap analysis of available data versus needed data<br>• Provide reports and presentations as necessary on the above issues |
| **Mandate** | N/A |
| **Procurement Method** | RFP |
| **Award** | Four Awarded Contractors |
| **Contract Term** | Initial Contract effective date September 1, 2019 through June 30, 2026. |

**BUDGET**

| | |
|---|---|
| **Total Contract Not-to-Exceed Requested for Approval.** | $3,000,000.00 |
| **50% Federal Match Costs within the Total Contract Not-to-Exceed; 50% State Match** | $1,500,000.00 |

**RECOMMENDATION**

The Authority affirms its ability to withstand the procurement decision made by the CEO based on the budget and available funds. Board approval is requested for an SFY 2021 increase to $3,000,000.00 for consultant services described above.

**Additional Information**

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|---|
| **Contract Term, Including all Optional Renewal Years**<br>(Oklahoma law limits State Agencies from encumbering funds for more than a single State Fiscal Year. As a result, all State of Oklahoma contracts are entered into for an initial year period with subsequent optional renewal years. Every OHCA professional services contract includes standard contract termination language, including immediate, 30 day for cause, 60 day without cause, and non-renewal terminations.) |
| **Total Contract Not-to-Exceed Requested for Approval.**<br>(Actual not-to-exceed amounts are established by the competitive bid process. If the not-to-exceed amount exceeds the amount previously approved by $125,000.00 or more, the contract increase shall require additional Board approval.) |
| **Federal Match Percentage(s)**<br>(CMS authorizes Federal Match based upon specific criteria, for example, a single Information Technology contract may qualify for 50% administrative match, 75% operational match, and 90% implementation match.) |

**SUBMITTED TO THE C.E.O. AND BOARD ON MARCH 17, 2021**
**Discussion and vote regarding the Authority's ability to withstand the procurement decision made by the CEO based on the Authority's budget and available funds**

## BACKGROUND

| | |
|---|---|
| **Services** | State-Wide Health Information Exchange |
| **Purpose and Scope** | Provide a statewide health information exchange (HIE) to be called the Oklahoma Statewide Health Information Network and Exchange (OKSHINE). Oklahoma is looking to achieve statewide health information exchange to allow health information to flow seamlessly to and from authorized organizations and individuals in Oklahoma. OKSHINE is intended to meet the needs of end users, allowing providers and their patients, hospitals and health systems, purchasers and payers, state health agencies and local health departments, health information business associates, and an increasingly inclusive ecosystem of human service organizations to have secure, accurate data available at the right time and place, for the right purposes.<br><br>The Electronic Master Patient Index (eMPI) has been shifted from OSDH to OHCA and added to this contract from the State-Wide Contracting process, which is the reason the amount has increased from the previous Board approval on March 30, 2020. |
| **Mandate** | Governors Top 5 Initiative |
| **Procurement Method** | Competitive Bid |
| **Award** | Single Contractor |
| **External Approvals** | OMES and CMS approval pending |
| **New Contract Term** | December 23, 2020 thru June 30, 2021 with 9 options to renew. |

## BUDGET

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|---|---|
| **Total Contract Not-to-Exceed Requested for Approval.** | Contract not to exceed $70,895,962.00 and is Pending CMS approval. This is an increase from a previously approved amount of $50,564,472.00 due to the eMPI addition. |
| **Not-to-Exceed considerations** | Federal matching considerations will be a blended rate. OHCA expects the first three years to be a matching rate of 90/10. Following years could be 50/50 or 75/25 depending on system certification and CMS Advance Planning Document approvals. |

| | |
|---|---|
| **Federal Match Percentage(s) within the Total Contract Not-to-Exceed**<br>**State Share Costs within the Total Contract Not-to-Exceed**<br>**Pricing Methodology** | The request for proposal is waiting for CMS Approval at the time of this Board meeting, OHCA expects a combination of hourly rate, price per service, and system hosting costs. |

**RECOMMENDATION**

The Authority affirms its ability to withstand the procurement decision made by the CEO based on the budget and available funds. Board approval is requested to increase the Health Information Exchange services contract to a 10-year total not-to-exceed of $70,895,962.00.

**Additional Information**

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

# Legislative Update

A major deadline has now passed for the 2021 legislative session – all bills needed to be heard in their chamber of origin by March 11. Any bills not heard are inactive for this session but can carry over into next session. So far, the Governor has only signed 2 measures including SB 1031 which extends the amendments to the Open Meetings Act allowing for virtual public meetings.

All OHCA request bills have been heard and passed the Senate. Secretary Corbett's nomination hearing will be heard on March 22 during the Senate Health and Human Services Committee meeting.

Next week begins committee work for bills to be heard in the opposite chamber. The legislature will most likely only meet for 2-3 days and break early for Spring Break.

## 2021 OHCA Legislative Requests

SB 293, Sen. Simpson - Lien Formula

Repealing section of law that requires OHCA to abide by a reduction formula reducing TPL lien by 1/3 – 50%. Repealing 12 O.S. 12 § 994.2 puts the agency on equal footing with others in the amount that can be collected from a settlement.

This legislation allows the state to recoup additional taxpayer dollars creating budget savings.

SB 689, Sen. Pugh - MAC Restructuring

Restructuring committee to reflect federal regulations, decrease the number of members to 15, and define tenure of member and chair/vice-chair.

SB 207, Sen. Garvin - CEO Appeals

Directing the CEO appeal process to an ALJ outside the agency.

SB 434, Sen. McCortney - Tribal Shared Savings

Incentivize tribes to participate in care coordination agreements by paying them back a percentage of the savings realized.

## Tracking and still active bills:

HB 1012 - requiring certain contracts to purchase transportation through Oklahoma public transit systems. Would establish the NEMT broker to use public transit as a preferred provider.

HB 1091 – directs OHCA to require any contract providers under a potential managed care plan to:

- process claims in a specific timeframe with no less than 90 percent of all claims paid within 14 days of submission to the plan

- provide authorizations within 24 hours for inpatients transferring to post-acute care and long-term acute care facilities
- offer network contracts to all community providers designated as essential by the Centers for Medicare and Medicaid Services
- offer rates to contracted providers that are no lower than the fess schedule of OHCA in effect on the date of service
- formally credential and recredential physicians or other providers at a frequency required by a single consolidated Medicaid provider enrollment and credentialing process established by OHCA
- increase reimbursement rates in accordance with OHCA increases set by the Legislature
- plan review and issue determinations for prior authorization for care ordered by primary care or specialist providers in a specified time and manner

and repeals all language on the Oklahoma Medicaid Healthcare Options System and development of managed care plans.

HB 2119 - directs the Oklahoma Health Care Authority to allocate to participating nursing facilities enhance the Federal Medical Assistance Percentage payments from funds available to the state by the federal government during periods of public health emergencies, without reducing other components of the nursing facility rate to offset increased revenue from temporarily enhanced FMAP payments.

- ✓ OHCA is currently planning a NF supplemental payment that utilizes the surplus of QOC funds (created by a combination of the enhanced FMAP and declining NF resident bed days) as the state share and is requesting CMS approval for federal financial participation.

HB 2299 - requires that when entering into contractual arrangements with any entity for the management of Medicaid patients the Oklahoma Health Care Authority must preserve and protect the supplemental payment programs and enhanced reimbursement payment programs payable to the Oklahoma State University Center for Health Sciences or the University of Oklahoma Health Sciences Center, their teaching hospitals, affiliated hospitals, and hospital partners.

- ✓ Current language creates a fiscal impact for the state to make up the difference if decreased utilization exists. OHCA submitted ideas for new language to the bill author.

SB 574 - provides for the Information Technology Advisory Board to advise the Oklahoma State Health Information Network and Exchange instead of the Chief Information Officer. It requires the Oklahoma State Health Information Network and Exchange to facilitate the seamless flow of health information to and from authorized individuals and healthcare organizations in Oklahoma.

SB 392 - requires insurance companies to provide direct payment or reimbursement to pharmacists.

SB 469 - expands donor milk Medicaid coverage to both the hospital and home setting.

<u>State government related:</u>

HB 1665 - requires all funds authorized or required to be paid to the State of Oklahoma to be held in a newly created Federal Funds Holding Account.

SB 913 - forms a Joint Committee on Administrative Rules; proposes expedited repeal process.

SB 650 - the state employee benefit allows. It sets it at $778.67 for an employee covering only themselves and sets a base of $667.32 for an employee who also covers certain dependents.

SB 1032 - allows a public body that maintains a website and utilizes a high-speed internet connection to stream live all meetings on such website and posted on the website after the meeting during a state of emergency declared by the Governor

HB 1767 - requires any question to be submitted to a vote of the people, whether pursuant to an initiative petition, a referendum petition with respect to an enacted statute, or pursuant to a referred measure by the Legislature, that would have the effect of increasing the funding requirements of any department of state government, including the legislative, the executive or judicial departments, or any combination of such departments, to contain a clear statement, in language understandable by a reasonable person, that if the proposal is approved, additional funding would be required by the applicable department or departments of state government.

HB 2294 - modifies leave benefits provided under the Oklahoma Personnel Act and increases accumulation limits.

HB 1146 - places all state employee positions under the administration of the Human Capital Management Division of the Office of Management and Enterprise Services effective January 1, 2022, except those employed by the Governor, Lt. Governor, Speaker of the House, or President Pro Tempore of the Senate, as well as elected officials, political appointees, and up to 5 percent of an agency's executive management. It directs the Human Capital Management Division to establish and maintain a dispute resolution system for state agencies and employees, to promulgate rules necessary to perform duties required by the act, receive and act on complaints arising from disciplinary actions by state employees, use administrative law judges as independent contractors, submit quarterly reports on workload statistics to the Legislature, and create and administer a confidential whistleblower program. It sunsets the existing Oklahoma Merit Protection Commission on December 31, 2022.

HB 2932 - states legislative findings related to the federal CARES Act funds. It prohibits, unless expressly authorized by the Legislature, any agency, board, commission, department, council, instrumentality or other entity organized within the executive branch to utilize the federal funds from the Coronavirus Aid, Relief, and Economic Security Act (CARES) allocated to it, in a manner that will or that will be likely to increase the demand for state-appropriated funds or any other state funds for the fiscal year ending June 30, 2021, or any fiscal year thereafter. The bill also applies its limits to any federal funds allocated or otherwise made available for expenditure by an act of Congress or pursuant to federal administrative rules or directives of an agency of the federal government authorized by federal law on or after December 1, 2020.

SB 333 - requires that following an emergency declaration as the accumulation limits for compensatory time will temporarily increase and carryover to the end of the fiscal year following the year in which the emergency declaration ended.

**Upcoming Deadlines**

Bills must be out of standing committees – April 8th

- Same committee process, but in the opposite chamber. Bills must clear standing committee by this date to be heard on the floor.

Deadline for third reading of bills from opposite chamber – April 22nd

- All bills must be passed off the floor from the opposite chamber. Next step – Governor's office OR if amendments were added, the bill must go back to its chamber of origin to reject/accept amendments

Sine Die Adjournment – May 28th

- Constitutionally, the Legislature must adjourn by this date.

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

***The following emergency rule HAS NOT previously been approved by the Board.***

I. **APA WF # 21-04 Diabetes Self-Management Education and Support (DSMES) Services —** The proposed revisions will clarify DSMES provider requirements for registered dieticians, registered nurses, and pharmacists. Revisions will also add other health care providers with certifications as Certified Diabetes Care and Education Specialist (CDCES) or as Board-Certified Advanced Diabetes Management (BC-ADM) as eligible DSMES providers. Further revisions will involve limited rewriting aimed at updating DSMES-related terminology.

**Budget Impact: Budget Neutral**

**Tribal Consultation: November 3, 2020**

**Medical Advisory Committee Meeting: March 11, 2021**

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

II. **APA WF # 20-04 Electronic Visit Verification (EVV) —** The proposed revisions are necessary to comply with the 21st Century Cures Act which requires providers of personal care services to utilize a system under which visits are electronically verified. The revisions will require that the type of service performed, the individual receiving the service, the date of the service, the location of service delivery, the individual providing the service, and the time the service begins and ends be included in the verification process.

**Budget Impact: The proposed permanent rule changes will not result in any additional costs to the OHCA. Budget allocation to establish EVV operations and procedures was approved during promulgation of the emergency rule in November 2020.**

**Tribal Consultation: July 11, 2018, November 5, 2019, and November 3, 2020**

**Medical Advisory Committee Meeting: November 12, 2020**

III. **APA WF # 20-13 Child Support Cooperation Exemption for Recipients of Indian Health Services —** The proposed revisions will update policy due to changes in federal regulations which state that a referral for medical support enforcement is not made from the state Medicaid agency to the state child support agency whenever the child is eligible for services through the Indian Health Service and the referral or the case is based solely on services provided through an Indian Health program. The revisions will add an additional instance when cooperation by the parent/caretaker with the state child support agency is not required.

**Budget Impact: The proposed permanent rule changes will not result in any additional costs to the OHCA. The changes will continue to be budget neutral as reflected during the promulgation of the emergency rule in November 2020.**

**Tribal Consultation: September 1, 2020**

**Medical Advisory Committee: November 12, 2020**

IV. **APA WF # 20-14 Therapy Assistants and Clinical Fellows —** The proposed revisions will add physical therapy assistants, occupational therapy assistants, speech-language pathology assistants (SLPAs), and speech-language pathology clinical fellows as eligible providers that can render therapy services to SoonerCare members. Additionally, the proposed revisions will outline provider qualifications and other requirements for provision of these therapy services. Finally, revisions will be made to clarify that these providers will be reimbursed at the rate established per the Oklahoma Medicaid State Plan.

**Budget Impact: The proposed permanent rule changes will not result in any additional costs to the OHCA. Budget allocation to establish coverage of and reimbursement for coverage of services provided by occupational therapy assistants, physical therapy assistants, speech-language pathology assistants, and speech-language pathology clinical fellows, was approved during promulgation of the emergency rule in November 2020.**

**Tribal Consultation: March 3, 2020, September 1, 2020, and January 5, 2021**

**Medical Advisory Committee Meeting: November 12, 2020**

V. **APA WF # 20-15A Residential Substance Use Disorder (SUD) Treatment Coverage —** The proposed revisions will support WF 20-15B, which proposes coverage of residential substance use disorder (SUD) treatment for Medicaid-eligible individuals and removes the eligibility exclusion of members in an institution for mental disease (IMD) under the SoonerCare Choice program.

**Budget Impact: The proposed permanent rule changes will not result in any additional costs and/or savings to the Oklahoma Department of Mental Health and Substance Abuse Services. Budget allocation to establish coverage of and reimbursement for coverage of services provided under the IMD Waiver authority and residential SUD treatment coverage in residential SUD treatment facilities with sixteen (16) beds or less (non-IMDs), was approved during promulgation of the emergency rule in November 2020.**

**Tribal Consultation: July 7, 2020 and September 1, 2020**

**Medical Advisory Committee Meeting: November 12, 2020**

VI. **APA WF # 20-16 Opioid Treatment Program (OTP) and Medication-Assisted Treatment (MAT) Services —** The proposed revisions will comply with the SUPPORT Act, HR 6, Section 1006, and establish coverage and reimbursement of medically necessary medication-assisted treatment (MAT) services and/or medications for SoonerCare members with opioid use disorder (OUD) in opioid treatment programs (OTPs) and within office-based opioid treatment (OBOT) settings.

**Budget Impact: The proposed permanent rule changes will not result in any additional costs and/or savings to the Oklahoma Health Care Authority or the**

**Oklahoma Department of Mental Health and Substance Abuse Services. Budget allocation to implement substance use disorder coverage in opioid treatment programs and MAT medication coverage, was approved during promulgation of the emergency rule in November 2020.**

**Tribal Consultation: July 7, 2020**

**Medical Advisory Committee Meeting: November 12, 2020**

VII. **APA WF # 20-19A Appeals Language Cleanup —** The proposed revisions will replace incorrect rule section references with the appropriate references. Additionally, revisions will remove appeals language for programs that no longer exist and will identify the appropriate appeal form to fill out when filing an appeal. Finally, revisions will include minor cleanup to fix grammatical and formatting errors.

**Budget Impact: The proposed permanent rule changes will not result in any additional costs to the OHCA. The changes will continue to be budget neutral as reflected during the promulgation of the emergency rule in November 2020.**

**Tribal Consultation: November 3, 2020**

**Medical Advisory Committee Meeting: November 12, 2020**

VIII. **APA WF # 20-20 Pay-for-Performance (PFP) program —** The proposed revisions will comply with Oklahoma Senate Bill 280, which directed the Oklahoma Health Care Authority (OHCA) to modify certain provisions related to reimbursement of long-term care facilities. The proposed policy revisions will update the Pay-for-Performance (PFP) program quality measures to align with the most recent metrics modified by the Centers for Medicare and Medicaid Services (CMS). Additional changes will specify the timeline in which a nursing facility can submit its quality of care documentation to be eligible for reimbursement.

**Budget Impact: The proposed permanent rule changes will not result in any additional costs to the OHCA. The changes will continue to be budget neutral as reflected during the promulgation of the emergency rule in November 2020.**

**Tribal Consultation: November 3, 2020**

**Medical Advisory Committee Meeting: November 12, 2020**

IX. **APA WF # 20-21 Employment Services Offered through Developmental Disabilities Services —** The proposed revisions will describe group job placements. Additional changes will authorize remote supports for individual placements and remove the specific limit that the cost of the member's employment services, excluding transportation and state-funded services, cannot exceed limits specified in OKDHS Appendix D-26. Furthermore, changes will clarify that adult members receiving In-Home Supports Waiver (IHSW) services can access individual placement in job coaching, stabilization, and employment training specialist services; however, not to exceed limits specified in OKDHS Appendix D-26 per Plan of Care year. Additional revisions will include updates to standard policy language including cleanup of formatting and grammatical errors plus clarify and update terminology used to reflect current business practices.

**Budget Impact: The proposed permanent rule changes will not result in any additional costs to the OHCA. The changes will continue to be budget neutral as reflected during the promulgation of the emergency rule in November 2020.**

**Tribal Consultation: November 3, 2020**

**Medical Advisory Committee Meeting: November 12, 2020**

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

X. **APA WF # 20-06C Durable Medical Equipment (DME) and Supplies Benefit Moved under the Scope of the Home Health Benefit —** The proposed revisions will comply with the home health final rule in which the DME and supplies benefit was revised from an optional benefit to a mandatory benefit and was made subject to the scope of the home health benefit. This change is being made to mirror language in federal regulation.

**Budget Impact: The proposed permanent rule changes will not result in any additional costs to the OHCA. The changes will continue to be budget neutral as reflected during the promulgation of the emergency rule in June 2020.**

**Tribal Consultation: January 7, 2020**

**Medical Advisory Committee: May 14, 2020**

XI. **APA WF # 20-15B Residential Substance Use Disorder (SUD) Treatment Coverage —** The proposed revisions will add residential substance use disorder (SUD) treatment coverage for Medicaid-eligible adults, ages twenty-one (21) to sixty-four (64), and members under the age of twenty-one (21) in residential SUD treatment facilities with seventeen (17) beds or more and/or residential SUD treatment facilities with sixteen (16) beds or less. Further revisions will outline provider requirements, medical necessity, service plan, and reimbursement policies. Other revisions will involve limited rewriting aimed at clarifying outdated policy sections and removing the institution for mental disease (IMD) exclusion for members, ages twenty-one (21) to sixty-four (64). Lastly, the proposed changes are authorized under 42 CFR 440.130(d) and comply with Oklahoma's 1115(a) IMD for serious mental illness (SMI) and SUD waiver request.

**Budget Impact: The proposed permanent rule changes will not result in any additional costs and/or savings to the Oklahoma Department of Mental Health and Substance Abuse Services. Budget allocation to establish coverage of and reimbursement for coverage of services provided under the IMD Waiver authority and residential SUD treatment coverage in residential SUD treatment facilities with sixteen (16) beds or less (non-IMDs), was approved during promulgation of the emergency rule in November 2020.**

**Tribal Consultation: July 7, 2020 and September 1, 2020**

**Medical Advisory Committee Meeting: November 12, 2020 and March 11, 2021**

XII. **APA WF # 20-19B Appeals and Incorrect References Language Cleanup —** The proposed revisions will replace incorrect rule section references with the appropriate references. Additionally, revisions will remove appeals language for programs that no longer exist and involve minor cleanup to fix grammatical and formatting errors.

**Budget Impact: The proposed permanent rule changes will not result in any additional costs to the OHCA. The changes will continue to be budget neutral as reflected during the promulgation of the emergency rule in November 2020.**

**Tribal Consultation: November 3, 2020**

**Medical Advisory Committee Meeting: November 12, 2020 and March 11, 2021**

XIII. **APA WF # 20-27 Specialty PRTF Staffing and Admission Revisions —** The proposed revisions will update the specialty Psychiatric Residential Treatment Facility (PRTF) staffing ratio from one (1) staff: three (3) members to one (1) staff: four (4) members. Revisions will also clarify inpatient psychiatric admission criteria for members under twenty-one (21) accessing specialty facilities. The proposed revisions will help support access to specialty providers for children with specialized treatment needs who are most in need of in-state specialty services.

**Budget Impact: The proposed permanent rule changes will not result in any additional costs to the OHCA. The changes will continue to be budget neutral as reflected during the promulgation of the emergency rule in November 2020.**

**Tribal Consultation: November 3, 2020**

**Medical Advisory Committee Meeting: November 12, 2020 and March 11, 2021**

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

XIV. **APA WF # 20-22 Programs of All Inclusive-Care for the Elderly (PACE) —** The proposed revisions will update policy regarding enrollment denials for PACE to reflect current business practices. Additional policy changes will add language to clarify and establish OHCA's role in reviewing justifications for expedited appeals from PACE organizations. The proposed rule changes will align policy with Section 460.122 of Title 42 of the Code of the Federal Regulations.

**Budget Impact: Budget Neutral**

**Tribal Consultation: November 3, 2020**

**Medical Advisory Meeting: March 11, 2021**

XV. **APA WF # 20-23 Developmental Disabilities Services (DDS) —** The proposed revisions will change the timeframe from ninety (90) days to one (1) calendar year for which a required physical health examination and medical evaluation can be completed when an individual is applying for the DDS Home and Community-Based Services (HCBS) waiver. These revisions improve the process of certifying cases for HCBS waivers by making it more efficient. DDS may also require a current medical evaluation when a significant change of condition, disability, or physical health status is noted. Additionally, revisions

will add language defining remote services that can be provided in the member's home, family home, or employment site. Remote services are created to promote the independence of a member who receives DDS services through remote services. Revisions will also address the new agency companion household criteria and agency companion service requirements, and modify the procedures for the DDS home profile process. Agency companion providers may not simultaneously serve more than three (3) members through any combination of companion or respite services. Further, revisions will establish new criteria on how the member is to obtain assistive technology (AT) devices and clarify instructions to staff who are providing stabilization services authorized through remote supports. The requirement to add AT devices must be prescribed by a physician with a SoonerCare contract. Additionally, the proposed revisions increase the designated amount that an area resource development staff can approve or deny for AT from $2500 up to $5000. Finally, revisions will also increase the amount the state office AT programs manager can approve for AT from $2500 to $5000 or more.

**Budget Impact: Budget Neutral**

**Tribal Consultation: November 3, 2020**

**Medical Advisory Committee Meeting: March 11, 2021**

XVI. **APA WF # 20-24 A&B ADvantage Waiver —** The proposed revisions will align waiver policy with the OHCA's overarching Electronic Visit Verification rules. Additional revisions will involve eliminating or updating outdated policy and correcting grammatical errors.

**Budget Impact: Budget neutral.**

**Tribal Consultation: January 5, 2021**

**Medical Advisory Committee Meeting: March 11, 2021**

XVII. **APA WF # 20-25 Peer Recovery Support Specialist (PRSS) Services in Indian Health Services, Tribal Programs and Urban Indian Clinics (I/T/Us)-** The proposed revisions will add coverage and reimbursement of PRSS services. The proposed revisions will also support other policy changes related to coverage and reimbursement of residential substance use disorder (SUD) treatment services. Further revisions will reorganize policy for clarity and correct grammatical errors.

**Budget Impact: The estimated budget impact for PRSS service coverage in I/T/Us is $0 total for FY2021 and $51,093 total for FY2022. Services provided to the Native American population are 100 percent federally funded; therefore, no impact on state revenue is expected.**

**The estimated budget impact for residential SUD treatment coverage in residential facilities was approved during promulgation of the emergency rule in December 2020.**

**Tribal Consultation: January 5, 2021**

**Medical Advisory Committee Meeting: March 11, 2021**

XVIII. **APA WF # 20-26 Applied Behavior Analysis (ABA) Services Revisions —** The proposed revisions will clarify individualized treatment plan requirements, common ABA-based techniques, medical necessity criteria, and required documentation for ABA treatment extension requests. The proposed revisions will allow licensed psychologists to render ABA services without any additional ABA-related certification requirements. Further revisions will involve limited rewriting aimed at clarifying policy language.

**Budget Impact: Budget neutral.**

**Tribal Consultation: January 5, 2021**

**Medical Advisory Committee Meeting: March 11, 2021**

XIX. **APA WF # 20-29 Provider Refund to Member when Copayment is Over-Collected** — The proposed revisions will put in policy the provider's requirement to refund any amount the provider collected from the member for copayment in error and/or collected after the family had reached its aggregate cost sharing maximum.

**Budget Impact: Budget neutral**

**Tribal Consultation: November 3, 2020**

**Medical Advisory Committee Meeting: March 11, 2021**

XX. **APA WF # 20-31 State Treasurer's Achieving a Better Life Experience (STABLE) Accounts** — The proposed revisions will further define rules regarding STABLE accounts by specifying that if a contribution is made to a SoonerCare member's STABLE account by another individual, and the individual making the contribution later applies for SoonerCare long-term care services, that contribution will be evaluated in accordance with OHCA long-term care eligibility rules. STABLE accounts are tax-favored savings accounts for individuals with disabilities.

**Budget Impact: Budget neutral**

**Tribal Consultation: January 5, 2021**

**Medical Advisory Committee Meeting: March 11, 2021**

XXI. **APA WF # 20-33 Bariatric Surgery Revisions —** The proposed revisions will update bariatric surgery requirements and guidelines to reflect current business practices. Additional revisions will involve fixing grammatical and/or formatting errors, as well as, revoking obsolete sections.

**Budget Impact: Budget neutral.**

**Tribal Consultation: September 1, 2020**

**Medical Advisory Committee Meeting: March 11, 2021**

XXII. **APA WF # 20-34 Dental Revisions —** The proposed revisions will add "scaling in the

presence of a generalized moderate or severe gingival inflammation" as a new procedure to dental policy. Additional revisions will specify that a caries risk assessment form must be documented when submitting a prior authorization for crowns. Further revisions will explain that written consent from a parent or court appointed legal guardian must be provided for any services that are rendered to a minor child. Finally, revisions will clarify billing language for administering nitrous oxide and involve cleanup of formatting and grammatical errors.

**Budget Impact: The estimated budget impact, for SFY2022 will be a savings in the total amount of $8,877; with $2,851 in state share. The estimated budget impact for SFY2023 will be a savings in the total amount of $10,652, with $3,384 in state share.**

**Tribal Consultation: November 3, 2020**

**Medical Advisory Committee Meeting: March 11, 2021**

XXIII. **APA WF # 20-36A Lodging, Meals, and SoonerRide —** The proposed revisions will update the lodging and meals policy by changing the allowed mileage radius from one hundred miles or more to fifty miles or more. This change improves access to the lodging and meals benefit and to medically necessary care. Additional changes will reformat and reorganize the existing policy to provide clarity on how the approval process works for the lodging and meals benefit.

Furthermore, the proposed revisions will update and reformat the SoonerRide Non-Emergency Transportation (NEMT) policy to provide providers and members clarity to on the service. The proposed revisions will outline the specific services that SoonerRide NEMT offers and how members and long-term care facilities can request transportation assistance through SoonerRide NEMT. The proposed revisions to lodging and meals, as well as SoonerRide, will align policy with current business practices.

**Budget Impact: The estimated budget impact, for SFY2022, will be an increase in the total amount of $130,033; with $41,311 state share.**

**Tribal Consultation: January 5, 2021**

**Medical Advisory Committee Meeting: March 11, 2021**

XXIV. **APA WF # 20-36B Lodging, Meals, and SoonerRide —** The proposed revisions will remove duplicate policy regarding lodging, meals, and SoonerRide non-emergency transportation. The policies regarding these services are already outlined in the Oklahoma Health Care Authority's Chapter 30.

**Budget Impact: Budget neutral.**

**Tribal Consultation: January 5, 2021**

**Medical Advisory Committee Meeting: March 11, 2021**

XXV. **APA WF # 20-37 Obstetrical (OB) Ultrasound —** The proposed revisions will update the OB ultrasound policy to allow for both an abdominal and vaginal ultrasound to be performed in the first trimester when clinically appropriate and medically necessary.

Currently, policy only allows for either an abdominal or vaginal ultrasound.

**Budget Impact: Budget Neutral**

**Tribal Consultation: January 5, 2021**

**Medical Advisory Committee Meeting: March 11, 2021**

XXVI. **APA WF # 20-38 Clinical Trials —** The proposed revisions will add guidelines for coverage of clinical trials including any medical necessity criteria for coverage of routine care services during a clinical trial and clarifying that other experimental and investigational treatment is not covered.

**Budget Impact: Budget Neutral**

**Tribal Consultation: January 5, 2021**

**Medical Advisory Committee Meeting: March 11, 2021**

XXVII. **APA WF # 20-39 Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Policy Revisions —** The proposed revisions will align RHC/FQHC policy language with the Oklahoma Medicaid State Plan, federal regulations and OHCA's current business practices. Other revisions will involve limited rewriting aimed at clarifying policy language, including basic laboratory services that may be reimbursed at an RHC; mid-level professional staff requirements in RHCs; and claims' requirements to indicate the setting in which a service was provided.

**Budget Impact: Budget neutral**

**Tribal Consultation: January 5, 2021**

**Medical Advisory Committee Meeting: March 11, 2021**

XXVIII. **APA WF # 20-40 Medicaid-Funded Abortion Certification Requirements —** The proposed revisions will align with Title 63 Oklahoma Statutes § 1-741.1 and require the Certification for Medicaid Funded Abortion form to be completed by the physician and the patient

**Budget Impact: Budget neutral**

**Tribal Consultation: January 5, 2021**

**Medical Advisory Committee Meeting: March 11, 2021**

XXIX. **APA WF # 20-41 Sunsetting of Health Homes —** The proposed revisions will remove language and references to health homes. The health homes benefit will be phased out in September 2021; thereby, rendering the associated rule language and references obsolete. However, other care coordination models will still be in place to serve this population.

**Budget Impact: The estimated budget impact will be a savings in the amount of $2,642,454 total, with $844,528 state share for SFY22 (9 months) and $2,300,475 total, with $729,021 state share for SFY23. The state share savings will be attributed to the Oklahoma Department of Mental Health and Substance Abuse Services from the transition of services to alternative service delivery models.**

**Tribal Consultation: January 5, 2021**

**Medical Advisory Committee Meeting: March 11, 2021**

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

**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**

**PART 109. DIABETES SELF-MANAGEMENT ~~TRAINING~~EDUCATION AND SUPPORT**

**317:30-5-1080. Definitions**

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

~~**"AADE"** means American Association of Diabetes Educators.~~

**"ADA"** means American Diabetes Association.

**"ADCES"** means the Association of Diabetes Care and Education Specialists.

**"BC-ADM"** means Board-certified advanced diabetes management.

**"~~CDE~~CDCES"** means certified diabetes ~~educator~~care and education specialist.

**"~~DSMT~~DSMES"** means diabetes self-management ~~training~~education and support.

**"OAC"** means Oklahoma Administrative Code.

**"OHCA"** means Oklahoma Health Care Authority.

**"Qualified non-physician provider"** means a physician assistant or advanced practice registered nurse.

**317:30-5-1081. Eligible providers and requirements**

~~(a) Eligible DSMT providers include any of the following professionals:~~

~~(1) A registered dietician (RD) who is licensed and in good standing in the state in which s/he practices, and who is:~~

~~(A) Certified as a CDE; and~~

~~(B) Fully contracted with SoonerCare as a CDE provider.~~

~~(2) A registered nurse (RN) who is licensed and in good standing in the state in which s/he practices, and who is:~~

~~(A) Certified as a CDE; and~~

~~(B) Fully contracted with SoonerCare as a CDE provider.~~

~~(3) A pharmacist who is licensed and in good standing in the state in which s/he practices, and who is:~~

~~(A) Certified as a CDE; and~~

~~(B) Fully contracted with SoonerCare as a CDE provider.~~

~~(b) In order to receive Medicaid reimbursement for DSMT services, professional service groups, outpatient hospitals, Indian Health Services, Tribal Programs and Urban Indian Clinics (I/T/Us), Rural Health Clinics (RHCs), and Federally Qualified Health Centers (FQHCs) must have a DSMT program that meets the quality standards of one (1) of the following accreditation organizations:~~

~~(1) The ADA; or~~

~~(2) The AADE.~~

~~(c) All DSMT programs must adhere to the national standards for diabetes self-management education.~~

~~(1) Each member of the instructional team must:~~

~~(A) Be a CDE; or~~

~~(B) Have documentation of at least fifteen (15) hours of recent diabetes education or diabetes management experience.~~

~~(2) At a minimum, every instructional team must consist of at least one (1) of the CDE professionals listed in subsection a, above.~~

~~(d) All members of the instructional team must obtain the nationally recommended annual continuing education hours for diabetes management.~~

(a) In order to receive Medicaid reimbursement for DSMES services, providers or provider groups must:

(1) Be working under an accredited DSMES program that meets the quality standards of one (1) of the following accreditation organizations:

(A) The ADA; or

(B) The ADCES.

(2) Be fully contracted with SoonerCare as a "diabetes educator". Eligible DSMES providers include:

(A) A registered dietician (RD) who is:

(i) Licensed and in good standing in the state in which s/he practices.

(ii) Has training and experience pertinent to diabetes self-management education and support verified by the OHCA Pharmacy Services unit.

(B) A registered nurse (RN) who is:

(i) Licensed and in good standing in the state in which s/he practices.

(ii) Has training and experience pertinent to diabetes self-management education and support verified by the OHCA Pharmacy Services unit.

(C) A pharmacist who is:

(i) Licensed and in good standing in the state in which s/he practices.

(ii) Has training and experience pertinent to diabetes self-management education and support verified by the OHCA Pharmacy Services unit.

(D) A health care provider, as defined in Section 3090.2 of Title 63 of the Oklahoma Statutes, who holds a certification as a:

(i) CDCES; or

(ii) BC-ADM.

(b) All DSMES programs must adhere to the national standards for diabetes self-management education.

(1) Each DSMES program must include at least one (1) of the eligible providers listed above in OAC 317:30-5-1081 (a) (2) (A) – (D).
(2) All members of the instructional team must complete the nationally recommended annual continuing education hours for diabetes management.

**317:30-5-1082. Scope of services**

(a) **General provisions.** The OHCA covers medically necessary ~~DSMT~~DSMES services when all the following criteria are met:

(1) The member has been diagnosed with diabetes by a physician or qualified non-physician provider working within the scope of his/her licensure;

(2) The services have been ordered by a physician or qualified non-physician provider who is actively managing the member's diabetes;

(3) The services are provided by a qualified ~~DSMT~~DSMES provider [Refer to OAC 317:30-5-1081~~(b)~~ (a)(2)]; and

(4) The program meets the current ADA or ~~ADE~~ADCES training standards.

(b) **Training.** ~~DSMT~~DSMES services shall provide one (1) initial assessment per lifetime. Initial ~~DSMT~~DSMES shall be comprised of up to ten (10) hours [can be performed in any combination of thirty (30) minute increments] of diabetes training within a consecutive twelve (12) month period beginning with the initial training date, including:

(1) One (1) hour of individual instruction, consisting of face-to-face encounters between the ~~CDE~~diabetes educator and the member; and

(2) Nine (9) hours of group instruction.

(c) **Follow-up ~~DSMT~~DSMES.** After the first twelve (12) month period has concluded, members shall only be eligible for two (2) hours of individual or group ~~DSMT~~DSMES instruction per calendar year.

**317:30-5-1083. Coverage by category**

The purpose of ~~DSMT~~DSMES services must be to provide the member with the knowledge, skill, and ability necessary for diabetes self-care.

(1) **Adults.** Payment is made for medically necessary ~~DSMT~~DSMES provided by ~~a registered nurse (RN), registered dietitian (RD), or pharmacist certified as a diabetes educator, as~~eligible providers described in OAC 317:30-5-1081. Refer to OAC 317:30-5-1082 for units of ~~DSMT~~DSMES training allowed.

(2) **Children/adolescents.** Payment is made for medically necessary ~~DSMT~~DSMES for members under twenty-one (21) years of age provided by ~~a RN, RD, or pharmacist certified as a diabetes educator, as~~eligible providers described in OAC 317:30-5-1081.

~~DSMT~~DSMES coverage for children is the same as for adults. Additional ~~DSMT~~DSMES services may be covered under EPSDT provisions if determined to be medically necessary.

**317:30-5-1084. Reimbursement methodology**

SoonerCare shall provide reimbursement for ~~DSMT~~DSMES services as follow:

(1) Payment shall be made to fully-contracted providers. If the rendering provider operates through an enrolled SoonerCare provider, or is contracted to provide services by an enrolled SoonerCare provider, payment may be made to that enrolled SoonerCare provider.

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

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

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

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

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

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

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

(4) Home health (refer to OAC 317:30-5-546);

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

(6) Non-emergency transportation ~~(refer to OAC 317:35-3-2);~~(refer to OAC 317:30-5-326 through 317:30-5-327.9);

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

(8) Psychosocial rehabilitative services (refer to OAC 317:30-5-241.3);

(9) Psychiatric residential treatment facility services (refer to OAC 317:30-5-95 through 317:30-5-97);
(10) Applied behavior analysis (ABA) (refer to OAC 317:30-3-65.12); and
(11) Diabetes self-management ~~training (DSMT)~~education and support (DSMES) (refer to OAC 317:30-5-1080 through 317:30-5-1084).

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

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

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

**SUBCHAPTER 3. GENERAL PROVIDER POLICIES**

**PART 1. GENERAL SCOPE AND ADMINISTRATION**

**317:30-3-34. Electronic visit verification (EVV) system**

An EVV system is a telephone-based, computer-based, or other electronic-based system that verifies and documents the time and location of services requiring an in-home visit, including, but not limited to, self-directed services, in accordance with an approved prior authorization or individual plan of care, and pursuant to Title 42 of the United States Code, Section (§) 1396b(l).

(1) **Verification requirements.** An EVV system must verify the following for in-home or community services:

(A) Type of service performed (service code and any applicable modifier);

(B) Date of service;

(C) SoonerCare member identification number of the individual receiving the service;

(D) Unique vendor identification number for the individual providing the service (service provider);

(E) Location where service starts and ends; and

(F) Time the service starts and ends.

(2) **Services requiring EVV system use.** An EVV system must be used for personal care services, as defined by Oklahoma Administrative Code (OAC) 317:35-15-2.

(3) **Services not requiring EVV system use.** When services are provided through home and community-based waivers, EVV is not required if those services are provided in:

(A) Combination with community residential supports, per Oklahoma Administrative Code (OAC) 340:100-5-22.1;

(B) Combination with group home services, per OAC 340:100-6;

(C) Congregate settings where twenty-four (24) hour service is available; or

(D) Settings where the member and service provider live-in the same residence.

(4) **Provider requirements.** Providers are required to use an OHCA authorized and approved EVV system or aggregator. Providers may use the designated statewide EVV system, or their own EVV compliant system. A provider of personal care services using an EVV system must:

(A) Comply with all applicable federal and state laws and regulations, including, but not limited to, HIPAA privacy

and security law, as defined in Section 3009 of the Public Health Service Act; required reporting of abused and/or neglected children, adolescents, and vulnerable adults [Section (§) 1-2-101 of Title 10A of the Oklahoma Statutes (O.S.) and 43A O.S. § 10-104]; and OAC 317:30-3-4.1, Uniform Electronic Transaction Act;

(B) Adopt internal policies and procedures regarding the EVV system;

(C) Ensure that employees are adequately trained on the EVV system's proper use, and make available to them real-time technical resources and support, such as a help desk or call center information;

(D) Ensure employees are adequately trained to properly engage the personal care agency's backup system when the EVV system is not available; and

(E) Ensure that the system:

(i) Accommodates members and service providers with hearing, physical, or visual impairments;

(ii) Accommodates multiple members and/or service providers in the same home or at the same phone number, as well as multiple work shifts per member per day;

(iii) Supports the addition or deletion of members, service providers, and health care services, at any time during the month, as authorized by the ~~Oklahoma Health Care Authority (OHCA)~~OHCA and/or the Oklahoma Department of Human Services (OKDHS);

(iv) Notifies supervisory staff at the personal care agency of any untimely or missed shifts, or any other deviation in scheduled care;

(v) Documents the existence of and justification for all manual modifications, adjustments, or exceptions after the service provider has entered or failed to enter the information in paragraph (1), above; and

(vi) Has the ability to respond to requests for records or documentation in the timeframe and format requested by OHCA.

(F) Be capable of retrieving current and archived data to produce summary reports of the information verified in Paragraph (1), above, as well as the information documented in (3)(E)(vi), above;

(G) Maintain reliable backup and recovery processes that ensure all data is preserved in the event of a system malfunction or disaster situation;

(H) Retain all data regarding the delivery of health care services for a minimum of six (6) years; and

(I) Establish a process to deactivate an employee's access to the EVV or designated system records upon termination of the designated employee's employment.

(5) **Claims reimbursement.** SoonerCare will not pay a claim for reimbursement unless the data is from an OHCA authorized and approved EVV system or aggregator; and includes all of the EVV verification requirements [refer to (1)(A through F] of this section:

(A) Corresponds with the health care services for which reimbursement is claimed; and

(B) Is consistent with any approved prior authorization or individual plan of care.

(6) **Program integrity.** Paid claims may be subject to retrospective review and recoupment, as appropriate, in accordance with OAC 317:30-3-2.1.

(7) **Procedures for EVV system failure or EVV system unavailability.** The EVV system provides alternate backup solutions if the automated system is unavailable; however, in the event of the EVV system failure, the provider documents the specified data in paragraph (1), above, in accordance with internal backup policies and procedures. This documentation is sufficient to account for in-home services. The personal care agency's backup procedures are only permitted when the EVV system is unavailable. For complete EVV system outages, providers would need to enter the specified data in paragraph (1), above, via web claim once the system is back online.

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

**SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME**

**PART 1. DETERMINATION OF QUALIFYING CATEGORICAL RELATIONSHIPS**

**317:35-5-7. Determining categorical relationship to the children and parent and caretaker relative groups**

(a) **Categorical relationship.** All individuals under age nineteen (19) are automatically related to the children's group and further determination is not required. Adults age nineteen (19) or older are related to the parent and caretaker relative group when there is a minor dependent child(ren) in the home and the individual is the parent, or is the caretaker relative other than the parent who meets the proper degree of relationship. A minor dependent child is any child who meets the AFDC eligibility requirements of age and relationship.

(b) **Requirement for referral to the Oklahoma Child Support Services Division (OCSS).** As a condition of eligibility, when both the parent or caretaker and minor child(ren) are receiving SoonerCare and a parent is absent from the home, the parent or caretaker relative must agree to cooperate with OCSS. ~~However, federal regulations provide for a waiver of this requirement when cooperation with OCSS is not in the best interest of the child. OCSS is responsible for making the good cause determination. If the parent or caretaker relative is claiming good cause, he/she cannot be certified for SoonerCare in the parent and caretaker relative group unless OCSS has determined good cause exists. There is no requirement of cooperation with OCSS for child(ren) or pregnant women to receive SoonerCare.~~ However, cooperation with OCSS is not required in the following instances:

(1) OCSS made a good cause determination that cooperation is not in the best interest of the child;

(2) The child is eligible for health care services through the Indian Health Service and the child support case was or would have been opened because of a Medicaid referral based solely on health care services provided through an Indian Health Program, in accordance with Section 533.152 of Title of the Code of Federal Regulations; or

(3) The SoonerCare application is only for child(ren) and/or pregnant women.

**PART 5. COUNTABLE INCOME AND RESOURCES**

**317:35-5-44. Child/spousal support**

The Omnibus Budget Reconciliation Act of 1987 requires the Oklahoma Department of Human Services (OKDHS) to provide Child Support Services to certain families receiving SoonerCare benefits through the Oklahoma Child Support Services Division (OCSS). The families are required to cooperate in assignment of medical support rights except as specified in Oklahoma Administrative Code (OAC) 317:35-5-7(b) In accordance with Section 433.152 of Title 42 of the Code of Federal Regulations, the Oklahoma Health Care Authority (OHCA) may not refer a case for medical support enforcement when the Medicaid referral is based solely upon health care services provided through an Indian Health Program [as defined at 25 United States Code § 1603(12)], including through the Purchased/Referred Care program, to a child who is eligible for health care services from the Indian Health Services. These families will not be required to cooperate with the OCSS in the assignment of child/spousal support rights. The families involved are those with a minor child(ren) in the home. The child(ren) must be related to the children's, the blind or the disabled groups and have a parent(s) absent from the home. Any support collected on behalf of these families will be paid to them as if they were receiving non-public assistance child support services, with one exception. The exception is regarding child support collected for foster care child(ren) in OKDHS temporary custody. This support is paid to OKDHS Children and Family Services Division (CFSD). The rules in OAC 317:10 are used, with the following exceptions:

(1) In the event the family already has an existing child support case, the only action required is a memo to the appropriate OCSS district office notifying them of the certification.

(2) Prior to October 1, 2013, child/spousal support is always counted as income less any applicable income disregard. This income inclusion applies whether it is redirected to the OCSS or retained by the member. Effective October 1, 2013, see rules regarding financial eligibility for the individual's eligibility group to determine whether child or spousal support is counted as income.

(3) Children who are in custody of OKDHS may be exempt from referral to OCSS. Should the pursuit of the OCSS services be determined to be detrimental to the OKDHS CFSD service plan, an exemption may be approved.

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

**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**

**PART 27. INDEPENDENT ~~LICENSED~~ PHYSICAL THERAPISTS AND PHYSICAL THERAPIST ASSISTANTS**

**317:30-5-290.1. Eligible providers**

~~(a) Eligible physical therapists must be appropriately licensed in the state in which they practice.~~

~~(b) All eligible providers of physical therapy services must have entered into a Provider Agreement with the Oklahoma Health Care Authority to perform physical therapy services.~~

(a) **Physical therapists.**

(1) Must be appropriately licensed in good standing in the state in which they practice and working in accordance with the Oklahoma Physical Therapy Practice Act or other applicable statute(s); and

(2) Entered into a provider agreement with the Oklahoma Health Care Authority (OHCA) to provide physical therapy services.

(b) **Physical therapist assistants.**

(1) Must be working under the supervision of a fully licensed physical therapist;

(2) Must be appropriately licensed in good standing in the state in which they practice and working in accordance with the Oklahoma Physical Therapy Practice Act or other applicable statute(s);

(3) Entered into a provider agreement with the OHCA to provide physical therapy services; and

(4) Provided the name of their OHCA-contracted supervising physical therapist upon enrollment.

**317:30-5-291. Coverage by category**

Payment is made to registered physical therapists as set forth in this Section.

(1) **Children.** Initial therapy evaluations do not require prior authorization and must be provided by a fully licensed physical therapist. All therapy services following the initial evaluation must be prior authorized for continuation of service. Prior to the initial evaluation, the therapist must have on file a signed and dated prescription or referral for the therapy services from the member's physician or other licensed practitioner of the healing arts. The prescribing or referring provider must be able to provide, if requested, clinical documentation from the member's medical record that supports the medical necessity for the evaluation and referral.

(2) **Adults.** There is no coverage for adults for services rendered by individually contracted providers. Coverage for

adults is permitted in an outpatient hospital setting as described in Oklahoma Administrative Code 317:30-5-42.1.

(3) **Individuals eligible for Part B of Medicare.** Services provided to Medicare eligible recipients are filed directly with the fiscal agent.

**317:30-5-291.1. Payment rates**

~~Payment is made in accordance with the current allowable Medicaid fee schedule.~~All physical therapy services are reimbursed per the methodology described in the Oklahoma Medicaid State Plan.

**317:30-5-293. Team therapy (Co-treatment)**

Therapists, or therapy assistants, working together as a team to treat one (1) or more members cannot ~~each~~ bill separately for the same or different service provided at the same time to the same member.

(1) ~~CPT~~Current Procedural Terminology (CPT) codes are used for billing the services of one (1) therapist or therapy assistant. The therapist cannot bill for his/her services and those of another therapist or a therapy assistant, when both provide the same or different services, at the same time, to the same member.

(2) If multiple therapies (physical therapy, occupational therapy, and/or speech therapy) are provided to one (1) member at the same time, only one (1) therapist can bill for the entire service, or each therapist can divide the service units.

(3) Providers must report the CPT code for the time actually spent in the delivery of the modality requiring constant attendance and therapy services. Pre- and post-delivery services are not to be counted in determining the treatment service time. The time counted must begin when the therapist is directly working with the member to deliver treatment services.

(4) The time counted is the time the member is being treated. If the member requires both a therapist and an assistant, or even two (2) therapists, each service unit of time the member is being treated can count as only one (1) unit of each code. The service units billed must equal the total time the member was receiving actual therapy services. It is not allowable for each therapist or therapy assistant to bill for the entire therapy session. The time the member spends not being treated, for any reason, must not be billed.

## PART 28. ~~OCCUPATIONAL THERAPY SERVICES~~OCCUPATIONAL THERAPISTS AND OCCUPATIONAL THERAPY ASSISTANTS

**317:30-5-295. Eligible providers**

~~(a) Eligible occupational therapists must be appropriately licensed in the state in which they practice.~~

~~(b) All eligible providers of occupational therapy services must~~

~~have entered into a Provider Agreement with the Oklahoma Health Care Authority to perform occupational therapy services.~~

(a) **Occupational therapists.**

(1) Must be appropriately licensed in good standing in the state in which they practice and working in accordance with the Oklahoma Occupational Therapy Practice Act or other applicable statute(s); and

(2) Entered into a provider agreement with the Oklahoma Health Care Authority (OHCA) to provide occupational therapy services.

(b) **Occupational therapy assistants.**

(1) Must be working under the supervision of a fully licensed occupational therapist;

(2) Must be appropriately licensed in good standing in the state in which they practice and working in accordance with the Oklahoma Occupational Therapy Practice Act or other applicable statute(s);

(3) Entered into a provider agreement with the OHCA to provide occupational therapy services; and

(4) Provided the name of their OHCA-contracted supervising occupational therapist upon enrollment.

**317:30-5-296. Coverage by category**

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

(1) **Children.** Initial therapy evaluations do not require prior authorization and must be provided by a fully licensed occupational therapist. All therapy services following the initial evaluation must be prior authorized for continuation of service. Prior to the initial evaluation, the therapist must have on file a signed and dated prescription or referral for the therapy services from the member's physician or other licensed practitioner of the healing arts. The prescribing or referring provider must be able to provide, if requested, clinical documentation from the member's medical record that supports the medical necessity for the evaluation and referral.

(2) **Adults.** There is no coverage for adults for services rendered by individually contracted providers. Coverage for adults is permitted in an outpatient hospital setting as described in Oklahoma Administrative Code 317:30-5-42.1.

(3) **Individuals eligible for Part B of Medicare.** Services provided to Medicare eligible recipients are filed directly with the fiscal agent.

**317:30-5-297. Payment rates**

~~Payment is made in accordance with the current allowable Medicaid fee schedule.~~All occupational therapy services are reimbursed per the methodology described in the Oklahoma Medicaid State Plan.

**317:30-5-299. Team therapy (Co-treatment)**

Therapists, or therapy assistants, working together as a team to treat one (1) or more members cannot ~~each~~ bill separately for the same or different service provided at the same time to the same member.

(1) ~~CPT~~Current Procedural Terminology (CPT) codes are used for billing the services of one (1) therapist or therapy assistant. The therapist cannot bill for his/her services and those of another therapist or a therapy assistant, when both provide the same or different services, at the same time, to the same member.

(2) If multiple therapies (physical therapy, occupational therapy, and/or speech therapy) are provided to one (1) member at the same time, only one (1) therapist can bill for the entire service, or each therapist can divide the service units.

(3) Providers must report the CPT code for the time actually spent in the delivery of the modality requiring constant attendance and therapy services. Pre- and post-delivery services are not to be counted in determining the treatment service time. The time counted must begin when the therapist is directly working with the member to deliver treatment services.

(4) The time counted is the time the member is being treated. If the member requires both a therapist and an assistant, or even two (2) therapists, each service unit of time the member is being treated can count as only one (1) unit of each code. The service units billed must equal the total time the member was receiving actual therapy services. It is not allowable for each therapist or therapy assistant to bill for the entire therapy session. The time the member spends not being treated, for any reason, must not be billed.

## PART 51. HABILITATION SERVICES

**317:30-5-482. Description of services**

Habilitation services include the services identified in (1) through (15) of this Section. Habilitation services providers must have an applicable agreement with the Oklahoma Health Care Authority (OHCA) to provide Developmental Disabilities Services (DDS) Home and Community-Based Services (HCBS).

(1) **Dental services.** Dental services are provided per Oklahoma Administrative Code (OAC) 317:40-5-112.

(A) **Minimum qualifications.** Dental services providers must have non-restrictive licensure by the Oklahoma State Board of Dentistry to practice dentistry in Oklahoma.

(B) **Description of services.** Dental services include services for maintenance or improvement of dental health as well as relief of pain and infection. These services may include:

(i) ~~an~~An oral examination;

(ii) ~~bite~~Bite-wing X-rays;
(iii) ~~dental~~Dental cleaning;
(iv) ~~topical~~Topical-fluoride treatment;
(v) ~~development~~Development of a sequenced treatment plan that prioritizes:
(I) ~~elimination~~Elimination of pain;
(II) ~~adequate~~Adequate oral hygiene; and
(III) ~~restoration~~Restoration or an improved ability to chew;
(vi) ~~routine~~Routine training of member or primary caregiver regarding oral hygiene; and
(vii) ~~preventive~~Preventive, restorative, replacement, and repair services to achieve or restore functionality provided after appropriate review when applicable, per OAC 317:40-5-112.

(C) **Coverage limitations.** Coverage of dental services is specified in the member's Individual Plan (IP) in accordance with applicable Waiver limits. Dental services are not authorized when recommended for cosmetic purposes.

(2) **Nutrition services.** Nutrition Services are provided per OAC 317:40-5-102.

(3) **Occupational therapy services.**

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

(B) **Description of services.** Occupational therapy services include evaluation, treatment, and consultation in leisure management, daily living skills, sensory motor, perceptual motor, and mealtime assistance. Occupational therapy services may include the use of occupational therapy assistants, within the limits of the occupational therapist's practice.

(i) Services are:
(I) ~~intended~~Intended to help the member achieve greater independence to reside and participate in the community; and
(II) ~~rendered~~Rendered in any community setting as specified in the member's IP. The IP must include a practitioner's prescription.

(ii) For purposes of this Section, a practitioner is defined as medical and osteopathic physicians, physician assistants, and other licensed health care professionals with prescriptive authority to order occupational therapy services in accordance with the rules and regulations governing the SoonerCare program.

(iii) The provision of services includes a written report or record documentation in the member's record, as

required.

(C) **Coverage limitations.** Payment is made for compensable services to the individual occupational therapist for direct services or for services provided by a qualified occupational therapist assistant, within the occupational therapist's employment. Payment is made in 15-minute units, with a limit of ~~480~~four hundred and eighty (480) units per Plan of Care year. Payment is not allowed solely for written reports or record documentation.

(4) **Physical therapy services.**

(A) **Minimum qualifications.** Physical therapists and physical therapist assistants must have current, non-restrictive licensure with the Oklahoma Board of Medical Licensure and Supervision. The physical therapist must ~~employ~~supervise the physical therapist assistant~~.~~, per OAC 317:30-5-290.1 (b)(1).

(B) **Description of services.** Physical therapy services include evaluation, treatment, and consultation in locomotion or mobility and skeletal and muscular conditioning to maximize the member's mobility and skeletal/muscular well-being. Physical therapy services may include the use of physical therapist assistants, within the limits of the physical therapist's practice.

(i) Services are intended to help the member achieve greater independence to reside and participate in the community. Services are provided in any community setting as specified in the member's IP. The IP must include a practitioner's prescription. For purposes of this Section, practitioners are defined as licensed medical and osteopathic physicians, and physician assistants in accordance with the rules and regulations covering the OHCA SoonerCare program.

~~(ii) For purposes of this Section, a practitioner is defined as a licensed medical and osteopathic physicians, and physician assistants in accordance with the rules and regulations covering the OHCA SoonerCare program.~~

~~(iii)~~(ii) The provision of services includes a written report or record documentation in the member's record, as required.

(C) **Coverage limitations.** Payment is made for compensable services to individual physical therapists for direct services or for services provided by a qualified physical therapist assistant within the physical therapist's employment. Payment is made in 15-minute units with a limit of ~~480~~four hundred and eighty (480) units per Plan of Care year. Payment is not allowed solely for written reports or record documentation.

(5) **Psychological services.**

(A) **Minimum qualifications.** Qualification as a provider of

psychological services requires current, non-restrictive licensure as a psychologist by the Oklahoma State Board of Examiners of Psychologists or licensing board in the state in which service is provided. Psychological technicians who have completed all board certification and training requirements may provide services under a licensed psychologist's supervision.

(B) **Description of services.** Psychological services include evaluation, psychotherapy, consultation, and behavioral treatment. Service is provided in any community setting as specified in the member's IP. The provider must develop, implement, evaluate and revise the Protective Intervention Protocol (PIP) corresponding to the relevant outcomes identified in the member's IP.

(i) Services are:

(I) ~~intended~~Intended to maximize a member's psychological and behavioral well-being; and

(II) ~~provided~~Provided in individual and group formats, with a six-person maximum.

(ii) Approval of services is based upon assessed needs per OAC 340:100-5-51.

(C) **Coverage limitations.**

(i) Payment is made in ~~15~~fifteen (15) minute units. A minimum of ~~15~~fifteen (15) minutes for each individual and group encounter is required.

(ii) Psychological services are authorized for a period, not to exceed twelve (12) months.

(I) Initial authorization must not exceed ~~192~~one hundred and ninety-two (192) units, ~~48~~forty-eight (48) hours of service.

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

(III) No more than ~~12~~twelve (12) hours of services, ~~48~~forty-eight (48) units, may be billed for PIP preparation. Any clinical document must be prepared within sixty (60) calendar days of the request. Further, if the document is not prepared, payments are suspended until the requested document is provided.

(IV) When revising a PIP to accommodate recommendations of a required committee review, the provider may bill for only one (1) revision. The time for preparing the revision must be clearly documented and must not exceed four (4) hours.

(6) **Psychiatric services.**

(A) **Minimum qualifications.** Qualification as a psychiatric services provider requires a current, non-restrictive license to practice medicine in Oklahoma. Certification by the

American Board of Psychiatry and Neurology or satisfactory completion of an approved residency program in psychiatry is required.

(B) **Description of services.** Psychiatric services include outpatient evaluation, psychotherapy, medication and prescription management and consultation, and are provided to eligible members. Services are provided in community setting specified in the member's IP.

(i) Services are intended to contribute to the member's psychological well-being.

(ii) A minimum of ~~30~~thirty (30) minutes for encounter and record documentation is required.

(C) **Coverage limitations.** A unit is ~~30~~thirty (30) minutes, with a limit of ~~200~~two hundred (200) units, per Plan of Care year.

(7) **~~Speech/language~~Speech-language pathology services.**

(A) **Minimum qualifications.** Qualification as a ~~speech and/or language~~speech-language pathology services provider requires current, non-restrictive licensure as a ~~speech and/or language~~speech-language pathologist, speech-language pathology assistant, or speech-language pathology clinical fellow, by the Oklahoma Board of Examiners for Speech-Language Pathology and Audiology~~.~~, per OAC 317:30-5-675.

(B) **Description of services.** Speech therapy includes evaluation, treatment, and consultation in communication and oral motor and/or feeding activities provided to eligible members. Services are intended to maximize the member's community living skills and may be provided in the community setting specified in the member's IP. ~~The IP must include a practitioner's prescription.~~

(i) The IP must include a practitioner's prescription. For purposes of this Section, practitioners are defined as licensed medical and osteopathic physicians, physician assistants, and other licensed professionals with prescriptive authority to order speech and/or language services in accordance with rules and regulations covering the OHCA SoonerCare program.

(ii) A minimum of ~~15~~fifteen (15) minutes for encounter and record documentation is required.

(C) **Coverage limitations.** A unit is ~~15~~fifteen (15) minutes, with a limit of ~~288~~two hundred and eighty-eight (288) units, per Plan of Care year.

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

(A) **Minimum qualifications.** Providers must complete the Oklahoma Department of Human Services (DHS) DDS-sanctioned training curriculum. Residential habilitation providers:

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

(ii) ~~are~~Are specifically trained to meet members' unique needs;

(iii) ~~were~~Were not convicted of, pled guilty to, or pled nolo contendere to misdemeanor assault and battery, or a felony, per Section (§) 1025.2 of Title 56 of the Oklahoma Statutes ~~(56 O.S. ' 1025.2)~~(O.S.); unless a waiver is granted, per 56 O.S. ' 1025.2; and

(iv) ~~receive~~Receive supervision and oversight from contracted-agency staff with a minimum of four (4) years of any combination of college-level education or full-time equivalent experience in serving persons with disabilities.

(B) **Description of services.** HTS services include services to support the member's self-care, daily living, and adaptive and leisure skills needed to reside successfully in the community. Services are provided in community-based settings in a manner that contributes to the member's independence, self-sufficiency, community inclusion, and well-being.

(i) Payment is not made for:

(I) ~~routine~~Routine care and supervision normally provided by family; or

(II) ~~services~~Services furnished to a member by a person who is legally responsible per OAC 340:100-3-33.2.

(ii) Family members who provide HTS services must meet the same standards as providers who are unrelated to the member. HTS staff residing in the same household as the member may not provide services in excess of ~~40~~forty (40) hours per week. Members requiring more than ~~40~~forty (40) hours per week of HTS services, must use staff members, who do not reside in the household and are employed by the member's chosen provider agency to deliver the balance of necessary support staff hours. Exceptions may be authorized, when needed, for members who receive services through the Homeward Bound Waiver.

(iii) Payment does not include room and board or maintenance, upkeep, or improvement of the member's or family's residence.

(iv) For members who also receive intensive personal supports (IPS), the member's IP must clearly specify the role of the HTS and person providing IPS to ensure there is no duplication of services.

(v) Review and approval by the DDS plan of care reviewer is required.

(vi) Pre-authorized HTS services accomplish the same objectives as other HTS services, but are limited to situations where the HTS provider is unable to obtain required professional and administrative oversight from an OHCA-approved oversight agency. For pre-authorized HTS services, the service:

(I) ~~provider~~Provider receives DDS area staff oversight; and

(II) ~~must~~Must be pre-approved by the DDS director or

his or her designee.

(C) **Coverage limitations.** HTS services are authorized per OAC 317:40-5-110, 317:40-5-111, 317:40-7-13, and 340:100-3-33.1.

(i) A unit is ~~15~~fifteen (15) minutes.

(ii) Individual HTS services providers are limited to a maximum of ~~40~~forty (40) hours per week regardless of the number of members served.

(iii) More than one (1) HTS may provide care to a member on the same day.

(iv) Payment cannot be made for services provided by two (2) or more HTSs to the same member during the same hours of a day.

(v) A HTS may receive reimbursement for providing services to only one (1) member at any given time. This does not preclude services from being provided in a group setting where services are shared among members of the group.

(vi) HTS providers may not perform any job duties associated with other employment including on-call duties, at the same time they are providing HTS services.

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

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

(11) **Audiology services.**

(A) **Minimum qualifications.** Audiologists must have licensure as an audiologist by the Oklahoma Board of Examiners for Speech Pathology and Audiology per OAC 317:30-5-675 (d) (1).

(B) **Description of services.** Audiology services include individual evaluation, treatment, and consultation in hearing to eligible members. Services are intended to maximize the member's auditory receptive abilities. ~~The member's IP must include a practitioner's prescription.~~

(i) The member's IP must include a practitioner's prescription. For purposes of this Section, practitioners are defined as licensed medical and osteopathic physicians, and physician assistants in accordance with rules and regulations covering the OHCA SoonerCare program.

(ii) A minimum of ~~15~~fifteen (15) minutes for encounter and record documentation is required.

(C) **Coverage limitations.** Audiology services are provided in accordance with the member's IP.

(12) **Prevocational services.**

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

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

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

(iii) ~~were~~Were not convicted of, pled guilty to, or pled nolo contendere to misdemeanor assault and battery, or a felony per 56 O.S. '_1025.2, unless a waiver is granted per 56 O.S. '_1025.2; and

(iv) ~~receive~~Receive supervision and oversight by a person with a minimum of four (4) years of any combination of college-level education or full-time equivalent experience in serving persons with disabilities.

(B) **Description of services.** Prevocational services are not available to persons who can be served under a program funded per Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (IDEA) per Section 1401 et seq. of Title 20 of the United States Code.

(i) Prevocational services are learning and work experiences where the individual can develop general, non-job, task-specific strengths that contribute to employability in paid employment in integrated community settings.

(ii) Activities include teaching concepts, such as communicating effectively with supervisors, co-workers, and customers, attendance, task completion, problem solving, and safety. These activities are associated with building skills necessary to perform work.

(iii) Pre-vocational services are delivered for the purpose of furthering habilitation goals that lead to greater opportunities for competitive, integrated employment. All prevocational services are reflected in the member's IP. Documentation must be maintained in the record of each member receiving this service, noting the service is not otherwise available through a program funded under the Rehabilitation Act of 1973 or IDEA.

(iv) Services include:

(I) ~~center~~Center-based prevocational services, per OAC 317:40-7-6;

(II) ~~community~~Community-based prevocational services per, OAC 317:40-7-5;

(III) ~~enhanced~~Enhanced community-based prevocational services per, OAC 317:40-7-12; and

(IV) ~~supplemental~~Supplemental supports, as specified in OAC 317:40-7-13.

(C) **Coverage limitations.** A unit of center-based or community-based prevocational services is one (1) hour and payment is based on the number of hours the member participates in the service. All prevocational services and supported-employment services combined may not exceed $27,000, per Plan of Care year. The services that may not be provided to the same member at the same time as prevocational services are:

(i) HTS;

(ii) Intensive Personal Supports;

(iii) Adult Day Services;
(iv) Daily Living Supports;
(v) Homemaker; or
(vi) ~~therapy~~Therapy services, such as occupational therapy; physical therapy; nutrition, speech, or psychological services; family counseling; or family training, except to allow the therapist to assess the individual's needs at the workplace or to provide staff training, per OAC 317:40-7-6.

(13) **Supported employment.**

(A) **Minimum qualifications.** Supported employment providers:
(i) ~~are~~Are at least ~~18~~eighteen (18) years of age;
(ii) ~~complete~~Complete the DHS DDS-sanctioned training curriculum;
(iii) ~~were~~Were not convicted of, pled guilty to, or pled nolo contendere to misdemeanor assault and battery, or a felony, per ~~Section 1025.2 of Title 56 of the Oklahoma Statutes (O.S. 56 ' 1025.2)~~56 O.S. ' 1025.2 unless a waiver is granted, per 56 O.S.' 1025.5; and
(iv) ~~receive~~Receive supervision and oversight by a person with a minimum of four (4) years of any combination of college-level education or full-time equivalent experience in serving persons with disabilities.

(B) **Description of services.** Supported employment is conducted in a variety of settings, particularly worksites in which persons without disabilities are employed, and includes activities that are outcome based and needed to sustain paid work by members receiving services through HCBS Waivers, including supervision and training. The outcome of supported employment is sustained paid employment at or above minimum wage, but not less than the customary wage and benefit level paid by the employer for the same or similar work performed by individuals without disabilities. The paid employment occurs in an integrated setting in the general workforce in a job that meets personal and career goals.
(i) When supported-employment services are provided at a worksite in which persons without disabilities are employed, payment:
(I) ~~is~~Is made for the adaptations, supervision, and training required by members as a result of their disabilities; and
(II) ~~does~~Does not include payment for the supervisory activities rendered as a normal part of the business setting.
(ii) Services include:
(I) ~~job~~Job coaching per OAC 317:40-7-7;
(II) ~~enhanced~~Enhanced job coaching per OAC 317:40-7-12;
(III) ~~employment~~Employment training specialist services per OAC 317:40-7-8; and

(IV) ~~stabilization~~Stabilization per OAC 317:40-7-11.

(iii) Supported-employment services furnished under HCBS Waivers are not available under a program funded by the Rehabilitation Act of 1973 or Individuals with Disabilities Education Act (IDEA).

(iv) Documentation that the service is not otherwise available under a program funded by the Rehabilitation Act of 1973 or IDEA must be maintained in the record of each member receiving the service.

(v) Federal financial participation (FFP) may not be claimed for incentive payment subsidies or unrelated vocational training expenses, such as:

(I) ~~incentive~~Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;

(II) ~~payments~~Payments passed through to users of supported-employment programs; or

(III) ~~payments~~Payments for vocational training not directly related to a member's supported-employment program.

(C) **Coverage limitations.** A unit is ~~15~~fifteen (15) minutes and payment is made per OAC 317:40-7-1 through 317:40-7-21. All prevocational services and supported-employment services combined cannot exceed $27,000, per Plan of Care year. The DDS case manager assists the member to identify other alternatives to meet identified needs above the limit. The services that may not be provided to the same member, at the same time as supported-employment services are:

(i) HTS;

(ii) Intensive Personal Supports;

(iii) Adult Day Services;

(iv) Daily Living Supports;

(v) Homemaker; or

(vi) ~~therapy~~Therapy services, such as occupational therapy; physical therapy; nutrition, speech, or psychological services, family counseling, or family training, except to allow the therapist to assess the individual's needs at the workplace or to provide staff training.

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

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

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

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

(iii) ~~were~~Were not convicted of, pled guilty to, or pled nolo contendere to misdemeanor assault and battery, or a felony, per ~~Section 1025.2 of Title 56 of the Oklahoma~~

~~Statutes (O.S. 56 ' 1025.2)~~56 O.S. ' 1025.2 unless a waiver is granted, per 56 O.S.' 1025.2;

(iv) ~~receive~~Receive supervision and oversight by a person with a minimum of four (4) years of any combination of college-level education or full-time equivalent experience in serving persons with disabilities; and

(v) ~~receive~~Receive oversight regarding specific methods to be used with the member to meet the member's complex behavioral or health support needs.

(B) **Description of services.**

(i) IPS:

(I) ~~are~~Are support services provided to members who need an enhanced level of direct support in order to successfully reside in a community-based setting; and

(II) ~~build~~Build upon the level of support provided by a HTS or daily living supports (DLS) staff by utilizing a second staff person on duty to provide assistance and training in self-care, daily living, and recreational and habilitation activities.

(ii) The member's Individual Plan (IP) must clearly specify the role of HTS and the person providing IPS to ensure there is no duplication of services.

(iii) Review and approval by the DDS plan of care reviewer is required.

(C) **Coverage limitations.** IPS are limited to ~~24~~twenty-four (24) hours per day and must be included in the member's IP, per OAC 317:40-5-151 and 317:40-5-153.

(15) **Adult day services.**

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

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

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

(B) **Description of services.** Adult day services provide assistance with the retention or improvement of self-help, adaptive and socialization skills, including the opportunity to interact with peers in order to promote a maximum level of independence and function. Services are provided in a non-residential setting away from the home or facility where the member resides.

(C) **Coverage limitations.** Adult day services are furnished four or more hours per day on a regularly scheduled basis, for one (1) or more days per week. A unit is ~~15~~fifteen (15) minutes for up to a maximum of six (6) hours daily, at which point a unit is one (1) day. All services must be authorized in the member's IP.

**PART 73. EARLY INTERVENTION SERVICES**

**317:30-5-641. Coverage by category**

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

(1) **Adults.** There is no coverage for services rendered to adults.

(2) **Children.** Payment is made for compensable services rendered by the ~~OSDH~~Oklahoma State Department of Health (OSDH) and its contractors, pursuant to the State's plan for Early Intervention services required under Part C of the ~~IDEIA~~IDEA.

(A) **Child health screening examination.** An initial screening may be requested by the family of an eligible individual at any time and must be provided without regard to whether the individual's age coincides with the established periodicity schedule. Coordination - referral is made to the SoonerCare provider to assure at a minimum, that periodic screens are scheduled and provided in accordance with the periodicity schedule following the initial screening.

(B) **Child health encounter (EPSDT partial screen).** The child health encounter (the EPSDT partial screen) may include a diagnosis and treatment encounter, a follow-up health encounter, or a home visit. A child health encounter may include:

(i) ~~child~~Child health history,

(ii) ~~physical~~Physical examination,

(iii) ~~developmental~~Developmental assessment,

(iv) ~~nutrition~~Nutrition assessment and counseling,

(v) ~~social~~Social assessment and counseling,

(vi) ~~indicated~~Indicated laboratory and screening tests,

(vii) ~~screening~~Screening for appropriate immunizations,

(viii) ~~health~~Health counseling, and

(ix) ~~treatment~~Treatment of common childhood illness and conditions.

(C) **Hearing and Hearing Aid evaluation.** Hearing evaluations must meet guidelines found at ~~OAC 317:30-5-675 and OAC~~ Oklahoma Administrative Code (OAC) 317:30-5-676.

(D) **Audiometry test.** Audiometric test (Immittance [Impedance] audiometry or tympanometry) includes bilateral assessment of middle ear status and reflex studies (when appropriate) provided by a state licensed audiologist ~~who:~~as listed in OAC 317:30-5-675 (d) (1) and (2).

~~(i) holds a certificate of clinical competencefrom the American Speech-Language Hearing Association(ASHA); or~~

~~(ii) has~~Has ~~completed the equivalent educational requirements and work experience necessary for the certificate; or~~

~~(iii) has~~Has ~~completed the academic program and is acquiring supervised work experience to qualify for the certificate.~~

(E) **Ear impression (for earmold).** Ear impression (for earmold) includes taking impression of client's ear and providing a finished earmold which is used with the client's hearing aid provided by a state licensed audiologist ~~who:~~as listed in OAC 317:30-5-675 (d) (1) and (2).

~~(i) holds a certificate of clinical competence from ASHA; or~~

~~(ii) has completed the equivalent educational requirements and work experience necessary for the certificate; or~~

~~(iii) has completed the academic program and is acquiring supervised work experience to qualify for the certificate.~~

(F) **Speech language evaluation.** Speech language evaluation must be provided by a ~~state~~fully licensed speech-language pathologist.

(G) **Physical therapy evaluation.** Physical therapy evaluation must be provided by a ~~State~~fully licensed physical therapist.

(H) **Occupational therapy evaluation.** Occupational therapy evaluation must be provided by a ~~State~~fully licensed occupational therapist.

(I) **Psychological evaluation and testing.** Psychological evaluation and testing must be provided by State-licensed, board certified, psychologists.

(J) **Vision testing.** Vision testing examination must be provided by a State licensed Doctor of Optometry (O.D.) or licensed physician specializing in ophthalmology (M.D. or D.O.). At a minimum, vision services include diagnosis and treatment for defects in vision.

(K) **Treatment encounter.** A treatment encounter may occur through the provision of individual, family or group treatment services to infants and toddlers who are identified as having specific disorders or delays in development, emotional or behavioral problems, or disorders of speech, language, vision, or hearing. These types of encounters are initiated following the completion of a diagnostic encounter and subsequent development of the Individual Family Services Plan (IFSP), and may include the following:

(i) **Hearing and Vision Services.** These services include assisting the family in managing the child's vision and/or hearing disorder such as auditory training, habilitation training, communication management, orientation and mobility, and counseling the family. This encounter is designed to assist children and families with management issues that arise as a result of hearing and/or vision loss. These services are usually provided by vision impairment teachers or specialists and orientation specialists, and mobility specialists. These services may be provided in the home or community setting, such as a specialized day care center. Hearing services must be provided by:

(I) ~~a State licensed, Master's Degree, ASHA certified audiologist~~A state-licensed audiologist; or

(II) ~~a State~~A fully licensed, ~~Master's degree, ASHA certified~~ speech-language pathologist; or

(III) ~~an~~An audiologist or speech-language pathologist who has completed the equivalent educational requirements and work experience necessary for the certificate or has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

~~(ii) **Speech language therapy services.** Speech language therapy services must be provided by a State licensed, speech language pathologist who:~~

~~(I) holds a certificate of clinical competence from ASHA; or~~

~~(II) has completed the equivalent educational requirements and work experience necessary for the certificate; or~~

~~(III) has completed the academic program and is acquiring supervised work experience to qualify for the certificate.~~

(ii) **Speech-language therapy services.** Speech-language therapy services must be provided by:

(I) A fully licensed, speech-language pathologist who meets the requirements found at OAC 317:30-5-675 (a) (1) through (3);

(II) A licensed speech-language pathology assistant who is working under the supervision of a speech-language pathologist and meets the requirements found at OAC 317:30-5-675 (b) (1) through (4); or

(III) A licensed speech-language pathology clinical fellow, who is working under the supervision of a fully licensed speech-language pathologist and meets the requirements found at OAC 317:30-5-675 (c) (1) through (4).

(iii) **Physical therapy services.** Physical therapy services must be provided by a ~~State~~fully licensed physical therapist or physical therapist assistant, per OAC 317:30-5-290.1.

(iv) **Occupational therapy services.** Occupational therapy may include provision of services to improve, develop or restore impaired ability to function independently and must be provided by a ~~State~~fully licensed occupational therapist or occupational therapy assistant, per OAC 317:30-5-295.

(v) **Nursing services.** Nursing services may include the provision of services to protect the health status of infants and toddlers, correct health problems, and assist in removing or modifying health related barriers and must

be provided by a registered nurse or licensed practical nurse under supervision of a registered nurse. Services may include medically necessary procedures rendered in the child's home.

(vi) **Psychological services.** Psychological and counseling services are planning and managing a program of psychological services, including the provision of counseling or consultation to the family of the infant or toddler, when the service is for the direct benefit of the child and assists the family to better understand and manage the child's disabilities. Psychological services must be provided by a State-licensed psychologist.

(vii) **Psychotherapy counseling services.** Psychotherapy counseling services are the provision of counseling for children and parents. All services must be for the direct benefit of the child. Psychotherapy counseling services must be provided by a State licensed Social Worker, a State Licensed Professional Counselor, a State licensed Psychologist, State licensed Marriage and Family Therapist, or a State licensed Behavioral Practitioner, or under Board Supervision to be licensed in one of the above stated areas.

(viii) **Family Training and Counseling for Child Development.** Family Training and Counseling for Child Development services are the provision of training and counseling regarding concerns and problems in development. Services integrate therapeutic intervention strategies into the daily routines of a child and family in order to restore or maintain function and/or to reduce dysfunction resulting from a mental or physical disability or developmental delay. All services must be for the direct benefit of the child. Family Training and Counseling for Child Development services must be provided by a Certified Child Development Specialist.

(L) **Immunizations.** Immunizations must be coordinated with the Primary Care Physician for those infants and toddlers enrolled in SoonerCare. An administration fee, only, can be paid for immunizations provided by the OSDH.

(M) **Assistive Technology.** Assistive technology is the provision of services that help to select a device and assist a student with a disability(ies) to use an Assistive Technology device including coordination with other therapies and training of the child and caregiver. Services must be provided by a:

(i) ~~State~~A fully licensed ~~Speech Language Pathologist who:~~speech-language pathologist as listed in OAC 317:30-5-675 (a) (1) through (3);

~~(I) holds a certificate of clinical competence from the American Speech and Hearing Association; or~~

~~(II) has completed the equivalent educational requirements and work experience necessary for the certificate; or~~

~~(III) has completed the academic program and is acquiring supervised work experience to qualify for the certificate;~~

(ii) ~~State~~A fully licensed ~~Physical Therapist; or~~physical therapist as listed in OAC 317:30-5-290.1 (a); or

(iii) ~~State~~A fully licensed ~~Occupational Therapist~~occupational therapist as listed in OAC 317:30-5-295 (a).

## PART 77. ~~SPEECH AND HEARING SERVICES~~ SPEECH-LANGUAGE PATHOLOGISTS, SPEECH-LANGUAGE PATHOLOGY ASSISTANTS, CLINICAL FELLOWS, AND AUDIOLOGISTS

### 317:30-5-675. Eligible providers

~~(a) Eligible speech and hearing providers must be either state licensed speech/language pathologists or state licensed audiologists who:~~

~~(1) hold a certificate of clinical competence from the American Speech and Hearing Association; or~~

~~(2) have completed the equivalent educational requirements and work experience necessary for the certificate; or~~

~~(3) have completed the academic program and are acquiring supervised work experience to qualify for the certificate.~~

~~(b) All eligible providers of speech and hearing services must have entered into a contract with the Oklahoma Health Care Authority to perform speech and hearing services.~~

(a) **Speech-language pathologist (SLP).**

(1) Must be appropriately licensed in good standing in the state in which they practice and working in accordance with the Speech-Language Pathology and Audiology Licensing Act or other applicable statute(s); and

(2) Entered into a Provider Agreement with the Oklahoma Health Care Authority (OHCA) to provide speech-language pathology services.

(b) **Speech-language pathology assistant (SLPA).**

(1) Must be working under the supervision of a fully licensed speech-language pathologist;

(2) Must be appropriately licensed in good standing in the state in which they practice and working in accordance with the Speech-Language Pathology and Audiology Licensing Act or other applicable statute(s);

(3) Entered into a provider agreement with the OHCA to provide speech-language pathology services; and

(4) Provided the name of their OHCA-contracted supervising speech-language pathologist upon enrollment.

(c) **Clinical fellow.**

(1) Must be working under the supervision of a fully licensed speech-language pathologist;
(2) Must have a clinical fellow license in good standing in the state in which they practice and working in accordance with the Speech-Language Pathology and Audiology Licensing Act or other applicable statute(s);
(3) Entered into a provider agreement with the OHCA to provide speech-language pathology services; and
(4) Provided the name of their OHCA-contracted supervising speech-language pathologist upon enrollment.

(d) **Audiologists.**
(1) Must be appropriately licensed in good standing in the state in which they practice and working in accordance the Speech-Language Pathology and Audiology Licensing Act or other applicable statute(s); and
(2) Entered into a provider agreement with the Oklahoma Health Care Authority (OHCA) to provide speech-language pathology and audiology services.

**317:30-5-676. Coverage by category**

Payment is made for speech and hearing services as set forth in this Section.

(1) **Children.** Coverage for children is as follows:

(A) **Preauthorization required.** All therapy services, including the initial evaluation, must be prior authorized. Prior to the initial evaluation, the therapist must have on file a signed and dated prescription or referral for the therapy services from the member's physician or other licensed practitioner of the healing arts. The prescribing or referring provider must be able to provide, if requested, clinical documentation from the member's medical record that supports the medical necessity for the evaluation and referral.

(B) ~~**Speech/Language Services**~~**Speech-language pathology services**. ~~Speech/language therapy services may include speech/language evaluations, individual and group therapy services provided by a state licensed speech/language pathologist.~~

(i) Speech-language pathology services may include speech-language evaluations, individual and group therapy services provided by a fully licensed and certified speech-language pathologist, a licensed speech-language pathology clinical fellow, and services within the scope of practice of a speech-language pathology assistant as directed by the supervising speech-language pathologist, as listed in Oklahoma Administrative Code (OAC) 317:30-5-675 (a) through (c).
(ii) Initial evaluations must be prior authorized and provided by a fully licensed speech-language pathologist.

(C) **Hearing aids.** Hearing and hearing aid evaluations include pure tone air, bone and speech audiometry by a state licensed audiologist. Payment is made for a hearing aid following a recommendation by a Medical or Osteopathic physician and a hearing aid evaluation by a state licensed audiologist.

(2) **Adults.** There is no coverage for adults for services rendered by individually contracted providers. Coverage for adults is permitted in an outpatient hospital setting as described in ~~30-5-42.1.~~OAC 317:30-5-42.1.

(3) **Individuals eligible for Part B of Medicare.** Services provided to Medicare eligible recipients are filed directly with the fiscal agent.

**317:30-5-677. Payment rates**

~~Payment is made in accordance with the current allowable Medicaid fee schedule.~~All speech-language pathology and hearing services are reimbursed per the methodology described in the Oklahoma Medicaid State Plan.

**317:30-5-680. Team therapy (Co-treatment)**

Therapists, or therapy assistants, working together as a team to treat one (1) or more members cannot ~~each~~ bill separately for the same or different service provided at the same time to the same member.

(1) ~~CPT~~Current Procedural Terminology (CPT) codes are used for billing the services of one (1) therapist or therapy assistant. The therapist cannot bill for his/her services and those of another therapist or a therapy assistant, when both provide the same or different services, at the same time, to the same member.

(2) If multiple therapies (physical therapy, occupational therapy, and/or speech therapy) are provided to one (1) member at the same time, only one (1) therapist can bill for the entire service, or each therapist can divide the service units.

(3) Providers must report the CPT code for the time actually spent in the delivery of the modality requiring constant attendance and therapy services. Pre- and post-delivery services are not to be counted in determining the treatment service time. The time counted must begin when the therapist is directly working with the member to deliver treatment services.

(4) The time counted is the time the member is being treated. If the member requires both a therapist and an assistant, or even two (2) therapists, each service unit of time the member is being treated can count as only one (1) unit of each code. The service units billed must equal the total time the member was receiving actual therapy services. It is not allowable for each therapist or therapy assistant to bill for the entire therapy session. The time the member spends not being treated, for any

reason, must not be billed.

## PART 103. QUALIFIED SCHOOLS AS PROVIDERS OF HEALTH-RELATED SERVICES

### 317:30-5-1023. Coverage by category

(a) **Adults.** There is no coverage for services rendered to adults twenty-one (21) years of age and older.

(b) **Children.** For non-Individualized Education Program (IEP) medical services that can be provided in a school setting, refer to Part 4, Early and Periodic Screening, Diagnostic and Treatment program, of Oklahoma Administrative Code at 317:30-3-65 through 317:30-3-63.12. Payment is made for the following compensable services rendered by qualified school providers:

(1) **Diagnostic encounters.** Diagnostic encounters are defined as those services necessary to fully evaluate defects, physical or behavioral health illnesses, or conditions discovered by the screening. Approved diagnostic encounters may include the following:

(A) **Hearing and hearing aid evaluation.** Hearing evaluation includes pure tone air, bone, and speech audiometry. Hearing evaluations must be provided by a ~~state- licensed~~state-licensed audiologist ~~who:~~as listed in OAC 317:30-5-675 (d) (1) and (2).

~~(i) Holds a Certificate of Clinical Competence from the American Speech-Language-Hearing Association (ASHA); or~~

~~(ii) Has completed the equivalent educational requirements and work experience necessary for the certificate; or~~

~~(iii) Has completed the academic program and is acquiring supervised work experience to qualify for the certificate.~~

(B) **Audiometry test.** Audiometric test (Immittance [Impedance] audiometry or tympanometry) includes bilateral assessment of middle ear status and reflex studies (when appropriate) provided by a state-licensed audiologist ~~who:~~as listed in OAC 317:30-5-675 (d) (1) and (2).

~~(i) Holds a Certificate of Clinical Competence from ASHA; or~~

~~(ii) Has completed the equivalent educational requirements and work experience necessary for the certificate; or~~

~~(iii) Has completed the academic program and is acquiring supervised work experience to qualify for the certificate.~~

(C) **Ear impression (for earmold).** Ear impression (for earmold) includes taking an impression of a member's ear and providing a finished earmold, to be used with the member's hearing aid as provided by a state-licensed audiologist ~~who:~~as listed in OAC 317:30-5-675 (d) (1) and (2).

~~(i) Holds a Certificate of Clinical Competence from the ASHA; or~~

~~(ii) Has completed the equivalent educational requirements~~

~~and work experience necessary for the certificate; or~~

~~(iii) Has completed the academic program and is acquiring supervised work experience to qualify for the certificate.~~

(D) **Vision screening.** Vision screening in schools includes application of tests and examinations to identify visual defects or vision disorders. The vision screening may be performed by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) under the supervision of an RN. The service can be billed when a SoonerCare member has an individualized documented concern that warrants a screening. A vision examination must be provided by a state-licensed Doctor of Optometry (O.D.) or licensed physician specializing in ophthalmology (M.D. or D.O.). This vision examination, at a minimum, includes diagnosis and treatment for defects in vision.

(E) **Speech-language evaluation.** Speech-language evaluation is for the purpose of identification of children or adolescents with speech or language disorders and the diagnosis and appraisal of specific speech and language services. Speech-language evaluations must be provided by ~~state-~~a fully licensed speech-language pathologist ~~who:~~as listed in OAC 317:30-5-675 (a) (1) through (3).

~~(i) Holds a Certificate of Clinical Competence from the ASHA; or~~

~~(ii) Has completed the equivalent educational requirements and work experience necessary for the certificate; or~~

~~(iii) Has completed the academic program and is acquiring supervised work experience to qualify for the certificate.~~

(F) **Physical therapy evaluation.** Physical therapy evaluation includes evaluating the student's ability to move throughout the school and to participate in classroom activities and the identification of movement dysfunction and related functional problems. It must be provided by a ~~state-licensed~~fully licensed physical therapist as listed in OAC 317:30-5-290.1 (a) (1) and (2). Physical therapy evaluations must adhere to guidelines found at OAC 317:30-5-291.

(G) **Occupational therapy evaluation.** Occupational therapy evaluation services include determining what therapeutic services, assistive technology, and environmental modifications a student requires for participation in the special education program and must be provided by a ~~state-licensed~~fully licensed occupational therapist~~.~~as listed in OAC 317:30-5-295 (a) (1) and (2). Occupational therapy evaluations must adhere to guidelines found at OAC 317:30-5-296.

(H) **Evaluation and testing.** Evaluation and testing by psychologists and certified school psychologists are for the purpose of assessing emotional, behavioral, cognitive, or developmental issues that are affecting academic performance

and for determining recommended treatment protocol. Evaluation or testing for the sole purpose of academic placement (e.g., diagnosis of learning disorders) is not a compensable service. These evaluations and tests must be provided by a state-licensed, board-certified psychologist or a certified school psychologist certified by the State Department of Education (SDE).

(2) **Child-guidance treatment encounter.** A child-guidance treatment encounter may occur through the provision of individual, family, or group treatment services to children and adolescents who are identified as having specific disorders or delays in development, emotional or behavioral problems, or disorders of speech, language, or hearing. These types of encounters are initiated following the completion of a diagnostic encounter and subsequent development of a treatment plan, or as a result of an IEP and may include the following:

(A) **Hearing and vision services.** Hearing and vision services may include provision of habilitation activities, such as: auditory training; aural and visual habilitation training including Braille, and communication management; orientation and mobility; and counseling for vision and hearing losses and disorders. Services must be provided by or under the direct guidance of one (1) of the following individuals practicing within the scope of his or her practice under state law:

(i) ~~state-licensed master's degree audiologist who: who:~~State-licensed audiologist as listed in OAC 317:30-5-675 (d) (1) and (2).

~~(I) Holds a Certificate of Clinical Competence from the ASHA; or~~

~~(II) Has completed the equivalent educational requirements and work experience necessary for the certificate; or~~

~~(III) Has completed the academic program and is acquiring supervised work experience to qualify for the certificate;~~

(ii) ~~State-licensed~~Fully licensed, ~~master's degree~~ speech-language pathologist ~~who:~~as listed in OAC 317:30-5-675 (a) (1) through (3).

~~(I) Holds a Certificate of Clinical Competence from the ASHA; or~~

~~(II) Has completed the equivalent educational requirements and work experience necessary for the certificate; or~~

~~(III) Has completed the academic program and is acquiring supervised work experience to qualify for the certificate; and~~

(iii) Certified orientation and mobility specialists~~; and~~.

(B) **Speech-language therapy services.** Speech-language therapy

services include provisions of speech and language services for the habilitation or prevention of communicative disorders. Speech-language therapy services must be provided by or under the direct guidance and supervision of a ~~state-licensed~~fully licensed speech-language pathologist within the scope of his or her practice under state law ~~who:~~ as listed in OAC 317:30-5-675 (a) (1) through (3).

~~(i) Holds a Certificate of Clinical Competence from the ASHA; or~~

~~(ii) Has completed the equivalent educational requirements and work experience necessary for the certificate; or~~

~~(iii) Has completed the academic program and is acquiring supervised work experience to qualify for the certificate; or~~

(C) **Physical therapy services.** Physical therapy services are provided for the purpose of preventing or alleviating movement dysfunction and related functional problems that adversely affect the member's education. Physical therapy services must adhere to guidelines found at OAC 317:30-5-291 and must be provided by or under the direct guidance and supervision of a ~~state-licensed~~fully licensed physical therapist; services may also be provided by a licensed physical therapy assistant who has been authorized by the Board of Examiners working under the supervision of a fully licensed physical therapist. ~~The licensed physical therapist may not supervise more than three (3) physical therapy assistants.~~

(D) **Occupational therapy services.** Occupational therapy may include provision of services to improve, develop, or restore impaired ability to function independently. Occupational therapy services must be provided by or under the direct guidance and supervision of a ~~state-licensed~~fully licensed occupational therapist; services may also be provided by ~~an~~a licensed occupational therapy assistant who has been authorized by the Board of Examiners, working under the supervision of a licensed occupational therapist.

(E) **Nursing services.** Nursing services may include provision of services to protect the health status of children and adolescents, correct health problems and assist in removing or modifying health-related barriers, and must be provided by a RN or LPN under supervision of a RN. Services include medically necessary procedures rendered at the school site, such as catheterization, suctioning, tube feeding, and administration and monitoring of medication.

(F) **Counseling services.** All services must be for the direct benefit of the member. Counseling services must be provided by a state-licensed social worker, a state-licensed professional counselor, a state-licensed psychologist or SDE-certified school psychologist, a state-licensed marriage and

family therapist, or a state-licensed behavioral health practitioner, or under Board supervision to be licensed in one (1) of the above-stated areas.

(G) **Assistive technology.** Assistive technology is the provision of services that help to select a device and assist a student with disability(ies) to use an assistive technology device, including coordination with other therapies and training of member and caregiver. Services must be provided by a:

(i) ~~State-licensed speech-language pathologist who:~~Fully licensed speech-language pathologist as listed in OAC 317:30-5-675 (a) (1) through (3).

~~(I) Holds a Certificate of Clinical Competence from the ASHA; or~~

~~(II) Has completed the equivalent educational requirements and work experience necessary for the certificate; or~~

~~(III) Has completed the academic program and is acquiring supervised work experience to qualify for the certificate;~~

(ii) ~~State-licensed~~Fully licensed physical therapist as listed in OAC 317:30-5-290.1 (a) (1) and (2); or

(iii) ~~State-~~Fully licensed occupational therapist as listed in OAC 317:30-5-295 (a) (1) and (2).

(H) **Personal care.** Provision of personal care services (PCS) allow students with disabilities to safely attend school. Services include, but are not limited to: dressing, eating, bathing, assistance with transferring and toileting, positioning, and instrumental activities of daily living such as preparing meals and managing medications. PCS also includes assistance while riding a school bus to handle medical or physical emergencies. Services must be provided by registered paraprofessionals that have completed training approved or provided by SDE, or personal care assistants, including LPNs, who have completed on-the-job training specific to their duties. PCS does not include behavioral monitoring. Paraprofessionals are not allowed to administer medication, nor are they allowed to assist with or provide therapy services to SoonerCare members. Tube feeding of any type may only be reimbursed if provided by a RN or LPN. Catheter insertion and Catheter/Ostomy care may only be reimbursed when done by a RN or LPN. All PCS must be prior authorized.

(I) **Therapeutic behavioral services (TBS).** Services are goal-directed activities for each client to restore, retain and improve the self-help, socialization, communication, and adaptive skills necessary to reside successfully in home and community-based settings. It also includes problem identification and goal setting, medication support,

restoring function, and providing support and redirection when needed. TBS activities are behavioral interventions to complement more intensive behavioral health services and may include the following components: basic living and self-help skills; social skills; communication skills; organization and time management; and transitional living skills. This service must be provided by a behavioral health school aide (BHSA) who has a high school diploma or equivalent and has successfully completed training approved by the SDE, and in collaboration with the Oklahoma Department of Mental Health and Substance Abuse Services, along with corresponding continuing education. BHSA must be supervised by a bachelor's level individual with a special education certification. BHSA must have CPR and First Aid certification. Six (6) additional hours of related continuing education are required per year.

(c) **Members eligible for Part B of Medicare.** EPSDT school health-related services provided to Medicare eligible members are billed directly to the fiscal agent.

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

**SUBCHAPTER 7. SOONERCARE**

**PART 3. ENROLLMENT CRITERIA**

**317:25-7-13. Enrollment ineligibility**

Members in certain categories are excluded from participation in the SoonerCare Choice program. All other members may be enrolled in the SoonerCare Choice program and subject to the provisions of this Subchapter. Members excluded from participation in SoonerCare Choice include:

(1) Individuals receiving services in a long-term care facility, in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), or through a Home and Community Based Waiver;

(2) Individuals in the former foster care children's group [see Oklahoma Administrative Code (OAC) 317:35-5-2];

(3) Individuals in benefit programs with limited scope, such as Tuberculosis, Family Planning, or pregnancy only;

(4) Non-qualified or ineligible aliens;

(5) Children in subsidized adoptions;

(6) Individuals who are dually-eligible for SoonerCare and Medicare; and/or

~~(7) Individuals who are in an Institution for Mental Disease (IMD); and/or~~

~~(8)~~ (7) Individuals who have other creditable coverage.

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

**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**

**PART 1. PHYSICIANS**

**317:30-5-9. Medical services**

(a) **Use of medical modifiers.** The ~~Physicians'~~physicians' Current Procedural Terminology (CPT) and the second level ~~HCPCS~~Healthcare Common Procedure Coding System (HCPCS) provide for 2-digit medical modifiers to further describe medical services. Modifiers are used when appropriate.

(b) **Covered office services.**

(1) Payment is made for four (4) office visits (or home) per month per member, for adults ~~(over age 21)~~[over age twenty-one (21)], regardless of the number of physicians involved. Additional visits per month are allowed for services related to emergency medical conditions.

(2) Visits for the purpose of family planning are excluded from the four (4) per month limitation.

(3) Payment is allowed for the insertion and/or implantation of contraceptive devices in addition to the office visit.

(4) Separate payment will be made for the following supplies when furnished during a physician's office visit.

(A) Casting materials;

(B) Dressing for burns;

(C) Contraceptive devices; and

(D) IV ~~Fluids~~fluids.

~~(5) Payment is made for routine physical exams only as prior authorized by the OKDHS and are not counted as an office visit.~~

~~(6)~~(5) Medically necessary office lab and X-rays are covered.

~~(7)~~(6) Hearing exams by physician for members between the ages of ~~21 and 65~~twenty one (21) and sixty five (65) are covered only as a diagnostic exam to determine type, nature and extent of hearing loss.

~~(8)~~(7) Hearing aid evaluations are covered for members under ~~21~~twenty one (21) years of age.

~~(9)~~(8) IPPB (Intermittent Positive Pressure Breathing) is covered when performed in physician's office.

~~(10)~~(9) Payment is made for an office visit in addition to allergy testing.

~~(11)~~(10) Separate payment is made for antigen.

~~(12)~~(11) Eye exams are covered for members between ages ~~21~~twenty one (21) and ~~65~~sixty five (65) for medical diagnosis only.

~~(13)~~(12) If a physician personally sees a member on the same day as a dialysis treatment, payment can be made for a separately identifiable service unrelated to the dialysis.

~~(14)~~(13) Separate payment is made for the following specimen

collections:

(A) Catheterization for collection of specimen; and

(B) Routine ~~Venipuncture~~venipuncture.

~~(15)~~(14) The Professional Component for electrocardiograms, electroencephalograms, electromyograms, and similar procedures are covered on an inpatient basis as long as the interpretation is not performed by the attending physician.

~~(16)~~(15) Cast removal is covered only when the cast is removed by a physician other than the one who applied the cast.

(16) Payment may be made for medication-assisted treatment (MAT) medications prescribed and/or administered by a physician.

(c) **Non-covered office services.**

(1) Payment is not made separately for an office visit and rectal exam, pelvic exam or breast exam. Office visits including one of these types of exams should be coded with the appropriate office visit code.

(2) Payment cannot be made for prescriptions or medication dispensed by a physician in his office.

(3) Payment will not be made for completion of forms, abstracts, narrative reports or other reports, separate charge for use of office or telephone calls.

(4) Additional payment will not be made for mileage.

(5) Payment is not made for an office visit where the member did not keep appointment.

(6) Refractive services are not covered for persons between the ages of ~~21 and 65~~twenty-one (21) and sixty-five (65).

(7) Removal of stitches is considered part of post-operative care.

(8) Payment is not made for a consultation in the office when the physician also bills for surgery.

(9) Separate payment is not made for oxygen administered during an office visit.

(d) Covered inpatient medical services.

(1) Payment is allowed for inpatient hospital visits for all SoonerCare covered admissions. Psychiatric admissions must be prior authorized.

(2) Payment is allowed for the services of two physicians when supplemental skills are required and different specialties are involved.

(3) Certain medical procedures are allowed in addition to office visits.

(4) Payment for critical care is all-inclusive and includes payment for all services that day. Payment for critical care, first hour is limited to one unit per day.

(e) **Non-covered inpatient medical services.**

(1) For inpatient services, all visits to a member on a single day are considered one service except where specified. Payment is made for only one (1) visit per day.

(2) A hospital admittance or visit and surgery on the same day would not be covered if post-operative days are included in the

surgical procedure. If there are no post-operative days, a physician can be paid for visits.

(3) Drugs administered to inpatients are included in the hospital payment.

(4) Payment will not be made to a physician for an admission or new patient work-up when the member receives surgery in out-patient surgery or ambulatory surgery center.

(5) Payment is not made to the attending physician for interpretation of tests on his own patient.

(f) **Other medical services.**

(1) Payment will be made to physicians providing Emergency Department services.

(2) Payment is made for two (2) nursing facility visits per month. The appropriate CPT code is used.

(3) When payment is made for ~~"Evaluation of arrhythmias" or "Evaluation of sinus node"~~evaluation of arrhythmias or evaluation of sinus node, the stress study of the arrhythmia includes inducing the arrhythmia and evaluating the effects of drugs, exercise, etc. upon the arrhythmia.

(4) When the physician bills twice for the same procedure on the same day, it must be supported by a written report.

## PART 21. OUTPATIENT BEHAVIORAL HEALTH AGENCY SERVICES

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

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

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

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

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

(A) Registered under federal law;

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

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

(D) Registered by the Drug Enforcement Agency (DEA);
(E) Registered by the Oklahoma Bureau of Narcotics and Dangerous Drugs (OBNDD); and
(F) Engaged in opioid treatment of individuals by use of an opioid agonist treatment medication, including methadone.

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

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

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

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

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

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

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

(b) **Coverage.** The SoonerCare program provides coverage of medically necessary MAT services in OTPs, including but not limited to, methadone treatment, to eligible individuals with OUD. An OTP must have the capacity to provide the full range of services included in the definition of MAT and must document both medication dosing and supporting behavioral health services, including but not limited to, individual, family and group therapy and rehabilitation services. MAT services and/or medications may also be provided in OBOT settings per OAC 317:30-5-9(b)(17).

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

(1) Have a current contract with the OHCA as an OTP provider;
(2) Hold a certification as an OTP from ODMHSAS, unless deemed an exempted entity as defined by federal law;
(3) Hold a certification from the Substance Abuse and Mental Health Services Administration (SAMHSA);
(4) Be appropriately accredited by a SAMHSA-approved accreditation organization;
(5) Be registered with the DEA and the OBNDD; and
(6) Meet all state and federal opioid treatment standards, including all requirements within OAC 450:70.

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

(1) **MAT provider** 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** 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. Treatment requirements for each phase shall include, but not limited to, the following:

(1) During phase I, the member shall participate in a minimum of four (4) sessions of therapy or rehabilitation services per month with at least one (1) session being individual therapy, rehabilitation, or case management.

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

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

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

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

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

(1) **Service plan development.** Service plans shall be completed by an LBHP or licensure candidate. Service plans completed by a licensure candidate must be co-signed and dated by a fully-licensed LBHP.

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

(A) Presenting problems or diagnosis;

(B) Strengths, needs, abilities, and preferences of the member;

(C) Goals for treatment with specific, measurable, attainable, realistic and time-limited;

(D) Type and frequency of services to be provided;

(E) Dated signature of primary service provider;

(F) Description of member's involvement in, and responses to, the service plan and his or her signature and date;

(G) Individualized discharge criteria or maintenance;

(H) Projected length of treatment;

(I) Measurable long and short term treatment goals;

(J) Primary and supportive services to be utilized with the patient;

(K) Type and frequency of therapeutic activities in which patient will participate;

(L) Documentation of the member's participation in the development of the plan; and

(M) Staff who will be responsible for the member's treatment.

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

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

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

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

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

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

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

(iv) Critical incident reports;

(v) Sentinel events; or

(vi) Phase change.

(4) **Service plan timeframes.** Service plans shall be completed by the fourth therapy or rehabilitation service visit after

admission.

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

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

(1) Acute intoxication and/or withdrawal potential;

(2) Biomedical conditions and complications;

(3) Emotional, behavioral or cognitive conditions and complications;

(4) Readiness to change;

(5) Relapse, continued use or continued problem potential; and

(6) Recovery/living environment.

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

(1) Components that are not provided to or exclusively for the treatment of the eligible individual;

(2) Services or components of services of which the basic nature is to supplant housekeeping or basic services for the convenience of a person receiving covered services;

(3) Telephone calls or other electronic contacts (not inclusive of telehealth);

(4) Field trips, social, or physical exercise activity groups; and

(k) **Reimbursement.** In order to 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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**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**
**CHAPTER 2. GRIEVANCE PROCEDURES AND PROCESS**

**317:2-1-2. Appeals**

(a) **Request for appeals.**

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

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

(b) **Member process overview.**

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

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

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

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

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

(6) Upon receipt of the member's appeal, a fair hearing before the ALJ will be scheduled. The member will be notified in writing of the date and time of the hearing. The member must appear at the hearing, either in person or telephonically. Requests for a telephone hearing must be received in writing on

OHCA's LD-4 (Request for Telephonic Hearing) form no later than ten (10) calendar days prior to the scheduled hearing date. Telephonic hearing requests will only be granted by the OHCA's chief executive officer (CEO) or his/her designee, at his/her sole discretion, for good cause shown, including, for example, the member's physical condition, travel distances, or other limitations that either preclude an in-person appearance or would impose a substantial hardship on the member.

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

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

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

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

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

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

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

(c) **Provider process overview.**

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

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

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

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

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

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

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

(1) **Member appeals.**

(A) Discrimination complaints regarding the SoonerCare program;

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

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

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

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

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

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

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

(2) **Provider appeals.**

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

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

(C) Appeals by long-term care facilities for administrative penalty determinations as a result of findings made under OAC 317:30-5-131.2(b)(5)(B) and (d)(8);

(D) Appeals of Professional Service Contract awards and other matters related to the Central Purchasing Act pursuant to Title 74 O.S. § 85.1 et seq.;

(E) Drug rebate appeals;

(F) Provider appeals of OHCA Program Integrity audit findings pursuant to OAC 317:2-1-7. This is the final and only appeals process for appeals of OHCA Program Integrity audit findings;

(G) Oklahoma Electronic Health Records Incentive program appeals related only to incentive payments, incentive payment amounts, provider eligibility determinations, and

demonstration of adopting, implementing, upgrading, and meaningful use eligibility for incentives;

(H) Supplemental Hospital Offset Payment Program (SHOPP) annual assessment, supplemental payment, fees or penalties as specifically provided in OAC 317:2-1-15; and

~~(I) The Nursing Facility Supplemental Payment Program (NFSPP) and its issues consisting of the amount of each component of the intergovernmental transfer, the Upper Payment Limit payment, the Upper Payment Limit gap, and the penalties specifically provided in OAC 317:30-5-136. This is the final and only process for appeals regarding NFSPP; and~~

~~(J)~~(I) Appeals from any adjustment made to a long-term care facility's cost report pursuant to OAC 317:30-5-132, including any appeal following a request for reconsideration made pursuant to OAC 317:30-5-132.1.

**317:2-1-2.5. Expedited appeals**

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

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

(1) Schedule the matter for hearing pursuant to OAC 317:2-1-5. Telephonic hearings may be scheduled as appropriate under the particular facts of the case; and

(2) Issue a preliminary or final decision as expeditiously as possible, but no later than three (3) working days the close of the expedited hearing.

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

(1) Schedule the appeal for hearing within the ordinary timeframe, in accordance with OAC 317:2-1-2(~~a~~b)(8); and

(2) Notify the Appellant of the denial orally or through a written notice as described in OAC 317:35-5-66. If oral notification is provided, the ALJ shall issue a written notification within three (3) calendar days of the denial.

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

(a) The Oklahoma Health Care Authority offers approximately forty (40) different types of administrative appeals. Some of the appeals are appealable to the chief executive officer (CEO) and some are not. The following appeals may be heard by the CEO following the decision of an administrative law judge:

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

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

~~(3) Appeals under 317:2-1-10.~~

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

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

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

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

Suppliers who respond to a solicitation issued and awarded by the Authority pursuant to 74 Oklahoma Statutes (O.S.) § 85.5 (~~T~~N) may protest the award of a contract under such solicitation.

(1) A supplier shall submit written notice to the OHCA Legal Division of a protest of an award of a contract by OHCA within ten (10) business days of contract award. The protest shall state supplier facts and reasons for protest.

(2) The OHCA Legal Division shall review the supplier's protest and contract award documents. Written notice of the decision to sustain or deny the supplier's protest will be sent to the supplier within ten (10) business days of receipt of supplier's written notice.

(3) If the OHCA Legal Division denies the supplier's protest, the supplier may request a hearing to administratively resolve the matter within thirty (30) calendar days of receipt of the written denial by filing a form ~~LD-2~~LD-3 with the Docket Clerk.

(4) The process afforded the supplier will be the process found at Oklahoma Administrative Code 317:2-1-2(c).

(5) The Administrative Law Judge's decision will constitute the final administrative decision of the Oklahoma Health Care Authority.

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

**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**

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

**317:30-5-136.1. Pay-for-Performance (PFP) program**

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

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

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

(1) Decrease percent of high risk/unstageable pressure ulcers for ~~long stay~~long-stay residents.

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

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

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

(d) **Payment.** Payment to long-term care facilities for meeting the metrics will be awarded quarterly. A facility may earn a minimum of ~~$1.25~~one dollar and twenty-five cents ($1.25) per Medicaid patient per day for each qualifying metric. A facility receiving a deficiency of "I" or greater related to a targeted quality measure in the program is disqualified from receiving an award related to that measure for that quarter.

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

(2) **Penalties.** Facilities shall have performance review(s) and provide documentation upon request from OHCA to maintain program compliance. Program payments will be withheld from facilities that fail to submit the requested documentation within fifteen (15) business days of the request.

(3) **Timeframe.** To qualify for program reimbursement by meeting a specific quality measure, facilities are required to provide metric documentation within thirty (30) days after the end of each quarter to the OHCA.

(e) **Appeals.** Facilities can file an appeal with the Quality Review Committee and in accordance, with the grievance procedures found at OAC 317:2-1-2(c) and ~~317:2-1-16.~~317:2-1-17.

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

**SUBCHAPTER 7. EMPLOYMENT SERVICES THROUGH HOME AND COMMUNITY-BASED SERVICES WAIVERS**

**317:40-7-7. Job coaching services**

(a) Job coaching services:

(1) ~~are~~Are pre-planned, documented activities related to the member's identified employment outcomes that include training at the work site and support by provider agency staff who have completed ~~DDSD~~Developmental Disabilities Services (DDS) sanctioned training, per ~~OAC~~Oklahoma Administrative Code (OAC) 340:100-3-38.2;

(2) ~~promote~~Promote the member's capacity to secure and maintain integrated employment at a job of the member's choice paying at or more than minimum wage, or working to achieve minimum wage;

(3) ~~provide~~Provide active participation in paid work. Efforts are made in cooperation with employers to adapt normal work environments to fit the needs of members through the maintenance of an active relationship with the business;

(4) ~~are~~Are available for individual and group placements.

(A) Individual placement is:

(i) ~~one~~One (1) member receiving job coaching services who:

(I) ~~works~~Works in an integrated job setting;

(II) ~~is~~Is paid at or more than minimum wage;

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

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

(V) ~~has~~Has a job description that is specific to the member's work~~; and~~.

(ii) ~~authorized~~Authorized when on-site supports by a certified job coach are provided more than ~~20%~~twenty percent (20%) of the member's compensable work time. Job coaching services rate continues until a member reaches ~~20%~~twenty percent (20%) or less job coach intervention for four (4) consecutive weeks, at which time stabilization services begin~~.~~ and;

(iii) Authorized through remote supports per Health Insurance Portability and Accountability Act (HIPAA) compliant technology, when the Personal Support Team (Team) has an approved remote supports risk assessment.

(B) ~~Group~~Small group placement is~~ two to eight members receiving continuous support in an integrated work site, who may earn less than minimum wage ; and~~:

(i) Two (2) to three (3) members receiving continuous support in an integrated work site who are paid at, or more than, minimum wage; or

(ii) Up to four (4) to five (5) members receiving continuous support in an integrated work site, who may earn less than minimum wage.

(5) ~~are~~Are based on the amount of time for which the member is compensated by the employer, except per OAC 317:40-7-11.

(b) For members in individual placements, the ~~Personal Support Team (Team):~~Team:

(1) ~~evaluates~~Evaluates the need for job coaching services at least annually; and

(2) ~~documents~~Documents a plan for fading job coaching services as the member's independence increases.

(c) When the member receives commensurate compensation, employment goals include, but are not limited to, increasing:

(1) ~~productivity;~~Productivity;

(2) ~~work quality;~~Work quality;

(3) ~~independence;~~Independence;

(4) ~~minimum wage opportunities; and~~Minimum wage opportunities; and

(5) ~~competitive work opportunities.~~Competitive work opportunities.

**317:40-7-15. Service requirements for employment services through Home and Community-Based Services (HCBS) Waivers**

(a) The Oklahoma~~ Department of~~ Human Services ~~(DHS)~~(OKDHS) Developmental Disabilities Services (DDS) case manager, the member, the member's family or, when applicable, the member's legal guardian, and the member's provider develop a preliminary plan of services including the:

(1) ~~site~~Site and amount of the services offered;

(2) ~~types~~Types of services to be delivered; and

(3) ~~expected~~Expected outcomes.

(b) To promote community integration and inclusion, employment services are delivered in non-residential sites.

(1) Employment services through HCBS waivers cannot be reimbursed when those services occur in the residence or property of the member or provider-paid staff, including garages and sheds, whether or not the garage or shed is attached to the home~~ or not~~.

(2) No exceptions to Oklahoma Administrative Code (OAC) 317:40-7-15(b) are authorized except when a home-based business is established and supported through~~ the~~ Oklahoma~~ Department of~~

Rehabilitation Services ~~(OKDRS).~~(DRS). Once ~~OKDRS~~DRS stabilization services end, DDS stabilization services are then utilized.

(c) The service provider is required to notify the DDS case manager in writing when the member:

(1) ~~is~~Is placed in a new job;

(2) ~~loses~~Loses his or her job. A personal support team (Team) meeting must be held when the member loses the job;

(3) ~~experiences~~Experiences significant changes in the community-based or employment schedule; or

(4) ~~is~~Is involved in critical and non-critical incidents per OAC 340:100-3-34.

(d) The provider submits a DHS Provider Progress Report, per OAC 340:100-5-52, for each member receiving services.

(e) The cost of a member's employment services, excluding transportation and state-funded services ~~per OAC 340:100-17-30,~~ cannot exceed ~~$27,000~~limits set forth in OKDHS Appendix D-26, Developmental Disabilities Services Rates Schedule, per Plan of Care (POC) year.

(f) Each member receiving HCBS is supported in opportunities to seek employment and work in competitive integrated settings. When the member is not employed in a competitive integrated job, the Team identifies outcomes, ~~and/or~~ action steps, or both, to create opportunities that move the member toward competitive integrated employment.

(g) Each member receiving residential supports, per OAC 340:100-5-22.1, or group-home services is employed for thirty (30) hours per week or receives a minimum of thirty (30) hours of employment services each week, excluding transportation to and from his or her residence.

(1) Thirty (30) hours of employment service each week may be a combination of community-based services, center-based services, employment training specialist (ETS) intensive training services, stabilization services, or job coaching services. Center-based services cannot exceed fifteen (15) hours per week for members receiving services through the Homeward Bound Waiver.

(2) When the member does not participate in thirty (30) hours per week of employment services, the Team:

(A) ~~documents~~Documents the outcomes and/or action steps to create a pathway that moves toward employment activities;

(B) ~~describes~~Describes a plan to provide a meaningful day in the community; or

(C) ~~increases~~Increases the member's employment activities to thirty (30) hours per week.

(h) Adult members receiving In-Home Supports waiver services can access individual placement in job coaching, stabilization, and

employment training specialist services not to exceed limits specified in OKDHS Appendix D-26, per POC year.

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

**SUBCHAPTER 5. MEMBER SERVICES**

**PART 9. SERVICE PROVISIONS**

**317:40-5-104. ~~Specialized medical supplies~~Medical supplies, equipment, and appliances**

(a) **Applicability.** ~~The rules in this section apply~~This section applies to ~~specialized medical supplies~~medical supplies, equipment, and appliances provided through ~~Home and Community Based Services (HCBS) Waivers~~home and community-based waiver services (HCBS) operated by the Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services ~~Division (DDSD)~~(DDS).

(b) **General information.** ~~Specialized medical supplies~~Medical supplies, equipment, and appliances include supplies specified in the plan of care that enable the member to increase his or her ability to perform activities of daily living. ~~Specialized medical supplies~~Medical supplies, equipment, and appliances include the purchase of ~~ancillary~~additional supplies not available through SoonerCare.

(1) ~~Specialized medical supplies~~Medical supplies, equipment, and appliances ~~must be~~are included in the member's plan, when prescribed by a physician with a SoonerCare contract, and arrangements for this service must be made through the member's case manager. Items reimbursed with ~~Home and Community Based Services (HCBS)~~HCBS funds are in addition to ~~any~~ supplies furnished by SoonerCare.

(2) ~~Specialized medical supplies~~Medical supplies, equipment, and appliances meet the criteria for service necessity ~~given in OAC 340:100-3-33.1~~, per Oklahoma Administrative Code (OAC) 340:100-3-33.1.

(3) All items must meet applicable standards of manufacture, design, and installation.

(4) ~~Specialized medical supplies~~Medical supplies, equipment, and appliance providers must hold a current SoonerCare Durable Medical Equipment (DME) and/or Medical Supplies Provider Agreement with the Oklahoma Health Care Authority, and be registered to do business in Oklahoma or in the state in which they are domiciled. Providers must enter into the agreement giving assurance of ability to provide products and services and agree to the audit and inspection of all records concerning goods and services provided.

(5) ~~Items that can be purchased as specialized~~Specialized medical supplies, equipment, and appliances include:

(A) ~~incontinence~~Incontinence supplies, ~~as described in~~per subsection (b) of this Section;

(B) ~~nutritional~~Nutritional supplements; and

(C) ~~supplies for respirator or ventilator care;~~

~~(D) decubitus care supplies;~~

~~(E) supplies for catheterization; and~~

~~(F) supplies~~Supplies needed for health conditions.

(6) Items that cannot be purchased as~~ specialized~~ medical supplies, equipment, and appliances include:

(A) ~~over the counter~~Over-the-counter medications(s);

(B) ~~personal~~Personal hygiene items;

(C) ~~medicine~~Medicine cups;

(D) ~~items~~Items that are not medically necessary;~~ and~~

(E) ~~prescription~~Prescription medication(s)~~.~~; and

(F) Incontinence wipes not used in conjunction with incontinence briefs or incontinence underwear/pull-ons.

(7) ~~Specialized medical supplies~~Medical supplies, equipment, and appliances must be:

(A) ~~necessary~~Necessary to address a medical condition;

(B) ~~of~~Of direct medical or remedial benefit to the member;

(C) ~~medical~~Medical in nature; and

(D) ~~consistent~~Consistent with accepted health care practice standards and guidelines for the prevention, diagnosis, or treatment of symptoms of illness, disease, or disability.

(c) **Limited coverage.** Items available in limited quantities through~~ specialized~~ medical supplies, equipment, and appliances include:

(1) ~~incontinence~~Incontinence wipes, ~~300~~three-hundred (300) wipes per month;

(2) Thirty-six hundred (3,600) individual non-sterile gloves, ~~as approved by the Team~~per plan year;

(3) Sixty (60) disposable underpads~~, 60 pads~~ per month;~~ and~~

(4) ~~incontinence briefs, 180 briefs per month.~~One-hundred eighty (180) disposable incontinence briefs per month (Adult disposable incontinence briefs are purchased only in accordance with the implementation of elimination guidelines developed by the team);

~~(A) Adult briefs are purchased only in accordance with the implementation of elimination guidelines developed by the Team.~~

~~(B) Exceptions to the requirement for implementation of elimination guidelines may be approved by the DDSD nurse when the member has a medical condition that precludes implementation of elimination guidelines, such as atonic bladder, neurogenic bladder, or following a surgical procedure.~~

(5) One-hundred fifty (150) disposable incontinence

underwear/pull-ons per month (Adult disposable incontinence underwear/pull-ons are purchased only in accordance with the implementation of elimination guidelines developed by the team);

(6) Any combination of disposable incontinence briefs and disposable incontinence underwear/pull-ons that do not exceed one-hundred fifty (150) per month; and

(7) One-hundred fifty (150) disposable liner/shield/guard/pads per month.

(d) **Exceptions.** Exceptions to the requirements of this ~~Section~~section: ~~are explained in this subsection.~~

(1) When a member's Team determines that the member needs medical supplies that:

(A) ~~are~~Are not available through SoonerCare and ~~for which no Health Care Procedure Code~~a healthcare common procedure code ~~exists~~does not exist, the case manager ~~e-mails~~emails pertinent information regarding the member's medical supply need to the Specialized Medical Supplies programs manager ~~responsible for Specialized Medical Supplies~~. The ~~e-mail~~email includes all pertinent information that supports the need for the supply~~,~~ including; but not limited to, quantity and purpose; or

(B) ~~exceed~~Exceed the limits stated in subsection(c) of this Section, the case manager documents the need in the ~~Individual Plan~~individual plan for review and approval, per OAC 340:100-33.

(2) Approval or denial of exception requests is made on a ~~case by case~~case-by-case basis and does not override the general applicability of this ~~Section~~section.

(3) Approval of a ~~specialized medical supplies~~medical supplies, equipment, and appliances exception does not exceed one (1) plan of care year.

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

**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**

**PART 6. INPATIENT PSYCHIATRIC AND SUBSTANCE USE DISORDER SERVICES**

**317:30-5-95. General provisions and eligible providers**

(a) **Eligible settings for inpatient psychiatric services.** The following individuals may receive SoonerCare-reimbursable inpatient psychiatric services in the following eligible settings:

~~(1) Individuals twenty-one (21) to sixty-four (64) years of age may receive SoonerCare-reimbursable inpatient psychiatric and/or chemical dependency/substance use/detoxification services in a psychiatric unit of a general hospital, provided that such hospital is not an IMD.~~

~~(2) Individuals sixty-five (65) years of age or older may receive SoonerCare-reimbursable inpatient psychiatric services in a psychiatric unit of a general hospital, or in a psychiatric hospital.~~

~~(3)~~ (1) Individuals under twenty-one (21) years of age, in accordance with OAC 317:30-5-95.23, may receive SoonerCare-reimbursable inpatient psychiatric services in a psychiatric unit of a general hospital, a psychiatric hospital, or a PRTF~~.~~; and may receive chemical dependency detoxification/withdrawal management services in a psychiatric unit of a general hospital or in a psychiatric hospital.

(2) Individuals ages twenty-one (21) and older may receive SoonerCare-reimbursable inpatient psychiatric and/or chemical dependency detoxification/withdrawal management services in a psychiatric unit of a general hospital or in a psychiatric hospital.

(b) **Psychiatric hospitals and psychiatric units of general hospitals.** To be eligible for payment under this Part, inpatient psychiatric programs must be provided to eligible SoonerCare members in a hospital that:

(1) Is a psychiatric hospital that:

(A) Successfully underwent a State survey to determine whether the hospital meets the requirements for participation in Medicare as a psychiatric hospital per 42 C.F.R. § 482.60; or

(B) Is accredited by a national organization whose psychiatric accrediting program has been approved by CMS; or

(2) Is a general hospital with a psychiatric unit that:

(A) Successfully underwent a State survey to determine whether the hospital meets the requirements for participation in Medicare as a hospital as specified in 42 C.F.R. Part 482; or

(B) Is accredited by a national accrediting organization whose accrediting program has been approved by CMS; and

(3) Meets all applicable federal regulations, including, but not limited to:

(A) Medicare Conditions of Participation for Hospitals (42 C.F.R. Part 482), including special provisions applying to psychiatric hospitals (42 C.F.R. § 482.60-.62);

(B) Medicaid for Individuals Age 65 or over in Institutions for Mental Diseases (42 C.F.R. Part 441, Subpart C);

(C) Inpatient Psychiatric Services for Individuals under Age 21 in Psychiatric Facilities or Programs (42 C.F.R. Part 441, Subpart D); and/or

(D) Utilization Control [42 C.F.R. Part 456, Subpart C (Utilization Control: Hospitals) or Subpart D (Utilization Control: Mental Hospitals)]; and

(4) Is contracted with the OHCA; and

(5) If located within Oklahoma and serving members under eighteen (18) years of age, is appropriately licensed by the Oklahoma Department of Human Services (OKDHS) as a residential child care facility (10 O.S. §§ 401 to 402) that is providing services as a residential treatment facility in accordance with OAC 340:110-3-168.

(c) **PRTF.** Every PRTF must:

(1) Be individually contracted with OHCA as a PRTF;

(2) Meet all of the state and federal participation requirements for SoonerCare reimbursement, including, but not limited to, 42 C.F.R. § 483.354, as well as all requirements in 42 C.F.R. 483 Subpart G governing the use of restraint and seclusion;

(3) Be appropriately licensed by OKDHS as a residential child care facility (10 O.S. § 401 to 402) that is providing services as a residential treatment facility in accordance with OAC 340:110-3-168;

(4) Be appropriately certified by the State Survey Agency, the Oklahoma State Department of Health (OSDH) as meeting Medicare Conditions of Participation; and

(5) Be accredited by TJC, the Council on Accreditation of Rehabilitation Facilities (CARF), or the Council on Accreditation (COA).

(d) **Out-of-state PRTF.** Any out-of-state PRTF must be appropriately licensed and/or certified in the state in which it does business, and must provide an attestation to OHCA that the PRTF is in compliance with the condition of participation for restraint and seclusion, as is required by federal law. Any out-of-state PRTF must also be accredited in conformance with OAC 317:30-5-95(c)(5).

(e) **Required documents.** The required documents for enrollment for each participating provider can be downloaded from the OHCA's website.

**317:30-5-95.1. Medical necessity criteria and coverage for adults**

**aged twenty-one (21) to sixty-four (64)**

(a) **Coverage for adults.** Coverage for adults aged twenty-one (21) to sixty-four (64) is limited to services in a psychiatric unit of a general hospital or in a psychiatric hospital (see ~~Oklahoma Administrative Code (OAC)~~OAC 317:30-5-95). Inpatient psychiatric services must be prior authorized in accordance with OAC 317:30-5-41.1. OHCA rules that apply to inpatient psychiatric coverage for adults aged twenty-one (21) to sixty-four (64) are found in Sections OAC 317:30-5-95.1 through 317:30-5-95.10.

(b) **Medical necessity criteria for admission of adults aged twenty-one (21) to sixty-four (64) for psychiatric disorders.** An inpatient admission of an adult aged twenty-one (21) to sixty-four (64) that is attributable to a psychiatric disorder must meet the terms or conditions contained in (1), (2), (3), (4), one of (5)(A) to (5)(D), and one of (6)(A) to (6)(C) of this subsection.

(1) A primary diagnosis from the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) with the exception of V-codes, adjustment disorders, and substance related disorders, accompanied by a detailed description of the symptoms supporting the diagnosis.

(2) Conditions are directly attributable to a psychiatric disorder as the primary need for professional attention (this does not include placement issues, criminal behavior, and/or status offenses). Adjustment or substance related disorder may be a secondary diagnosis.

(3) It has been determined by the OHCA designated agent that the current disabling symptoms could not have been managed or have not been manageable in a less intensive treatment program.

(4) Adult must be medically stable.

(5) Within the past forty-eight (48) hours, the behaviors present an imminent life-threatening emergency such as evidenced by:

(A) Specifically described suicide attempts, suicidal intent, or serious threat by the patient.

(B) Specifically described patterns of escalating incidents of self-mutilating behaviors.

(C) Specifically described episodes of unprovoked significant physical aggression and patterns of escalating physical aggression in intensity and duration.

(D) Specifically described episodes of incapacitating depression or psychosis that result in an inability to function or care for basic needs.

(6) Requires secure twenty-four (24) hour nursing/medical supervision as evidenced by:

(A) Stabilization of acute psychiatric symptoms.

(B) Needs extensive treatment under physician direction.

(C) Physiological evidence or expectation of withdrawal symptoms which require twenty-four (24) hour medical supervision.

(c) **Medical necessity criteria for admission of adults aged twenty-one (21) to sixty-four (64) for inpatient chemical dependency detoxification/withdrawal management.** An inpatient admission of an adult aged twenty-one (21) to sixty-four (64) for chemical dependency/ substance use/ detoxification must meet the terms and conditions contained in (1), (2), (3), and one of (4)(A) through (D) of this subsection.

(1) Any psychoactive substance dependency disorder described in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) with detailed symptoms supporting the diagnosis and need for medical detoxification, except for cannabis, nicotine, or caffeine dependencies.

(2) Conditions are directly attributable to a substance dependency disorder as the primary need for professional attention (this does not include placement issues, criminal behavior, and/or status offenses).

(3) It has been determined by the OHCA designated agent that the current disabling symptoms could not be managed or have not been manageable in a less intensive treatment program.

(4) Requires secure twenty-four (24) hour nursing/medical supervision as evidenced by:

(A) Need for active and aggressive pharmacological interventions.

(B) Need for stabilization of acute psychiatric symptoms.

(C) Need extensive treatment under physician direction.

(D) Physiological evidence or expectation of withdrawal symptoms which require twenty-four (24) hour medical supervision.

**317:30-5-95.42. Service quality review (SQR) of psychiatric facilities and residential substance use disorder (SUD) facilities**

(a) The ~~service quality review (SQR)~~SQR conducted by the OHCA or its designated agent meets the utilization control requirements as set forth in 42 C.F.R. Part 456.

(b) There will be an SQR of each in-state psychiatric facility and residential SUD facility that provides services to SoonerCare members which will be performed by the OHCA or its designated agent. Out-of-state ~~psychiatric~~ facilities that provide services to SoonerCare members will be reviewed according to the procedures outlined in the Medical Necessity Manual. Ad hoc reviews may be conducted at the discretion of the agency.

(c) The OHCA will designate the members of the SQR team. The SQR team will consist of one (1) to three (3) team members and will be comprised of LBHPs or registered nurses (RNs).

(d) The SQR will include, but not be limited to, review of facility and clinical record documentation ~~as well as~~and may include observation and contact with members. The clinical record review will consist of ~~those~~ records of members ~~present or listed as facility residents at the beginning of the visit~~currently at the

facility as well as records of members ~~on~~for which claims have been filed with OHCA for acute, ~~or~~ PRTF, or residential SUD levels of care. The SQR includes validation of compliance with policy, which must be met for the services to be compensable.

(e) Following the SQR, the SQR team will report its findings in writing to the facility. ~~The facility will be provided with written notification if the findings of the review have resulted in any deficiencies.~~ A copy of the final report will be sent to the facility's accrediting agency, as well as the State Survey Agency, if applicable, and any licensing agencies.

(f) Deficiencies identified during the SQR may result in full or partial recoupment of paid claims. The determination of whether to assess full or partial recoupment shall be at the discretion of the OHCA based on the severity of the deficiencies.

(g) Any days during which the facility is determined to be out of compliance with Federal Conditions of Participation, excluding residential SUD facilities, or in which a member does not meet medical necessity criteria ~~will~~may result in full recoupment. Full recoupment may also result from a facility's failure to provide requested documentation within the timeframes indicated on requests for such documents or if the SQR team is denied timely admittance to a facility and/or access to facility records during ~~the~~any on-site portion of the SQR.

(h) Items which may result in full or partial recoupment of paid claims shall include, but not be limited to:

(1) **Assessments and evaluations.** Assessments and evaluations must be completed, with dated signature(s), by qualified staff within the timeframes outlined in Oklahoma Administrative Code (OAC) 317:30-5-95.6~~ and~~, 317:30-5-95.37~~.~~, and 317:30-5-95.47(1).

(2) **Plan of care.** Plans of care must be completed, with all required dated signatures within the timeframes described in OAC 317:30-5-95.4~~ and~~, 317:30-5-96.33~~.~~, and 317:30-5-95.47(2).

(3) **Certification of need (CON).** CONs for psychiatric facilities must be completed by the appropriate team and in the chart within the timeframes outlined in 42 C.F.R. §§ 441.152, 456.160, and 456.481.

(4) **Active treatment.** Treatment must be documented in the chart at the required frequency by appropriately qualified staff as described in OAC 317:30-5-95.5, 317:30-5-95.7, 317:30-5-95.8, 317:30-5-95.9, 317:30-5-95.10~~ and~~, 317:30-5-95.34~~.~~, and 317:30-5-95.46(b).

(5) **Documentation of services.** Services must be documented in accordance with OAC 317:30-5-95.5, 317:30-5-95.8, 317:30-5-95.10, 317:30-5-95.41, and 317:30-5-95.47 and 42 C.F.R. §§ 412.27(c)(4) and 482.61. Documentation with missing elements or documentation that does not clearly demonstrate the therapeutic appropriateness and benefit of the service may result in recoupment.

(6) **Staffing.** Staffing must meet the ratios described in OAC 317:30-5-95.24(b)-(d) & (h) and OAC 317:30-5-95.38 per unit/per shift; and credentialing requirements as outlined in OAC 317:30-5-95.8, 317:30-5-95.9, 317:30-5-95.35, 317:30-5-95.36, 317:30-5-95.46 (b) and 42 C.F.R. §§ 412.27(d), 441.153, 441.156, and 482.62.

(7) **Restraint/seclusion.** Orders for restraint and seclusion must be completely and thoroughly documented with all required elements as described in OAC 317:30-5-95.39 and 42 C.F.R. § 482.13(e) & (f) and 42 C.F.R. Part 483. Documentation must support the appropriateness and necessity for the use of restraint/seclusion. For PRTFs, documentation must include evidence that staff and resident debriefings occurred as required by OAC 317:30-5-95.39 and 42 C.F.R. Part 483. For residential SUD facilities, restraint may only be used when less restrictive interventions, according to facility policy, have been attempted or when an immediate intervention is required to protect the resident, a staff member, or others. A written incident report must be completed within twenty-four (24) hours following each use of physical restraint.

(i) If the review findings have resulted in a recoupment, the days and/or services involved will be reported in the notification.

(j) In the event that CMS recoups from OHCA an amount that exceeds the provider's liability for findings described in this Section, the provider will not be held harmless and will be required to reimburse OHCA the total federal amount identified by CMS and/or its designated audit contractor, limited to the amount of the original paid claim less any previously recouped amounts.

(k) Penalties of non-compensable days which are the result of the facility's failure to appropriately provide and document the services described herein, or adhere to applicable accreditation, certification, and/or state licensing standards, are not compensable or billable to the member or the member's family.

(l) Facilities that are determined to owe recoupment of paid claims will have the ability to request a reconsideration of the findings. Details and instructions on how to request a reconsideration will be part of the report documentation sent to the facility.

(m) Facilities that are determined by the SQR process to be out of compliance in significant areas will be required to submit a Corrective Action Plan (CAP) detailing steps being taken to bring performance in line with requirements. Facilities that are required to submit a CAP may be further assessed through a formal, targeted post-CAP review process.

**317:30-5-95.43. Residential substance use disorder (SUD) treatment**

(a) **Purpose.** The purpose of sections OAC 317:30-5-95.43 - 317:30-5-95.49 is to establish the procedures and requirements for residential treatment facilities providing SUD treatment services.

(b) **Definitions.** The following words and terms, when used in the

aforementioned sections, shall have the following meanings unless the context clearly indicates otherwise.

(1) **"ASAM"** means the American Society of Addiction Medicine.

(2) **"ASAM criteria"** means the most recent edition of the American Society of Addiction Medicine's published criteria for admission to treatment, continued services, and discharge.

(3) **"ASAM levels of care"** means the different options for treatment as described below and in the current edition of the ASAM criteria that vary according to the intensity of the services offered. Each treatment option is a level of care.

(A) **"ASAM level 3"** means residential and inpatient services and encompasses ASAM levels 3.1, 3.3, 3.5 and 3.7.

(B) **"ASAM level 3.1"** means clinically managed low-intensity residential services for adolescents and adults. This level of care typically provides at least five (5) hours of clinical services a week and provides a twenty-four (24) hour living support and structure with trained personnel. The corresponding service description for this level of care is halfway house services.

(C) **"ASAM level 3.3"** means clinically managed population-specific high-intensity residential services. This level of care is for adults only and typically offers twenty-four (24) hour care with trained personnel and is designed to accommodate individuals with cognitive or other impairments. The corresponding service description for this level of care is residential treatment for adults with co-occurring disorders.

(D) **"ASAM level 3.5"** means clinically managed medium-intensity residential services for adolescents and clinically managed high-intensity residential services for adults. This level of care provides twenty-four (24) hour care and offers a wide range of therapeutic services. The corresponding service descriptions for this level of care are residential treatment and intensive residential treatment.

(E) **"ASAM level 3.7"** means medically monitored high-intensity inpatient services for adolescents and medically monitored intensive inpatient withdrawal management for adults. This level of care provides twenty-four (24) hour nursing care with physician supervision and medication availability. This level of care is appropriate for individuals withdrawing from alcohol or other drugs with subacute biomedical and emotional, behavioral, or cognitive problems severe enough to require inpatient treatment but for whom hospitalization is not necessary. The corresponding service description for this level of care is medically supervised withdrawal management.

(4) **"Care management services"** means an assessment of a member, development of a care plan, and referral and linkage to SUD community supports and community-based or lower level of care services to promote continued recovery after the individual

discharges from the treatment facility.

(5) **"Co-occurring disorder (COD)"** means any combination of mental health symptoms and SUD symptoms or diagnoses that affect a member and are typically determined by the Diagnostic and Statistical Manual of Mental Disorders (DSM).

(6) **"DSM"** means the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association.

(7) **"ODMHSAS"** means the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS).

(8) **"Rehabilitation services"** means face-to-face individual or group services provided by qualified staff to develop skills necessary to perform activities of daily living and successful integration into community life. Rehabilitation services for substance use disorders are also referred to as skill development services.

(9) **"Service plan"** means the document used during the process by which an LBHP or a licensure candidate and the member together and jointly identify and rank problems, establish agreed-upon immediate short-term and long-term goals, and decide on the treatment process and resources to be utilized.

(10) **"Substance use disorder (SUD)"** means alcohol or drug dependence, or psychoactive SUD as defined by the most recent DSM criteria.

(11) **"Therapeutic services"** means professional services during which members engage in identifying, addressing and/or resolving issues identified in the member's service plan.

(12) **"Treatment hours – residential"** means the structured hours in which a member is involved in receiving professional services to assist in achieving recovery.

**317:30-5-95.44. Residential substance use disorder (SUD) - Eligible providers and requirements**

(a) Eligible providers shall:

(1) Have and maintain current certification from the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) as a residential level of care provider of SUD treatment services, unless exempt from state jurisdiction or an exempted entity as defined in Section 3-415 of Title 43A of the Oklahoma Statutes;

(2) Have a contract with the OHCA;

(3) Have a Certificate of Need, if required by ODMHSAS in accordance with OAC 450:18-17-2 or OAC 450:24-27-2.

(4) Have a current accreditation status appropriate to provide residential behavioral health services from:

(A) The Joint Commission; or

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

(C) The Council on Accreditation (COA).

(b) Providers certified by ODMHSAS as a residential level of care

provider of SUD treatment services prior to October 1, 2020 shall have until January 1, 2022 to obtain accreditation as required in (4) above.

(c) Residential treatment facilities providing SUD treatment services to individuals under the age of eighteen (18) must have a residential child care facility license from the Oklahoma Department of Human Services (DHS). Residential treatment facilities providing child care services must have a child care center license from DHS.

**317:30-5-95.45. Residential substance use disorder (SUD) - Coverage by category**

(a) **Adults.** Members age twenty-one (21) to sixty-four (64) who meet eligibility and clinical criteria may receive medically necessary residential treatment for SUD.

(1) The member must meet residential level of care as determined through completion of the designated ASAM level of care tool as required in the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) Prior Authorization Manual.

(2) Each presenting member for SUD treatment shall be assessed, according to ASAM criteria, which includes a list of symptoms for all six (6) dimensions and each level of care to determine a clinically appropriate placement in the least restrictive level of care.

(b) **Children.** Coverage for children is the same as adults.

(c) **Individuals with dependent children.** Coverage for individuals with dependent children is the same as adults and/or children.

**317:30-5-95.46. Residential substance use disorder (SUD) - Covered services and medical necessity criteria**

(a) In order for the services described in this Section to be covered, individuals shall:

(1) Be diagnosed with an SUD as described in the most recent edition of the DSM; and

(2) Meet residential level of care in accordance with the American Society of Addiction Medicine (ASAM) criteria, as determined by the ASAM level of care determination tool designated by the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS).

(3) For additional medical necessity criteria, refer to the ODMHSAS Prior Authorization Manual available at http://www.odmhsas.org/arc.htm.

(b) Coverage includes the following services:

(1) **Clinically managed low intensity residential services (ASAM Level 3.1).**

(A) **Halfway house services – Individuals age thirteen (13) to seventeen (17).**

(i) **Service description.** This service places a major emphasis on continuing SUD care and community ancillary

services in an environment supporting continued abstinence. The facility shall have scheduled services to assess and address the individual needs of each member. Services include individual, family, and/or group therapy, individual and/or group rehabilitation services, care management, crisis intervention, and for members age sixteen (16) and older, community recovery support services. Group therapy is limited to a total of six (6) individuals. Rehabilitation services shall not exceed a staffing ratio of eight (8) individuals to one (1) qualified provider.

(ii) **Staffing requirements.** A licensed physician must be available by telephone twenty-four (24) hours a day, seven (7) days a week. A minimum of two (2) direct care and/or clinical staff must be on-site and awake twenty-four (24) hours a day, seven (7) days a week. Staffing ratios shall not exceed those specified in OAC 340:110-3-153.2. All staff who provide treatment services shall meet qualifications in accordance with the Oklahoma Medicaid State Plan and OAC 450:18.

(iii) **Treatment hours.** A minimum of six (6) treatment hours per week shall be provided. A week begins on Sunday and ends on Saturday.

(B) **Halfway house services – Individuals age eighteen (18) to sixty-four (64).**

(i) **Service description.** This service places a major emphasis on continuing SUD care and community ancillary services in an environment supporting continued abstinence. The facility shall have scheduled services to assess and address the individual needs of each member. Services include individual, family, and/or group therapy, individual and/or group rehabilitation services, care management, crisis intervention, and community recovery support services. Group therapy is limited to a total of eight (8) individuals. Rehabilitation services shall not exceed a staffing ratio of fourteen (14) individuals to one (1) qualified provider.

(ii) **Staffing requirements.** A licensed physician must be available by telephone twenty-four (24) hours a day, seven (7) days a week. Additional clinical and/or direct care staff must be on-site and awake twenty-four (24) hours a day, seven (7) days a week. All staff who provide treatment services shall meet qualifications in accordance with the Oklahoma Medicaid State Plan and OAC 450:18.

(iii) **Treatment hours.** A minimum of six (6) treatment hours per week shall be provided. A week begins on Sunday and ends on Saturday.

(C) **Halfway house services – Individuals with minor dependent children or women who are pregnant.**

(i) **Service description.** This service provides a planned regimen of twenty-four (24) hours, seven (7) days a week, supervised living arrangements, to include professionally directed evaluation, care, and treatment. The facility shall have scheduled services to assess and address the individual needs of each member. Services include individual, family, and/or group therapy, individual and/or group rehabilitation services, care management, crisis intervention, and community recovery support services. Group therapy is limited to a total of eight (8) individuals for adults a total of six (6) individuals for children. Rehabilitation services shall not exceed a staffing ratio of fourteen (14) individuals to one (1) qualified provider for adults and eight (8) individuals to one (1) qualified provider for children.

(ii) **Staffing requirements.** A licensed physician must be available by telephone twenty-four (24) hours a day, seven (7) days a week. Additional clinical and/or direct care staff must be on-site twenty-four (24) hours a day, seven (7) days a week. All staff who provide treatment services shall meet qualifications in accordance with the Oklahoma Medicaid State Plan and OAC 450:18.

(iii) **Treatment services for dependent children.** Services are available to the child when provided to address the impacts related to the parent's addiction, including, but not limited to, individual and family therapy. Compliance with separate provider qualifications, in accordance with OAC 317:30-5-240.2, is required for other treatment services provided to dependent children by the residential SUD provider. Provision of such treatment services shall be provided in accordance with OAC 317:30-5, Part 21.

(iv) **Treatment hours.** A minimum of six (6) treatment hours per week shall be provided to the individual with minor dependent children and women who are pregnant. A week begins on Sunday and ends on Saturday. Dependent children shall be provided treatment services in accordance with the child's service plan if services are provided by the residential SUD provider.

(2) **Clinically managed, population specific, high intensity residential services (ASAM Level 3.3).** This service includes residential treatment for adults with co-occurring disorders.

(A) **Service description.** This service provides a planned regimen of twenty-four (24) hours, seven / (7) days a week, structured evaluation, care, and treatment. Daily treatment service shall be provided to assess and address individual needs of the member. Services include individual, family, and group therapy, individual and/or group rehabilitation services, crisis intervention, care management, and community recovery support services. Psychiatric and/or psychological

and/or mental health evaluations shall be completed on all members. In addition to the requirements in OAC 317:30-5-95.47, the service plan shall address the member's mental health needs and medications. The member's medications shall be re-assessed a minimum of once every thirty (30) days and monitoring of medications shall be provided. Group therapy is limited to a total of eight (8) individuals. Rehabilitation services shall not exceed a staffing ratio of fourteen (14) individuals to one (1) qualified provider. Treatment services must address both mental health and SUD needs as identified in the service plan.

(B) **Staffing requirements.** A licensed psychiatrist must be available by telephone twenty-four (24) hours a day, seven (7) days a week. Additional staff must be on-site twenty-four (24) hours a day, seven (7) days a week. All staff who provide treatment services shall meet qualifications in accordance with the Oklahoma Medicaid State Plan and OAC 450:18.

(C) **Treatment hours.** A weekly minimum of twenty-four (24) service hours shall be provided, which shall include a minimum of one (1) hour of individual, group, or family therapy and a minimum of seven (7) hours of individual or group rehabilitation services. A week begins on Sunday and ends on Saturday. A maximum of seven (7) hours per week of community (peer) recovery support services may count toward the weekly required treatment hours.

(3) **Clinically managed medium and high intensity (ASAM Level 3.5).**

(A) **Residential treatment, medium intensity - individuals age thirteen (13) to seventeen (17).**

(i) **Service description.** This service provides a planned regimen of twenty-four (24) hours / seven (7) day a week, professionally directed evaluation, care, and treatment. A multidisciplinary team approach shall be utilized in providing daily treatment services to assess and address the individual needs of each member, including individual, family, and/or group therapy, individual and/or group rehabilitation services, care management, crisis intervention, and, for members age sixteen (16) or older, community recovery support services. Group therapy is limited to a total of six (6) individuals. Rehabilitation services shall not exceed a staffing ratio of eight (8) individuals to one (1) qualified provider.

(ii) **Staffing requirements.** A licensed physician must be available by telephone twenty-four (24) hours a day, seven (7) days a week. A minimum of two (2) direct care and/or clinical staff must be on-site and awake twenty-four (24) hours a day, seven (7) days a week. Staffing ratios shall not exceed those specified in OAC 340:110-3-153.2. All

staff who provide treatment services shall meet qualifications in accordance with the Oklahoma Medicaid State Plan and OAC 450:18.

(iii) **Treatment hours.** A weekly minimum of fifteen (15) treatment hours for members attending academic training and twenty-four (24) treatment hours for members not attending academic training shall be provided. Weekly treatment hours shall include a minimum of one (1) hour of individual, family and/or group therapy and a minimum of seven (7) hours of individual or group rehabilitation services. A maximum of seven (7) hours per week of community (peer) recovery support services may count toward the weekly required treatment hours. A week begins on Sunday and ends on Saturday.

(B) **Residential treatment, high intensity – adults.**

(i) **Service description.** This service provides a planned regimen of twenty-four (24) hours / seven (7) day a week, professionally directed evaluation, care, and treatment. Daily treatment service shall be provided to assess and address individual needs of each member. Services include individual, family, and/or group therapy, individual and/or group rehabilitation services, crisis intervention, care management, and community recovery support services. Group therapy is limited to a total of eight (8) individuals. Rehabilitation services shall not exceed a staffing ratio of fourteen (14) individuals to one (1) qualified provider.

(ii) **Staffing requirements.** A licensed physician must be available by telephone twenty-four (24) hours a day, seven (7) days a week. Additional clinical and/or direct care staff must be on-site twenty-four (24) hours a day, seven (7) days a week. All staff who provide treatment services shall meet qualifications in accordance with the Oklahoma Medicaid State Plan and OAC 450:18.

(iii) **Treatment hours.** A weekly minimum of twenty-four (24) service hours shall be provided, which shall include a minimum of one (1) hour of individual, family, and/or group therapy and a minimum of seven (7) hours of individual or group rehabilitation services. A maximum of seven (7) hours per week of community (peer) recovery support services may count toward the weekly required treatment hours. A week begins on Sunday and ends on Saturday.

(C) **Intensive residential treatment, high intensity – adults.**

(i) **Service description.** This service provides a planned regimen of twenty-four (24) hours / seven (7) day a week, professionally directed evaluation, care, and treatment. Daily treatment service shall be provided to assess and address individual needs of each member. Services include

individual, family, and/or group therapy, individual and/or group rehabilitation services, crisis intervention, care management, and community recovery support services. Group therapy is limited to a total of eight (8) individuals. Rehabilitation services shall not exceed a staffing ratio of fourteen (14) individuals to one (1) qualified provider.

(ii) **Staffing requirements.** A licensed psychiatrist must be available by telephone twenty-four (24) hours a day, seven (7) days a week. Additional clinical and/or direct care staff must be on-site twenty-four (24) hours a day, seven (7) days a week. All staff who provide treatment services shall meet qualifications in accordance with the Oklahoma Medicaid State Plan and OAC 450:18.

(iii) **Treatment hours.** A weekly minimum of thirty-seven (37) service hours shall be provided, which shall include a minimum of four (4) hours of individual, family, and/or group therapy and a minimum of seven (7) hours of individual or group rehabilitation services. A maximum of eleven (11) hours per week of community (peer) recovery support services may count toward the weekly required treatment hours. A week begins on Sunday and ends on Saturday.

(D) **Intensive residential treatment, high intensity – individuals age thirteen (13) to seventeen (17).**

(i) **Service description.** This service provides a planned regimen of twenty-four (24) hours / seven (7) day a week, professionally directed evaluation, care, and treatment. Daily treatment service shall be provided to assess and address individual needs of each member. Services include individual, family, and/or therapy, individual and/or group rehabilitation services, crisis intervention, care management, and, for members age sixteen (16) or older, community recovery support services. Group therapy is limited to a total of six (6) individuals. Rehabilitation services shall not exceed a staffing ratio of eight (8) individuals to one (1) qualified provider.

(ii) **Staffing requirements.** A licensed psychiatrist must be available by telephone twenty-four (24) hours a day, seven (7) days a week. Additional clinical and/or direct care staff must be on-site twenty-four (24) hours a day, seven (7) days a week. Staffing ratios shall not exceed those specified in OAC 340:110-3-153.2. All staff who provide treatment services shall meet qualifications in accordance with the Oklahoma Medicaid State Plan and OAC 450:18.

(iii) **Treatment hours.** A weekly minimum of thirty-seven (37) service hours shall be provided, which shall include a minimum of four (4) hours of individual, family, or

group therapy and a minimum of seven (7) hours of individual or group rehabilitation services. A maximum of eleven (11) hours per week of community (peer) recovery support services may count toward the weekly required treatment hours. A week begins on Sunday and ends on Saturday.

(E) **Residential treatment for individuals with minor dependent children and women who are pregnant.**

(i) **Service description.** This service provides a planned regimen of twenty-four (24) hours / seven (7) day a week, professionally directed evaluation, care, and treatment. The facility shall provide SUD treatment services to assess and address individual needs of each member. Services include individual, family, and/or group therapy, individual and/or group rehabilitation services, crisis intervention, care management, and community recovery support services. Group therapy is limited to a total of eight (8) individuals for adults a total of six (6) individuals for children. Rehabilitation services shall not exceed a staffing ratio of fourteen (14) individuals to one (1) qualified provider for adults and eight (8) individuals to one (1) qualified provider for children.

(ii) **Staffing requirements.** A licensed physician must be available by telephone twenty-four (24) hours a day, seven (7) days a week. Additional staff must be on-site twenty-four (24) hours a day, seven (7) days a week. All staff who provide treatment services shall meet qualifications in accordance with the Oklahoma Medicaid State Plan and OAC 450:18.

(iii) **Treatment services for dependent children.** Services are available to the child when provided to address the impacts related to the parent's addiction, including but not limited to individual and family therapy. Compliance with separate provider qualifications, in accordance with OAC 317:30-5-240.2, is required for other treatment services provided to dependent children by the residential SUD provider. Provision of such treatment services shall be provided in accordance with OAC 317:30-5, Part 21.

(iv) **Treatment hours.** A minimum of twenty-four (24) service hours shall be provided to the individual with minor dependent children and women who are pregnant. Treatment hours shall include a minimum of one (1) hour of individual, family, and/or group therapy and a minimum of seven (7) hours of individual or group rehabilitation services. A maximum of seven (7) hours per week of community (peer) recovery support services may count toward the weekly required treatment hours. A week begins on Sunday and ends on Saturday. Dependent children shall be provided treatment services in accordance with the

child's service plan if services are provided by the residential SUD provider.

(F) **Intensive residential treatment for individuals with dependent children and women who are pregnant.**

(i) **Service description.** This service provides a planned regimen of twenty-four (24) hours / seven (7) day a week, professionally directed evaluation, care, and treatment. The facility shall provide SUD treatment services to assess and address individual needs of each member. Services include individual, family, and/or group therapy, individual and/or group rehabilitation services, crisis intervention, care management, and community recovery support services. Group therapy is limited to a total of eight (8) individuals for adults a total of six (6) individuals for children. Rehabilitation services shall not exceed a staffing ratio of fourteen (14) individuals to one (1) qualified provider for adults and eight (8) individuals to one (1) qualified provider for children.

(ii) **Staffing requirements.** A licensed psychiatrist must be available by telephone twenty-four (24) hours a day, seven (7) days a week. Additional clinical and/or direct care staff must be on-site twenty-four (24) hours a day, seven (7) days a week. All staff who provide treatment services shall meet qualifications in accordance with the Oklahoma Medicaid State Plan and OAC 450:18.

(iii) **Treatment services for dependent children.** Services are available to the child when provided to address the impacts related to the parent's addiction, including but not limited to individual and family therapy. Compliance with separate provider qualifications, in accordance with OAC 317:30-5-240.2, is required for other treatment services provided to dependent children by the residential SUD provider. Provision of such treatment services shall be provided in accordance with OAC 317:30-5, Part 21.

(iv) **Treatment hours.** A weekly minimum of thirty-five (35) service hours shall be provided to the individual with minor dependent children and women who are pregnant. Treatment hours shall include a minimum of four (4) hours of individual, family, and/or group therapy and a minimum of seven (7) hours of individual and/or group rehabilitation services. A maximum of eleven (11) hours per week of community (peer) recovery support services may count toward the weekly required treatment hours. A week begins on Sunday and ends on Saturday. Dependent children shall be provided treatment services in accordance with the child's service plan if services are provided by the residential SUD provider.

(4) **Medically monitored high intensity withdrawal management (ASAM Level 3.7).**

(A) **Medically supervised withdrawal management – individuals age thirteen (13) to seventeen (17).**

(i) **Service description and requirements.** This service is provided under the direction of a licensed physician and a licensed registered nurse supervisor, for members who are withdrawing or are intoxicated from alcohol or other drugs. Members shall be assessed as currently experiencing no apparent medical or neurological symptoms that would require hospitalization. Daily SUD withdrawal management treatment services shall be provided, which include, but are not limited to, taking of vital signs (temperature, pulse, respiration rate, blood pressure), documentation of fluid and food intake a minimum of one (1) time every six (6) hours or more often as indicated by the member's condition. Medications shall be prescribed if needed during withdrawal management. The medications are to include those needed for physical health issues and mental impairment if acquired during the withdrawal process.

(ii) **Staffing requirements.** A licensed physician providing supervision of withdrawal management must be available on site or on call twenty-four (24) hours a day, seven (7) days a week. A licensed nurse must provide twenty-four (24) hours a day, seven (7) days a week monitoring and statutorily approved personnel administer medication. A minimum of two (2) medical and/or clinical/direct care staff must be on-site and awake twenty-four (24) hours a day, seven (7) days a week. Staffing ratios shall not exceed those specified in OAC 340:110-3-153.2.

(B) **Medically supervised withdrawal management – adults.**

(i) **Service description and requirements.** This service is provided under the direction of a licensed physician and a licensed registered nurse supervisor, for members who are withdrawing or are intoxicated from alcohol or other drugs. Members shall be assessed as currently experiencing no apparent medical or neurological symptoms that would require hospitalization. Daily SUD withdrawal management treatment services shall be provided, which include, but are not limited to, taking of vital signs (temperature, pulse, respiration rate, blood pressure), documentation of fluid and food intake a minimum of one (1) time every six (6) hours or more often as indicated by the member's condition. Medications prescribed if needed during withdrawal management. The medications are to include those needed for physical health issues and mental impairment if acquired during the withdrawal process.

(ii) **Staffing requirements.** A licensed physician providing supervision of withdrawal management must be available on site or on call twenty-four (24) hours a day, seven (7) days a week. A licensed nurse must provide twenty-four

(24) hours a day, seven (7) days a week monitoring and statutorily approved personnel administer medication.

**317:30-5-95.47. Residential substance use disorder (SUD) - Individualized service plan requirements**

All SUD services provided in residential treatment facilities are rendered as a result of an individual assessment of the member's needs and documented in the service plan.

(1) **Assessment.** A biopsychosocial assessment shall be completed for members receiving ASAM Level 3.1, 3.3, or 3.5 services, including dependent children receiving services from the residential SUD provider, to gather sufficient information to assist the member in developing an individualized service plan. The assessment must also list the member's past and current psychiatric medications. The assessment must be completed by an LBHP or licensure candidate. Licensure candidate signatures must be co-signed by a fully-licensed LBHP in good standing. Assessments for ASAM Level 3.7 services shall be completed in accordance with (E) below.

(A) **Assessments for adolescents.** A biopsychosocial assessment using the Teen Addiction Severity Index (T-ASI) shall be completed. A physical examination shall be conducted by a licensed physician to include, at a minimum, a physical assessment, health history, immunization status, and evaluation of motor development and function, speech, hearing, visual, and language functioning.

(B) **Assessments for adults.** A biopsychosocial assessment using the Addiction Severity Index (ASI) shall be completed.

(C) **Assessments for dependent children.** In accordance with OAC 450:18-7-25, assessments of children (including infants) accompanying their parent into treatment and receiving services from the residential SUD provider shall include the following items:

(i) Parent-child relationship;
(ii) Physical and psychological development;
(iii) Educational needs;
(iv) Parent related issues; and
(v) Family issues related to the child.

(D) **Assessments for parents/pregnant women.** In accordance with OAC 450:18-7-25, assessments of the parent and/or pregnant women bringing their children into treatment shall include the following items:

(i) Parenting skills;
(ii) Knowledge of age appropriate behaviors;
(iii) Parental coping skills;
(iv) Personal issues related to parenting; and
(v) Family issues as related to the child.

(E) **Assessments for medically supervised withdrawal management.** In accordance with OAC 450:18-13-61, a medical

assessment for the appropriateness of placement shall be completed and documented by a licensed physician during the admission process.

(F) **Assessment timeframes.** Biopsychosocial assessments shall be completed within two (2) days of admission or during the admission process for medically supervised withdrawal management.

(2) **Service plan.** Pursuant to OAC 450:18-7-81, a service plan shall be completed for each member receiving ASAM Level 3.1, 3.3, or 3.5 services, including dependent children receiving services from the residential SUD provider. The service plan is performed with the active participation of the member and a support person or advocate, if requested by the member. In the case of children under the age of sixteen (16), it is performed with the participation of the parent or guardian, if allowed by law, and the child as age and developmentally appropriate. Service plans for ASAM Level 3.7 services shall be developed in accordance with (D) below.

(A) **Service plan development.** The service plan shall:

(i) Be completed by an LBHP or licensure candidate. Licensure candidate signatures must be co-signed by a fully-licensed LBHP in good standing.

(ii) Provide the formation of measurable service objectives and reflect ongoing changes in goals and objectives based upon member's progress or preference or the identification of new needs, challenges, and problems.

(iii) Be developed after and based on information obtained in the assessment and includes the evaluation of the assessment information by the clinician and the member.

(iv) Have an overall general focus on recovery which, for adults, may include goals like employment, independent living, volunteer work, or training, and for children, may include areas like school and educational concerns and assisting the family in caring for the child in the least restrictive level of care.

(B) **Service plan content.** Service plans must include dated signatures for the member [if over fourteen (14)], the parent/guardian [if under sixteen (16) and allowed by law], and the primary service practitioner. Signatures must be obtained after the service plan is completed. The contents of a service plan shall address the following:

(i) Member strengths, needs, abilities, and preferences;

(ii) Identified presenting challenges, needs, and diagnosis;

(iii) Goals for treatment with specific, measurable, attainable, realistic, and time-limited objectives;

(iv) Type and frequency of services to be provided;

(v) Description of member's involvement in, and response to, the service plan;

(vi) The service provider who will be rendering the services identified in the service plan; and

(vii) Discharge criteria that are individualized for each member and beyond that which may be stated in the ASAM criteria.

(C) **Service plan updates.** Service plan updates shall occur a minimum of once every thirty (30) days while services are provided. Service plan updates must include dated signatures for the member [if over fourteen (14)], the parent/guardian [if under sixteen (16) and allowed by law], and the LBHP and licensure candidate. Licensure candidate signatures must be co-signed by a fully-licensed LBHP in good standing. Signatures must be obtained after the service plan is completed. Service plan updates shall address the following:

(i) Progress on previous service plan goals and/or objectives;

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

(iii) Change in goals and/or objectives based upon member's progress or identification of new needs and challenges;

(iv) Change in frequency and/or type of services provided;

(v) Change in staff who will be responsible for providing services on the plan; and

(vi) Change in discharge criteria.

(D) **Service plans for medically supervised withdrawal management.** Pursuant to OAC 450:18-7-84, a service plan shall be completed for each member receiving ASAM Level 3.7 services that addresses the medical stabilization treatment and services needs of the member. Service plans shall be completed by a licensed physician or licensed registered nursing staff.

(E) **Service plan timeframes.** Service plans shall be completed within four (4) days of admission, except for service plans for individuals receiving medically supervised withdrawal management services, which must be completed within three (3) hours of admission.

(3) **Progress notes.** Progress notes shall chronologically describe the services provided, the member's response to the services provided, and the member's progress in treatment.

(A) **Content.** Progress notes shall address the following:

(i) Date;

(ii) Member's name;

(iii) Start and stop time for each timed treatment session or service;

(iv) Signature of the service provider;

(v) Credentials of the service provider;

(vi) Specific service plan needs, goals and/or objectives addressed;

(vii) Services provided to address needs, goals, and/or objectives;
(vii) Progress or barriers to progress made in treatment as it relates to the goals and/or objectives;
(ix) Member (and family, when applicable) response to the session or service provided; and
(x) Any new needs, goals and/or objectives identified during the session or service.

(B) **Frequency.** Progress notes shall be completed in accordance with the following timeframes:
(i) Progress notes for therapy, crisis intervention and care management must be documented in an individual note and reflect the content of each session provided.
(ii) Documentation for rehabilitation and community recovery support services must include daily member sign-in/sign-out record of member attendance (including date, time, type of service and service focus), and a daily progress note or a summary progress note weekly.

(4) **Transition/discharge planning.** All facilities shall assess each member for appropriateness of discharge from a treatment program. Each member shall be assessed using ASAM criteria to determine a clinically appropriate placement in the least restrictive level of care.

(A) **Transition/discharge plans.** Transition/discharge plans shall be developed with the knowledge and cooperation of the member. The transition/discharge plan shall be included in the discharge summary. The discharge plan is to include, at a minimum, recommendations for continued treatment services and other appropriate community resources. Appointments for outpatient therapy and other services, as applicable, should be scheduled prior to discharge from residential care. Development of the transition/discharge plan shall begin no later than two (2) weeks after admission.

(B) **Discharge summary.** The discharge summary shall document the member's progress made in treatment and response to services rendered. A completed discharge summary shall be entered in each member's record within fifteen (15) days of the member completing, transferring, or discontinuing services. The summary must be signed and dated by the staff member completing the summary.

**317:30-5-95.48. Staff training**

(a) All clinical and direct care staff shall have non-physical intervention training in techniques and philosophies addressing appropriate non-violent interventions for potentially physical interpersonal conflicts, staff attitudes which promote dignity and enhanced self-esteem, keys to effective communication skills, verbal and non-verbal interaction and non-violent intervention within thirty (30) days of being hired with updates each calendar

year thereafter.
(b) All staff shall receive training in accordance with OAC 450:18-9-3(f).

**317:30-5-95.49. Medication policies and records**
(a) The facility shall have policies in place addressing the safe storage, handling, and administration of medications.
(b) Medication records shall be maintained in accordance with OAC 450:18-7-144.

**317:30-5-95.50. Residential substance use disorder (SUD) - Reimbursement**
(a) In order to be eligible for payment, residential treatment providers of SUD treatment services must have an approved provider agreement on file with the OHCA. Through this agreement, the residential provider assures that they are in compliance with all applicable federal and State Medicaid law and regulations, including, but not limited to, OHCA administrative rules, ODMHSAS administrative rules, and the Oklahoma Medicaid State Plan.
(b) Covered SUD treatment services for adolescents and adults in SUD residential treatment shall be reimbursed utilizing the per diem rates for each level of care. All SUD residential treatment services must be prior authorized by the OHCA or its designated agent before the service is rendered by an eligible provider. Without prior authorization, payment is not authorized.
(c) Covered SUD treatment services for adolescents and adults in SUD residential treatment shall be reimbursed utilizing the per diem rates for each level of care. Separate payment may be made for medications, physician services, and treatment services provided to dependent children in accordance with the Oklahoma Medicaid State Plan. Separate payment for such services will follow existing prior authorization requirements, if applicable.
(d) Treatment services for dependent children accompanying a parent to treatment shall be reimbursed on a fee-for-service basis in accordance with the Oklahoma Medicaid State Plan. Outpatient services rendered to dependent children may be provided by the residential facility if appropriately certified or a separate outpatient provider. Such services shall not duplicate any services provided by the residential provider that are reimbursed through the residential per dime rate.
(e) The following services are excluded from coverage/reimbursement:
(1) Room and board;
(2) Services or components that are not provided to or exclusively for the treatment of the member;
(3) Services or components of services of which the basic nature is to supplant housekeeping or basic services for the convenience of a member receiving covered services;
(4) Physician directed services and medications (these services

are reimbursed outside of the residential SUD per diem);
(5) Telephone calls or other electronic contacts (not inclusive of telehealth); and
(6) Field trips, social, or physical exercise activity groups.

**317:30-5-96.3. Methods of payment**

(a) **Reimbursement.**

(1) Covered inpatient psychiatric ~~and/or substance use disorder~~chemical dependency detoxification/withdrawal management services will be reimbursed using one (1) of the following methodologies:

(A) Diagnosis related group (DRG);

(B) Cost-based; or

(C) A predetermined per diem payment.

(2) ~~For members twenty-one (21) to sixty-four (64) years of age, payment shall not be made to any inpatient psychiatric facility that qualifies as an IMD, except as provided by OAC 317:30-5-95.23 and 317:30-5-95.11.~~For members twenty-one (21) to sixty-four (64) years of age, payment shall not be made for any inpatient psychiatric episodes over sixty (60) days in a facility that qualifies as an IMD.

(b) **Levels of care.**

(1) **Acute.**

(A) Payment will be made to psychiatric units within general medical surgical hospitals and critical access hospitals utilizing a DRG methodology. [See OAC 317:30-5-41]. Psychiatric professional (physicians and psychologists) services provided in conjunction with the inpatient stay are separately payable from the DRG paid to the hospital;

(B) Payment will be made to psychiatric hospitals utilizing a predetermined statewide per diem payment for all facility services provided during the inpatient stay. Psychiatric professional (physicians and psychologists) services provided in conjunction with the inpatient stay are separately payable from the per diem paid to the hospital. Rates vary for public and private providers.

(2) **Acute II.**

(A) Payment will be made to in-state psychiatric hospitals or inpatient psychiatric programs utilizing a predetermined all-inclusive per diem payment for routine, ancillary, and professional services.

(B) Public facilities will be reimbursed using either the statewide or facility-specific interim rates and settled to total allowable costs as determined by analyses of the cost reports (Form CMS 2552) filed with the OHCA.

(3) **PRTFs.**

(A) A pre-determined per diem payment will be made to private PRTFs with sixteen (16) beds or less for routine services. All other services are separately billable.

(B) A predetermined all-inclusive per diem payment will be made for routine, ancillary, and professional services to private facilities with more than sixteen (16) beds.

(C) Public facilities will be reimbursed using either the statewide or facility-specific interim rates and settled to total allowable costs as determined by analyses of the cost reports (Form CMS 2552) filed with the OHCA.

(c) **Out-of-state services.**

(1) **Border and "border status" placements.** Facilities are reimbursed in the same manner as in-state hospitals or PRTFs. Refer to OAC 317:30-3-90 and 317:30-3-91.

(2) **Out-of-state placements.** In the event comparable services cannot be purchased from an Oklahoma facility and the current payment levels are insufficient to obtain access for the member, the OHCA may negotiate a predetermined, all-inclusive per diem rate for specialty programs/units. An incremental payment adjustment may be made for one (1): one (1) staffing (if clinically appropriate and prior authorized). Payment may be up to, but no greater, than usual and customary charges. The one (1): one (1) staffing adjustment is limited to sixty (60) days annually. Refer to OAC 317:30-3-90 and 317:30-3-91.

(d) **Add-on payments.**

(1) Additional payment shall only be made for services that have been prior authorized by OHCA or its designee and determined to be medically necessary. For medical necessity criteria applicable for the add-on payment(s), refer to the SoonerCare Medical Necessity Criteria Manual for Inpatient Behavioral Health Services found on the OHCA website.

(2) SoonerCare shall provide additional payment for the following services rendered in an Acute II and PRTF, as per the Oklahoma Medicaid State Plan.

(A) **Intensive treatment services (ITS) add-on.** Payment shall be made for members requiring intensive staffing supports.

(B) **Prospective complexity add-on.** Payment shall be made to recognize the increased cost of serving members with a mental health diagnosis complicated with non-verbal communication.

(C) **Specialty add-on.** Payment shall be made to recognize the increased cost of serving members with complex needs.

(e) **Services provided under arrangement.**

~~(1) **Health home transitioning services.**~~

~~(A) Services for the provision of comprehensive transitional care to existing members are considered to be inpatient psychiatric services, when services exceed and do not duplicate ordinary inpatient discharge planning during the last thirty (30) days of a covered acute or residential stay.~~

~~(B) Payment for health home transitioning services provided under arrangement with the inpatient provider will be directly reimbursed to the health home outside of the facility's per diem or DRG rate.~~

~~(2)~~ (1) **Case management transitioning services.**

(A) Services for the provision of case management transitioning services to existing members are considered to be inpatient psychiatric services, when services exceed and do not duplicate ordinary inpatient discharge planning during the last thirty (30) days of a covered acute or residential stay.

(B) Payment for case management transitioning services provided under arrangement with the inpatient provider will be directly reimbursed to a qualified community-based provider.

~~(3)~~ (2) **Evaluation and psychological testing by a licensed psychologist.**

(A) Services for the provision of evaluation and psychological testing by a licensed psychologist to existing members are considered to be inpatient psychiatric services, when services exceed and do not duplicate ordinary inpatient discharge planning during the last thirty (30) days of a covered acute or residential stay.

(B) Payment for evaluation and psychological testing by a licensed psychologist for services provided under arrangement with the inpatient provider will be directly reimbursed to a qualified provider in accordance with the Oklahoma Medicaid State Plan.

## PART 21. OUTPATIENT BEHAVIORAL HEALTH AGENCY SERVICES

### 317:30-5-241.6. Behavioral health targeted case management

Payment is made for behavioral health targeted case management services as set forth in this Section. The limitations set forth in this Section do not apply to case management provided in programs and service delivery models which are not reimbursed for case management on a fee-for-service basis.

(1) **Description of behavioral health case management services.** Behavioral health case management services are provided to assist eligible individuals in gaining access to needed medical, social, educational and other services essential to meeting basic human needs. Services under behavioral health targeted case management are not comparable in amount, duration and scope. The target groups for behavioral health case management services are persons under age twenty-one (21) who are in imminent risk of out-of-home placement for psychiatric or substance abuse reasons or are in out-of-home placement due to psychiatric or substance abuse reasons, and chronically and/or severely mentally ill adults who are institutionalized or are at risk of institutionalization. All behavioral health case management services will be authorized based on established medical necessity criteria.

(A) The behavioral health case manager provides assessment of

case management needs, development of a case management care plan, referral, linkage, monitoring and advocacy on behalf of the member to gain access to appropriate community resources. The behavioral health case manager must monitor the progress in gaining access to services and continued appropriate utilization of necessary community resources. Behavioral case management is designed to promote recovery, maintain community tenure, and to assist individuals in accessing services for themselves following the case management guidelines established by ODMHSAS. In order to be compensable, the service must be performed utilizing the Strengths Based model of case management. This model of case management assists individuals in identifying and securing the range of resources, both environmental and personal, needed to live in a normally interdependent way in the community. The focus for the helping process is on strengths, interests, abilities, knowledge and capacities of each person, not on their diagnosis, weakness or deficits. The relationship between the service member and the behavioral health case manager is characterized by mutuality, collaboration, and partnership. Assistive activities are designed to occur primarily in the community, but may take place in the behavioral health case manager's office, if more appropriate.

(B) The provider will coordinate transition services with the member and family (if applicable) by phone or face to face, to identify immediate needs for return to home/community no more than seventy-two (72) hours after notification that the member/family requests case management services. For members discharging from a higher level of care than outpatient, the higher level of care facility is responsible for scheduling an appointment with a case management agency for transition and post discharge services. The case manager will make contact with the member and family (if applicable) for transition from the higher level of care other than outpatient back to the community, within seventy-two (72) hours of discharge, and then conduct a follow-up appointment/contact within seven (7) days. The case manager will provide linkage/referral to physicians/medication services, psychotherapy services, rehabilitation and/or support services as described in the case management service plan.

(C) Case managers may also provide crisis diversion (unanticipated, unscheduled situation requiring supportive assistance, face to face or telephone, to resolve immediate problems before they become overwhelming and severely impair the individual's ability to function or maintain in the community) to assist member(s) from progression to a higher level of care. During the follow-up phase of these referrals or links, the behavioral health case manager will provide

aggressive outreach if appointments or contacts are missed within two (2) business days of the missed appointments. Community/home based case management to assess the needs for services will be scheduled as reflected in the case management service plan, but not less than one (1) time per month. The member/parent/guardian has the right to refuse behavioral health case management and cannot be restricted from other services because of a refusal of behavioral health case management services.

(D) An eligible member/parent/guardian will not be restricted and will have the freedom to choose a behavioral health case management provider as well as providers of other medical care.

(E) In order to ensure that behavioral health case management services appropriately meet the needs of the member and family and are not duplicated, behavioral health case management activities will be provided in accordance with an individualized plan of care.

(F) The individual plan of care must include general goals and objectives pertinent to the overall recovery of the member's (and family, if applicable) needs. Progress notes must relate to the individual plan of care and describe the specific activities to be performed. The individual plan of care must be developed with participation by, as well as, reviewed and signed by the member, the parent or guardian [if the member is under eighteen (18)], the behavioral health case manager, and an LBHP or licensure candidate as defined in OAC 317:30-5-240.3(a) and (b).

(G) SoonerCare reimbursable behavioral health case management services include the following:

(i) Gathering necessary psychological, educational, medical, and social information for the purpose of individual plan of care development.

(ii) Face-to-face meetings with the member and/or the parent/guardian/family member for the implementation of activities delineated in the individual plan of care.

(iii) Face-to-face meetings with treatment or service providers, necessary for the implementation of activities delineated in the individual plan of care.

(iv) Supportive activities such as ~~non face-to-face~~non-face-to-face communication with the member and/or parent/guardian/family member.

(v) Non face-to-face communication with treatment or service providers necessary for the implementation of activities delineated in the individual plan of care.

(vi) Monitoring of the individual plan of care to reassess goals and objectives and assess progress and or barriers to progress.

(vii) Crisis diversion (unanticipated, unscheduled situation requiring supportive assistance, face to face or

telephone, to resolve immediate problems before they become overwhelming and severely impair the individual's ability to function or maintain in the community) to assist member(s) from progression to a higher level of care.

(viii) Behavioral health targeted case management is available to individuals transitioning from institutions to the community [except ~~individuals ages twenty-two (22) to sixty-four (64) who reside in an IMD or~~ individuals who are inmates of public institutions]. Individuals are considered to be transitioning to the community during the last thirty (30) consecutive days of a covered institutional stay. This time is to distinguish case management services that are not within the scope of the institution's discharge planning activities from case management required for transitioning individuals with complex, chronic, medical needs to the community. Transition services provided while the individual is in the institution are to be claimed as delivered on the day of discharge from the institution.

(2) **Levels of case management.**

(A) Standard case management/resource coordination services are targeted to adults with serious mental illness or children with serious emotional disturbance, or who have or are at-risk for mental disorders, including substance use disorders (SUD), and their families, who need assistance in accessing, coordination, and monitoring of resources and services. Services are provided to assess an individual's strengths and meet needs in order to achieve stability in the community. Standard case managers have caseloads of thirty (30) to thirty-five (35) members. Standard case management/resource coordination is limited to twelve (12) units per member per month. Additional units may be authorized up to twenty-five (25) units per member per month if medical necessity criteria for transitional case management are met.

(B) Intensive case management (ICM) is targeted to adults with serious and persistent mental illness in PACT programs. To ensure that these intense needs are met, caseloads are limited to between ten (10) to fifteen (15) members. The ICM shall: be a certified behavioral health case manager II; have a minimum of two (2) years' behavioral health case management experience; have crisis diversion experience; have attended the ODMHSAS six (6) hour ICM training and be available twenty-four (24) hours a day. ICM is limited to fifty-four (54) units per member per month.

(C) Wraparound facilitation case management (WFCM) is targeted to children with significant mental health conditions being treated in a System of Care (SOC) Network

who are deemed at imminent risk of out-of-home placement due to psychiatric or SUD reasons and in need of more intensive case management services. It is designed to ensure access to community agencies, services, and people whose functions are to provide the support, training and assistance required for a stable, safe, and healthy community life, and decreased need for higher levels of care. To produce a high fidelity wraparound process, a facilitator can facilitate between eight (8) and ten (10) families. Staff providing WFCM must meet the requirements for the SOC/WFCM. WFCM is limited to fifty-four (54) units per member per month.

(3) **Excluded services.** SoonerCare reimbursable behavioral health case management does not include the following activities:

(A) Physically escorting or transporting a member or family to scheduled appointments or staying with the member during an appointment;

(B) Managing finances;

(C) Providing specific services such as shopping or paying bills;

(D) Delivering bus tickets, food stamps, money, etc.;

(E) Counseling, rehabilitative services, psychiatric assessment, or discharge planning;

(F) Filling out forms, applications, etc., on behalf of the member when the member is not present;

(G) Filling out SoonerCare forms, applications, etc.;

(H) Mentoring or tutoring;

(I) Provision of behavioral health case management services to the same family by two (2) separate behavioral health case management agencies;

(J) Non-face-to-face time spent preparing the assessment document and the service plan paperwork;

(K) Monitoring financial goals;

(L) Leaving voice or text messages for clients and other failed communication attempts.

(4) **Excluded individuals.** The following SoonerCare members who are receiving similar services through another method are not eligible for behavioral health case management services without special arrangements with the Oklahoma Department of Human Services (OKDHS), OJA, OHCA or ODMHSAS as applicable, in order to avoid duplication in payment. Services/programs include, but may not be limited to:

(A) Members/families (when applicable) for whom at-risk case management services are available through OKDHS and OJA staff;

(B) Members in out-of-home placement and receiving targeted case management services through staff in a foster care or group home setting, unless transitioning into the community;

(C) Residents of ICF/IIDs and nursing facilities unless

transitioning into the community;
(D) Members receiving targeted case management services under a Home and Community Based Services (HCBS) waiver program;
~~(E) Members receiving services in the health home program;~~
~~(F)~~ (E) Members receiving case management through the ADvantage waiver program;
~~(G)~~ (F) Members receiving targeted case management available through a Certified Community Behavioral Health Center (CCBHC);
~~(H)~~ (G) Members receiving case management services through Programs of All-Inclusive Care for the Elderly (PACE); ~~or~~
~~(I)~~ (H) Members receiving Early Intervention case management (EICM);
~~(J)~~ (I) Members receiving case management services through certified school-based targeted case management (SBTCM) providers;
~~(K)~~ (J) Members receiving partial hospitalization services; or
~~(L)~~ (K) Members receiving MST.

(5) **Filing requirements.** Case management services provided to Medicare eligible members should be filed directly with the fiscal agent.

(6) **Documentation requirements.** The service plan must include general goals and objectives pertinent to the overall recovery needs of the member. Progress notes must relate to the service plan and describe the specific activities performed. Behavioral health case management service plan development is compensable time if the time is spent communicating with the member and it must be reviewed and signed by the member, the behavioral health case manager, and an LBHP or licensure candidate as defined at OAC 317:30-5-240.3(a) and (b). All behavioral health case management services rendered must be reflected by documentation in the records. In addition to a complete behavioral health case management service, plan documentation of each session must include but is not limited to:

(A) Date;
(B) Person(s) to whom services are rendered;
(C) Start and stop times for each service;
(D) Original signature or the service provider [original signatures for faxed items must be added to the clinical file within thirty (30) days];
(E) Credentials of the service provider;
(F) Specific service plan needs, goals, and/or objectives addressed;
(G) Specific activities performed by the behavioral health case manager on behalf of the member related to advocacy, linkage, referral, or monitoring used to address needs, goals, and/or objectives;
(H) Progress and barriers made towards goals, and/or objectives;

(I) Member/family (when applicable) response to the service;
(J) Any new service plan needs, goals, and/or objectives identified during the service; and
(K) Member satisfaction with staff intervention.

(7) **Case management travel time.** The rate for case management services assumes that the case manager will spend some amount of time traveling to the member for the face-to-face service. The case manager must only bill for the actual face-to-face time that they spend with the member and not bill for travel time. This would be considered duplicative billing since the rate assumes the travel component already.

## PART 24. CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS

### 317:30-5-268. Limitations

(a) The following are non-billable opportunities for CCBHCs serving eligible members:

(1) Employment services;
(2) Personal care services;
(3) Childcare
(4) Respite services; and
(5) Care coordination.

(b) The following SoonerCare members are not eligible for CCBHC services:

~~(1) Members receiving care in an IM);~~
~~(2)~~ (1) Members residing in a nursing facility or ICF/IID;
~~(3)~~ (2) Inmates of a public correctional institution; and
~~(4)~~ (3) SoonerCare members being served by a PACE provider.

~~(c) SoonerCare members receiving services from a CCBHC are not eligible for enrollment in a SoonerCare behavioral health home.~~

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

**SUBCHAPTER 3. GENERAL PROVIDER POLICIES**

**PART 6. OUT-OF-STATE SERVICES**

**317:30-3-90. Out-of-state services**

(a) Consistent with Section 431.52 of Title 42 of the Code of Federal Regulations (C.F.R.), an eligible SoonerCare member who is a resident of Oklahoma but who is temporarily out of state, may receive services from an out-of-state provider to the same extent that he or she would receive such services in Oklahoma, if:

(1) Medical services are needed for a medical emergency, as determined by the attending physician or other provider (M.D., D.O., P.A., or A.P.R.N). For any provider, who is not contracted at the time the services are provided, documentation as requested from the Oklahoma Health Care Authority (OHCA) of the emergency must be submitted, including, but not limited to, emergency room reports, medical histories, discharge summaries, and all other relevant medical reports.

(2) Medical services are needed and the member's health would be endangered if he or she were required to return to Oklahoma for medical care and treatment, as determined by the attending physician or other provider (M.D., D.O., P.A., or A.P.R.N). For any provider, who is not contracted at the time the services are provided, documentation of the nature and possible extent of the endangerment must be submitted as requested from the OHCA.

(3) The Oklahoma Health Care Authority's (OHCA) Chief Medical Officer (CMO), or his or her designee, determines, on the basis of medical advice, that the needed medical services, or necessary supplemental resources, are more readily available in the state where the member is located at the time of needing medical treatment. Prior authorization must be obtained from the OHCA's CMO, or his or her designee, before the services are rendered; or

(4) The customary or general practice for members residing in a particular locality within Oklahoma is to use medical resources in another state, and the member is using a provider that is contracted with the OHCA.

(A) Except for out-of-state inpatient psychiatric services, no prior authorization is necessary for services provided in accordance with paragraph (a)(4), above, if the member obtains them from an out-of-state provider that is:

(i) Located in a border state (Arkansas, Colorado, Kansas, Missouri, New Mexico, or Texas) within fifty (50) miles of the Oklahoma border; and

(ii) Contracted with the OHCA;

(iii) Provided, however, that nothing in this paragraph shall be interpreted to eliminate or otherwise affect a prior authorization requirement established by any other OHCA rule, including, but not limited to, Oklahoma Administrative Code (OAC) 317:30-3-31, that would have to be met if the health care-related good and/or service were provided in Oklahoma.

(B) In all other instances, prior authorization must be obtained from the OHCA's CMO, or his or her designee, before the services are rendered.

(b) Except as provided in subsections (a)(1),(a)(2) and (a)(4)(A), above, SoonerCare will not pay for any services furnished by an out-of-state provider unless prior authorization has been obtained from the OHCA's CMO, or his or her designee, before the services are rendered. Prior authorization must be obtained in all instances in which the member is located in Oklahoma at the time the services are determined to be medically necessary.

(1) As part of this authorization process, the following documents must be submitted to the OHCA's CMO, or his or her designee:

(A) Documents sufficient to establish the "medical necessity" of the services requested, as that term is defined by OAC 317:30-3-1(f). See also OAC 317:30-3-31, Prior authorization for health care-related goods and services. Examples of such documents may include, but are not limited to, Histories of Present Illnesses (HPIs), physical exams, laboratory reports, imaging reports, progress notes, hospital charts, and/or other relevant medical records; and

(B) Documents sufficient to establish that the health care needs of the member cannot be met in Oklahoma. Such documents shall include, but not be limited to, a letter from the referring provider that contains:

(i) A clear presentation of the member's medical condition and diagnosis for which out-of-state treatment is requested, including a summary of treatment to date that is supported by the documents in paragraph (b)(1)(A), above;

(ii) Names of physicians and/or facilities in Oklahoma that the member has previously been referred to for diagnosis and/or treatment;

(iii) Physicians consulted by the attending physician relative to diagnosis and/or availability of recommended treatment in Oklahoma;

(iv) Recommended treatment or further diagnostic work; and

(v) Reasons why medical care cannot be provided in Oklahoma or the next closest location outside Oklahoma.

(C) Except for emergency medical or behavioral health cases, prior authorization requests for out-of-state services must be made in writing with all the necessary documents that show medical necessity and details of the services provided, including but not limited to, relevant medical history, description of services and procedures to be performed, Histories of Present Illnesses (HPIs), physical exams, laboratory reports, imaging reports, and received by the OHCA at least ten (10) calendar days prior to the date services are to be provided in another state or at the discretion of the CMO or his/her designee.

(i) Emergency medical or behavioral health cases must be identified as such by the physician or provider in the prior authorization request.

(ii) Any telephone request for prior authorization of out-of-state services will only be accepted in emergency situations, and must be promptly followed by a written request.

(2) Prior authorization requirements for medically necessary lodging, transportation, and/or meals assistance associated with out-of-state services are established in other OHCA rules, including, but not limited to, OAC 317:30-3-92~~,~~ and 317:30-5-327.1~~, and 317:35-3-2~~.

(c) The restrictions established in subsections (a) through (b), above, shall not apply to children who reside outside Oklahoma and for whom the Oklahoma Department of Human Services makes Title IV-E adoption assistance payments or Title IV-E foster care maintenance payments.

(d) Denials of requests for prior authorization may be appealed in accordance with OAC 317:2-1-2(d)(1)(C).

(e) Out-of-state providers shall, upon request by authorized OHCA representatives, make available fiscal and medical records as required by applicable federal regulations, OHCA rules, and the Provider Agreement. Such records shall be made available for review by authorized OHCA representatives at the OHCA's address in Oklahoma City, Oklahoma.

**317:30-3-91. Reimbursement of services rendered by out-of-state providers**

(a) Before an out-of-state provider can receive reimbursement, it shall contract with SoonerCare and be subject to enrollment, including, but not limited to, providing information requested by the Oklahoma Health Care Authority (OHCA) such as name, address,

Social Security Number or Tax Identification Number, and verification of licensure and insurance. Out-of-state providers are also subject to the same screening rules, policies, and procedures as in-state providers, including, but not limited to Oklahoma Administrative Code (OAC) 317:30-3-2, and 317:30-3-19.3 through 317:30-3-19.4. Once the OHCA approves enrollment, the provider will receive a SoonerCare provider number that will allow claims to be processed.

(b) While the member's physician may suggest where the member be sent, the OHCA's Chief Medical Officer (CMO), or his or her designee, is responsible for making the final determination based on the most cost effective institution and treatment consistent with the recognized standards of care. Reimbursement for services rendered by out-of-state providers shall be as follows:

(1) Reimbursement for inpatient hospital services shall be made in accordance with OAC 317:30-5-47.

(2) Reimbursement for outpatient hospital services shall be made in accordance with OAC 317:30-5-42.14 and 317:30-5-566.

(3) Reimbursement for physician services shall be the lower of the SoonerCare maximum allowable fee as of the date the service was rendered, available at www.okhca.org (SoonerCare Fee Schedules), or the provider's actual charge. Exceptions to the above reimbursement method are payments for outpatient clinical diagnostic laboratory tests performed by a physician or independent laboratory. These tests will be reimbursed at the lower of the provider's actual charge or a rate of reimbursement equal to the rate paid by Medicare.

(4) Unless authorized by the Oklahoma State Plan, any reimbursement shall not exceed the rate paid by Medicare.

(c) The OHCA may negotiate a higher reimbursement rate for an out-of-state service that is prior authorized, provided that:

(1) The service is not available in Oklahoma; and

(2) The negotiated reimbursement does not exceed the rate paid by Medicare, unless as authorized by the Oklahoma State Plan. Services not covered by Medicare but covered by SoonerCare may be reimbursed as determined by the OHCA.

(d) Individual cases which are adversely affected by these reimbursement procedures may be presented to the OHCA's CMO, or his or her designee, for consideration as an exception to this rule on a case-by-case basis. The CMO's decision, or that of his or her designee, shall be the agency's final decision and is not otherwise appealable under these rules.

(e) Reimbursement of medically necessary lodging, transportation, and/or meals assistance associated with out-of-state services is governed by other OHCA rules, including, but not limited to, OAC 317:30-3-92~~,~~ and 317:30-5-327.1~~, and 317:35-3-2~~, as well as Part 31 of OAC 317:30-5.

## SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

## PART 1. PHYSICIANS

**317:30-5-22.1. Enhanced services for medically high risk pregnancies**

(a) **Enhanced services.** Enhanced services are available for pregnant women eligible for SoonerCare and are in addition to services for uncomplicated maternity cases. Women deemed high risk based on criteria established by the Oklahoma Health Care Authority (OHCA) must receive prior authorization for medically necessary enhanced benefits which include:

(1) Prenatal at risk antepartum management;

(2) A combined maximum of five (5) fetal non stress test(s) and biophysical profiles (additional units can be prior authorized for multiple fetuses)with one (1) test per week beginning at thirty-two (32) weeks gestation and continuing to thirty-eight (38) weeks; and

(3) A maximum of three (3) follow-up ultrasounds not covered under ~~OAC~~Oklahoma Adminisrative Code (OAC) 317:30-5-22(b)(2).

(b) **Prior authorization.** To receive enhanced services, the following documentation must be received by the OHCA Medical Authorization Unit for review and approval:

(1) A comprehensive prenatal assessment from the American College of Obstetricians and Gynecologist (ACOG) or other comparable comprehensive prenatal assessment; and

(2) Appropriate documentation supporting medical necessity from a board eligible/board certified Maternal Fetal Medicine (MFM) specialist, a board eligible/board certified Obstetrician-Gynecologist (OB-GYN), or a board eligible/board certified Family Practice Physician who has completed an Accreditation Council for Graduate Medical Education (ACGME) approved residency. The medical residency program must include appropriate obstetric training, and the physician must be credentialed by the hospital at which they provide obstetrical services in order to perform such services. The documentation must include information identifying and detailing the qualifying high risk condition. Non-MFM obstetrical providers requesting enhanced services are limited to a specific set of diagnoses as outlined on the OHCA website (www.okhca.org).

(c) **Reimbursement.** When prior authorized, enhanced benefits will be reimbursed as follows:

(1) Antepartum management for high risk is reimbursed to the primary obstetrical provider. If the primary provider of obstetrical care is not the MFM and wishes to request

authorization of the antepartum management fee, the treatment plan must be signed by the primary provider of OB care. Additionally, reimbursement for enhanced at risk antepartum management is not made during an in-patient hospital stay.
(2) Non stress tests, biophysical profiles and ultrasounds [in addition to those covered under OAC ~~317:30-5-22(a)(2) subparagraphs (A) through (C)~~317:30-5-22 (b)(2) (A) through (C)] are reimbursed when prior authorized.
(3) Reimbursement for enhanced at risk antepartum management is not available to physicians who already qualify for enhanced reimbursement as state employed physicians.

## PART 9. LONG-TERM CARE FACILITIES

### 317:30-5-131.2. Quality of care fund requirements and report

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

(1) **"Annualize"** means that the calculations, including, for example, total patient days, gross revenue, or contractual allowances and discounts, is divided by the total number of applicable days in the relevant time period.

(2) **"Direct-Care Staff"** means any nursing or therapy staff who provides direct, hands-on care to residents in a nursing facility and intermediate care facility for individuals with intellectual disabilities pursuant to Section 1-1925.2 of Title 63 of the Oklahoma Statutes, pursuant to OAC 310:675-1 et seq., and as defined in subsection (c) of this Section.

(3) **"Major Fraction Thereof"** means an additional threshold for direct-care-staff-to-resident ratios at which another direct-care staff person(s) is required due to the peak in-house resident count exceeding one-half of the minimum direct-care-staff-to-resident ratio pursuant to Section 1-1925.2 of Title 63 of the Oklahoma Statutes.

(4) **"Nursing Facility and Intermediate Care Facility for Individuals with Intellectual Disabilities"** means any home, establishment, or institution or any portion thereof, licensed by the Oklahoma State Department of Health (OSDH) as defined in Section 1-1902 of Title 63 of the Oklahoma Statutes.

(5) **"Peak In-House Resident Count"** means the maximum number of in-house residents at any point in time during the applicable shift.

(6) **"Quality of Care Fee"** means the fee assessment created for the purpose of quality care enhancements pursuant to Section 2002 of Title 56 of the Oklahoma Statutes upon each nursing facility and intermediate care facility for individuals with intellectual disabilities licensed in this state.

(7) **"Quality of Care Fund"** means a revolving fund established in the State Treasury pursuant to Section 2002 of Title 56 of the Oklahoma Statutes.

(8) **"Quality of Care Report"** means the monthly report developed by the Oklahoma Health Care Authority (OHCA) to document the staffing ratios, total patient gross receipts, total patient days, and minimum wage compliance for specified staff for each nursing facility and intermediate care facility for individuals with intellectual disabilities licensed in the state.

(9) **"Service Rate"** means the minimum direct-care-staff-to-resident rate pursuant to Section 1-1925.2 of Title 63 of Oklahoma Statutes and pursuant to OAC 310:675-1 et seq.

(10) **"Staff Hours Worked by Shift"** means the number of hours worked during the applicable shift by direct-care staff.

(11) **"Staffing Ratios"** means the minimum direct-care-staff-to-resident ratios pursuant to Section 1-1925.2 of Title 63 of the Oklahoma Statutes and pursuant to OAC 310:675-1 et seq.

(12) **"Total Gross Receipts"** means all cash received in the current Quality of Care Report month for services rendered to all residents in the facility. Receipts should include all Medicaid, Medicare, private pay, and insurance including receipts for items not in the normal per diem rate. Charitable contributions received by the nursing facility are not included.

(13) **"Total Patient Days"** means the monthly patient days that are compensable for the current monthly Quality of Care Report.

(b) **Quality of care fund assessments.**

(1) The OHCA was mandated by the Oklahoma Legislature to assess a monthly service fee to each licensed nursing facility in the state. The fee is assessed on a per patient day basis. The amount of the fee is uniform for each facility type. The fee is determined as six percent (6%) of the average total gross receipts divided by the total days for each facility type.

(2) Annually, the Nursing Facilities Quality of Care Fee shall be determined by using the daily patient census and patient gross receipts report received by the OHCA for the most recent available twelve months and annualizing those figures. Also, the fee will be monitored to never surpass the federal maximum.

(3) The fee is authorized through the Medicaid State Plan and by the Centers for Medicare and Medicaid Services regarding waiver of uniformity requirements related to the fee.

(4) Monthly reports of Gross Receipts and Census are included in the monthly Quality of Care Report. The data required includes, but is not limited to, the Total Gross Receipts and Total Patient Days for the current monthly report.

(5) The method of collection is as follows:

(A) The OHCA assesses each facility monthly based on the reported patient days from the Quality of Care Report filed two months prior to the month of the fee assessment billing. As defined in this subsection, the total assessment is the fee times the total days of service. The OHCA notifies the facility of its assessment by the end of the month of the Quality of Care Report submission date.

(B) Payment is due to the OHCA by the 15th of the following month. Failure to pay the amount by the 15th or failure to have the payment mailing postmarked by the 13th will result in a debt to the State of Oklahoma and is subject to penalties of 10 percent (10%) of the amount and interest of 1.25 percent (1.25%) per month. The Quality of Care Fee must be submitted no later than the 15th of the month. If the 15th falls upon a holiday or weekend (Saturday-Sunday), the fee is due by 5 p.m., Central Standard Time (CST), of the following business day (Monday-Friday).

(C) The monthly assessment, including applicable penalties and interest, must be paid regardless of any appeals action requested by the facility. If a provider fails to pay the OHCA the assessment within the time frames noted on the second invoice to the provider, the assessment, applicable penalty, and interest will be deducted from the facility's payment. Any change in payment amount resulting from an appeals decision will be adjusted in future payments. Adjustments to prior months' reported amounts for gross receipts or patient days may be made by filing an amended part C of the Quality of Care Report.

(D) The Quality of Care fee assessments excluding penalties and interest are an allowable cost for OHCA cost reporting purposes.

(E) The Quality of Care fund, which contains assessments collected including penalties and interest as described in this subsection and any interest attributable to investment of any money in the fund, must be deposited in a revolving fund established in the State Treasury. The funds will be used pursuant to Section 2002 of Title 56 of the Oklahoma Statutes.

(c) **Quality of care direct-care-staff-to resident-ratios.**

(1) All nursing facilities and intermediate care facilities for individuals with intellectual disabilities (ICFs/IID) subject to the Nursing Home Care Act, in addition to other state and federal staffing requirements, must maintain the minimum direct-care-staff-to-resident ratios or direct-care service rates as cited in Section 1-1925.2 of Title 63 of the Oklahoma Statutes and pursuant to OAC 310:675-1 et seq.

(2) For purposes of staff-to-resident ratios, direct-care staff are limited to the following employee positions:

(A) Registered Nurse;

(B) Licensed Practical Nurse;

(C) Nurse Aide;

(D) Certified Medication Aide;

(E) Qualified Intellectual Disability Professional (ICFs/IID only);

(F) Physical Therapist;

(G) Occupational Therapist;

(H) Respiratory Therapist;

(I) Speech Therapist; and

(J) Therapy Aide/Assistant.

(3) The hours of direct care rendered by persons filling non-direct care positions may be used when those persons are certified and rendering direct care in the positions listed in OAC 317:30-5-131.2(c)(2) when documented in the records and time sheets of the facility.

(4) In any shift when the direct-care-staff-to-resident ratio computation results in a major fraction thereof, direct-care staff is rounded to the next higher whole number.

(5) To document and report compliance with the provisions of this subsection, nursing facilities and ICFs/IID must submit the monthly Quality of Care Report pursuant to subsection (e) of this Section.

(d) **Quality of care reports.** All nursing facilities and intermediate care facilities for individuals with intellectual disabilities must submit a monthly report developed by the OHCA, the Quality of Care Report, for the purposes of documenting the extent to which such facilities are compliant with the minimum direct-care-staff-to-resident ratios or direct-care service rates.

(1) The monthly report must be signed by the preparer and by the owner, authorized corporate officer, or administrator of the facility for verification and attestation that the reports were compiled in accordance with this section.

(2) The owner or authorized corporate officer of the facility must retain full accountability for the report's accuracy and completeness regardless of report submission method.

(3) Penalties for false statements or misrepresentation made by or on behalf of the provider are provided at 42 U.S.C. Section 1320a-7b.

(4) The Quality of Care Report must be submitted by 5 p.m. (CST) on the 15th of the following month. If the 15th falls upon a holiday or a weekend (Saturday-Sunday), the report is due by 5 p.m. (CST) of the following business day (Monday - Friday).

(5) The Quality of Care Report will be made available in an electronic version for uniform submission of the required data elements.
(6) Facilities must submit the monthly report through the OHCA Provider Portal.
(7) Should a facility discover an error in its submitted report for the previous month only, the facility must provide to the Long-term Care Financial Management Unit written notification with adequate, objective, and substantive documentation within five business days following the submission deadline. Any documentation received after the five business day period will not be considered in determining compliance and for reporting purposes by the OHCA.
(8) An initial administrative penalty of $150.00 is imposed upon the facility for incomplete, unauthorized, or non-timely filing of the Quality of Care Report. Additionally, a daily administrative penalty will begin upon the OHCA notifying the facility in writing that the report was not complete or not timely submitted as required. The $150.00 daily administrative penalty accrues for each calendar day after the date the notification is received. The penalties are deducted from the Medicaid facility's payment. For 100 percent (100%) private pay facilities, the penalty amount(s) is included and collected in the fee assessment billings process. Imposed penalties for incomplete reports or non-timely filing are not considered for OHCA cost reporting purposes.
(9) The Quality of Care Report includes, but is not limited to, information pertaining to the necessary reporting requirements in order to determine the facility's compliance with subsections (b) and (c) of this Section. Such reported information includes, but is not limited to: total gross receipts, patient days, available bed days, direct care hours, Medicare days, Medicaid days, number of employees, monthly resident census, and tenure of certified nursing assistants, nurses, directors of nursing, and administrators.
(10) Audits may be performed to determine compliance pursuant to subsections (b), and (c) of this Section. Announced/unannounced on-site audits of reported information may also be performed.
(11) Direct-care-staff-to-resident information and on-site audit findings pursuant to subsection (c), will be reported to the OSDH for their review in order to determine "willful" non-compliance and assess penalties accordingly pursuant to Title 63 Section 1-1912 through Section 1-1917 of the Oklahoma Statutes. The OSHD informs the OHCA of all final penalties as required in order to deduct from the Medicaid facility's

payment. Imposed penalties are not considered for OHCA Cost Reporting purposes.

~~(12) If a Medicaid provider is found non-compliant pursuant to subsection (d) based upon a desk audit and/or an on-site audit, for each hour paid to specified staff that does not meet the regulatory minimum wage of $6.65, the facility must reimburse the employee(s) retroactively to meet the regulatory wage for hours worked. Additionally, an administrative penalty of $25.00 is imposed for each non-compliant staff hour worked. For Medicaid facilities, a deduction is made to their payment. Imposed penalties for non-compliance with minimum wage requirements are not considered for OHCA cost reporting purposes.~~

~~(13)~~(12) Under OAC 317:2-1-2, long-term care facility providers may appeal the administrative penalty described in (b)(5)(B) and ~~(e)(8) and (e)(12)~~(d)(8) of this section.

~~(14)~~(13) Facilities that have been authorized by the OSDH to implement flexible staff scheduling must comply with OAC 310:675-1 et seq. The authorized facility is required to complete the flexible staff scheduling section of Part A of the Quality of Care Report. The owner, authorized corporate officer, or administrator of the facility must complete the flexible staff scheduling signature block, acknowledging their OSDH authorization for flexible staff scheduling.

## PART 18. GENETIC COUNSELORS

### 317:30-5-221. Coverage

(a) Genetic counseling services are covered for SoonerCare members who meet the criteria for receiving medically necessary genetic testing as set forth in ~~317:30-5-2(a)(1)(GG)~~317:30-5-2 (a)(1)(FF) and for pregnant/postpartum SoonerCare members as set forth in this section. Services for pregnant/postpartum SoonerCare members must be referred by a provider involved in the provision of obstetric or pediatric care. Members are eligible for genetic counseling during pregnancy which includes ~~60~~sixty (60) days postpartum. Reasons for genetic counseling include but are not limited to the following:

(1) ~~advanced~~Advanced maternal age;

(2) ~~abnormal~~Abnormal maternal serum first or second screening;

(3) ~~previous~~Previous child or current fetus/infant with an abnormality;

(4) ~~consanguinity/incest;~~Consanguinity/incest;

(5) ~~parent~~Parent is a known carrier or has a family history of a genetic condition;

(6) ~~parent~~Parent was exposed to a known or suspected reproductive hazard;

(7) ~~previous~~Previous fetal demise, stillbirth, or neonatal death involving known/suspected abnormalities;
(8) ~~history~~History of recurrent pregnancy loss; or
(9) ~~parent(s)~~Parent(s) are in an ethnic or racial group associated with an increased risk for specific genetic conditions.

(b) These services may be provided in an office or outpatient setting.

## PART 23. PODIATRISTS

### 317:30-5-261. Coverage by category

Payment is made to podiatrists as set forth in this Section:

(1) **Adults.** Payment is made for medically necessary surgical procedures, x-rays, and outpatient visits. Procedures which are generally considered as preventative foot care, i.e. cutting or removal of corns, warts, callouses, or nails, are not covered unless the diagnoses on the claim, i.e. diabetes, multiple sclerosis, cerebral vascular accident, peripheral vascular disease establishes the medical necessity for the service. The patient must be under the active care of a doctor of medicine or osteopathy who documents the condition. All services must be medically appropriate and related to systemic disease for which foot care is viewed as preventative in nature. Nursing home visits must be ordered by the attending physician. The nursing home record must contain appropriate documentation that the visit was not performed for screening purposes. A specific foot ailment, symptom or complaint must be documented. In instances where the examination is performed in response to specific symptoms or complaints which suggests the need for care, the visit is compensable regardless of the resulting diagnosis. All outpatient visits are subject to existing visit limitations.

(2) **Children.** Coverage of podiatric services for children is the same as for adults. Refer to OAC ~~317:30-3-57(a)(20)~~317:30-3-57 (13) for additional coverage under the Early and Periodic Screening, Diagnosis and Treatment Program.

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

## PART 73. EARLY INTERVENTION SERVICES

### 317:30-5-641.1. Periodic and interperiodic screening examination

~~Refer to OAC 317:30-3-55.~~Refer to Oklahoma Administrative Code 317:30-3-65 through 317:30-3-65.12.

## PART 103. QUALIFIED SCHOOLS AS PROVIDERS OF HEALTH-RELATED SERVICES

### 317:30-5-1020. General provisions

(a) School-based services are medically necessary health-related and rehabilitative services that are provided by a qualified school provider to a student under the age of ~~21~~twenty-one (21) pursuant to an Individualized Education Program (IEP), in accordance with the Individuals with Disabilities Education Act (IDEA). Payment is made to qualified school providers for delivery of school-based services, provided that such services are, among other things, medically necessary and sufficiently supported by medical records and/or other documentation, as explained below.

(b) An IEP and all relevant supporting documentation, including, but not limited to, the documentation required by ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-5-1020(c), below, serves as the plan of care for consideration of reimbursement for school-based services. The plan of care must contain, among other things, the signatures, including credentials, of the provider(s) and the direct care staff delivering services under the supervision of the professional; as well as a complete, signed, and current IEP which clearly establishes the type, frequency, and duration of the service(s) to be provided, the specific place of services if other than the school (e.g., field trip, home), and measurable goals for each of the identified needs. Goals must be updated to reflect the current therapy, evaluation, or service that is being provided and billed to SoonerCare.

(1) Except for those services, referenced in ~~Oklahoma Administrative Code (OAC)~~OAC 317:30-5-1023(b)(~~4~~2)(H), a plan of care that meets the requirements of OAC 317:30-5-1020(b), above, shall serve as a prior medical authorization for the purpose of providing medically necessary and appropriate school-based services to students.

(2) For the purposes of occupational therapy services, and services for members with speech, hearing, and language disorders, a plan of care that meets the requirements of OAC 317:30-5-1020(b), above, may also, in accordance with sections (§§) 725.2(H) and 888.4(C) of Title 59 of the Oklahoma Statutes (O.S.) serve as a valid prescription or referral for an initial evaluation and any subsequent services, as is required by Title 42 of Code of Federal Regulations (C.F.R.), § 440.110.

(3) Physical therapy services, by contrast, shall require a signed and dated prescription from the student's physician prior to that student's initial evaluation, in accordance with OAC 317:30-5-291(1). Prescriptions for school-based physical therapy must be reauthorized at least annually, and documented

within Oklahoma State Department of Education's (OSDE) online IEP system, as set forth in subsection (c), below.

(c) Qualified school providers must ensure that adequate documentation is maintained within the OSDE online IEP system in order to substantiate that all school-based services billed to SoonerCare are medically necessary and comply with applicable state and federal Medicaid law. Such documentation shall include, among other things:

(1) Documentation establishing sufficient notification to a member's parents and receipt of adequate, written consent from them, prior to accessing a member's or parent's public benefits or insurance for the first time, and annually thereafter, in accordance with 34 C.F.R. § 300.154;

(2) Any referral or prescription that is required by state or federal law for the provision of school-based services, or for the payment thereof, in whole or in part, from public funds, including, but not limited to, 42 C.F.R. § 440.110. However, any prescription or referral ordered by a physician or other licensed practitioner of the healing arts who has, or whose immediate family member has, a financial interest in the delivery of the underlying service in violation of Section 1395nn, Title 42 of United States Code shall not be valid, and services provided thereto shall not be eligible for reimbursement by the Oklahoma Health Care Authority (OHCA);

(3) An annual evaluation located in or attached to the IEP that clearly demonstrates, by means of the member's diagnosis and any other relevant supporting information, that school-based services are medically necessary, in accordance with OAC 317:30-3-1(f). Evaluations completed solely for educational purposes are not compensable. Evaluations must be completed annually and updated to accurately reflect the student's current status. Any evaluation for medically necessary school-based services, including but not limited to, hearing and speech services, physical therapy, occupational therapy, and psychological therapy, must include the following information:

(A) Documentation that supports why the member was referred for evaluation;

(B) A diagnosis that clearly establishes and supports the need for school-based services;

(C) A summary of the member's strengths, needs, and interests;

(D) The recommended interventions for identified needs, including outcomes and goals;

(E) The recommended units and frequency of services; and

(F) A dated signature and the credentials of the professional completing the evaluation; and

(4) Documentation that establishes the medical necessity of the school-based services being provided between annual evaluations, including, for example, professional notes or updates, reports, and/or assessments that are signed, dated, and credentialed by the rendering practitioner.

(d) All claims related to school-based services that are submitted to OHCA for reimbursement must include any numeric identifier obtained from OSDE.

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

**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**

**PART 6. INPATIENT PSYCHIATRIC SERVICES AND SUBSTANCE USE DISORDER SERVICES**

**317:30-5-95.24. Prior authorization of inpatient psychiatric services for individuals under twenty-one (21)**

(a) All inpatient psychiatric services for members under twenty-one (21) years of age must be prior authorized by the OHCA or its designated agent. All inpatient Acute, Acute II, and PRTF services will be prior authorized for an approved length of stay. Admission requirements for services must be provided in accordance with 42 C.F.R. Part 441 and 456. Additional information will be required for SoonerCare-compensable approval on enhanced treatment units or in special population programs.

(b) Unit staffing ratios shall always meet the requirements in OAC 317:30-5-95.24 (c), (d) ~~and~~, (h) and (i). The facility cannot use staff that is also on duty in other units of the facility in order to meet the unit staffing ratios. Patients shall be grouped for accommodation by gender, age, and treatment needs. At a minimum, children, adolescent, and adult treatment programs shall be separate with distinct units for each population. A unit is determined by separate and distinct sleeping, living, and treatment areas often separated by walls and/or doors. A unit that does not allow clear line of sight due to the presence of walls or doors is considered a separate unit. Each individual unit shall have assigned staff to allow for appropriate and safe monitoring of patients and to provide active treatment.

(c) In Acute and Acute II settings, at least one (1) registered nurse (RN) must be on duty per unit at all times, with additional RNs to meet program needs. RNs must adhere to Oklahoma State Department of Health (OSDH) policy at OAC 310:667-15-3 and 310:667-33-2(a)(3).

(d) Acute, non-specialty Acute II, and non-specialty PRTF programs require a staffing ratio of one (1) staff: six (6) patients during routine waking hours and one (1) staff: eight (8) patients during time residents are asleep with twenty-four (24) hour nursing care supervised by an RN for management of behaviors and medical complications. For PRTF programs, at a minimum, a supervising RN must be available by phone and on-site within one (1) hour. If the supervising RN is off-site, then an RN or licensed practical nurse (LPN) must be on-site to adhere to a twenty-four (24) hour nursing care coverage ratio of one (1) staff: thirty (30) patients during routine waking hours and one (1) staff: forty (40) patients during time residents are asleep.

(e) Specialty treatment at Acute II or PRTF is a longer-term

treatment that requires a higher staff-to-member ratio because of the need for constant, intense, and immediate reinforcement of new behaviors to develop an understanding of the behaviors. The environment of specialized residential treatment centers requires special structure and configuration (e.g., sensory centers for autistic members) and specialized training for the staff in the area of the identified specialty. The physician will see the child at least one (1) time a week.

(f) An Acute II or PRTF will not be considered a specialty treatment program for SoonerCare without prior approval of the OHCA behavioral health unit.

(g) A treatment program that has been approved as a specialized treatment program must maintain medical records that document the degree and intensity of the psychiatric care delivered to the members and must meet active treatment requirements found at OAC 317:30-5-95.34.

(h) Criteria for classification as a specialty Acute II ~~or PRTF~~ will require a staffing ratio of one (1) staff: ~~three (3)~~four (4) patients at a minimum during routine waking hours and one (1) staff: six (6) patients during time residents are asleep with twenty-four (24) hour nursing care supervised by a RN for management of behaviors and medical complications. The specialty Acute II ~~or PRTF~~ will be a secure unit, due to the complexity of needs and safety considerations. ~~Admissions will be restricted to members who meet the medical necessity criteria for the respective level of care and also meet at least two (2) or more of the following:~~

~~(1) Have failed at other levels of care or have not been accepted by other non-specialty levels of care;~~

~~(2) Have behavioral, emotional, and cognitive problems requiring secure treatment that includes one (1) staff: one (1) patient, one (1) staff: two (2) patients, or one (1) staff: three (3) patients staffing due to the member being a danger to themselves and others, for impairments in socialization problems, communication problems, and restricted, repetitive, and stereotyped behaviors. These symptoms must be severe and intrusive enough that management and treatment in a less restrictive environment places the member and others in danger but, do not meet acute medical necessity criteria. These symptoms must be exhibited across multiple environments and must include at least two (2) or more of the following:~~

~~(A) Marked impairments in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction;~~

~~(B) Inability to regulate impulse control with frequent displays of aggression or other dangerous behavior toward self and/or others regularly;~~

~~(C) Failure to develop peer relationships appropriate to developmental level;~~

~~(D) Lack of spontaneously seeking to share enjoyment,~~

~~interests, or achievements with other people;~~
~~(E) Lack of social or emotional reciprocity;~~
~~(F) Lack of attachment to caretakers;~~
~~(G) Require a higher level of assistance with activities of daily living requiring multiple verbal cues at least fifty (50) percent of the time to complete tasks;~~
~~(H) Delay, or total lack of, the development of spoken language which is not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime;~~
~~(I) Marked impairment in individuals with adequate speech in the ability to initiate or sustain a conversation with others;~~
~~(J) Stereotyped and repetitive use of language or idiosyncratic language;~~
~~(K) Lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level;~~
~~(L) Encompassing preoccupation with one (1) or more stereotyped and restricted pattern and interest that is abnormal in intensity of focus;~~
~~(M) Inflexible adherence to specific, nonfunctional routines or rituals;~~
~~(N) Stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting or complex whole body movements); and/or~~
~~(O) Persistent occupation with parts of objects;~~

~~(3) Member is medically stable, but has co-morbid medical conditions which require specialized medical care during treatment; and/or~~

~~(4) Has full-scale IQ below forty (40) (profound intellectual disability).~~Admissions and authorization for continued stay for a specialty Acute II will be restricted to members who meet the medical necessity criteria at OAC 317:30-5-95.29 and OAC 317:30-5-95.30 for the respective level of care and meet the additional criteria found in the Behavioral Health Services Medical Necessity Criteria Manual, available on OHCA's website, www.okhca.org.

(i) Criteria for classification as a specialty PRTF will require a staffing ratio of one (1) staff: four (4) patients at a minimum during routine waking hours and one (1) staff: six (6) patients during time residents are asleep with twenty-four (24) hour nursing care supervised by a RN for management of behaviors and medical complications. The specialty PRTF will be a secure unit, due to the complexity of needs and safety considerations. Admissions and authorization for continued stay in a specialty PRTF will be restricted to members who meet the medical necessity criteria at OAC 317:30-5-95.29 and OAC 317:30-5-95.30 for the respective level of care and meet the additional criteria found in the Behavioral Health Services Medical Necessity Criteria Manual, available on OHCA's website, www.okhca.org.

~~(i)~~ (j) Non-authorized inpatient psychiatric services will not be SoonerCare compensable.

~~(j) The OHCA, or its designated agent, will prior authorize all services for an approved length of stay based on the medical necessity criteria described in OAC 317:30-5-95.25 through 317:30-5-95.30.~~

(k) For out-of-state placement policy, refer to OAC 317:30-3-89 through 317:30-3-92. A prime consideration for placements will be proximity to the family or guardian in order to involve the family or guardian in active treatment, including discharge and reintegration planning. Out-of-state facilities are responsible for insuring appropriate medical care, as needed under SoonerCare provisions, as part of the per-diem rate.

(l) Reimbursement for ~~Inpatient~~inpatient psychiatric services in all psychiatric units of general hospitals, psychiatric hospitals, and PRTFs are limited to the approved length of stay. OHCA, or its designated agent, will approve lengths of stay using the current OHCA Behavioral Health medical necessity criteria as described in OAC 317:30-5-95.25 through OAC 317:30-5-95.30. The approved length of stay applies to both facility and physician services.

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

**SUBCHAPTER 18. PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY**

**317:35-18-5. Eligibility criteria**

(a) To be eligible for participation in Programs of All-Inclusive Care for the Elderly (PACE), the applicant must:

(1) ~~be~~Be age fifty-five (55) years or older;

(2) ~~live~~Live in a PACE service area;

(3) ~~be~~Be determined by the state to meet nursing facility level of care; and

(4) ~~be~~Be determined by the PACE interdisciplinary team (IDT) as able to be safely served in the community at the time of enrollment. If the PACE provider denies enrollment because the IDT determines that the applicant cannot be served safely in the community, the PACE provider must:

(A) ~~notify~~Notify the applicant in writing of the reason for the denial;

(B) ~~refer~~Refer the applicant to alternative services as appropriate;

(C) ~~maintain~~Maintain supporting documentation for the denial and notify the Centers for Medicare and Medicaid Services and the Oklahoma Health Care Authority (OHCA) of the denial and ~~make the supporting documentation available for review; and~~submit that documentation to the OHCA for review; and

(D) ~~advise~~Advise the applicant orally and in writing of the grievance and appeals process.

(b) To be eligible for SoonerCare capitated payments, the individual must:

(1) ~~meet~~Meet categorical relationship for the aged, blind, or disabled [refer to Oklahoma Administrative Code (OAC) 317:35-5-4];

(2) ~~be~~Be eligible for Title XIX services if institutionalized as determined by the Oklahoma Department of Human Services ~~(DHS);~~(OKDHS)

(3) ~~be~~Be eligible for SoonerCare State Plan services;

(4) ~~meet~~Meet the same financial eligibility criteria as set forth for the SoonerCare ADvantage program per OAC 317:35-17-10 and 317:30-17-11; and

(5) ~~meet~~Meet appropriate medical eligibility criteria.

(c) The nurse designee makes the medical determination utilizing professional judgment, the Uniform Comprehensive Assessment Tool (UCAT) Part I, Part III, and other available medical information.

(1) When PACE services are requested:

(A) The PACE nurse or ~~DHS~~OKDHS nurse is responsible for

completing the UCAT assessment.

(B) The PACE intake staff is responsible for aiding the PACE enrollee in contacting ~~DHS~~OKDHS to initiate the financial eligibility application process.

(2) The nurse completes the UCAT, Part III visit with the PACE enrollee, in the participant's home, within ten (10) days of receipt of the referral for PACE services.

(3) The nurse sends the UCAT, Part III to the designated OHCA nurse staff member for review and level of care determination.

(4) A new medical level of care determination may be required when a member requests any of the following changes in service programs:

(A) ~~from~~From PACE to ADvantage;

(B) ~~from~~From PACE to State Plan Personal Care Services;

(C) ~~from~~From Nursing Facility to PACE;

(D) ~~from~~From ADvantage to PACE if previous UCAT was completed more than six (6) months prior to member requesting PACE enrollment; or

(E) ~~from~~From PACE site to PACE site.

(d) To obtain and maintain eligibility, the individual must agree to accept the PACE providers and its contractors as the individual's only service provider. The individual may be held financially liable for services received without prior authorization except for emergency medical care.

**317:35-18-7. Programs of All-Inclusive for the Elderly (PACE) organization's ~~Appeals~~appeals process**

(a) Internal appeals:

(1) Any individual who is denied program services is entitled to an appeal through the provider.

(2) If the individual also chooses to file an external appeal, the provider must assist the individual in filing an external appeal.

(b) External appeals may be filed through the OHCA legal division and follow the process outlined in Oklahoma Administrative Code (OAC) 317:2-1-2.

(c) Expedited appeals process (refer to 42 CFR § 460.122).

(1) A PACE organization must have an expedited appeals process for situations in which the participant believes that his or her life, health, or ability to regain or maintain maximum function could be seriously jeopardized, absent provision of the service in dispute.

(2) Except as provided in paragraph (c)(3) of this section, the PACE organization must respond to the appeal as expeditiously as the participant's health condition requires, but no later than seventy-two (72) hours after it receives the appeal.

(3) The PACE organization may extend the seventy-two (72) hour

timeframe by up to fourteen (14) calendar days for either of the following reasons:

(A) The participant requests the extension; or

(B) The organization justifies to the State administering agency (OHCA) the need for additional information and how the delay is in the interest of the participant.

(4) Supporting documentation must be submitted to (OHCA) once it has been determined that they will be unable to respond to the appeal within the seventy-two (72) hour timeframe.

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

**SUBCHAPTER 1. GENERAL PROVISIONS**

**317:40-1-1. Home and Community-Based Services (HCBS) Waivers for persons with intellectual disabilities or certain persons with related conditions**

(a) **Applicability.** This Section applies to services funded through Medicaid HCBS Waivers per Oklahoma Administrative Code (OAC) 317:35-9-5 and Section 1915(c) of the Social Security Act. Specific Waivers are the In-Home Supports Waiver (IHSW) for Adults, IHSW for Children, Community Waiver, and Homeward Bound Waiver.

(b) **Program provisions.** Each individual requesting services provided through an HCBS Waiver and his or her family or guardian, are responsible for:

(1) ~~accessing,~~Accessing with the Oklahoma Department of Human Services ~~(DHS)~~ (OKDHS) staff assistance, all benefits available under Oklahoma's Medicaid State Plan or other payment sources prior to accessing funding for those same services under an HCBS Waiver program;

(2) ~~cooperating~~Cooperating in the determination of medical and financial eligibility including prompt reporting of changes in income or resources;

(3) ~~choosing~~Choosing between services provided through an HCBS Waiver or institutional care; and

(4) ~~reporting~~Reporting any changes in address or other contact information to ~~DHS~~OKDHS within ~~30-calendar~~thirty (30) calendar days.

(c) **Waiver eligibility.** To be eligible for Waiver services, an applicant must meet the criteria established in (1) of this Subsection and the criteria for one (1) of the Waivers established in (1) through (8) of this Subsection.

(1) **HCBS Waiver services.** Services provided through an HCBS Waiver are available to Oklahoma residents meeting SoonerCare (Medicaid) eligibility requirements established by law, regulatory authority, and policy within funding available through ~~State~~state or ~~Federal~~federal resources. To be eligible and receive services funded through any of the Waivers listed in (a) of this Section, an applicant must meet conditions, per OAC 317:35-9-5. The applicant:

(A) ~~must~~Must be determined financially eligible for SoonerCare, per OAC 317:35-9-68;

(B) ~~may~~May not simultaneously be enrolled in any other Medicaid Waiver program or receiving services in an institution including a hospital, rehabilitation facility, mental health facility, nursing facility, or residential

care home per Section (§) 1-820 of Title 63 of the Oklahoma Statutes (O.S.), ~~(O.S. 63-1-820),~~ or Intermediate Care facility for individuals with intellectual disabilities (ICF/IID);

(C) ~~may~~May not be receiving Developmental Disabilities Services (DDS) state-funded services, such as the Family Support Assistance Payment, Respite Voucher Program, sheltered workshop services, community integrated employment services, or assisted living without Waiver supports, per OAC 340:100-5-22.2; and

(D) ~~must~~Must also meet other Waiver-specific eligibility criteria.

(2) **In-Home Supports Waivers (IHSW).** To be eligible for services funded through the IHSW, an applicant must:

(A) ~~meet~~Meet all criteria listed in (c) of this Section; and

(B) ~~be~~Be determined by the Social Security Administration (SSA) to have a disability and a diagnosis of intellectual disability; or

(C) ~~be~~Be determined to have a disability and a diagnosis of intellectual disability as defined in the Diagnostic and Statistical Manual of Mental Disorders by the Oklahoma Health Care Authority (OHCA) Level of Care Evaluation Unit (LOCEU);

(D) ~~be 3~~Be three (3) years of age or older;

(E) ~~be~~Be determined by the OHCA LOCEU to meet the ICF/IID Institutional Level of Care requirements, per OAC 317:30-5-122; and

(F) ~~reside~~Reside in:

(i) ~~the home of~~ a family ~~member or friend;~~A family member's or friend's home;

(ii) ~~his~~His or her own home;

(iii) ~~a DHS~~An OKDHS Child Welfare Services (CWS) foster home; or

(iv) ~~a~~A CWS group home; and

(vii) ~~have~~Have critical support needs that can be met through a combination of non-paid, non-Waiver, and SoonerCare (Medicaid) resources available to the individual; and HCBS Waiver resources within the annual per capita Waiver limit, agreed on between the State of Oklahoma and the Centers for Medicare and Medicaid Services (CMS).

(3) **Community Waiver.** To be eligible for services funded through the Community Waiver, the applicant must:

(A) ~~meet~~Meet all criteria listed in (c) of this Section;

(B) ~~be~~Be determined by the SSA to have a disability and a diagnosis of intellectual disability; or

(C) ~~have~~Have an intellectual disability as defined in the Diagnostic and Statistical Manual of Mental Disorders or a related condition by DDS and be covered under the State's alternative disposition plan, adopted under Section 1919(e)(7)(E) of the Social Security Act; or

(D) ~~be~~Be determined to have a disability and a diagnosis of intellectual disability as defined in the Diagnostic and Statistical Manual of Mental Disorders or the OHCA LOCEU; and

(E) ~~be 3~~Be three (3) years of age or older; and

(F) ~~be~~Be determined by the OHCA LOCEU, to meet ICF/IID Institutional Level of Care requirements, per OAC 317:30-5-122; and

(G) ~~have~~Have critical support needs that can be met by the Community Waiver and cannot be met by IHSW services or other service alternatives, as determined by the DDS director or designee.

(4) **Homeward Bound Waiver.** To be eligible for services funded through the Homeward Bound Waiver, the applicant must:

(A) ~~be~~Be certified by the United States District Court for the Northern District of Oklahoma as a member of the plaintiff class in *Homeward Bound et al. v. The Hissom Memorial Center*, Case No. 85-C-437-E;

(B) ~~meet~~Meet all criteria for HCBS Waiver services listed in (c) of this Section; and

(C) ~~be~~Be determined by SSA to have a disability and a diagnosis of intellectual disability; or

(D) ~~have~~Have an intellectual disability as defined in the Diagnostic and Statistical Manual of Mental Disorders or a related condition, per OAC 317:35-9-45 as determined by DDS, and to be covered under the State's alternative disposition plan adopted under Section 1919(e)(7)(E) of the Social Security Act; or

(E) ~~have~~Have a disability as defined in the Diagnostic and Statistical Manual of Mental Disorders by the OHCA/LOCEU; and

(F) ~~meet~~Meet ICF/IID Institutional Level of Care requirements, per OAC 317:30-5-122, as determined by the OHCA LOCEU.

(5) **Evaluations and information.** Applicants desiring services through any of the Waivers listed in (a) of this Section participates in diagnostic evaluations and provides information necessary to determine HCBS Waiver services eligibility, including:

(A) ~~a~~A psychological evaluation, by a licensed psychologist that includes:

(i) ~~a~~A full-scale, functional and/or adaptive assessment;

and
(ii) ~~a~~A statement of age of onset of the disability; and
(iii) ~~intelligence~~Intelligence testing that yields a full-scale, intelligence quotient.
(I) Intelligence testing results obtained at ~~16~~sixteen (16) years of age and older are considered valid of the current status, provided they are compatible with current behavior. Intelligence testing results obtained between ~~7 to 16~~seven to sixteen (7 to 16) years of age are considered current for four (4) years when the full-scale intelligence quotient is less than ~~40,~~forty (40) and for two (2) years when the intelligence quotient is ~~40~~forty (40) or above.
(II) DDS may require a current psychological evaluation when a significant change of condition, disability, or psychological status is noted;
(B) ~~a~~A social service summary, current within ~~12~~twelve (12) months of the requested approval date that includes a developmental history; and
(C) ~~a~~A medical evaluation, current within ~~90-calendar days~~one (1) calendar year of the requested approval date; and
(D) ~~a~~A completed Form LTC-300, ICF/IID Level of Care Assessment; and
(E) ~~proof~~Proof of disability per SSA guidelines. When a disability determination is not made by SSA, OHCA LOCEU may make a disability determination using SSA guidelines.
(6) **Eligibility determination.** OHCA reviews the diagnostic reports listed in (2) of this subsection and makes an eligibility determination for DDS HCBS Waivers.
(7) **State's alternative disposition plan.** For individuals who are determined to have an intellectual disability or a related condition by DDS per the State's alternative disposition plan adopted under Section 1919(e)(7)(E) of the Social Security Act, DDS reviews the diagnostic reports listed in (2) of this subsection and, on behalf of OHCA, makes a determination of eligibility for DDS HCBS Waiver services and ICF/IID level of care.
(8) **Member's choice.** A determination of need for ICF/IID Institutional Level of Care does not limit the opportunities of the person receiving services to participate in community services. Individuals are assured of the opportunity to exercise informed choice in the selection of services.
(d) **Request list.** When state DDS resources are unavailable to add individuals to services funded through an HCBS Waiver, persons are placed on a statewide Request for Waiver Services List.
(1) The Request for Waiver Services List is maintained in

chronological order, based on the date of receipt of a written request for services on Form 06MP001E, Request for Developmental Disabilities Services. The applicant must submit the required documentation, per Form 06MP001E, Request for Developmental Disabilities Services, for initial consideration of potential eligibility. Active United States Armed Forces personnel, who have a pending HCBS Waiver application in another state for an immediate family member, may be placed on the list with the date they applied in the other state. The person's name is added to the list when he or she provides proof of application date from the other state.

(2) The Request for Waiver Services List for persons requesting services provided through an HCBS Waiver is administered by DDS uniformly throughout the state.

(3) An individual applicant is removed from the Request for Waiver Services List, when he or she:

(A) ~~is~~Is found to be ineligible for services;

(B) ~~cannot~~Cannot be located by ~~DHS;~~OKDHS;

(C) ~~does~~Does not provide ~~DHS-requested~~OKDHS-requested information or fails to respond;

(D) ~~is~~Is not an Oklahoma resident at the requested Waiver approval date; or

(E) ~~declines~~Declines an offer of Waiver services.

(4) An applicant removed from the Request for Waiver Services List, because he or she could not be located, may submit a written request to be reinstated to the list. The applicant is returned to the same chronological place on the Request for Waiver Services List, provided he or she was on the list prior to January 1, 2015.

(e) **Applications.** When resources are sufficient for initiation of HCBS Waiver services, DDS ensures action regarding a request for services occurs within ~~45-calendar~~forty-five (45) calendar days. When action is not taken within the required ~~45-calendar~~forty-five (45) calendar days, the applicant may seek resolution, per OAC 340:2-5-61.

(1) Applicants are allowed ~~60-calendar~~sixty (60) calendar days to provide information requested by DDS to determine eligibility for services.

(2) When requested information is not provided within ~~60-calendar~~sixty (60) calendar days, the applicant is notified that the request was denied, and he or she is removed from the Request for Waiver Services List.

(f) **Admission protocol.** Initiation of services funded through an HCBS Waiver occurs in chronological order from the Request for Waiver Services List, per (d) of this Section based on the date of DDS receipt of a completed request for services, as a result of the informed choice of the person requesting services or the

individual acting on the member's behalf, and upon determination of eligibility, per (c) of this Section. Exceptions to the chronological requirement may be made, when:

(1) ~~an~~An emergency situation exists in which the health or safety of the person needing services or of others is endangered and there is no other resolution to the emergency. An emergency exists, when:

(A) ~~the~~The person is unable to care for himself or herself and:

(i) the person's caretaker, ~~per 43A O.S. ' 10-103:~~43A O.S. § 10-103:

(I) ~~is~~Is hospitalized;

(II) ~~moved~~Moved into a nursing facility;

(III) ~~is~~Is permanently incapacitated; or

(IV) ~~died;~~Died; and

(ii) ~~there~~There is no caretaker to provide needed care to the individual; or

(iii) ~~an~~An eligible person is living at a homeless shelter or on the street;

(B) ~~DHS~~OKDHS finds the person needs protective services due to ongoing physical, sexual, or emotional abuse or neglect in his or her present living situation, resulting in serious jeopardy to the person's health or safety;

(C) ~~the~~The behavior or condition of the person needing services is such that others in the home are at risk of being seriously harmed by the person. For example, when the person is routinely physically assaultive to the caretaker or others living in the home and sufficient supervision cannot be provided to ensure the safety of those in the home or community; or

(D) ~~the~~The person's medical, psychiatric, or behavioral challenges are such that the person is seriously injuring or harming himself or herself, or is in imminent danger of doing so~~;~~.

(2) ~~the~~The Legislature appropriated special funds with which to serve a specific group or a specific class of individuals, per HCBS Waiver provisions;

(3) Waiver services may be required for people who transition to the community from a public ICF/IID or children in ~~DHS~~OKDHS custody receiving services from ~~DHS.~~OKDHS. Under some circumstances Waiver services related to accessibility may be authorized in advance of transition, but may not be billed until the day the member leaves the ICF/IID and enters the Waiver; or

(4) ~~individuals~~Individuals subject to the provisions of Public Law 100-203 residing in nursing facilities for at least 30-continuous months prior to January 1, 1989, and are determined by Preadmission Screening and Resident Review (PASRR)

evaluation conducted per Title 42 Section 483.100 of the Federal Code of Regulations to have an intellectual disability or a related condition, who are covered under the State's alternative disposition plan adopted under Section 1919(e)(7)(E) of the Social Security Act, and choose to receive services funded through the Community or Homeward Bound Waiver.

(g) **Movement between DDS HCBS Waiver programs.** A person's movement from services funded through one (1) DDS-administered HCBS Waiver to services funded through another DDS-administered HCBS Waiver is explained in this subsection.

(1) When a member receiving services funded through the IHSW for children becomes ~~18~~eighteen (18) years of age, services through the IHSW for adults becomes effective.

(2) Change to services funded through the Community Waiver from services funded through the IHSW occurs only when:

(A) ~~a~~A member has critical health and safety support needs that cannot be met by IHSW services, non-Waiver services, or other resources as determined by the DDS director or designee; and

(B) ~~funding~~Funding is available, per OAC 317:35-9-5.

(3) Change to services funded through the IHSW from services funded through the Community Waiver may only occur when a member's history of annual service utilization was within the IHSW per capita allowance.

(4) When a member served through the Community Waiver has support needs that can be met within the per capita Waiver allowance of the applicable IHSW and through a combination of non-Waiver resources, the individual may choose to receive services through the IHSW.

(h) **Continued eligibility for HCBS Waiver services.** Eligibility for members receiving services provided through the HCBS Waiver is re-determined by the OHCA LOCEU when a determination of disability was not made by the Social Security Administration. The OHCA LOCEU determines categorical relationship to the SoonerCare disabled category according to Social Security Administration guidelines. OHCA LOCEU also approves the level of care, per OAC 317:30-5-122, and confirms a diagnosis of intellectual disability per the Diagnostic and Statistical Manual of Mental Disorders.

(1) DDS may require a new psychological evaluation and re-determination of eligibility at any time when a significant change of condition, disability, or psychological status is noted.

(2) Annual review of eligibility requires a medical evaluation that is current within one year of the requested approval date. The medical evaluation must be submitted by the member or the individual acting on his or her behalf ~~30-calendar~~thirty (30) calendar days prior to the Plan of Care expiration.

(i) **HCBS Waiver services case closure.** Services provided through an HCBS Waiver are terminated, when:

(1) ~~a~~A member or the individual acting on the member's behalf chooses to no longer receive Waiver services;

(2) ~~a~~A member is incarcerated;

(3) ~~a~~A member is financially ineligible to receive Waiver services;

(4) ~~a~~A member is determined by SSA to no longer have a disability qualifying the individual for services under these Waivers;

(5) ~~a~~A member is determined by the OHCA LOCEU to no longer be eligible;

(6) ~~a~~A member moves out of state or the custodial parent or guardian of a member who is a minor moves out of state;

(7) ~~a~~A member is admitted to a nursing facility, ICF/IID, residential care facility, hospital, rehabilitation facility, or mental health facility for more than ~~30-consecutive~~thirty (30) consecutive calendar days;

(8) ~~the~~The guardian of a member who is a minor or adjudicated adult fails to cooperate during the annual review process, per OAC 340:100-5-50 through 340:100-5-58;

(9) ~~the~~The guardian of a member who is a minor or adjudicated adult fails to cooperate in the implementation of ~~DHS policy~~the OKDHS rule or service delivery in a manner that places the health or welfare of the member at risk, after efforts to remedy the situation through Adult Protective Services or Child Protective Services were not effective;

(10) ~~the~~The member is determined to no longer be SoonerCare eligible;

(11) ~~there~~There is sufficient evidence the member or the individual acting on the member's behalf engaged in fraud or misrepresentation, failed to use resources as agreed on in the Individual Plan, or knowingly misused public funds associated with these services;

(12) ~~the~~The member or the individual acting on the member's behalf either cannot be located, did not respond, or did not allow case management to complete plan development or monitoring activities as required, per OAC 340:100-3-27, and the member or the individual acting on the member's behalf:

(A) ~~does~~Does not respond to the notice of intent to terminate; or

(B) ~~the~~The response prohibits the case manager from being able to complete plan development or monitoring activities as required, per OAC 340:100-3-27;

(13) ~~the~~The member or the individual acting on the member's behalf fails to cooperate with the case manager to implement a Fair Hearing decision;

(14) ~~it~~It is determined services provided through an HCBS Waiver are no longer necessary to meet the member's needs and professional documentation provides assurance the member's health, safety, and welfare can be maintained without Waiver supports;

(15) ~~the~~The member or the individual acting on the member's behalf fails to cooperate with service delivery;

(16) ~~a~~A family member, the individual acting on the member's behalf, other individual in the member's household, or persons who routinely visit, pose a threat of harm or injury to provider staff or official ~~DHS~~OKDHS representatives; or

(17) ~~a~~A member no longer receives a minimum of one (1) Waiver service per month and DDS is unable to monitor the member on a monthly basis.

(j) **Reinstatement of services.** Waiver services are reinstated when:

(1) ~~the~~The situation resulting in case closure of a Hissom class member is resolved;

(2) ~~a~~A member is incarcerated for ~~90-calendar~~ninety (90) calendar days or less;

(3) ~~a~~A member is admitted to a nursing facility, ICF/IID, residential care facility, hospital, rehabilitation facility, or mental health facility for ~~90-calendar~~ninety (90) calendar days or less; or

(4) ~~a~~A member's SoonerCare eligibility is re-established within ~~90-calendar~~ninety (90) calendar days of the SoonerCare ineligibility date.

**317:40-1-4. Remote support (RS)**

(a) **General Information.** RS services are intended to promote a member's independence. RS services are provided in the member's home, family home, or employment site to reduce reliance on in person support while ensuring the member's health and safety. RS services are included in the member's Individual Plan (Plan) and arrangements for this service are made through the case manager.

(1) RS services are:

(A) Based on the member's needs as documented and supported by the Plan and Person-Centered Assessment;

(B) The least-restrictive option and the member's preferred method to meet an assessed need;

(C) Provided when all adult members of the household; his or her guardians, when applicable; and Personal Support Team (Team) agree to the provision of RS services as documented in the Plan; and

(D) Reviewed by the Team after sixty (60) calendar days of initial installation to determine continued appropriateness of services.

(2) RS services are not a system to provide surveillance or for staff convenience.

(b) **Service description.** RS is monitoring of an adult member; allowing for live, two-way communication with him or her in his or her residence or employment site, by monitoring staff using one or more of the systems in one (1) through eight (8) that are:

(1) Live-video feed;

(2) Live-audio feed;

(3) Motion-sensing monitoring;

(4) Radio-frequency identification;

(5) Web-based monitoring;

(6) Personal Emergency Response System (PERS);

(7) Global positioning system (GPS) monitoring devices; or

(8) Any other device approved by the Developmental Disabilities Services (DDS) director or designee.

(c) **General provider requirements.** RS service providers must have a valid Oklahoma Health Care Authority (OHCA) SoonerCare (Medicaid) provider agreement to provide agency-based RS services to Oklahoma Human Services (OKDHS) DDS Home-and-Community Based Services (HCBS) Waiver members. Requests for applications to provide RS are made to and approved by OKDHS DDS state office.

(1) An RS assessment is completed:

(A) Annually;

(B) Prior to RS implementation; and

(C) As required by ongoing progress and needs assessments.

(2) Each member is required to identify at least two emergency response staff. The member's emergency response staff are documented in his or her Plan.

(3) RS observation sites are not located in a member's residence.

(4) The use of camera or video equipment in the member's bedroom or other private area is prohibited.

(5) RS services are provided in real time by awake staff at a monitoring base using the appropriate connection, not by a recording. While RS is provided the RS staff does not have duties other than remote supports.

(6) RS equipment used in the member's residence includes a visual indicator to the member that the system is on and operating.

(7) RS provider agencies must immediately notify in writing, the member's residential provider agency, vocational provider agency, assigned DDS case manager, or guardian of activity in the household, who could potentially compromise the member's health or safety.

(8) Emergency response provider agency staff records are maintained, per Oklahoma Administrative Code (OAC) 340:100-3-40.

(9) RS provider records are maintained for seven (7) calendar years or until any pending litigation involving the service recipient is completed, whichever occurs last and include at a minimum:

(A) The member's name;

(B) The staff's name who delivered the service;

(C) Service dates;

(D) Service begin and end times;

(E) Provider's location;

(F) Description of services provided or observation note;

(G) Method of contact with member; and

(H) The member's current photograph.

(10) RS providers must have:

(A) Safeguards in place including, but not limited to:

(i) A battery or generator to insure continued coverage during an electrical outage at the member's home and monitoring facility;

(ii) Back-up procedures at the member's home and monitoring site for:

(I) Prolonged power outage;

(II) Fire;

(III) Severe weather; and

(IV) The member's personal emergency.

(iii) The ability to receive alarm notifications, such as home security, smoke, or carbon monoxide at each residence monitored, as assessed by the team as necessary for health and safety.

(B) Two-way audio communication allowing staff monitors to effectively interact with, and address the member's needs in each residence;

(C) A secure Health Insurance Portability and Accountability Act (HIPAA)-compliant network system requiring data authentication, authorization, and encryption to ensure access to computer vision, audio, sensor, or written information is limited to authorized staff or team members per the Plan;

(D) A current file for each member receiving RS services including:

(i) The member's photograph;

(ii) The member's Plan;

(iii) The member's demographics; and

(iv) Any other pertinent data to ensure the member's safety.

(E) Capability to maintain all video and make it available to OKDHS staff upon request for a minimum of twelve (12) calendar months. OKDHS may require an extended timeframe when necessary.

(d) **RS staff requirements.** RS staff:

(1) May not have any assigned duties other than oversight and member support at the time they are monitoring;

(2) Receive member specific training per the member's Plan prior to providing support to a member;

(3) Assess urgent situations at a member's home or employment site and call 911 first when deemed necessary; then contact the member's residential provider agency or employment provider agency designated emergency response staff; or the member's natural support designated emergency response person while maintaining contact with the member until persons contacted or emergency response personnel arrive on site;

(4) Implement the member's Plan as written by the Team and document the member's status at least hourly;

(5) Complete and submit incident reports, per OAC 340:100-3-34, unless emergency backup staff is engaged;

(6) Provide simultaneous support to no more than sixteen (16) members;

(7) Are eighteen (18) years of age and older; and

(8) Are employed by an approved RS agency.

(e) **Emergency response requirement.**

(1) Emergency response staff are employed by a provider agency with a valid OHCA SoonerCare (Medicaid) provider agreement to provide residential services, vocational services or habilitation training specialist (HTS) services to OKDHS/DDS HCBS Waiver members and:

(A) May not have any assigned duties other than oversight and support of members at the time they are assigned as response staff;

(B) Receive all trainings required, per OAC 340:100-3-38.1, for members in residential settings; OAC 340:100-3-38.2 for members in employment settings; or OAC 340:100-3-38.3, for members in non-residential settings per the Plan prior to providing support;

(C) Provide a response on site at the member’s residence or employment site within twenty (20) minutes when contacted by RS staff unless a shorter timeframe is indicated in the member's Plan;

(D) Have an on-call back-up person who responds when the primary response staff engaged at another home or employment site is unable to respond within the specified time frame;

(E) Provide written or verbal acknowledgement of a request for assistance from the RS staff;

(F) Complete and document emergency drills with the member quarterly when services are provided in the member's home;

(G) Implement the Plan as written and document each time they are contacted to respond, including the nature of the

intervention and the duration;
(H) Complete incident reports, per OAC 340:100-3-34; and
(I) Are eighteen (18) years of age and older.
(2) Natural emergency response persons:
(A) Are unpaid family members or other interested parties who agree to become, and are approved as, an emergency response person by the member's Team;
(B) Are available to respond in the case of an emergency within twenty (20) minutes from the time they are contacted by RS staff, unless a shorter response time is indicated in the Plan;
(C) Have an on-call back-up person who responds when the primary response staff is unable to respond within the specified time frame;
(D) Provide written or verbal acknowledgement of a request for assistance from the remote support staff; and
(E) Are eighteen (18) years of age and older.

(f) **Service limitations.** RS is limited to twenty-four (24) hours per day. RS is not provided simultaneously with HTS services, homemaker services, agency companion services, group home services, specialized foster care, respite, intensive personal supports services, group job coaching, or where foster care is provided to children. RS can be provided in conjunction with daily living supports, individual job coaching, employment stabilization services, and center and community based services.

(1) Services not covered include, but are not limited to:
(A) Direct care staff monitoring;
(B) Services to persons under the age of eighteen (18); or
(C) Services provided in any setting other than the member's primary residence or employment site.
(2) RS services are shared among OKDHS/DDS Waiver members of the same household in a residential setting. RS provider agencies may only bill for one (1) member of a household at a time. Only one (1) remote support provider per household;
(3) Assistive technology purchases are authorized, per OAC 317:40-5-100.

(g) **RS Discontinuation.** The member and his or her Team determine when it is appropriate to discontinue RS services. When RS services are terminated, the RS provider agency coordinates termination of service with the member's residential provider agency or vocational provider agency and Team to ensure a safe transition. When a member requests the termination of RS services while RS is being provided, the RS staff:

(1) Notifies the provider to request an emergency response staff;
(2) Leaves the system operating until the emergency response staff arrives; and

(3) Turns off the system once relieved by the emergency response staff.

## SUBCHAPTER 5. MEMBER SERVICES

## PART 1. AGENCY COMPANION SERVICES

### 317:40-5-3. Agency companion services (ACS)

(a) ~~Agency companion services (ACS)~~ACS are:

(1) ~~provided~~Provided by agencies that have a provider agreement with the Oklahoma Health Care Authority (OHCA);

(2) ~~provided by~~Provider Agency independent contractors ~~of the provider agency~~ and provide a shared living arrangement developed to meet the member's specific needs ~~of the member~~ that ~~includes~~include supervision, supportive assistance, and training in daily living skills, and integrates the member into the shared experiences of a family in a home owned or rented by the companion;

(3) ~~available~~Available to members ~~18~~eighteen (18) years of age or older who are eligible for services through Community or Homeward Bound Waivers. Persons under ~~18~~eighteen (18) years of age may be served with approval from the Oklahoma Department of Human Services Developmental Disabilities Services (DDS) director or designee;

(4) ~~based~~Based on the member's need for residential services, per Oklahoma Administrative Code(OAC) 340:100-5-22, and support as described in the member's Individual Plan (Plan), per OAC 340:100-5-50 through 340:100-5-58.

(b) An agency companion:

(1) ~~must~~Must have an approved home profile, per OAC 317:40-5-3, and contract with a ~~provider contract with a~~DDS-approved provider agency ~~approved by DDS~~;

(2) ~~may~~May provide companion services for one (1) member. Exceptions to serve as companion for two (2) members may be approved by the DDS director or designee. Exceptions for up to two(2) members may be approved when members have an existing relationship and to separate them would be detrimental to their well being and the companion demonstrates the skill and ability required to serve as companion for two (2) members~~;~~. Exceptions for additional members may be granted when the DDS director or designee determines an emergency situation exists and there is no other resolution, and the companion demonstrates the skill and ability required to serve as a companion.

(3) ~~household~~Household is limited to one (1) individual companion provider. Exceptions for two (2) individual companion providers in a household who each provide companion services to different members may be approved by the DDS director or

designee;
(4) ~~may~~May not provide companion services to more than two (2) members at any time;
(5) ~~household~~Household may not simultaneously serve more than ~~three~~four (4) members through any combination of companion or respite services~~;~~.
(6) ~~may~~May not have employment, volunteer activities, or personal commitments that prevent the companion from fulfilling his or her responsibilities to the member, per OAC 317:40-5.
(A) The companion may have employment when:
~~(i) personal support team (Team) documents and addresses all related concerns in the member's Plan;~~
~~(ii) employment is approved in advance by the DDS area manager or designee; and~~
(i) Employment is approved in advance by the DDS area residential services program manager;
~~(iii) companion's~~(ii) Companion's employment does not require on-call duties and occurs during time the member is engaged in outside activities such as school, employment or other routine scheduled meaningful activities; and
~~(iv) companion~~(iii) Companion provides assurance the employment is such that the member's needs will be met by the companion should the member's outside activities be disrupted.
(B) If, after receiving approval for employment, authorized DDS staff determines the employment interferes with the care, training, or supervision needed by the member, the companion must terminate, within ~~30~~thirty (30) calendar days:
(i) ~~his~~His or her employment; or
(ii) ~~his~~His or her contract as an agency companion.
(C) Homemaker, habilitation training specialist, and respite services are not provided for the companion to maintain ~~other~~ employment.
(c) Each member may receive up to ~~60~~sixty (60) calendar days per year of therapeutic leave without reduction in the agency companion's payment.
(1) Therapeutic leave:
(A) ~~is~~Is a SoonerCare (Medicaid) payment made to the contract provider to enable the member to retain services; and
(B) ~~is~~Is claimed when the:
(i) ~~member~~Member does not receive ACS for ~~24~~twenty-four (24) consecutive hours due to:
(I) ~~a~~A visit with family or friends without the companion;
(II) ~~vacation~~Vacation without the companion; or

(III) ~~hospitalization,~~Hospitalization, regardless of whether the companion is present; or

(ii) ~~companion~~Companion uses authorized respite time;

(C) ~~is~~Is limited to no more than ~~14~~fourteen (14) consecutive, calendar days per event, not to exceed ~~60~~sixty (60) days per Plan of Care (POC) year; and

(D) ~~cannot~~Cannot be carried over from one (1) POC year to the next.

(2) The therapeutic leave daily rate is the same amount as the ACS per diem rate ~~except for the pervasive rate that is paid at the enhanced agency companion per diem rate~~.

(3) The provider agency pays the agency companion the payment he or she would earn if the member were not on therapeutic leave.

(d) The companion may receive a combination of hourly or daily respite per POC year equal to ~~660~~seven-hundred and twenty (720) hours.

(e) Habilitation Training Specialist (HTS) services:

(1) ~~may~~May be approved by the DDS director or designee when providing ACS with additional support represents the most cost-effective placement for the member when there is an ongoing pattern of not:

(A) ~~sleeping~~Sleeping at night; or

(B) ~~working~~Working or attending employment, educational, or day services;

(2) ~~may~~May be approved when a time-limited situation exists in which the companion provider is unable to provide ACS, and the provision of HTS will maintain the placement or provide needed stability for the member, and must be reduced when the situation changes;

(3) ~~must~~Must be reviewed annually or more frequently as needed, which includes a change in agencies or individual companion providers; and

(4) ~~must~~Must be documented by the Team and the Team must continue efforts to resolve the need for HTS.

(f) The contractor model does not include funding for the provider agency for the provision of benefits to the companion.

(g) The agency receives a daily rate based on the member's level of support. Levels of support for the member and corresponding payment are:

(1) ~~determined~~Determined by authorized DDS staff per levels described in (A) through(D); and

(2) ~~re-evaluated~~Re-evaluated when the member has a change in agency companion providers that includes a change in ~~agencies or~~ individual companion providers.

(A) **Intermittent level of support.** Intermittent level of support is authorized when the member:

(i) ~~requires~~Requires minimal physical assistance with basic daily living skills, such as bathing, dressing, and eating;

(ii) ~~may~~May be able to spend short periods of time unsupervised inside and outside the home; and

(iii) ~~requires~~Requires assistance with medication administration, money management, shopping, housekeeping, meal preparation, scheduling appointments, arranging transportation or other activities.

(B) **Close level of support.** Close level of support is authorized when the member ~~requires:~~requires the level of assistance outlined in (g)(2)(A) and at least two (2) of the following:

(i) ~~regular,~~Regular frequent and sometimes constant physical assistance and support to complete daily living skills, such as bathing, dressing, eating, and toileting;

(ii) ~~extensive~~Extensive assistance with medication administration, money management, shopping, housekeeping, meal preparation, scheduling appointments, arranging transportation or other activities; ~~and~~or

(iii) ~~assistance~~Assitance with health, medication, or behavior interventions that may include the need for specialized training, equipment, and diet.

(C) **Enhanced level of support.** Enhanced level of support is authorized when the ~~member:~~member requires the level of assistance outlined in (g)(2)(B) and at least one (1) of the following:

(i) ~~is~~Is totally dependent on others for:

(I) ~~completion~~Completion of daily living skills, such as bathing, dressing, eating, and toileting; and

(II) ~~medication~~Medication administration, money management, shopping, housekeeping, meal preparation, scheduling appointments, and arranging transportation or other activities;

(ii) ~~demonstrates~~Demonstrates ongoing complex medical issues requiring specialized training courses, per OAC 340:100-5-26; or

(iii) ~~has~~Has behavioral issues that requires a protective intervention ~~plan~~protocol (PIP) with a restrictive or intrusive procedure, per OAC 340:100-1-2. The PIP must:

(I) ~~be~~Be approved by the Statewide Human Rights Behavior Review Committee ~~(SBRC),~~(SHRBRC), per OAC 340:100-3-14; or

~~(II) be reviewed by the Human Rights Committee (HRC), per OAC 340:100-3-6, or~~

~~(III)~~(II) ~~have~~Have received expedited approval, per OAC 340:100-5-57~~.~~;

(iv) Meets the requirements of (g)(2)(C)(i) through (iv); and does not have an available personal support system. The need for this service level:

(I) Must be identified by the grand staffing committee, per OAC 340:75-8-40; and

(II) Requires the provider to market, recruit, screen, and train potential companions for the member identified.

(D) **Pervasive level of support.** Pervasive level of support requires the level of assistance outlined in (g)(2)(C), and is authorized when the member:

(i) ~~requires~~Requires additional professional level support to remain in an agency companion setting due to pervasive behavioral or emotional challenges. The support must be provided:

(I) ~~by~~By a licensed professional counselor (LPC) or professional with a minimum of Masters of Social Work (MSW) degree; and

(II) ~~as~~As ongoing support and training to the companion, offering best practice approaches in dealing with specific members; and

(III) As part of the ACS and not billed as a separate service. Waiver services may be authorized for the development of a PIP, per OAC 340:100-5-57; and

(ii) ~~does~~Does not have an available personal support system. The need for this service level:

(I) ~~must~~Must be identified by the grand staffing committee, per OAC 340:75-8-40; and

(II) ~~requires~~Requires the provider to market, recruit, screen, and train potential companions for the member identified.

(h) Authorization for payment of ~~Agency Companion Service~~ACS is contingent upon receipt of:

(1) ~~the~~The applicant's approval letter authorizing ACS for the identified member;

(2) ~~an~~An approved relief and emergency back-up plan addressing a back-up location and provider;

(3) ~~the~~The Plan;

(4) ~~the~~The POC; and

(5) ~~the~~The date the member ~~moved~~is scheduled to move to the ~~companion~~companions home. When a member transitions from a DDS placement funded by a pier diem the incoming provider may request eight (8) hours of HTS for the first day of service.

(i) The Plan reflects the amount of room and board the member pays to the companion. The provider must use the room and board reimbursement payment to meet the member's needs. Items purchased with the room and board reimbursement payment include housing and

food.

(j) ~~If the amount exceeds $500, the additional amount must be:~~

~~(1) agreed upon by the member and, when applicable, legal guardian;~~

~~(2) recommended by the Team; and~~

~~(3) approved by the DDS area manager or designee.~~The room and board payment may include all but one-hundred and fifty dollars ($150) per month of the service recipient's income, up to a maximum of ninety (90) percent of the current minimum Supplemental Security Income (SSI) payment for a single individual.

**317:40-5-5. Agency ~~Companion Services~~companion services (ACS) provider responsibilities**

(a) Companions are required to meet all applicable standards outlined in this subchapter and competency-based training per Oklahoma Administrative Code (OAC) 340:100-3-38. The provider agency ensures all companions meet the criteria in this Section.

(b) Failure to follow any rules or standards, failure to promote the independence of the member, or failure to follow recommendation(s) of the personal support team (Team) results in problem resolution, per OAC 340:100-3-27, for the companion, and when warranted, revocation of approval of the companion.

(c) The companion:

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

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

(3) ~~transports~~Transports or arranges transportation for the member to and from school, employment programs, recreational activities, medical appointments, and therapy appointments;

(4) ~~delivers~~Delivers services in a manner that contributes to the member's enhanced independence, self-sufficiency, community inclusion, and well-being;

(5) ~~participates~~Participates as a member of the member's Team and assists in the development of the member's Individual Plan(Plan) for service provision;

(6) ~~develops,~~Develops, implements, evaluates, and revises the training strategies corresponding to the relevant outcomes for which the companion is responsible, as identified in the Plan. The companion may request assistance from the case manager or

program coordinator. The companion documents and provides monthly data and health care summaries to the provider agency program coordination staff~~.~~;
(7) ~~delivers~~Delivers services at appropriate times as directed in the Plan;
(8) ~~does~~Does not deliver services that duplicate the services mandated to be provided by the public school district pursuant to the Individuals with Disabilities Education Act (IDEA);
(9) ~~is~~Is sensitive to and assists the member in participating in the member's chosen religious faith. No member is expected to attend any religious service against his or her wishes;
(10) ~~participates~~Participates in, and supports visitation and contact with the member's natural family, guardian, and friends, when visitation is desired by the member;
(11) ~~obtains~~Obtains permission from the member's legal guardian, a guardian is assigned, and notifies the family, the provider agency program coordination staff, and the case manager prior to:
(A) ~~traveling out of state;~~Traveling out-of-state;
(B) ~~overnight~~Overnight visits; or
(C) ~~involvement~~Involvement of the member in any publicity;
(12) ~~serves~~Serves as the member's health care coordinator, per OAC 340:100-5-26;
(13) ~~ensures~~Ensures the monthly room and board contribution received from the member is used toward the cost of operating the household;
(14) ~~assists~~Assist the member in accessing entitlement programs for which the member may be eligible and maintains records required for the member's ongoing eligibility;
(15) ~~works~~Works closely with the provider agency program coordination staff and the DDS case manager, to ensure all aspects of the member's program are implemented to the satisfaction of the member, the member's family or legal guardian, when appropriate, and the member's Team;
(16) ~~assists~~Assist the member to achieve the member's maximum level of independence;
(17) ~~submits,~~Submits, in a timely manner, to the provider agency program coordination staff all necessary information regarding the member;
(18) ~~ensures~~Ensures the member's confidentiality is maintained per, OAC 340:100-3-2;
(19) ~~supports~~Supports the member in forming and maintaining friendships with neighbors, co-workers, and peers, including people who do not have disabilities;
(20) ~~implements~~Implements training and provides supports that enable the member to actively join in community life;

(21) ~~does~~Does not serve as representative payee for the member without a written exception from the DDS area residential services programs manager or ~~designee.~~state office residential services program manager.

(A) ~~The~~The written exception ~~is~~and approved DDS home profile are retained in the member's home record.

(B) ~~When~~When serving as payee, the companion complies with OAC 340:100-3-4 requirements;

(22) ~~ensures~~Ensures the member's funds are properly safeguarded;

(23) ~~obtains~~Obtains prior approval from the member's representative payee when making a purchase of over ~~$50~~fifty dollars ($50) with the member's funds;

(24) ~~allows~~Allows provider agency and DDS staff to make announced and unannounced visits to the home;

(25) ~~develops~~Develops an Evacuation Plan, using ~~DHS~~(OKDHS) Form 06AC020E, Evacuation/Escape Plan, for the home and conducts training with the member;

(26) ~~conducts~~Conducts fire and weather drills at least quarterly and documents the fire and weather drills using OKDHS Form 06AC021E, Fire and Weather Drill Record;

(27) ~~develops~~Develops and maintains a personal possession inventory for personal possessions and adaptive equipment, using OKDHS Form 06AC022E, Personal Possession Inventory;

(28) ~~supports~~Supports the member's employment program by:

(A) ~~assisting~~Assisting the member to wear appropriate work attire; and

(B) ~~contacting~~Contacting the member's employer as outlined by the Team and in the Plan;

(29) ~~is~~Is responsible for the cost of the member's meals and entertainment during recreational and leisure activities. Activities must be affordable to the member. Concerns about affordability are presented to the Team for resolution;

(30) ~~for~~For adults, reports suspected maltreatment including abuse, verbal abuse, sexual abuse, neglect, financial neglect, ~~and/or~~or exploitation of a vulnerable adult per Section 10-104 of Title 43A of the Oklahoma Statutes, to the ~~DHS~~OKDHS Office of Client Advocacy (OCA);

(31) ~~for~~For children, reports abuse, neglect, sexual abuse, or sexual exploitation per Section 1-2-101 of Title 10A of the Oklahoma Statutes to the Child Abuse and Neglect Hotline at 1-800-522-3511;

(32) ~~follows~~Follows all applicable rules promulgated by the Oklahoma Health Care Authority and DDS, including:

~~(A) OAC 340:100-3-40;~~

~~(B) OAC 340:100-5-50 through 100-5-58;~~

~~(C) OAC 340:100-5-26;~~

~~(D) OAC 340:100-5-34;~~340:100-5-33;
~~(E) OAC 340:100-5-32;~~
~~(F) OAC 340:100-5-22.1;~~
~~(G) OAC 340:100-3-27;~~
~~(H) OAC 340:100-3-38; and~~
~~(I) OAC 340:100-3-34;~~
(A) OAC 340:100-3-27;
(B) OAC 340:100-3-34;
(C) OAC 340:100-3-38;
(D) OAC 340:100-3-40;
(E) OAC 340:100-5-22.1;
(F) OAC 340:100-5-26;
(G) OAC 340:100-5-32;
(H) OAC 340:100-5-33; and
(I) OAC 340:100-5-50 through 340:100-5-58.

(33) ~~is~~Is neither the member's spouse, nor when the member is a minor child, the member's parent. A family member servicing as companion must meet all requirements listed in this Subchapter; and

(34) ~~is~~Is not the Chief Executive Officer of a provider agency.

## PART 3. GUIDELINES TO STAFF

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

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

(1) ~~agency~~Agency companion services (ACS);

(2) ~~specialized~~Specialized foster care (SFC) services;

(3) ~~respite~~Respite services delivered in the provider's home;

(4) ~~approving~~Approving services in a home shared by a non-relative provider and a member; and

(5) ~~any~~Any other situation that requires a home profile.

(b) **Pre-screening.** Designated ~~(DDS)~~DDS staff provides the applicant with program orientation and completes pre-screening ~~information that includes, but is~~activities to include, but are not limited to:

(1) ~~facts,~~Facts description, and guiding principles of the Home and Community-Based Services (HCBS) program;

(2) ~~an~~An explanation of:

(A) ~~the~~The home profile process;

(B) ~~basic~~Basic provider qualifications;

(C) ~~health,~~Health, safety, and environmental issues; and

(D) ~~training~~Training required per Oklahoma Administrative Code (OAC) 340:100-3-38;

(3) ~~the Oklahoma Department of Human Services (DHS) Form 06AC012E, Specialized Foster Care/Agency Companion Services~~

~~Information Sheet;~~Gathering relevant information about the family, including household members, addresses, and contact information, and motivation to provide services; and

(4) ~~explanation~~An explanation of a background investigation conducted on the applicant and any adult or child living in the applicant's home.

(A) Background investigations are conducted at the time of application and include, but are not limited to:

(i) ~~an~~An Oklahoma State Bureau of Investigation (OSBI) name and criminal records history search, including the Oklahoma Department of Public Safety (DPS), Sex Offender Registry, ~~and~~ Mary Rippy Violent Offender Registries~~;~~, and Nurse Aide and Non-technical Services Worker Registry;

(ii) Federal Bureau of Investigation (FBI) national criminal history search, based on the fingerprints of the applicant and any adult members of the household; except when an exception is necessary as outlined below.

(I) When fingerprints are low quality (as determined by OSBI, FBI, or both) and make it impossible for the national crime information databases to provide results, a name-based search (state, national, or both) may be authorized.

(II) When the DDS State Office residential staff request an exception from an individual, who has a severe physical condition precluding the individual from being fingerprinted, a name-based search (state, national, or both) may be authorized.

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

(iv) ~~search~~Search of all ~~DHS~~OKDHS records, ~~and the~~ Community Services Worker Registry~~;~~, and Restricted Registry;

(v) ~~a~~A search of all applicable out-of-state child abuse and neglect registries for any applicant or adult household member who has not lived in Oklahoma continuously for the past five (5) years. A home is not approved without the results of the out-of-state ~~maintained~~ child abuse and neglect registry checks, when a registry is maintained in the applicable state, for all adult household members living in the home. When a child abuse and neglect registry is not maintained in the applicable state, a request for information is made to the applicable state; and

(vi) ~~search~~Search of Juvenile Justice Information System (JOLTS) records for any child older than ~~13~~thirteen (13) years of age in the applicant's household.

(B) An application is denied when the applicant or any person residing in the applicant's home:

(i) ~~has~~Has a criminal conviction of or pled guilty or no contest to:

(I) ~~physical~~Physical assault, battery, or a drug-related offense in the five-year period preceding the application date;

(II) ~~child~~Child abuse or neglect;

(III) ~~domestic~~Domestic abuse;

(IV) ~~a~~A crime against a child, including, but not limited to, child pornography;

(V) ~~a~~A crime involving violence, including, but not limited to, rape, sexual assault, or homicide, including manslaughter, excluding physical assault and battery; or

(ii) ~~does~~Does not meet OAC 340:100-3-39 requirements;

~~(5) DHS Form 06AC015E, Agency Companion/Specialized Foster Care Employment Record;~~

~~(6) DHS Form 06AC016E, DDS Reference Information Waiver;~~

~~(7) DHS Form 06AC029E, Employer Reference Letter; and~~

~~(8) DHS Form 06AC013E, Pre-Screening for Specialized Foster Care/Agency Companion Services.~~

(c) **Home profile process.** When the applicant meets the requirements of the prescreening, the initial home profile process described in (1) through (8) of this subsection is initiated.

(1) The applicant ~~completes the required forms and returns the forms to the DDS address provided. Required forms include DHS Forms:~~provides required information for the completion of the home profile.

~~(A) 06AC008E, Specialized Foster Care/Agency Companion Services Application;~~

~~(B) 06AC009E, Financial Assessment;~~

~~(C) 06AC011E, Family Health History;~~

~~(D) 06AC018E, Self Study Questionnaire;~~

~~(E) 06AC019E, Child's Questionnaire;~~

~~(F) 06AC010E, Medical Examination Report, when Form 06AC011E indicates conditions that may interfere with the provision of services;~~

~~(G) 06AC017E, Insurance Information; and~~

~~(H) 06AC020E, Evacuation/Escape Plan.~~

(2) When an incomplete form or other information is returned to DDS, designated DDS staff sends a letter to the provider or provider agency identifying information needed to complete the required forms. The home profile is not completed until all required information is provided to DDS.

(3) Designated DDS staff completes the home profile when all required forms are completed and provided to DDS.

(4) For each reference provided by the applicant, designated DDS staff ~~completes DHS Form 06AC058E, Reference Letter;~~documents the results of each completed reference check.

(5) Designated DDS staff, through interviews, visits, and phone calls, gathers information required to complete ~~DHS Form 06AC047E, Home Profile Notes.~~the home profile.

(6) ~~DHS Form 06AC069E, Review of Policies and Areas of Responsibilities, is dated and signed~~DDS staff review policies and areas of responsibilities with the applicant and acknowledgement is made in writing by the applicant and designated DDS staff.

(7) The DDS area residential services programs manager sends to the applicant:

(A) ~~a~~A provider approval letter confirming the applicant is approved to serve as a provider; or

(B) ~~a~~A denial letter stating the application and home profile are denied.

(8) DDS staff records the dates of completion of each part of the home profile process.

(d) **Home standards.** In order to qualify and remain in compliance, the applicant's or provider's home must meet the provisions in (1) through (11) of this subsection.

(1) **General conditions.**

(A) The home, buildings, and furnishings must be comfortable, clean, and in good repair and the grounds must be maintained. There must be no accumulation of garbage, debris, or rubbish or offensive odors.

(B) The home must:

(i) ~~be~~Be accessible to school, employment, church, day programming, recreational activities, health facilities, and other community resources as needed;

(ii) ~~have~~Have adequate heating, cooling and plumbing; and

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

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

(C) Provisions for the member's safety must be present, as needed, including:

(i) ~~guards~~Guards and rails on stairways;

(ii) ~~wheelchair~~Wheelchair ramps;

(iii) ~~widened~~Widened doorways;

(iv) ~~grab~~Grab bars;

(v) ~~adequate~~Adequate lighting;

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

(vii) ~~heat~~Heat and air conditioning equipment guarded and installed in accordance with manufacturer requirements.

Home modifications and equipment may be provided through HCBS Waivers operated by DDS.

(D) Providers must not permit members to access or use swimming or other pools, hot tubs, saunas, ponds, or spas on the premises without supervision. Swimming pools, hot tubs, saunas, ponds, or spas must be equipped with sufficient safety barriers or devices designed to prevent accidental injury or unsupervised access.

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

(2) **Sanitation.**

(A) Sanitary facilities must be adequate and safe, including toilet and bathing facilities, water supply, and garbage and sewer disposal.

(B) When a septic tank or other non-municipal sewage disposal system is used, it must be in good working order.

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

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

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

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

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

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

(G) Laundry equipment, if in the home, must be located in a safe, well-ventilated, and clean area, with the dryer vented to the outside.

(3) **Bathrooms.** A bathroom must:

(A) ~~provide~~Provide for individual privacy and have a finished interior;

(B) ~~be~~Be clean and free of objectionable odors; and

(C) ~~have~~Have a bathtub or shower, flush toilet, and sink in good repair, and hot and cold water in sufficient supply to meet the member's hygiene needs.

(i) A sink must be located near each toilet.

(ii) A toilet and sink must be provided on each floor where rooms of members who are non-ambulatory or with limited mobility are located.

(iii) There must be at least one (1) toilet, one (1) sink,

and one (1) bathtub or shower for every six (6) household occupants, including the provider and family.

(4) **Bedrooms.** A bedroom must:

(A) ~~have~~Have been constructed as such when the home was built or remodeled under permit;

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

(i) Exception to allow members to share a bedroom may be made by DDS area residential program manager, when DDS determines sharing a bedroom is in the best interest of the member. ~~Minor members must not share bedrooms with adults.~~

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

(iii) Minor members must not share bedrooms with adults.

(C) ~~have~~Have a minimum of ~~80~~eighty (80) square feet of usable floor space for each member or ~~120~~one-hundred and twenty (120) square feet for two (2) members and two (2) means of egress. The provider, family members, or other occupants of the home must not sleep in areas designated as common use living areas, nor share bedrooms with members;

(D) ~~be~~Be finished with walls or partitions of standard construction that go from floor to ceiling;

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

(F) ~~include~~Include an individual bed for each member consisting of a frame, box spring, and mattress at least ~~36~~thirty-six (36) inches wide, unless a specialized bed is required to meet identified needs. Cots, rollaways, couches, futons, and folding beds must not be used for members.

(i) Each bed must have clean bedding in good condition consisting of a mattress pad, bedspread, two (2) sheets, pillow, pillowcase, and blankets adequate for the weather.

(ii) Sheets and pillowcases must be laundered at least weekly or more often if necessary.

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

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

(i) Members must be allowed to keep and use reasonable amounts of personal belongings and have private, secure storage space.

(ii) The provider assists the member in furnishing and decorating the member's bedroom.

(iii) Window coverings must be in good condition and allow privacy for members;

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

(I) ~~be~~Be in close enough proximity to the provider to alert the provider to nighttime needs or emergencies, or be equipped with ~~a call bell or intercom.~~an alert system.

(5) **Food.**

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

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

(C) Utensils, dishes, and glassware must be washed and stored to prevent contamination.

(D) Food storage and preparation areas and equipment must be clean, free of offensive odors, and in good repair.

(6) **Phone.**

(A) A working phone must be provided in the home that is available and accessible for the member's use for incoming and outgoing calls.

(B) Phone numbers to the home and providers must be kept current and provided to DDS and, when applicable, the provider agency.

(7) **Safety.**

(A) Buildings must meet all applicable state building, mechanical, and housing codes.

(B) Heating, in accordance with manufacturer's specifications, and electrical equipment, including wood stoves, must be installed in accordance with all applicable fire and life safety codes. Such equipment must be used and maintained properly and in good repair.

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

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

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

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

(8) **Emergencies.**

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

(B) At least one (1) working fire extinguisher must be in a

readily accessible location.

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

(D) The provider:

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

(ii) ~~maintains~~Mainstays a written evacuation plan for the home and conducts training for evacuation with the member;

(iii) ~~conducts~~Conducts fire drills quarterly and severe weather drills twice per year;

(iv) ~~makes~~Makes fire and severe weather drill documentation available for review by DDS;

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

(vi) ~~is~~Is responsible to re-establish a residence, if the home becomes uninhabitable.

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

(F) The address of the home must be clearly visible from the street.

(9) **Special hazards.**

(A) Firearms and other dangerous weapons must be stored in a locked permanent enclosure. Ammunition must be stored in a separate locked location. Providers are prohibited from assisting members to obtain, possess, or use dangerous or deadly weapons, per OAC 340:100-5-22.1.

(B) Flammable and combustible liquids and hazardous materials must be safely and properly stored in original, properly labeled containers.

(C) Cleaning supplies, medical sharps containers, poisons, and insecticides must be properly stored in original, properly labeled containers in a safe area away from food, food preparation areas, dining areas, and medications.

(D) Illegal substances are not permitted on the premises.

(10) **Vehicles.**

(A) All vehicles used to transport members must meet local and state requirements for accessibility and safe transit, licensing, inspection, insurance, and capacity.

(B) Drivers of vehicles must have valid and appropriate driver licenses.

(11) **Medication.** Medication for the member is stored, per OAC 340:100-5-32.

(e) **Evaluating the applicant and home.** The initial home profile evaluation includes, but is not limited to:

(1) ~~evaluating~~Evaluating the applicant's:

(A) ~~interest~~Interest and motivation;

(B) ~~life~~Life skills;

(C) ~~children;~~Children;

(D) ~~methods~~Methods of behavior support and discipline;

(E) ~~marital~~Marital status, background, and household composition;

(F) ~~income~~Income and money management; and

(G) ~~teamwork~~Teamwork and supervision, back-up plan, and use of relief; and

(2) ~~assessment~~Assessment and recommendation. DDS staff:

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

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

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

(ii) ~~demonstrate~~Demonstrate the skills to meet the individual needs of the member;

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

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

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

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

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

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

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

(ii) ~~an~~An effective date for determining the applicant does not meet standards. Reasons for denying a request to be a provider may include, but are not limited to:

(I) ~~a~~A lack of stable, adequate income to meet the applicant's own or total family needs or poor management of the available income;

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

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

(IV) ~~relationships~~Relationships in the applicant's

household that are unstable and unsatisfactory;
(V) ~~the~~The mental health of the applicant or other family or household member that impedes the applicant's ability to provide appropriate care for a member;
(VI) ~~references~~References who are guarded or have reservations in recommending the applicant;
(VII) ~~the~~The applicant failed to complete the application, required training, or verifications in a timely manner as requested or provided incomplete, inconsistent, or untruthful information;
(VIII) ~~the~~The home is determined unsuitable for the member requiring placement;
(IX) ~~confirmed~~Confirmed abuse, neglect, or exploitation of any person;
(X) ~~breach~~Breach of confidentiality;
(XI) ~~involvement~~Involvement of the applicant or provider involvement in criminal activity or criminal activity in the home;
(XII) ~~failure~~Failures to complete training, per OAC 340:100-3-38;
(XIII) ~~failure~~Failures of the home to meet standards per subsection (d) of this Section; and
(XIV) ~~failure~~Failures to follow applicable ~~DHS~~OKDHS or Oklahoma Health Care Authority ~~(OHCA) rules;~~(OHCA) rules;

(E) ~~notifies~~Notifies the applicant in writing of the final approval or denial of the home profile;
(F) ~~when~~When an application is canceled or withdrawn prior to completion of the home profile, completes a final written assessment that includes the:
(i) ~~reason~~Reason the application was canceled or withdrawn; ~~and~~
(ii) DDS staff's impression of the applicant based on information obtained; and
(iii) ~~effective~~Effective date of cancellation or withdrawal. Written notice is sent to the applicant to confirm cancellation or withdrawal of the application, and a copy is included in local and State Office records.

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

member and the home to ensure ongoing compliance with home standards. A home profile review is conducted when a provider notifies DDS of his or her intent to move to a new residence. DDS staff ~~asses~~assesses the home to ensure the new home meets home standards and is suitable to meet the member's needs. The annual home profile review;

(1) ~~includes~~Includes information specifically related to the provider's home and is documented~~ on DHS Form 06AC024E, Annual Review;~~as an annual review;

(2) ~~includes form 06AC010E,Medical Examination Report,~~Includes a medical examination report completed a minimum of every three (3) years following the initial approval, unless medical circumstances warrant more frequent completion;

(3) ~~includes~~Includes information from the DDS case manager, the provider of agency companion or SFC services, the Child Welfare specialist, Adult Protective Services, and Office of Client Advocacy staff, and the provider agency program coordinator when applicable.

(4) ~~includes~~Includes information from the service member indicating satisfaction with service and a desire to continue the arrangement;

(5) ~~addresses~~Includes areas of service where improvement is needed;

(6) ~~includes~~Includes areas of service where progress was noted or were of significant benefit to the member;

(7) ~~ensures~~Ensures background investigation, per OAC 317:40-5-40(b), is repeated every year, except for the OSBI and FBI national criminal history search;

(8) ~~ensures~~Ensures the FBI national criminal history search, per OAC 317:40-5-40(b)(4)(A)(ii), is repeated every five (5) years;

(9) ~~includes~~Ensures written notification to providers and agencies, when applicable, of the continued approval of the provider.

(10) ~~includes~~Includes written notification to providers and agencies, when the provider or agency fails to comply with the home standards, per OAC 317:40-5-40 including deadlines for correction of the identified standards~~; and includes copies of DHS Forms 06AC024E and, when applicable, 06AC010E, in local and State Office records~~.

(g) Reasons a home profile review may be denied include, but are not limited to:

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

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

concerns;
(3) ~~the~~The age, health, or any other condition of the provider that impedes the provider's ability to provide appropriate care for a member;
(4) ~~relationships~~Relationships in the provider's household that are unstable and unsatisfactory;
(5) ~~the~~The mental health of the provider or other family or household member impedes the provider's ability to provide appropriate care for a member;
(6) ~~the~~The provider fails to complete required training, or verifications in a timely manner as requested or provides incomplete, inconsistent, or untruthful information;
(7) ~~the~~The home is determined unsuitable for the member;
(8) ~~failure~~Failure of the provider to complete tasks related to problem resolution, as agreed, per OAC 340:100-3-27;
(9) ~~failure~~Failure of the provider to complete a plan of action, as agreed, per OAC 317:40-5-63;
(10) ~~confirmed~~Confirmed abuse, neglect, or exploitation of any person;
(11) ~~breach~~Breach of confidentiality;
(12) ~~involvement~~Involvement of the applicant or provider involvement in the criminal activity or criminal activity in the home;
(13) ~~failure~~Failure to provide for the care and well-being of the service member;
(14) ~~failure~~Failure or continued failure to implement the individual Plan, per OAC 340:100-5-50 through 100-5-58;
(15) ~~failure~~Failure to complete and maintain training, per OAC 340:100-3-38;
(16) ~~failure~~Failure to report changes in the household;
(17) ~~failure~~Failure to meet standards of the home per subsection (d) of this Section;
(18) ~~failure~~Failure or continued failure to follow applicable ~~DHS~~OKDHS or OHCA rules;
(19) ~~decline~~Decline of the provider's health to the point he or she can no longer meet the needs of the service member;
(20) ~~employment~~Employment by the provider without prior approval of the DDS area programs manager for residential services; or
(21) ~~domestic~~Domestic disputes that cause emotional distress to the member.

(h) **Termination of placement.** When an existing placement is terminated for any reason:
(1) ~~the~~The Team meets to develop an orderly transition plan; and

(2) DDS staff ensures the property of the member and state is removed promptly and appropriately by the member or his or her designee.

## PART 9. SERVICE PROVISIONS

**317:40-5-100. Assistive technology (AT) devices and services**

(a) **Applicability.** ~~The rules in this~~This Section ~~apply~~applies to AT services and devices authorized by~~ the~~ Oklahoma Department of Human Services ~~(DHS)~~OKDHS Developmental Disabilities Services (DDS) through Home and Community Based Services (HCBS) Waivers.

(b) **General information.**

(1) AT devices include the purchase, rental, customization, maintenance, and repair of devices, controls, and appliances. AT devices include:

(A) ~~visual~~Visual alarms;

(B) ~~telecommunication~~Telecommunication devices (TDDS);

(C) ~~telephone~~Telephone amplifying devices;

(D) ~~other devices~~Devices for the protection of health and safety of members who are deaf or hard of hearing;

(E) ~~tape~~Tape recorders;

(F) ~~talking~~Talking calculators;

(G) ~~specialized~~Specialized lamps;

(H) ~~magnifiers;~~Magnifiers;

(I) ~~braille~~Braille writers;

(J) ~~braille~~Braille paper;

(K) ~~talking~~Talking computerized devices;

(L) ~~other devices~~Devices for the protection of health and safety of members who are blind or visually impaired;

(M) ~~augmentative~~Augmentative and alternative communication devices including language board and electronic communication~~,~~ devices;

(N) ~~competence based~~Competence-based cause and effect systems, such as switches;

(O) ~~mobility~~Mobility and positioning devices including:

(i) ~~wheelchairs;~~Wheelchairs;

(ii) ~~travel~~Travel chairs;

(iii) ~~walkers;~~Walkers;

(iv) ~~positioning~~Positioning systems;

(v) ~~ramps;~~Ramps;

(vi) ~~seating~~Seating systems;

(vii) ~~standers;~~Standers;

(viii) ~~lifts;~~Lifts;

(ix) ~~bathing~~Bathing equipment;

(x) ~~specialized~~Specialized beds; and

(xi) ~~specialized~~Specialized chairs;

(P) ~~orthotic~~Orthotic and prosthetic devices, including:

(i) ~~braces;~~Braces
(ii) ~~prescribed~~Precribed modified shoes; and
(iii) ~~splints;~~Splints;
(Q) ~~environmental~~Environmental controls or devices;
(R) ~~items~~Items necessary for life support, and devices necessary for the proper functioning of such items, including durable and non-durable medical equipment not available through SoonerCare~~; and~~ (Medicaid); and
(S) ~~devices for the protection of~~Devices to protect the member's health and safety~~.~~ can include, but are not limited to:
(i) Motion sensors;
(ii) Smoke and carbon monoxide alarms;
(iii) Bed and/or chair sensors;
(iv) Door and window sensors;
(v) Pressure sensors in mats on the floor;
(vi) Stove guards or oven shut off systems;
(vii) Live web-based remote supports;
(viii) Cameras;
(ix) Automated medication dispenser systems;
(x) Software to operate accessories included for environmental control;
(xi) Software applications;
(xii) Personal Emergency Response Systems (PERS) or Mobile;
(xiii) Emergency Response Systems (MER);
(xiv) Global positioning system (GPS) monitoring devices;
(xv) Radio frequency identification;
(xvi) Computers and tablets;
(xvii) Any other device approved by the Developmental; and
(xviii) Disabilities Services (DDS) director or designee.

(2) AT services include:
(A) ~~sign~~Sign language interpreter services for members who are deaf;
(B) ~~reader~~Reader services;
(C) ~~auxiliary~~Auxillary aids;
(D) ~~training~~Training the member and provider in the use and maintenance of equipment and auxiliary aids;
(E) ~~repair~~Repair of AT devices; and
(F) ~~evaluation~~Evaluation of the member's AT needs.

(3) AT devices and services must be included in the member's Individual Plan (IP), prescribed by a physician with a SoonerCare (Medicaid) contract, and arrangements for this HCBS service must be made through the member's case manager.

(4) AT devices are provided by vendors with a Durable Medical Equipment (DME) contract with the Oklahoma Health Care

Authority (OHCA).

(5) AT devices and services are authorized in accordance with requirements of The Oklahoma Central Purchasing Act, other applicable statutory provisions, Oklahoma Administrative Code ~~OAC~~OAC 580:15 and ~~DHS approved~~OKDHS-approved purchasing procedures.

(6) AT services are provided by an appropriate professional services provider with a current HCBS contract with OHCA and current, unrestricted licensure and certification with their professional board, when applicable.

(7) AT devices or services may be authorized when the device or service:

(A) ~~has~~Has no utility apart from the needs of the person receiving services;

(B) ~~is~~Is not otherwise available through SoonerCare~~,~~ (Medicaid) an AT retrieval program, the Oklahoma Department of Rehabilitative Services, or any other third party or known community resource;

(C) ~~has~~Has no less expensive equivalent that meets the member's needs;

(D) ~~is~~Is not solely for family or staff convenience or preference;

(E) ~~is~~Is based on the assessment and Personal Support Team (Team) consideration of the member's unique needs;

(F) ~~is~~Is of direct medical or remedial benefit to the member;

(G) enables the member to maintain, increase, or improve functional capabilities;

(H) ~~is~~Is supported by objective documentation included in a professional assessment, except as specified, per OAC 317:40-5-100;

(I) ~~is~~Is within the scope of assistive technology, per OAC 317:40-5-100;

(J) ~~is~~Is the most appropriate and cost effective bid, ~~if~~when applicable; and

(K) ~~exceeds~~Exceeds a cost of ~~$50.~~seventy-five dollars ($75) AT devices or services with a cost of ~~$50~~seventy-five dollars ($75) or less, are not authorized through DDS HCBS Waivers.

(8) The homeowner must sign a written agreement for any AT equipment that attaches to the home or property.

(c) **Assessments.** Assessments for AT devices or services are performed by a licensed, professional service provider and reviewed by other providers whose services may be affected by the ~~type of~~ device selected. A licensed, professional service provider must:

(1) ~~determine whether~~Determine if the member's identified outcome can be accomplished through the creative use of other resources, such as:

(A) ~~household~~Household items or toys;

(B) ~~equipment~~Equipment loan programs;

(C) ~~low-technology~~Low-technology devices or other less intrusive options; or

(D) ~~a~~A similar, more cost-effective device;

(2) ~~recommend~~Recommend the most appropriate AT based on the member's:

(A) ~~present~~Present and future needs, especially for members with degenerative conditions;

(B) ~~history~~History of use of similar AT, and his or her current ability to use the device~~ currently and for at least the foreseeable future no less than 5~~and for the next five (5) years; and

(C) ~~outcomes;~~Outcomes;

(3) ~~complete~~Complete an assessment, including a decision making review and device trial that provides supporting documentation for purchase, rental, customization, or fabrication of an AT device. Supporting documentation must include:

(A) ~~a review of the device considered;~~A dice review;

(B) ~~availability~~Availability of the device rental with discussion of advantages and disadvantages;

(C) ~~how~~How frequently~~,~~ and in what situations the device will be used in daily activities and routines;

(D) ~~how~~How the member and caregiver(s) will be trained to safely use the AT device; and

(E) ~~the~~The features and specifications of the device necessary for the member, including rationale for why other alternatives are not available to meet the member's needs; and

(4) Upon DDS staff's request, provide a current, unedited ~~videotape or pictures~~video or photographs of the member using the device, including ~~the~~recorded trial time frames~~ of the trials recorded, upon request by DDS staff~~.

(d) **~~Authorization of repairs, or replacement of parts.~~Repairs and placement part authorization.** ~~Repairs to AT devices, or replacement of device parts,~~ AT device repairs or parts replacements, do not require a professional assessment or recommendation. DDS~~ area office~~ resource development staff with assistive technology experience may authorize repairs and replacement of parts for previously recommended ~~assistive technology.~~AT.

(e) **~~Retrievals of assistive technology devices.~~AT device retrieval.** When~~ devices are no longer needed by~~ a member~~,~~ no longer needs an AT device, ~~DHS~~OKDHS DDS staff may retrieve the device.

(f) **Team decision-making process.** The member's Team reviews the licensed professional's assessment and decision-making review. The Team ensures the recommended AT:

(1) ~~is~~Is needed by the member to achieve a specific, identified functional outcome.

(A) A functional outcome, in this Section, means the activity is meaningful to the member, occurs on a frequent basis, and would require assistance from others, if the member could not perform the activity independently, such as self-care, assistance with eating, or transfers.

(B) Functional outcomes must be reasonable and necessary given a member's age, diagnosis, and abilities;

(2) ~~allows~~Allows the member receiving services to:

(A) ~~improve~~Improve or maintain health and safety;

(B) ~~participate~~Participate in community life;

(C) ~~express~~Express choices; or

(D) ~~participate~~Participate in vocational training or employment;

(3) ~~will~~Will be used frequently or in a variety of situations;

(4) ~~will~~Will easily fit into the member's lifestyle and work place;

(5) ~~is~~Is specific to the member's unique needs; and

(6) ~~is~~Is not authorized solely for family or staff convenience.

(g) **Requirements and standards for AT devices and service providers.**

(1) Providers guarantee devices, work, and materials for one (1) calendar year, and supply necessary follow-up evaluation to ensure optimum usability.

(2) Providers ensure a licensed occupational therapist, physical therapist, speech therapist, or rehabilitation engineer evaluates the need for AT, and individually customizes AT devices~~ as needed~~.

(h) **Services not covered through AT devices and services.** ~~Assistive technology~~AT devices and services do not include:

(1) ~~trampolines;~~Trampolines;

(2) ~~hot~~Hot tubs;

(3) ~~bean~~Bean bag chairs;

(4) ~~recliners~~Recliners with lift capabilities;

(5) ~~computers~~Computers, except as adapted for individual needs as a primary means of oral communication, and approved, per OAC 317:40-5-100;

(6) ~~massage~~Massage tables;

(7) ~~educational~~Educational games and toys; or

(8) ~~generators.~~Generators.

(i) **~~Approval or denial of AT.~~AT approval or denial.** DDS approval, conditional approval for pre-determined trial use, or denial of

the purchase, rental, or ~~lease/purchase~~lease or purchase of the AT is determined, per OAC 317:40-5-100.

(1) The DDS case manager sends the AT request to designated DDS ~~area office~~AT-experienced resource development staff ~~with AT experience~~. The request must include:

(A) ~~the~~The licensed professional's assessment and decision making review;

(B) ~~a~~A copy of the Plan of Care (POC);

(C) ~~documentation of~~Documentaion of the current Team consensus, including consideration of issues, per OAC 317:40-5-100; and

(D) ~~all~~All additional documentation to support the ~~need for the~~ AT device or service~~.~~ need.

(2) The designated ~~area office~~AT-experienced resource development staff~~, with AT experience,~~ approves or denies the AT request when the device costs less than ~~$2500.~~$5000.

(3) The State Office programs manager for AT approves or denies the AT request when the device has a cost of ~~$2500~~$5000 or more.

(4) Authorization for purchase or a written denial is provided within ~~10~~ten (10) business days of receipt of a complete request~~.~~:

(A) If the AT is approved, a letter of authorization is issued~~.~~;

(B) If additional documentation is required by the ~~area office~~AT-experienced resource development staff ~~with AT experience~~, to authorize the recommended AT, the request packet is returned to the case manager for completion~~.~~;

(C) When necessary, the case manager contacts the licensed professional to request the additional documentation~~.~~; and

(D) The authorization of ~~a $2,500~~an AT device of $5000 or more ~~AT~~ is completed per (2) of this subsection, ~~except that~~and the ~~area office~~AT-experienced resource development staff with ~~AT experience~~:

(i) ~~solicits three bids for the AT;~~Solicits three (3) AT bids;

(ii) ~~submits~~Submits the AT request, bids, and other relevant information to the ~~DDS~~ State Office DDS AT programs manager or designee within five (5) business days of receipt of the required bids; and

(iii) ~~the~~The State Office DDS AT programs manager or designee issues a letter of authorization, a written denial, or a request for additional information within five (5) business days of receipt of all required AT documentation ~~for the AT~~.

(j) **~~Approval of vehicle~~Vehicle approval adaptations.** Vehicle adaptations are assessed and approved, per OAC 317:40-5-100. In

addition, the requirements in (1) through (3) of this subsection must be met.

(1) The vehicle~~ to be adapted~~ must be owned or in the process of being purchased by the member receiving services or his or her family~~.~~ in order to be adapted.

(2) The AT request must include a certified mechanic's statement that the vehicle and adaptations are mechanically sound.

(3) Vehicle adaptations are limited to one vehicle in a ~~10-calendar~~ten (10) year period per member. Authorization for more than one vehicle adaptation in a ~~10-year~~ten (10) year period must be approved by the DDS ~~division administrator~~director or designee.

(k) **~~Denial.~~AT denial.** Procedures for denial of an AT device or service are described in (1) through (3) of this subsection.

(1) The person denying the AT request provides a written denial to the case manager citing the reason for denial, per OAC 317:40-5-100.

(2) The case manager sends ~~DHS FORM~~OKDHS Form 06MP004E, ~~the~~ Notice of Action, to the member and his or her family or guardian.

(3) ~~Denial of AT services~~AT service denials may be appealed through the ~~DHS~~OKDHS hearing process, per OAC 340:2-5.

(l) **~~Return of an~~ AT device~~.~~ returns.** When, during a trial use period or rental of a device, the therapist or Team including the licensed professional~~ when available,~~ who recommended the AT~~,~~ and, when available, determines the device is not appropriate, the licensed professional sends a brief report describing the ~~reason(s) for the~~ change of device recommendation to the DDS case manager. The DDS case manager forwards the report to the designated~~ area office~~ resource development staff, who arranges for the~~ return of the~~ equipment return to the vendor or manufacturer.

(m) **~~Rental of AT devices.~~AT device rental.** AT devices are rented when the licensed professional or ~~area office~~AT-experienced resource development staff~~ with AT experience~~ determines rental of the device is more cost effective than purchasing the device or the licensed professional recommends a trial period to determine if the device meets the member's needs.

(1) The rental period begins on the date the manufacturer or vendor delivers the equipment to the member, unless otherwise stated in advance by the manufacturer or vendor.

(2) ~~Area office~~AT-experienced resource development staff~~ with AT experience~~ monitor use of equipment during the rental agreement for:

(A) ~~cost effectiveness of the rental time frames;~~Rental time frame cost effectiveness;

(B) ~~conditions of renewal; and~~Renewal conditions; and

(C) ~~the~~The Team's, including the licensed ~~professional,~~professional's re-evaluation of the member's need for the device, per OAC 317:40-5-100.

(3) Rental costs are applied toward the purchase price of the device ~~whenever such~~when the option is available from the manufacturer or vendor.

(4) When a device is rented for a ~~trial use~~trial-use period, the Team~~,~~ including the licensed professional, decides within ~~90 calendar~~ninety (90) calendar days whether the device:

(A) ~~the equipment meets~~Meets the member's needs; and

(B) ~~to purchase the equipment or return it.~~Should be purchased or returned.

(n) **~~Assistive Technology Committee.~~AT committee.** The AT committee reviews equipment requests when deemed necessary by the ~~DHS~~OKDHS DDS State Office AT programs manager~~ for AT~~.

(1) The AT committee is comprised of:

(A) DDS professional staff members of the appropriate therapy;

(B) DDS~~ AT~~ State Office AT programs manager;

(C) ~~the~~The DDS area ~~manager~~field administrator or designee; and

(D) ~~an~~An AT expert, not employed by ~~DHS.~~OKDHS.

(2) The AT committee performs a paper review, providing technical guidance, oversight, and consultation.

(3) The AT committee may endorse or recommend denial of a device or service, based on criteria provided in this Section. Any endorsement or denial includes a written rationale for the decision and, ~~if~~when necessary, an alternative solution, directed to the case manager within ~~20~~twenty (20) business days of the receipt of the request. Requests reviewed by the AT committee result in suspension of time frames specified, per OAC 317:40-5-100.

## PART 11. OTHER COMMUNITY RESIDENTIAL SUPPORTS

### 317:40-5-152. Group home services for persons with an intellectual disability or certain persons with related conditions

(a) **General Information.** Group homes provide a congregate living arrangement offering up to ~~24-hour~~twenty-four (24) hours per day supervision, supportive assistance, and training in daily living skills to persons who are eligible and ~~18~~eighteen (18) years of age or older. Upon approval of the Oklahoma Department of Human Services ~~DHS~~OKDHS Developmental Disabilities Services ~~DDS~~(DDS) director or designee, persons younger than ~~18~~eighteen (18) years of age may be served.

(1) Group homes ensure members reside and participate in the community. Services are provided in homes located in close

proximity to generic community services and activities.

(2) Group homes must be licensed by ~~DHS~~OKDHS per Section 1430.1 et seq. of Title 10 of the Oklahoma Statutes.

(3) Residents of group homes receive no other form of residential supports.

(4) Habilitation training specialist (HTS) services or homemaker services for residents of group homes may only be approved by the DDS director or designee:

(A) ~~for~~For a resident of a group home to resolve a temporary emergency when no other resolution exists; or

(B) ~~for~~For a resident of a community living group home when the resident's needs are so extensive that additional supports are needed for identified specific activities; and

(C) ~~weekly~~Weekly average of ~~56~~fifty-six (56) hours of direct contact staff must be provided to the resident before HTS services may be approved.

(b) **Minimum provider qualifications.** Approved providers must have a current contract with the Oklahoma Health Care Authority (OHCA) to provide DDS Home and Community-Based Services (HCBS) for persons with an intellectual disability or related conditions.

(1) Group home providers must have a completed and approved application to provide DDS group home services.

(2) Group home staff must:

(A) ~~complete~~Complete the ~~DHS~~OKDHS DDS-sanctioned training curriculum, per OAC 340:100-3-38; and

(B) ~~fulfill~~Fulfill requirements for pre-employment screening, per ~~OAC~~Oklahoma Administrative Code (OAC) 340:100-3-39.

(c) **Description of services.**

(1) Group home services:

(A) ~~meet~~Meet all applicable requirements of OAC 340:100; and

(B) ~~are~~Are provided in accordance with each member's Individual Plan (IP) developed, per OAC 340:100-5-50 through 340:100-5-58.

(i) Health care services are secured for each member, per OAC 340:100-5-26.

(ii) Members are offered recreational and leisure activities maximizing the use of generic programs and resources, including individual and group activities.

(2) Group home providers:

(A) ~~follow~~Follow protective intervention practices, per OAC 340:100-5-57 and 340:100-5-58;

(B) ~~in~~In addition to the documentation required, per OAC 340:100-3-40, must maintain:

(i) ~~staff~~Staff time sheets that document the hours each staff was present and on duty in the group home; and

(ii) ~~documentation~~Documentation of each member's presence or absence on the daily attendance form provided by DDS; and

(C) ~~ensure~~Ensure program coordination staff (PCS) meet staff qualifications and supervise, guide, and oversee all aspects of group home services, per OAC 340:100-5-22.6 and 340:100-6, as applicable.

(d) **Coverage limitations.** Group home services are provided up to ~~366~~three-hundrend and sixty-six (366) days per year.

(e) **Types of group home services.** Three (3) types of group home services are provided through HCBS Waivers.

(1) **Traditional group homes.** Traditional group homes serve no more than ~~12~~twelve (12) members, per OAC 340:100-6.

(2) **Community living homes.** Community living homes serve no more than ~~12~~twelve (12) members.

(A) Members who receive community living home services:

(i) ~~have~~Have needs that cannot be met in a less structured setting; and

(ii) ~~require~~Require regular, frequent, and sometimes constant assistance and support to complete daily living skills, such as bathing, dressing, eating, and toileting; or

(iii) ~~require~~Require supervision and training in appropriate social and interactive skills, due to on-going behavioral issues to remain included in the community.

(B) Services offered in a community living home include:

(i) ~~24-hour~~Twenty-four (24) hour awake supervision when a member's IP indicates it is necessary; and

(ii) ~~program~~Program supervision and oversight including hands-on assistance in performing activities of daily living, transferring, positioning, skill-building, and training.

(C) Services may be approved for individuals in a traditional group home at the community living service rate when the member has had a change in health status or behavior and meets the requirements to receive community living home services. ~~Requests to receive community living home services are sent to the DDS Community Services Residential Unit.~~

(3) **Alternative group homes.** Alternative group homes serve no more than four (4) members who have evidence of behavioral or emotional challenges in addition to an intellectual disability and require extensive supervision and assistance in order to remain in the community.

(A) Members who receive alternative group home services must meet criteria, per ~~in~~ OAC 340:100-5-22.6.

(B) A determination must be made by the DDS ~~Community Services Unit~~director or designee that alternative group home services are appropriate.

## SUBCHAPTER 7. EMPLOYMENT SERVICES THROUGH HOME AND COMMUNITY-BASED SERVICES WAIVERS

### 317:40-7-11. Stabilization Services

Stabilization Services are ongoing support services needed to maintain a member in an integrated competitive employment site. Stabilization Services are provided for up to two (2) years per job. Stabilization Services continue until the next Plan of Care following the end of two (2) years of Stabilization Services.

(1) Stabilization Services are provided when the job coach intervention time required at the job site is ~~20%~~twenty percent (20%) or less of the member's total work hours for four (4) consecutive weeks or when the member moved from Department of Rehabilitation Services (DRS) services.

(A) If, after the member moves to Stabilization~~,~~ Services the Team determines that support is needed above ~~20%~~twenty percent (20%) for longer than two (2) weeks, the Team may revise the member's Plan of Care to reflect the need for Job Coaching Services.

(B) A member receiving services from DRS moves to services funded by ~~DDSD~~DDS upon completion of the Job Stabilization milestone. The employment provider agency submits the request for transfer of funding during the Job Stabilization milestone as described in the DRS Supported Employment contract.

(2) Stabilization Services must:

(A) ~~identify~~Identify the supports needed, including development of natural supports;

(B) ~~specify,~~Specify, in a measurable manner, the services ~~to be~~ provided.

(3) Reimbursement for Stabilization Services is based upon the number of hours the member is employed at a rate of minimum wage or above.

(4) ~~If the member needs job coach services after the expiration of Stabilization Services, Employment Training Specialist Services may be authorized for the hours necessary to provide direct support to the member or consultation to the employer as described in outcomes and methods in the Individual Plan.~~ Stabilization Services may be authorized through remote supports per a Health Insurance Portability and Accountability Act (HIPAA) compliant technology, when the Team has an approved remote supports risk assessment.

(5) If the member needs job coach services after the expiration

of Stabilization Services, Employment Training Specialist Services may be authorized for the hours necessary to provide direct support to the member or consultation to the employer as described in outcomes and methods in the Individual Plan.

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

**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**

**PART 85. ADVANTAGE PROGRAM WAIVER SERVICES**

**317:30-5-764. Reimbursement**

(a) Rates for Waiver services are set in accordance with the rate-setting process by the State Plan Amendment and Rate Committee (SPARC) and approved by the Oklahoma Health Care Authority (OHCA) Board.

(1) The rate for Nursing Facility (NF) respite is set equivalent to the rate for routine level of care NF services that require providers having equivalent qualifications;

(2) The rate for daily units for Adult Day Health is set equivalent to the rate established by the Oklahoma Department of Human Services ~~(DHS)~~ (OKDHS) for equivalent services provided for the ~~(DHS)~~OKDHS Adult Day Service Program that requires providers have equivalent qualifications.

(3) The rate for units of home-delivered meals is~~ are~~ set equivalent to the rate established by the ~~DHS~~OKDHS for the equivalent services provided for the ~~DHS~~OKDHS Home-Delivered Meals Program that require providers having equivalent qualifications.

(4) The rates for units of ADvantage Personal Care and In-Home Respite are set equivalent to State Plan Agency Personal Care unit rate that requires providers have equivalent qualifications.

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

(6) Consumer-Directed Personal Assistance Services and Supports (CD-PASS) rates are determined using the Individual Budget Allocation (IBA) Expenditure Accounts Determination process for each member. The IBA Expenditure Accounts Determination process includes consideration and decisions about the items listed in (A) B (C) of this paragraph.

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

(B) The ~~PSA and APSA~~Personal Care (PSA) and Personal Care Advanced Supportive/Restorative (APSA) service unit rates are calculated by the ~~DHS~~OKDHS Aging Services (AS) during the CD-PASS service eligibility determination process. ~~DHS~~OKDHS AS sets the PSA and APSA unit rates at a level that

is not less than ~~80~~eighty percent (80%) and not more than ~~95~~ninety-five percent (95%) of the comparable ~~Agency Personal Care (PSA) or Advanced Supportive/Restorative (APSA)~~PSA or APSA service rates. The allocation of portions of the PSA and/or APSA rates to cover salary, mandatory taxes, and optional benefits including Worker's Compensation insurance, when available, is determined individually for each member using the CD-PASS ~~Individualized Budget Allocation (IBA)~~IBA Expenditure Accounts Determination Process.

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

(7) Three (3) per diem reimbursement rate levels for the ADvantage assisted living services are set. Different rate per diem levels are established to adequately reimburse the provider for the provision of different levels of service to accommodate different level of member need for services-type, intensity and frequency to address member Activities of Daily Living and Instrumental Activities of Daily Living (ADL/IADL) and health care needs. Rounded to the nearest cent, the lowest level Assisted Living Services per diem rate is set equivalent to 11.636 times the State Plan Agency Personal Care unit rate; the mid-level per diem rate is set equivalent to 15.702 times the State Plan Agency Personal Care unit rate; and the highest level Assisted Living Services per diem rate is set equivalent to 21.964 times the State Plan Agency Personal Care unit rate. The specific rate level appropriate to a particular member's service is determined by Uniform Comprehensive Assessment Tool, Part III (UCAT III) assessment by the member's Advantage case manager employed by a case management agency independent of the Assisted Living Services provider. ADvantage payment is not made for ~~24-hour~~twenty-four (24) hour skilled care in an

assisted living center. Federal financial participation is not available for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. Separate payment is not made for ADvantage services of personal care, advanced supportive/restorative assistance, skilled nursing, Personal Emergency Response System, home-delivered meals, adult day health or environmental modifications to a member while receiving assisted living services since these services are integral to and inherent in the provision of assisted living service. However, separate payment may be made for Medicaid State Plan and/or Medicare Home Health benefits to members receiving ADvantage assisted living. Separate payment is not made for ADvantage respite to a member while receiving assisted living services since by definition assisted living services assume the responsibility for ~~24-hour~~twenty-four (24) hour oversight/monitoring of the member, eliminating the need for informal support respite. The member is responsible for room and board costs; however, for an ADvantage member, the ADvantage assisted living services provider is allowed to charge a maximum for room and board that is no more than ~~90~~ninety (90) percent of the Supplemental Security Income (SSI) Federal Benefit Rate. When, per ~~OAC~~Oklahoma Administrative Code (OAC) 317:35-17-1(b) and 317:35-17-11, the member has a vendor payment obligation, the provider is responsible for collecting the vendor payment from the member.

~~(7)~~(8) The maximum total annual reimbursement for a member's hospice care within a ~~12-month~~twelve (12) month period is limited to an amount equivalent to ~~85~~eighty-five (85) percent of the Medicare Hospice Cap payment.

(b) The ~~DHS~~OKDHS AS approved ADvantage person-centered service plan is the basis for the Medicaid Management Information Systems (MMIS) service prior authorization, specifying the:

(1) ~~service;~~Service;

(2) ~~service~~Service provider;

(3) ~~units~~Units authorized; and

(4) ~~begin~~Begin and end dates of service authorization.

(c) Service time for personal care, case management services ~~for institution transitioning~~, nursing, skilled nursing, supportive/restorative assistance, and in-home respite, is documented~~ solely~~ through the use of the designated statewide Electronic Visit Verification System (EVV)~~, previously known as Interactive Voice Response Authentication system,~~ when services are provided in the home. Providers are required to use the EVV system after access to the system is made available by ~~DHS.~~OKDHS. Refer to OAC 317:30-3-34(7) for additional procedures for EVV system failure or EVV system unavailability. ~~The EVV system provides alternate backup solutions should the automated system be~~

~~unavailable. In the event of EVV backup system failure, the provider documents time in accordance with their agency backup plan. The agency's backup plans are only permitted when the EVV system is unavailable.~~

(d) As part of ADvantage quality assurance, provider audits evaluate whether paid claims are consistent with service plan authorizations and documentation of service provision. Evidence of paid claims not supported by service plan authorization and documentation of service provisions are given to OHCA's Program Integrity Unit for follow-up investigation.

## PART 95. AGENCY PERSONAL CARE SERVICES

### 317:30-5-950. Eligible providers

Reimbursement for personal care is made only to agencies that are certified as home care agency providers by the Oklahoma State Department of Health and are certified by the ADvantage Administration ~~(AA)~~ as meeting applicable federal, state and local laws, rules and regulations. In order to be eligible for reimbursement, the home care agency must have an approved provider agreement on file with the Oklahoma Health Care Authority ~~(OHCA)~~, per Oklahoma Administrative Code (OAC) ~~317:30-30-3-2~~317:30-3-2. Service time of personal care is documented ~~solely~~ through the designated statewide Electronic Visit Verification (EVV) system when services are provided in the member's home. The home care agency is required to use the EVV system. ~~The EVV system provides alternate backup solutions when the automated system is unavailable. In the event of EVV backup system failure, the provider documents the time in accordance with their agency backup plan. The agency's backup procedures are only permitted when the EVV system is unavailable.~~ Refer to OAC 317:30-3-34(7) for additional procedures for EVV system failure or EVV system unavailability. Refer to OAC 317:35-17-22 for additional instructions.

### 317:30-5-953. Billing

A billing unit for personal care services provided by a home care agency is ~~15~~fifteen (15) minutes of service delivery and equals a visit. Billing procedures for personal care services are contained in the Oklahoma Medicaid Management Information Systems (OKMMIS) Billing and Procedure Manual. Service time for personal care and nursing is documented ~~solely~~ through the designated statewide Electronic Visit Verification (EVV) system. Refer to OAC 317:30-3-34(7) for additional procedures for EVV system failure or EVV system unavailability. ~~The EVV system provides alternate backup solutions when the automated system is unavailable. In the~~

~~event of EVV backup system failure, the provider documents time in accordance with their agency backup plan. The agency's backup procedures are permitted only when the EVV system is unavailable.~~

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

**SUBCHAPTER 17. ADVANTAGE WAIVER SERVICES**

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

(a) Billing procedures for long-term care medical services are contained in the Oklahoma Medicaid Management Information Systems (OKMMIS) Billing and Procedure Manual. Questions regarding billing procedures that cannot be resolved through a study of the manual are referred to the Oklahoma Health Care Authority (OHCA).

(b) The Oklahoma Department of Human Services ~~(DHS)~~OKDHS Aging Services (AS) approved ADvantage service plan is the basis for the Medicaid Management Information Systems~~ (MMIS)~~ service prior authorization, specifying the:

(1) ~~service;~~Service;

(2) ~~service~~Service provider;

(3) ~~units~~Units authorized; and

(4) ~~begin-~~Begin- and end-dates of service authorization.

(c) As part of ADvantage quality assurance, provider audits are used to evaluate if paid claims are consistent with service plan authorizations and documentation of service provision. Evidence of paid claims not supported by service plan authorization and/or documentation of service provision are turned over to the OHCA Clinical Provider Audits Unit for follow-up investigation.

(d) All contracted providers for ADvantage Waiver services must submit billing to the ~~State Medicaid agency,~~OHCA, Soonercare using the appropriate designated software, or web-based solution ~~to submit~~for all claims transactions. When the designated system is unavailable, contracted providers submit billing directly to OHCA.

(e) Service time of personal care, case management~~, case management for transitioning~~, nursing, advanced supportive/restorative assistance, in-home respite, consumer-directed personal assistance services and supports~~ (CD-PASS)~~, personal services assistance, and advanced personal services assistance is documented~~ solely~~ through the designated statewide Electronic Visit Verification System (EVV) when provided in the home. Providers are required to use the EVV system. ~~The EVV system provides alternate backup solutions when the automated system is unavailable. In the event of EVV system failure, the provider documents time in accordance with internal policy and procedures. This documentation suffices to account for in-home and office services delivered. Provider agency backup procedures are only permitted when the EVV system is unavailable.~~Refer to OAC 317:30-3-34(7) for additional procedures for EVV system failure or EVV system unavailability.

(f) The provider must document the amount of time spent for each

service, per Oklahoma Administrative Code (OAC) 317:30-5-763. For service codes that specify a time segment in their description, such as fifteen (15) minutes, each timed segment equals one (1) unit. Only time spent fulfilling the service for which the provider is authorized, per OAC 317:30-5-763 is authorized for time-based services. Providers do not bill for a unit of time when not more than one-half of a timed unit is performed, such as, when a unit is defined as fifteen (15) minutes, providers do not bill for services performed for less than eight (8) minutes. The rounding rules utilized by the EVV and web-based billing system to calculate the billable unit-amount of care, services provided for duration of:

(1) ~~less~~Less than ~~eight-minutes (8-minutes)~~eight (8) minutes cannot be rounded up and do not constitute a billable ~~fifteen-minute (15-minute)~~fifteen (15) minute unit; and

(2) ~~eight~~Eight (8) to fifteen (15) minutes are rounded up and do constitute a billable ~~fifteen-minute (15-minute)~~fifteen (15) minute unit.

~~(g) Providers required to use EVV must do so in compliance with OAC 317:30-3-4.1, Uniform Electronic Transaction Act (UETA). Providers must ensure:~~

~~(1) an established process is in place to deactivate an employee's access to EVV or designated system records upon termination of employment of the designated employee;~~

~~(2) safeguards are put in place to ensure improper access or use of EVV or designated system is prohibited and sanctions will be applied for improper use or access by staff;~~

~~(3) that staff providing or delivering in-home personal care services must use the EVV system for checking-in and checking out when providing services;~~

~~(4) staff delivering personal-care services is trained in the use of the EVV system;~~

~~(5) a record of services delivered is maintained;~~

~~(6) that staff confirms in writing that they will use the system as they are trained or directed;~~

~~(7) that staff will access the system using their assigned personal identification number (PIN) for in-home service delivery;~~

~~(8) staff accessing EVV or other designated systems for billing, properly use the authentication features of the system to properly document work and confirm work that is submitted for billing for services that were rendered;~~

~~(9) procedures as outlined in the UETA pertaining to electronic signatures, will be applied at such time when use of the electronic signatures is approved and applicable for necessary transaction;~~

~~(10) the EVV or other designated system is responsible for retention of all records that are associated with and generated for the purpose of claims and billing submitted for payment of services rendered;~~

~~(11) that they produce and enforce a security policy that outlines who has access to their data and what transactions employees are permitted to complete as outlined; and~~

~~(12) when using EVV or other designated system for billing and claims submissions, each new invoice or claim, must include the following information in (i) through (vi). The:~~

- ~~(A) type of service performed;~~
- ~~(B) individual receiving the services;~~
- ~~(C) date of the service;~~
- ~~(D) location of service delivery;~~
- ~~(E) individual providing the service; and~~
- ~~(F) time the service begins and ends.~~

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

**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**

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

**317:30-5-1094. Behavioral health services provided at I/T/Us**

~~(a) Behavioral health services that are primary, preventive, and therapeutic and would be covered if provided in another setting may be provided by I/T/U providers. Services provided by an I/T/U (refer to OAC 317:30-5-241 for a description of services) must meet the same requirements as services provided by another provider. Services include:~~

~~(1) Mental Health and/or Substance Use Assessment/Evaluation And Testing;~~

~~(2) Service Plan Development;~~

~~(3) Crisis Intervention Services;~~

~~(4) Medication Training and Support;~~

~~(5) Individual/Interactive Psychotherapy;~~

~~(6) Group Psychotherapy; and~~

~~(7) Family Psychotherapy.~~

~~(b) Behavioral health professional therapy services are covered when provided in accordance with a documented individualized treatment plan, developed to treat the identified mental health and/or substance use disorder(s). Behavioral health services must be billed on an appropriate claim form using the appropriate procedure code and guidelines. The time indicated on the claim form must be the time actually spent with the member.~~

~~(c) In order to support access to mental health services, these services may be provided in settings outside of the I/T/U. Offsite services must take place in a confidential setting.~~

~~(d) The outpatient behavioral health services' provider enrollment and reimbursement process in no way changes the OHCA's policy with regard to reimbursement of practitioners. Licensed clinical social workers (LCSW), licensed marital and family therapists (LMFT), licensed professional counselors (LPC), licensed behavioral practitioners (LBP), licensed alcohol and drug counselors (LADC), and licensure candidates are not eligible for direct reimbursement as practitioners. Their services are compensable only when billed by their employers and when provided in those clinical settings in which they are currently approved to render services. Licensure candidates must meet the requirements contained in OAC 317:30-5-240.3.~~

~~(e) For the provision of behavioral health related case management services, I/T/U providers must meet the requirements found at OAC 317:30-5-241.6, and be contracted as such. The provision of these~~

~~services is considered to be outside of the I/T/U encounter. Contracted behavioral health case management providers are responsible for obtaining all necessary prior authorizations, if needed, and will be paid at the current fee-for-service rate.~~

~~(f) For the provision of psychosocial rehabilitation services, I/T/U facilities must meet the requirements found at OAC 317:30-5-241.3, and must contract as an outpatient behavioral health agency. The provision of these services is considered to be outside of the I/T/U encounter. Contracted psychosocial rehabilitation service providers are responsible for obtaining all necessary prior authorizations, if needed, and will be paid at the current fee-for-service rate.~~

(a) **Inpatient behavioral health.** Services are covered when provided in accordance with a documented individualized service plan developed to treat the identified behavioral health needs. Inpatient psychiatric service providers must meet the requirements and applicable limitations, restrictions, or prior authorization requirements set forth in Oklahoma Administrative Code (OAC) 317:30-5-95 through 317:30-5-97.

(1) The provision of inpatient psychiatric services are not included in the I/T/U outpatient encounter rate and will be reimbursed at the fee-for-service (FFS) rate, with the exception of residential substance use disorder (SUD) treatment services, which will be reimbursed at the I/T/U encounter rate.

(2) For the provision of residential substance use disorder (SUD) treatment services, I/T/U facilities must be contracted as residential SUD service providers and meet the requirements found at OAC 317:30-5-95.43 through 317:30-5-95.49.

(b) **Outpatient behavioral health.** Services are covered when provided in accordance with a documented individualized service plan developed to treat the identified mental health needs and/or SUD. Outpatient behavioral health services are reimbursed at the I/T/U outpatient encounter rate unless otherwise noted in the section.

(1) A full description of services may be found at OAC 317:30-5-241 and 317:30-5-241.5(d), 317:30-5-241.7. Services may include, but are not limited to:

(A) Mental health and/or substance use assessment/evaluation and testing;

(B) Service plan development;

(C) Crisis intervention services;

(D) Medication training and support;

(F) Individual/interactive psychotherapy;

(G) Group psychotherapy;

(H) Family psychotherapy;

(I) Medication-assisted treatment (MAT) services and/or medication; and

(J) Peer recovery support specialist (PRSS) services.

(2) In order to support access to behavioral health services, these services may be provided in settings outside of the I/T/U. Offsite services must take place in a confidential setting.
(3) For the provision of behavioral health related case management services, I/T/U facilities must be fully contracted with the Oklahoma Health Care Authority (OHCA) as an outpatient behavioral health agency. The provision of these services is considered to be outside of the I/T/U encounter and will be paid at the current FFS rate. Contracted behavioral health case management providers must comply with the requirements found at OAC 317:30-5-241.6 and are responsible for obtaining all necessary prior authorizations, if needed.
(4) For the provision of psychosocial rehabilitation services, I/T/U facilities must be fully contracted with the OHCA as an outpatient behavioral health agency. The provision of these services is considered to be outside of the I/T/U encounter and will be paid at the current FFS rate. Contracted psychosocial rehabilitation service providers must comply with the requirements found at OAC 317:30-5-241.3 and are responsible for obtaining all necessary prior authorizations, if needed.
(5) Services provided by behavioral health practitioners, such as, licensed clinical social workers (LCSW), licensed marital and family therapists (LMFT), licensed professional counselors (LPC), licensed behavioral health practitioners (LBHP), licensed alcohol and drug counselors (LADC), and licensure candidates are not eligible for direct reimbursement as practitioners. Services provided by the aforementioned practitioners are compensable only when billed by their OHCA-contracted employer and when provided in those clinical settings in which they are currently approved to render services. Licensure candidates must meet the requirements contained in OAC 317:30-5-240.3.
(6) Behavioral health services must be billed on an appropriate claim form using the appropriate procedure code and guidelines. The time indicated on the claim form must be the time actually spent with the member.

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

**SUBCHAPTER 3. GENERAL PROVIDER POLICIES**

**PART 1. GENERAL SCOPE AND ADMINISTRATION**

**317:30-3-5. Assignment and cost sharing**

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

(1) **"Fee-for-service contract"** means the provider agreement specified in Oklahoma Administrative Code (OAC) 317:30-3-2. This contract is the contract between the Oklahoma Health Care Authority (OHCA) and medical providers which provides for a fee with a specified service involved.

(2) **"Within the scope of services"** means the set of covered services defined at OAC 317:25-7 and the provisions of the SoonerCare Choice contracts in the SoonerCare program.

(3) **"Outside of the scope of the services"** means all medical benefits outside the set of services defined at OAC 317:25-7 and the provisions of the SoonerCare Choice contracts in the SoonerCare program.

(b) **Assignment in fee-for-service.** Oklahoma's Medicaid State Plan provides that participation in the medical program is limited to providers who accept, as payment in full, the amounts paid by OHCA plus any deductible, coinsurance, or co-payment required by the State Plan to be paid by the member and make no additional charges to the member or others.

(1) OHCA presumes acceptance of assignment upon receipt of an assigned claim. This assignment, once made, cannot be rescinded, in whole or in part by one party, without the consent of the other party.

(2) Once an assigned claim has been filed, the member must not be billed and the member is not responsible for any balance except the amount indicated by OHCA. The only amount a member may be responsible for is a co-payment, or the member may be responsible for services not covered under the medical programs. In any event, the member should not be billed for charges on an assigned claim until the claim has been adjudicated or other notice of action received by the provider. Any questions regarding amounts paid should be directed to OHCA, Provider Services.

(3) When potential assignment violations are detected, the OHCA will contact the provider to assure that all provisions of the assignment agreement are understood. When there are repeated or uncorrected violations of the assignment agreement, the OHCA is

required to suspend further payment to the provider.

(c) **Assignment in SoonerCare.** Any provider who holds a fee-for-service contract and also executes a contract with a provider in the SoonerCare Choice program must adhere to the rules of this subsection regarding assignment.

(1) If the service provided to the member is outside of the scope of the services outlined in the SoonerCare contract, then the provider may bill or seek collection from the member.

(2) In the event there is a disagreement whether the services are in or out of the scope of the contracts referenced in (1) of this subsection, the OHCA shall be the final authority for this decision.

(3) Violation of this provision shall be grounds for a contract termination in the fee-for-service and SoonerCare programs.

(d) **Cost sharing/co-payment.** Section 1902(a)(14) of the Social Security Act permits states to require certain members to share some of the costs of SoonerCare by imposing upon them such payments as enrollment fees, premiums, deductibles, coinsurance, co-payments, or similar cost sharing charges. OHCA requires a co-payment of some SoonerCare members for certain medical services provided through the fee-for-service program. A co-payment is a charge which must be paid by the member to the service provider when the service is covered by SoonerCare. Section 1916(e) of the Act requires that a provider participating in the SoonerCare program may not deny care or services to an eligible individual based on such individual's inability to pay the co-payment. A person's assertion of their inability to pay the co-payment establishes this inability. This rule does not change the fact that a member is liable for these charges, and it does not preclude the provider from attempting to collect the co-payment.

(1) Co-payment is not required of the following members:

(A) Individuals under age twenty-one (21). Each member's date of birth is available on the REVS system or through a commercial swipe card system.

(B) Members in nursing facilities (NF) and intermediate care facilities for individuals with intellectual disabilities (ICF/IID).

(C) Home and Community-Based Services (HCBS) waiver members except for prescription drugs.

(D) American Indian and Alaska Native members, per Section 5006 of the American Recovery and Reinvestment Act of 2009 and as established in the federally-approved Oklahoma Medicaid State Plan.

(E) Individuals who are categorically eligible for SoonerCare through the Breast and Cervical Cancer Treatment program.

(F) Individuals receiving hospice care, as defined in section 1905(o) of the Social Security Act.

(2) Co-payment is not required for the following services:

(A) Family planning services. This includes all contraceptives and services rendered.

(B) Emergency services provided in a hospital, clinic, office, or other facility.

(C) Services furnished to pregnant women, if those services relate to the pregnancy or to any other medical condition which may complicate the pregnancy, including prenatal vitamins.

(D) Smoking and tobacco cessation counseling and products.

(E) Blood glucose testing supplies and insulin syringes.

(F) Medication-assisted treatment (MAT) drugs.

(3) Co-payments are required in an amount not to exceed the federal allowable for the following:

(A) Inpatient hospital stays.

(B) Outpatient hospital visits.

(C) Ambulatory surgery visits including free-standing ambulatory surgery centers.

(D) Encounters with the following rendering providers:

(i) Physicians;

(ii) Advanced practice registered nurses;

(iii) Physician assistants;

(iv) Optometrists;

(v) Home health agencies;

(vi) Certified registered nurse anesthetists;

(vii) Anesthesiologist assistants;

(viii) Durable medical equipment providers; and

(ix) Outpatient behavioral health providers.

(E) Prescription drugs.

(F) Crossover claims. Dually eligible Medicare/SoonerCare members must make a co-payment in an amount that does not exceed the federal allowable per visit/encounter for all Part B covered services. This does not include dually eligible HCBS waiver members.

(4) Medicaid premiums and cost sharing incurred by all individuals in the Medicaid household may not exceed an aggregate limit of five percent (5%) of the family's income applied on a monthly basis, as specified by the agency.

(5) Providers will be required to refund any co-payment amounts the provider collected from the member in error and/or above the family's aggregate cost sharing maximum.

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

**SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME**

**PART 5. COUNTABLE INCOME AND RESOURCES**

**317:35-5-41.9. Exclusions from resources**

(a) The following are excluded resources. In order for payments and benefits listed in paragraph (b) and (c) to be excluded from resources, such funds must be segregated and not commingled with other countable resources so that the excludable funds are identifiable.

(b) Resources excluded by the Social Security Act, in accordance with Section 416.1210 of Title 20 of the Code of Federal Regulations (C.F.R.), unless otherwise noted:

(1) The home that is the principal place of residence, as described at Oklahoma Administrative Code (OAC) 317:35-5-41.1;

(2) Household goods and personal effects, as described at OAC 317:35-5-41(a)(5);

(3) One automobile, as described at OAC 317:35-5-41.3;

(4) Property essential to self-support:

(A) Property of a trade or business which is essential to the means of self-support, as described at OAC 317:35-5-41.12(c);

(B) Nonbusiness property used to produce goods or services essential to self-support, as described at OAC 317:35-5-41.12(c);

(C) Nonbusiness income producing property, as described at OAC 317:35-5-41.12(c);

(5) Resources of a blind or disabled individual which are necessary to fulfill an approved plan for achieving self-support;

(6) Stock in regional or village corporations held by natives of Alaska during the twenty-year (20-year) period in which the stock is inalienable pursuant to the Alaska Native Claims Settlement Act;

(7) Life insurance policies, as described at OAC 317:35-5-41.2(b);

(8) Restricted allotted Indian lands;

(9) Disaster relief assistance provided under Federal law or by state or local government;

(10) Burial spaces, as described at OAC 317:35-5-41.2(c);

(11) Burial funds, as described at OAC 317:35-5-41.2(d);

(12) Irrevocable burial contracts as described at OAC 317:35-5-41.2(e);

(13) Supplemental Security Income (SSI) and Social Security retroactive payments for nine (9) months following the month of receipt;
(14) Housing assistance paid pursuant to:
(A) The United States Housing Act of 1937;
(B) The National Housing Act;
(C) Section 101 of the Housing and Urban Development Act of 1965;
(D) Title V of the Housing Act of 1949;
(E) Section 202(h) of the Housing Act of 1959;
(15) Refunds of Federal income taxes and advances made by an employer relating to an earned income tax credit for nine (9) months following the month of receipt;
(16) Payments received as compensation for expenses incurred or losses suffered as a result of a crime;
(17) Relocation assistance for nine (9) months beginning with the month following the month of receipt. The assistance must be provided by a State or local government that is comparable to assistance provided under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 that is subject to the treatment required by Section 216 of that Act;
(18) Money in a dedicated account for SSI-eligible individuals under age eighteen (18) that is required by 20 C.F.R. § 416.640(e);
(19) Gifts to children under age eighteen (18) with life-threatening conditions from an organization described at 26 United States Code (U.S.C.) § 501(c)(3) that is exempt from taxation under 26 U.S.C. § 501(a);
(20) Restitution of Social Security, SSI, or a Special Benefit for World War II Veterans made because of misuse by a representative payee, for nine (9) months following the month of receipt;
(21) Any portion of a grant, scholarship, fellowship, or gift used or set aside for paying tuition, fees, or other necessary educational expenses, for nine (9) months beginning the month after the month of receipt;
(22) Payment of a refundable child tax credit for nine (9) months following the month of receipt;
(23) Any annuity paid by a State to a person (or his or her spouse) based on the State's determination that the person is:
(A) A veteran (as defined in 38 U.S.C. § 101); and
(B) Blind, disabled, or aged;
(24) The principal and income of trusts complying with OAC 317:35-5-41.6(6). See also 42 U.S.C. § 1396p(d)(4);

(25) Workers' Compensation Medicare Set Aside Arrangements (WCMSAs) which allocate a portion of the workers' compensation settlement for future medical expenses; and/or

(26) For individuals with an Oklahoma Long-Term Care Partnership Program approved policy, resources equal to the amount of benefits paid on the insured's behalf by the long-term care insurer. Said disregard is made at the time of application for long-term care services provided by SoonerCare. The Oklahoma Insurance Department approves policies as Long-term Care Partnership Program policies.

(c) Resources excluded by federal laws other than the Social Security Act, in accordance with 20 C.F.R. § 416.1236, unless otherwise noted:

(1) An Achieving a Better Life Experience (ABLE) account is regulated by the Internal Revenue Service as a tax-advantaged account that protects resources from being counted toward the resource limit of public benefits programs (including Medicaid) if used according to the federal regulations. The responsibility of an Oklahoma Medicaid administrator is to ask the ABLE account beneficiary or Authorized Legal Representative (ALR) if the account has been used only in accordance with ABLE regulations and, if so, to exclude the balance of the ABLE account from the determination of countable resources. The testimony of the ABLE account beneficiary or ALR is all that is required in the determination of appropriate use of the ABLE account. Funds and interest held in an ~~Achieving a Better Life Experience (~~ABLE~~)~~ account, pursuant to 26 U.S.C. § 529A:

(A) A contribution to an ABLE account by another individual is neither income nor a resource to the individual with the ABLE account.~~, unless such contribution exceeds the annual federal gift tax exclusion established by 26 U.S.C. § 2503(b), in which case, any contribution in excess of the annual federal gift tax exclusion is a countable resource and income in the month deposited.~~If the individual who made the contribution later requests Medicaid for long-term care services, the contribution shall be evaluated in accordance with OAC 317:35-5-41.8.

(B) A distribution from an ABLE account that is retained after the month of receipt is neither income nor a resource to the individual in any month when spent on a qualified disability expense (QDE).

(C) A QDE is any expense related to the blindness or disability of the individual and made for the benefit of the individual. QDE's include but are not limited to:

(i) Education;

(ii) Housing;

(iii) Transportation;

(iv) Employment training and support;
(v) Assistive technology;
(vi) Health;
(vii) Prevention and wellness;
(viii) Financial management and administrative services;
(ix) Legal fees;
(x) Expenses for ABLE account oversight and monitoring;
(xi) Funeral and burial; and
(xii) Basic living expenses.

(D) A distribution, or portion of a distribution, from an ABLE account that is retained after the month of receipt, and used for a non-QDE in the next or subsequent month, is a countable resource to the individual in the month in which the funds were spent. Any unspent portion of the distribution the individual continues to retain is not a countable resource.

(E) A distribution, or portion of a distribution, from an ABLE account that is received and used for a non-QDE in the same month, is considered unearned income to the individual in the month of receipt. Any unspent portion of the distribution the individual retains after the month of receipt is not a countable resource;

(2) Payments made under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (84 Stat. 1902, 42 U.S.C. ' 4636);

(3) Payments made to Native Americans as listed in paragraphs (b) and (c) of section IV of the Appendix to Subpart K of Part 416 of C.F.R. Title 20;

(4) Indian judgment funds held in trust by the Secretary of the Interior or distributed per capita pursuant to a plan prepared by the Secretary of the Interior and not disapproved by a joint resolution of the Congress under Public Law 93-134, as amended by Public Law (Pub.L.) 97-458 (25 U.S.C. § 1407). Indian judgment funds include interest and investment income accrued while the funds are so held in trust. This exclusion extends to initial purchases made with Indian judgment funds, but will not apply to proceeds from sales or conversions of initial purchases or to subsequent purchases;

(5) Supplemental Nutrition Assistance Program benefits;

(6) The value of assistance to children under the National School Lunch Act (60 Stat. 230, 42 U.S.C. §§ 1751 et seq.) as amended by Pub.L. 90-302 [82 Stat. 117, 42 U.S.C. § 1761 (h)(3)];

(7) The value of assistance to children under the Child Nutrition Act of 1966 [80 Stat. 889, 42 U.S.C. § 1780(b)];

(8) Any grant or loan to any undergraduate student for educational purposes made or insured under any program

administered by the Commissioner of Education as provided by section 507 of the Higher Education Amendments of 1968, Pub.L. 90-575 (82 Stat. 1063);
(9) Incentive allowances received under Title I of the Comprehensive Employment and Training Act of 1973 [87 Stat. 849, 29 U.S.C. § 821(a)];
(10) Compensation provided to volunteers by the Corporation for National and Community Service (CNCS), unless determined by the CNCS to constitute the minimum wage in effect under the Fair Labor Standards Act of 1938 (29 U.S.C. §§ 201 et seq.) or applicable State law, pursuant to 42 U.S.C. § 5044(f)(1). Programs include:
(A) AmeriCorps;
(B) Special and demonstration volunteer programs;
(C) University year for ACTION;
(D) Retired senior volunteer program;
(E) Foster grandparents program; and
(F) Senior companion program;
(11) Distributions received by an individual Alaska Native or descendant of an Alaska Native from an Alaska Native Regional and Village Corporation pursuant to the Alaska Native Claims Settlement Act, as follows: cash, including cash dividends on stock received from a Native Corporation, is disregarded to the extent that it does not, in the aggregate, exceed two-thousand ($2,000) per individual each year [the $2,000 limit is applied separately each year, and cash distributions up to $2,000 which an individual received in a prior year and retained into subsequent years will not be counted as resources in those years]; stock, including stock issued or distributed by a Native Corporation as a dividend or distribution on stock; a partnership interest; land or an interest in land, including land or an interest in land received from a Native Corporation as a dividend or distribution on stock; and an interest in a settlement trust. This exclusion is pursuant to the exclusion under section 15 of the Alaska Native Claims Settlement Act Amendments of 1987, Pub.L. 100-241 [43 U.S.C. § 1626(c)], effective February 3, 1988;
(12) Value of Federally donated foods distributed pursuant to section 32 of Pub.L. 74B320 or section 416 of the Agriculture Act of 1949 [7 C.F.R. § 250.6(e)(9) as authorized by 5 U.S.C. § 301];
(13) All funds held in trust by the Secretary of the Interior for an Indian tribe and distributed per capita to a member of that tribe under Pub.L. 98-64;
(14) Home energy assistance payments or allowances under the Low-Income Home Energy Assistance Act of 1981, as added by Title

XXVI of the Omnibus Budget Reconciliation Act of 1981, Pub.L. 97-35 [42 U.S.C. § 8624(f)];
(15) Student financial assistance for attendance costs received from a program funded in whole or in part under Title IV of the Higher Education Act of 1965, as amended, or under Bureau of Indian Affairs (BIA) Student assistance programs if it is made available for tuition and fees normally assessed a student carrying the same academic workload, as determined by the institution, including costs for rental or purchase of any equipment, materials, or supplies required of all students in the same course of study; and an allowance for books, supplies, transportation, and miscellaneous personal expenses for a student attending the institution on at least a half-time basis, as determined by the institution, under section 14(27) of Pub.L. 100-50, the Higher Education Technical Amendments Act of 1987 (20 U.S.C. § 1087uu) or under BIA student assistance programs. This includes, but is not limited to:
(A) Pell grants;
(B) Student services incentives;
(C) Academic achievement incentive scholarships;
(D) Byrd scholars;
(E) Federal supplemental education opportunity grants;
(F) Federal educational loans (federal PLUS loans, Perkins loans, Stafford loans, Ford loans, etc.);
(G) Upward Bound;
(H) GEAR UP (Gaining Early Awareness and Readiness for Undergraduate Programs);
(I) State educational assistance programs funded by the leveraging educational assistance programs; and
(J) Work-study programs;
(16) Amounts paid as restitution to certain individuals of Japanese ancestry and Aleuts under the Civil Liberties Act of 1988 and the Aleutian and Pribilof Islands Restitution Act, sections 105(f) and 206(d) of Pub.L. 100-383 (50 U.S.C. app. 1989 b and c);
(17) Payments made on or after January 1, 1989, from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In Re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.) under Pub.L. 101-201 (103 Stat. 1795) and section 10405 of Pub.L. 101-239 (103 Stat. 2489);
(18) Payments made under section 6 of the Radiation Exposure Compensation Act, Pub.L. 101-426 (104 Stat. 925, 42 U.S.C. § 2210);
(19) Payments made to individuals because of their status as victims of Nazi persecution excluded pursuant to section 1(a) of the Victims of Nazi Persecution Act of 1994, Pub.L. 103-286

(108 Stat. 1450);
(20) Any matching funds and interest earned on matching funds from a demonstration project authorized by Pub.L. 105-285 that are retained in an Individual Development Account, pursuant to section 415 of Pub.L. 105-285 (112 Stat. 2771);
(21) Any earnings, Temporary Assistance for Needy Families matching funds, and accrued interest retained in an Individual Development Account, pursuant to section 103 of Pub.L. 104-193 [42 U.S.C. § 604(h)(4)];
(22) Payments made to individuals who were captured and interned by the Democratic Republic of Vietnam as a result of participation in certain military operations, pursuant to section 606 of Pub.L. 105-78 and section 657 of Pub.L. 104-201 (110 Stat. 2584);
(23) Payments made to certain Vietnam veteran's children with spina bifida, pursuant to section 421 of Pub.L. 104-204 [38 U.S.C. § 1805(d)];
(24) Payments made to the children of women Vietnam veterans who suffer from certain birth defects, pursuant to section 401 of Pub.L. 106-419, [38 U.S.C. § 1833(c)];
(25) Assistance provided for flood mitigation activities under section 1324 of the National Flood Insurance Act of 1968, pursuant to section 1 of Public Law 109-64 (119 Stat. 1997, 42 U.S.C. § 4031); and/or
(26) Payments made to individuals under the Energy Employees Occupational Illness Compensation Program Act of 2000, pursuant to section 1, app. [Div. C. Title XXXVI section 3646] of Public Law 106-398 (114 Stat. 1654A-510, 42 U.S.C. § 7385e).

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

**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**

**PART 10. BARIATRIC SURGERY**

**317:30-5-137. ~~Eligible providers to perform bariatric surgery~~Bariatric surgery**

~~The Oklahoma Health Care Authority (OHCA) covers bariatric surgery under certain conditions as defined in this section. Bariatric surgery is not covered for the treatment of obesity alone. To be eligible for reimbursement, bariatric surgery providers must be certified by the American College of Surgeons (ACS) as a Level I Bariatric Surgery Center or certified by the American Society for Bariatric Surgery as a Bariatric Surgery Center of Excellence (BSCOE) or the surgeon and facility are currently participating in a bariatric surgery quality assurance program and a clinical outcomes assessment review. All qualifications must be met and approved by the OHCA. Bariatric surgery facilities and their providers must be contracted with OHCA.~~(a) **Bariatric surgery.** Gastric bypass and other types of weight-loss surgery, known as bariatric surgery, makes surgical changes to the stomach and digestive system, limits food intake and nutrient absorption, which leads to weight loss.

(b) **Eligible providers.** Bariatric surgery providers must be:

(1) Certified by the American College of Surgeons (ACS) Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) as a Comprehensive Bariatric Surgery Center; or

(2) Currently participating in a comprehensive multidisciplinary bariatric surgery quality assurance program and a clinical outcomes assessment review as a pathway to accreditation; and

(3) Completed a fellowship training in bariatric surgery or be a fellow of the American Society of Metabolic and Bariatric Surgery (ASMBS) or a MBSAQIP verified surgeon; and

(4) Contracted with the Oklahoma Health Care Authority (OHCA); and

(5) Have a demonstrated record of quality assurance.

(c) **Documentation.** All documentation submitted to request services must demonstrate, through adequate objective medical records, evidence sufficient to justify the member's need for the service, in accordance with OAC 317:30-3-1(f). Documentation requirements include, but are not limited to:

(1) Documents sufficient to show that member is between the ages of fifteen (15) to sixty-five (65);

(2) Psychosocial evaluation;

(2) Independent medical evaluation by a health care professional

with dedicated expertise in the care of bariatric surgery patients;

(3) Surgical evaluation by an OHCA-contracted surgeon who is credentialed to perform bariatric surgery;

(4) Record on participation in a nutrition and lifestyle modification program under the supervision of an OHCA contracted medical provider; and

(5) For full guidelines, please refer to www.okhca.org/mau.

(d) **Non-covered services.**

(1) Procedures considered experimental or investigational are not covered.

(2) The OHCA may withdraw authorization of payment for the bariatric surgery at any time if the OHCA determines that the member, provider, or bariatric program is not in compliance with any of the requirements.

(e) **Reimbursement.**

(1) Reimbursement shall only be made for services that have been prior-authorized by OHCA or its designee.

(2) To be eligible for reimbursement, bariatric surgery providers must meet the requirements listed in (b) (1) through (5) of this Section.

(3) Payment shall be made at the lower of the provider's usual and customary charge or the OHCA fee schedule for Medicaid compensable services and in accordance with the Oklahoma Medicaid State Plan.

**317:30-5-137.1. Member candidacy [REVOKED]**

~~Documentation must be submitted to the OHCA prior authorization unit prior to beginning any treatment program to ensure all requirements are met and the member is an appropriate candidate for bariatric surgery. This is the first of two prior authorizations required to approve a member for bariatric surgery. To be considered, members must meet the following candidacy criteria:~~

~~(1) be between 18 and 65 years of age;~~

~~(2) have body mass index (BMI) of 35 or greater;~~

~~(3) be diagnosed with one of the following:~~

~~(A) diabetes mellitus;~~

~~(B) degenerative joint disease of a major weight bearing joint(s). The member must be a candidate for joint replacement surgery when optimal weight loss is achieved; or~~

~~(C) a rare co-morbid condition in which there is medical evidence that bariatric surgery is medically necessary to treat such a condition and that the benefits of bariatric surgery outweigh the risk of surgical mortality.~~

~~(4) have presence of obesity that has persisted for at least 5 years;~~

~~(5) have attempted weight loss in the past without successful long term weight reduction, which must be documented by a physician;~~

~~(6) have absence of other medical conditions that would increase the member's risk of surgical mortality or morbidity; and~~
~~(7) the member is not pregnant or planning to become pregnant in the next two years.~~

**317:30-5-137.2. General coverage [REVOKED]**

~~(a) After receiving member candidacy prior authorization from OHCA and the determination that member candidacy requirements are met (see OAC 317:30-5-137.1), the primary care provider coordinates a pre-operative assessment and weight loss process to include:~~
~~(1) a comprehensive psychosocial evaluation including:~~
~~(A) evaluation for substance abuse;~~
~~(B) evaluation for psychiatric illness which would preclude the member from participating in pre-surgical weight loss and evaluation program or successfully adjusting to the post surgical lifestyle changes;~~
~~(C) if applicable, documentation that the member has been successfully treated for a psychiatric illness and has been stabilized for at least six months; and~~
~~(D) if applicable, documentation that the member has been rehabilitated and is free from drug and/or alcohol for a period of at least one year.~~
~~(2) an independent medical evaluation performed by an internist experienced in bariatric medicine who is contracted with the OHCA to assess the member=s operative morbidity and mortality risks.~~
~~(3) a surgical evaluation by an OHCA contracted surgeon who has credentials to perform bariatric surgery.~~
~~(4) participation in a six month weight loss program prior to surgery, under the supervision of an OHCA contracted medical provider. The member must, within 180 days from the initial or member candidacy prior authorization approval, lose at least five percent of member=s initial body weight.~~
~~(b) When all requirements have been met, a prior authorization for surgery must be obtained from OHCA. This authorization can not be requested before the initial 180 day weight loss program has been completed.~~
~~(1) If the member does not meet the weight loss requirement in the allotted time the member will not be approved for bariatric surgery.~~
~~(2) The member=s provider must restart the prior authorization process if this requirement is not met.~~
~~(c) The bariatric surgery facility or surgeon must, on an annual basis, provide to the OHCA the members statistical data which includes but is not limited to, mortality, hospital readmissions, re-operation, morbidity and average weight loss data.~~
~~(d) OHCA considers surgery to correct complications from bariatric surgery, such as obstruction or stricture, medically necessary.~~
~~(e) OHCA considers repeat bariatric surgery medically necessary for a member whose initial bariatric surgery was medically necessary,~~

~~and member meets either of the following criteria:~~

~~(1) has not lost more than fifty percent of excess body weight two years following the primary bariatric surgery procedure and is in compliance with prescribed nutrition and exercise programs following the procedure; or~~

~~(2) failure due to dilation of the gastric pouch if the initial procedure was successful in inducing weight loss prior to the pouch dilation and the member is in compliance with prescribed nutrition and exercise programs following the initial procedure.~~

~~(f) OHCA may withdraw authorization of payment for the bariatric surgery at any time if the OHCA determines that the member or provider is not in compliance with any of the requirements.~~

**317:30-5-140. Coverage for children**

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

~~(b) Federal Medicaid regulations also require the state to make the determination as to whether the service is medically necessary and do not require the provision of any items or services that the state determines are not safe and effective or which are considered experimental.~~Bariatric surgery services are currently allowed for members aged fifteen (15) to sixty-five (65), per OAC 317:30-5-137 (c) (1). Exceptions may be granted for member's younger than fifteen (15) if they are proven to be medically necessary and are prior authorized. State and Federal Medicaid law, including, but not limited to, Oklahoma's federally-approved State Medicaid Plan, require the State to make the determination as to whether services are medically necessary and does not allow for reimbursement of any items or services that the State determines are not safe and effective or which are considered experimental. For more information regarding experimental or investigational including clinical trials, see OAC 317:30-3-57.1.

**317:30-5-141. Reimbursement [REVOKED]**

~~Payment is made at the lower of the provider's usual and customary charge or the OHCA fee schedule for Medicaid compensable services.~~

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

**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**

**PART 79. DENTISTS**

**317:30-5-696. Coverage by category**

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

(1) **Adults.**

(A) Dental coverage for adults is limited to:

(i) Medically necessary extractions, as defined in Oklahoma Administrative Code (OAC) 317:30-5-695. Tooth extraction must have medical need documented;

(ii) Limited oral examinations and medically necessary images, as defined in OAC 317:30-5-695, associated with the extraction or with a clinical presentation with reasonable expectation that an extraction will be needed;

(iii) Smoking and tobacco use cessation counseling; and

(iv) Medical and surgical services performed by a dentist or physician to the extent such services may be performed under State law when those services would be covered if performed by a physician.

(B) Payment is made for dental care for adults residing in private intermediate care facilities for individuals with intellectual disabilities (ICF/IID) and who have been approved for ICF/IID level of care, similar to the scope of services available to individuals under age twenty-one (21).

(C) Limited dental services are available for members who meet all medical criteria, but need dental clearance to obtain organ transplant approval. Providers must obtain prior authorization before delivery of dental service, with the exception of evaluation and extractions. All requests must be filed on the currently approved American Dental Association (ADA) form and must include diagnostic images, six-point periodontal charting, narratives and comprehensive treatment plans. The Oklahoma Health Care Authority (OHCA) will notify the provider of determination using OHCA Prior Authorization Request Decision form. Prior authorized services must be billed exactly as they appear on the prior authorization request. The following dental services are available:

(i) Comprehensive oral evaluation;

(ii) Two (2) bitewing images;

(iii) Prophylaxis;

(iv) ~~Flouride~~Fluoride application;

(v) Limited restorative procedures; and
(vi) Periodontal scaling/root planing.

(2) **Home and community-based services (HCBS) waiver for the intellectually disabled.** All providers participating in the HCBS must have a separate contract with the OHCA to provide services under the HCBS. Dental services are defined in each waiver and must be prior authorized.

(3) **Children.** The OHCA Dental Program provides the basic medically necessary treatment. For services rendered to a minor, the minor's parent or legal guardian must provide a signed, written consent prior to the service being rendered, unless there is an explicit state or federal exception to this requirement. The services listed below are compensable for members under twenty-one (21) years of age without prior authorization. All other dental services must be prior authorized. Anesthesia services are covered for children in the same manner as adults. All providers performing preventive services must be available to perform needed restorative services for those members receiving any evaluation and preventive services.

(A) **Comprehensive oral evaluation.** This procedure should precede any images, and chart documentation must include image interpretations, caries risk assessment, six-point periodontal charting (as applicable), and both medical and dental health history of member. The comprehensive treatment plan should be the final result of this procedure.

(B) **Periodic oral evaluation.** This procedure may be provided for a member of record once every six (6) months. An examination should precede any images, and chart documentation must include image interpretations, caries risk assessment, and both medical and dental health history of member. The comprehensive treatment plan should be the final result of this procedure.

(C) **Limited oral evaluation.** This procedure is only compensable to the same dentist or practice for two (2) visits prior to a comprehensive or periodic evaluation examination being completed.

(D) **Images.** To be SoonerCare compensable, images must be of diagnostic quality and medically necessary. A clinical examination must precede any images, and chart documentation must include member history, prior images, caries risk assessment, the six-point periodontal charting (as applicable), and both dental and general health needs of the member. The referring dentist is responsible for providing properly identified images of acceptable quality with a referral, if that provider chooses to expose and submit for reimbursement prior to referral. Periapical images must

include at least three (3) millimeters beyond the apex of the tooth being imaged. Panoramic films and two (2) bitewings are considered full mouth images. Full mouth images as noted above or traditional [minimum of twelve (12) periapical films and two (2) posterior bitewings] are allowable once in a three (3) year period and must be of diagnostic quality. Individually listed intraoral images by the same dentist/dental office are considered a complete series if the number of individual images equals or exceeds the traditional number for a complete series. Panoramic films are only compensable when chart documentation clearly indicates reasons for the exposure based on clinical findings. This type of exposure is not to rule out or evaluate caries. Prior authorization and a detailed medical need narrative are required for additional panoramic films taken within three (3) years of the original set.

(E) **Dental sealants.** Tooth numbers 2, 3, 14, 15, 18, 19, 30 and 31 must be caries free on the interproximal and occlusal surfaces to be eligible for this service. This service is available through eighteen (18) years of age and is compensable once every thirty-six (36) months if medical necessity is documented.

(F) **Interim caries arresting medicament application.** This service is available for primary and permanent teeth once every one hundred eighty-four (184) days for two (2) occurrences per tooth in a lifetime. The following criteria must be met for reimbursement:

(i) A member is documented to be unable to receive restorative services in the typical office environment within a reasonable amount of time;

(ii) A tooth that has been treated should not have any non-carious structure removed;

(iii) A tooth that has been treated should not receive any other definitive restorative care for three (3) months following an application;

(iv) Reimbursement for extraction of a tooth that has been treated will not be allowed for three (3) months following an application; and

(v) The specific teeth treated and number and location of lesions must be documented.

(G) **Dental prophylaxis.** This procedure is provided once every one hundred eighty-four (184) days along with topical application of fluoride.

(H) **Stainless steel crowns for primary teeth.** The use of any stainless steel crowns is allowed as follows:

(i) Stainless steel crowns are allowed if:

(I) The child is five (5) years of age or under;

(II) Seventy percent (70%) or more of the root structure remains; or

(III) The procedure is provided more than twelve (12) months prior to normal exfoliation.

(ii) Stainless steel crowns are treatment of choice for:

(I) Primary teeth treated with pulpal therapy, if the above conditions exist;

(II) Primary teeth where three (3) surfaces of extensive decay exist; or

(III) Primary teeth where cuspal occlusion is lost due to decay or accident.

(iii) Preoperative periapical images and/or written documentation explaining the extent of decay must be available for review, if requested.

(iv) Placement of a stainless steel crown is allowed once for a minimum period of twenty-four (24) months. No other restoration on that tooth is compensable during that period of time. A stainless steel crown is not a temporizing treatment to be used while a permanent crown is being fabricated.

(I) **Stainless steel crowns for permanent teeth.** The use of any stainless steel crowns is allowed as follows:

(i) Stainless steel crowns are the treatment of choice for:

(I) Posterior permanent teeth that have completed endodontic therapy if three (3) or more surfaces of tooth is destroyed;

(II) Posterior permanent teeth that have three (3) or more surfaces of extensive decay; or

(III) Where cuspal occlusion is lost due to decay prior to age sixteen (16) years.

(ii) Preoperative periapical images and/or written documentation explaining the extent of decay must be available for review, if requested.

(iii) Placement of a stainless steel crown excludes placement of any other type of crown for a period of twenty-four (24) months. No other restoration on that tooth is compensable during that period of time.

(J) **Pulpotomies and pulpectomies.**

(i) Therapeutic pulpotomies and pulpal debridement are allowable once per lifetime. Pre-and post-operative periapical images must be available for review, if requested. Therapeutic pulpotomies and pulpal debridement is available for the following:

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

exfoliation;

(II) Tooth numbers O and P before age five (5) years;

(III) Tooth numbers E and F before six (6) years;

(IV) Tooth numbers N and Q before five (5) years;

(V) Tooth numbers D and G before five (5) years.

(ii) Therapeutic pulpotomies and pulpal debridement are allowed for primary teeth if exfoliation of the teeth is not expected to occur for at least one (1) year or if seventy percent (70%) or more of root structure is remaining.

(K) **Endodontics.** Payment is made for the services provided in accordance with the following:

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

(ii) The provider documents history of member's improved oral hygiene and flossing ability in records.

(iii) Prior authorization is required for members who have a treatment plan requiring more than two (2) anterior and/or any posterior root canals.

(iv) Pre and post-operative periapical images must be available for review.

(v) Pulpal debridement may be performed for the relief of pain while waiting for the decision from the OHCA.

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

(vii) Endodontically treated teeth should be restored to limited occlusal function and all contours should be replaced. These teeth are not automatically approved for any type of crown.

(L) **Space maintainers.** Certain limitations apply with regard to this procedure. Providers are responsible for recementation of any maintainer placed by them for six (6) months post insertion.

(i) **Band and loop type space maintenance.** This procedure must be provided in accordance with the following guidelines:

(I) This procedure is compensable for all primary molars where permanent successor is missing or where succedaneous tooth is more than ~~5mm~~five (5) millimeters below the crest of the alveolar ridge.

(II) First primary molars are not allowed space maintenance if the second primary and first permanent molars are present and in cuspal interlocking occlusion regardless of the presence or absence of normal relationship.

(III) If there are missing posterior teeth bilaterally in the same arch, under the above guidelines, bilateral space maintainer is the treatment of choice.
(IV) The teeth numbers shown on the claim should be those of the missing teeth.
(V) Post-operative bitewing images must be available for review.
(VI) Bilateral band and loop space maintainer is allowed if member does not have eruption of the four (4) mandibular anterior teeth in position or if sedation case that presents limitations to fabricate other space maintenance appliances.

(ii) **Lingual arch bar.** Payment is made for the services provided in accordance with the following:
(I) Lingual arch bar is used when permanent incisors are erupted and the second primary molar (K or T) is missing in the same arch.
(II) The requirements are the same as for band and loop space maintainer.
(III) Pre and post-operative images must be available.

(M) **Analgesia.** Analgesia services are reimbursable in accordance with the following:

(i) **Inhalation of nitrous oxide.** Use of nitrous oxide is compensable for four (4) occurrences per year and is not separately reimbursable, if provided on the same date ~~by the same provider~~ as IV sedation, non-intravenous conscious sedation, or general anesthesia. The medical need for this service must be documented in the member's record.

(ii) **Non-intravenous conscious sedation.** Non-intravenous conscious sedation is not separately reimbursable, if provided on the same date by the same provider as analgesia, anxiolysis, inhalation of nitrous oxide, IV sedation, or general anesthesia. Non-intravenous conscious sedation is reimbursable when determined to be medically necessary for documented handicapped members, uncontrollable members or justifiable medical or dental conditions. The report must detail the member's condition. No services are reimbursable when provided primarily for the convenience of the member and/or the dentist, it must be medically necessary.

(N) **Pulp caps.** Indirect and direct pulp cap must be ADA accepted calcium hydroxide or mineral trioxide aggregate (MTA) materials, not a cavity liner or chemical used for dentinal hypersensitivity. Indirect and direct pulp cap codes require specific narrative support addressing materials used, intent and reasons for use. Application of

chemicals used for dentinal hypersensitivity is not allowed as indirect pulp cap. Utilization of these codes is verified by post payment review.

(O) **Protective restorations.** This restoration includes removal of decay, if present, and is reimbursable for the same tooth on the same date of service with a direct or indirect pulp cap, if needed. Permanent restoration of the tooth is allowed after sixty (60) days unless the tooth becomes symptomatic and requires pain relieving treatment.

(P) **Smoking and tobacco use cessation counseling.** Smoking and tobacco use cessation counseling is covered when performed utilizing the five (5) intervention steps of asking the member to describe his/her smoking, advising the member to quit, assessing the willingness of the member to quit, assisting with referrals and plans to quit, and arranging for follow-up. Up to eight (8) sessions are covered per year per individual who has documented tobacco use. It is a covered service when provided by physicians, physician assistants, nurse practitioners, certified nurse midwives, Oklahoma State Health Department (OSDH) and Federally Qualified Health Center (FQHC) nurses, and maternal/child health licensed clinical social workers with a Tobacco Treatment Specialist Certification (TTS-C). Chart documentation must include a separate note that addresses the 5A's, separate signature, and the member specific information addressed in the five (5) steps and the time spent by the practitioner performing the counseling. Anything under three (3) minutes is considered part of a routine visit.

(Q) **Diagnostic casts and/or oral/facial images.** Diagnostic casts and/or oral/facial images may be requested by OHCA or representatives of OHCA. If cast and/or images are received they will be considered supporting documentation and may be used to make a determination for authorization of services. Submitted documentation used to base a decision will not be returned. Providers will be reimbursed for either the study model or images.

(i) Documentation of photographic images must be kept in the client's medical record and medical necessity identified on the submitted electronic or paper claim.

(ii) Oral/facial photographic images are allowed under the following conditions:

(I) When radiographic images do not adequately support the necessity for requested treatment.

(II) When photo images better support medical necessity for the requested treatment rather than diagnostic models.

(III) If a comprehensive orthodontic workup has not been performed.

(iii) For photographic images, the oral/facial portfolio must include a view of the complete lower arch, complete upper arch, and left and right maximum intercuspation of teeth.

(I) Maximum intercuspation refers to the occlusal position of the mandible in which the cusps of the teeth of both arches fully interpose themselves with the cusps of the teeth of the opposing arch.

(II) Intercuspation defines both the anterior-posterior and lateral relationships of the mandible and the maxilla, as well as the superior-inferior relationship known as the vertical dimension of occlusion.

(iv) Study models or photographic images not in compliance with the above described diagnostic guidelines will not be compensable. The provider may be allowed to resubmit new images that adhere to the diagnostic guidelines. If the provider does not provide appropriate documentation, the request for treatment will be denied.

**317:30-5-698. Services requiring prior authorization**

(a) Providers must have prior authorization for certain specified services before delivery of that service, unless the service is provided on an emergency basis [See Oklahoma Administrative Code (OAC) 317:30-5-695(d)(2)]. Requests for dental services requiring prior authorization must be accompanied by sufficient documentation.

(b) Requests for prior authorization are filed on the currently approved American Dental Association (ADA) form. Prior authorized services must be billed exactly as they appear on the prior authorization. Payment is not made for any services provided prior to receiving authorization except for the relief of pain.

(c) Prosthodontic services provided to members who have become ineligible mid-treatment are covered if the member was eligible for SoonerCare on the date the final impressions were made.

(d) Listed below are examples of services requiring prior authorization for members under twenty-one (21) and eligible intermediate care facilities for individuals with intellectual disabilities (ICF/IID) residents. Minimum required records to be submitted with each request are right and left mounted bitewings and periapical films or images of tooth/teeth involved or the edentulous areas if not visible in the bitewings. Images must be of diagnostic quality. Images must be identified by the tooth number and include date of exposure, member name, member ID, provider name, and provider ID. All images, regardless of the

media, must be submitted together with a completed and signed comprehensive treatment plan that details all needed treatment at the time of examination, and a completed current ADA form requesting all treatments requiring prior authorization. The images, digital media, photographs, or printouts must be of sufficient quality to clearly demonstrate for the reviewer, the pathology which is the basis for the authorization request. If radiographs are not taken, provider must include in narrative sufficient information to confirm diagnosis and treatment plan.

(1) **Endodontics.** Root canal therapy is not considered an emergency procedure unless due to trauma to an anterior tooth. The provider must document the member's oral hygiene and flossing ability in the member's records. Pulpal debridement may be performed for the relief of pain while waiting for the decision from the Oklahoma Health Care Authority (OHCA) on request for endodontics.

(A) **Anterior endodontics.** Prior authorization is required for members who have a treatment plan requiring more than two (2) anterior root canals. All rampant, active caries should be removed prior to requesting anterior endodontics. Payment is made for services provided in accordance with the following:

(i) Permanent teeth only;

(ii) Accepted ADA materials must be used;

(iii) Pre and post-operative periapical images must be available for review;

(iv) Providers are responsible for any follow-up treatment required by a failed endodontically treated tooth within twenty-four (24) months post completion;

(v) A tooth will not be approved if it appears there is not adequate natural tooth structure remaining to establish good tooth/restorative margins or if crown to root ratio is poor; and

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

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

(i) The provider must document the member's oral hygiene and flossing ability in the member's records.

(ii) Teeth that require pre-fabricated post and cores to retain a restoration due to lack of natural tooth structure ~~should not be treatment planned~~may not be approved for root canal therapy.

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

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

tooth within twenty-four (24) months post completion.

(v) A tooth will not be approved if it appears there is not adequate natural tooth structure remaining to establish good tooth/restorative margins or if there is a poor crown to root ratio or weakened root furcation area. Approval of second molars is contingent upon proof of medical necessity.

(vi) Only ADA accepted materials are acceptable under the OHCA policy.

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

(viii) Endodontics will not be considered if:

(I) An opposing tooth has super erupted;

(II) Loss of tooth space is one third or greater;

(III) Opposing second molars are involved unless prior authorized;

(IV) The member has multiple teeth failing due to previous inadequate root canal therapy or follow-up; or

(V) All rampant, active caries must be removed prior to requesting posterior endodontics.

(ix) Endodontically treated teeth must be restored to limited occlusal function and all contours must be replaced. Core build-up code is only available for use if other restorative codes are not sufficient. These teeth will not be approved for a crown if it appears the apex is not adequately sealed.

(2) **Crowns for permanent teeth.** Crowns are compensable for restoration of natural teeth for members who are sixteen (16) years of age or older and adults residing in private ICF/IID and who have been approved for ICF/IID level of care. Certain criteria and limitations apply.

(A) The following conditions must exist for approval of this procedure:

(i) All rampant, active caries must be removed prior to requesting any type of crown;

(ii) The tooth must be decayed to such an extent to prevent proper cuspal or incisal function;

(iii) The clinical crown is fractured or destroyed by one-half or more; and

(iv) Endodontically treated teeth must have three (3) or more surfaces restored or lost due to carious activity to be considered for a crown.

(B) The conditions listed above in (A)(i) through (iv) should be clearly visible on the submitted images when a request is made for any type of crown.

(C) Routine build-up(s) for authorized crowns are included in the fee for the crown. Non authorized restorative codes may be used if available.

(D) A crown will not be approved if adequate tooth structure does not remain to establish cleanable margins, there is invasion of the biologic width, poor crown to root ratio, or the tooth appears to retain insufficient amounts of natural tooth structure. Cast dowel cores are not allowed for molar or pre-molar teeth.

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

(F) ~~The provider must document the member's oral hygiene and flossing ability in the member's records including improved oral hygiene for at least twelve (12) months.~~Chart documentation must include the OHCA caries risk assessment form.

(G) Provider is responsible for replacement or repair of all crowns if failure is caused by poor laboratory processes or procedure by provider for forty-eight (48) months post insertion.

(3) **Cast frame partial dentures.** This appliance is the treatment of choice for replacement of missing anterior permanent teeth or two (2) or more missing posterior teeth in the same arch for members sixteen (16) through twenty (20) years of age. Provider must indicate which teeth will be replaced. Members must have improved oral hygiene documented for at least twelve (12) months in the provider's records and submitted with prior authorization request to be considered. Provider is responsible for any needed follow up for a period of two (2) years post insertion.

(4) **Acrylic partial.** This appliance is the treatment of choice for replacement of three (3) or more missing teeth in the same arch for members twelve (12) through sixteen (16) years of age. Provider must indicate tooth numbers to be replaced. This appliance includes all necessary clasps and rests.

(5) **Occlusal guard.** Narrative of medical necessity must be sent with prior authorization. Model should not be made or sent unless requested.

(6) **Fixed cast non-precious metal or porcelain/metal bridges.** Only members seventeen (17) through twenty (20) years of age will be considered for this treatment. Destruction of healthy teeth to replace a single missing tooth is not considered medically necessary. Members must have excellent oral hygiene documented for at least eighteen (18) months in the requesting provider's records and submitted with prior authorization request to be considered. Provider is responsible for any needed follow up until member loses eligibility.

(7) **Periodontal scaling and root planing.** Procedure is designed for the removal of calculus or tissue that is contaminated and may require anesthesia and some soft tissue removal. This procedure requires that each tooth have three (3) or more of the six point measurements ~~five (5)~~four (4) millimeters or greater, and have multiple areas of image supported bone loss, subgingival calculus and must involve two (2) or more teeth per quadrant for consideration. This procedure is not allowed in conjunction with any other periodontal surgery.

(8) **Scaling in the presence of generalized moderate or severe gingival inflammation.** Procedure is designed for removal of plaque, calculus and stain from supra- and sub-gingival tooth surfaces when there is generalized moderate or severe gingival inflammation, as indicated by generalized suprabony pockets and bleeding on probing, in the absence of periodontitis (bone loss). This procedure is only performed after a comprehensive evaluation has been completed and is not performed in conjunction with a prophylaxis.

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

**SUBCHAPTER 3. GENERAL PROVIDER POLICIES**

**PART 6. OUT-OF-STATE SERVICES**

**317:30-3-92.Payment for lodging and meals**

(a) Payment for lodging and/or meals assistance for an eligible member and ~~an~~one (1) approved medical escort, if needed, is provided only when medically necessary in connection with ~~transportation to and from~~ SoonerCare compensable services. ~~The member and any medical escort must make a reasonable effort to secure lodging at a hospital or non-profit organization.~~For medically necessary criteria please refer to Oklahoma Administrative Code 317:30-3-1 (f) (1) through (6). The Oklahoma Health Care Authority (OHCA) has discretion and final authority to approve or deny any lodging and/or meal services.

(1) Lodging and/or meals are reimbursable when prior ~~authorized~~approved. Payment for lodging and/or meals is limited to a period of up to twenty-four (24) hours prior to the start of member's medical services and up to twenty-four (24) hours after the services end. If travel arrangements cannot meet the aforementioned stipulations, due to travel issues/restrictions and/or medically necessary services, then lodging and/or meals may be provided with approval from the OHCA. ~~Lodging is authorized for the member and one approved medical escort, if needed. The following factors may be considered by the OHCA when approving reimbursement for a member and any medical escort:~~

~~(A) Travel is to obtain specialty care; and~~

~~(B) The trip cannot be completed during SoonerRide operating hours; and/or~~

~~(C) The trip is one hundred (100) miles or more from the member's residence, as listed in the OHCA system, to the medical facility; and/or~~

~~(D) The member's medical treatment requires an overnight stay, or the condition of the member discourages traveling.~~

(2) Lodging and/or meals will not be provided if a suitable alternative is available at a hospital or non-profit. Factors to be considered in determining availability include, but are not limited to:

(A) Type of hospital room;

(B) Availability of "rooming-in";

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

(D) Member's anticipated length of stay.

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

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

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

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

~~(2) When a member is not required to have a Primary Care Provider (PCP) or when a PCP referral is not required to obtain a SoonerCare covered service, a member may go to any provider they choose, but SoonerCare will not reimburse for transportation, lodging, or meals if the distance is beyond what is considered the nearest appropriate facility.~~

~~(3)~~ (4) Meals will be reimbursed if lodging criteria is met. Duration of the trip must be eighteen (18) hours or greater.

~~(4)~~ (5) Reimbursement for meals is based on a daily per diem and may be used for breakfast, lunch or dinner, or all three (3) meals, as required. If meals or meal vouchers are provided by either the hospital or the lodging provider, additional reimbursement will not be provided to the member.

~~(5) During inpatient or outpatient medical stays, lodging and/or meals services are reimbursed for a period of up to fourteen (14) days without prior authorization; stays exceeding the fourteen (14) day period must be prior authorized. A member may not receive reimbursement for lodging and/or meals services for days the member is an inpatient in a hospital or medical facility.~~

~~(6) For eligible members in the Neonatal Intensive Care Unit (NICU), a minimum visitation of six (6) hours per day for the approved medical escort is required for reimbursement of lodging and/or meals services. Non-emergency transportation services for medically necessary visitation may be provided for eligible medical escorts.~~

(6) During the first fourteen (14) days of a member's inpatient or outpatient stay, lodging and meals can be approved per a hospital social worker/provider without prior approval. Additional lodging and/or meals beyond the fourteen (14) days must be prior approved by the OHCA.

(7) A member may not receive reimbursement for lodging and/or meals services for days the member is inpatient in a hospital or medical facility since that will be provided at the location

that the member is receiving inpatient services.

(b) ~~Lodging must be with a SoonerCare contracted Room and Board provider, when available, before direct reimbursement to a member and/or medical escort can be authorized. If lodging and/or meals assistance with contracted Room and Board providers are not available, the member and any medical escort may request reimbursement assistance by submitting the appropriate travel reimbursement forms. The travel reimbursement forms may be obtained by contacting SoonerCare Care Management division. Any lodging and/or meal expenses claimed on the travel reimbursement forms must be documented with the required receipts and medical records to document the lodging criteria have been met. Reimbursement must not exceed state per diem amounts. The OHCA has discretion and the final authority to approve or deny lodging and/or meals reimbursement.~~Criteria for lodging and/or meals reimbursement is as follows:

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

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

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

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

(5) In order for lodging to be reimbursed for a medical escort of a hospitalized member, the medical escort must be able to assist the member during escort and be of an age of legal majority recognized under state law. In cases where the lodging facility has additional requirements, the medical escort must comply with them. This includes, but is not limited to, being compliant with the lodging facility's required age to check in.

~~(c) Payment for transportation and lodging and/or meals of one medical escort may be authorized if the service is required.~~

~~(d)~~ (c) If the Oklahoma Department of Human Services (DHS) removes a child from his/her home, a court must appoint a temporary guardian. During this time, the temporary guardian is eligible for medical escort-related lodging and/or meals services. If the minor is in need of medical services and a temporary guardian has not been appointed, then the DHS case worker accompanying the minor is eligible for lodging and/or meal services. It is the responsibility

of the OHCA to determine this necessity. The decision should be based on the following circumstances:

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

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

## SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

## PART 32. SOONERRIDE NON-EMERGENCY TRANSPORTATION (NEMT)

### 317:30-5-326. Provider eligibility

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

### 317:30-5-326.1. Definitions

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

**"Attendant"** means ~~an employee of the nursing facility who is provided by and trained by the nursing facility at the nursing facility's expense.~~one (1) of the following:

(1) An employee of a long-term care facility who is provided by and trained by the long-term care facility at the long-term care facility's expense; or

(2) A provider of private duty nursing (PDN) services.

**"Emergency/Emergent"** means a serious situation or occurrence that happens unexpectedly and demands immediate action such as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected, by a reasonable and prudent layperson, to result in placing the members' health in serious jeopardy, serious impairment to bodily function, or serious dysfunction of any bodily organ or part.

**"Medical escort"** means a family member, legal guardian, or

volunteer whose presence is required and medically necessary to assist a member during transport and while at the place of treatment. A medical escort voluntarily accompanies the member during transport and leaves the vehicle at its destination and remains with the member. A medical escort must be of an age of legal majority recognized under Oklahoma State law, an emancipated minor, or a minor who is escorting his or her child to treatment.

**"Medically necessary"** means services that meet the criteria described in Oklahoma Administrative Code 317:30-3-1 (f) (1) - (6), and are not primarily for the convenience of the member.

**"Member/eligible member"** means any person eligible for SoonerCare and individuals considered to be Medicare/SoonerCare ~~full dually eligible~~dual eligible. ~~This does not include those individuals who are categorized only as Qualified Medicare Beneficiaries(QMB), Specified Low Income Medicare Beneficiaries (SLMB), Qualifying Individuals-1(QI-1), individuals who are in an institution for mental disease (IMD), inpatient, institutionalized, Home and Community Based Waiver members, with the exception of the In-home Supports Waiver for Children, the Advantage Waiver, the Living Choice demonstration, the Sooner Seniors Waiver, the My Life; My Choice Waiver and the Medically Fragile Waiver.~~

**"Nearest appropriate facility"** means a medical facility that is generally equipped and legally permitted to provide the needed care for the illness or injury involved that is the closest in geographical proximity to the members' residence with exceptions. In the case of approved hospital services, it also means that a physician or physician specialist is available to provide the necessary care required to treat the member's condition. The fact that a particular physician does or does not have staff privileges in a hospital is not a consideration in determining whether the hospital has appropriate facilities. ~~Thus, non-emergency transportation service to a more distant hospital, clinic, practitioner or physicians' office solely to avail a member of the service of a specific physician or physician specialist does not make the institution in which the physician has staff privileges the nearest institution with appropriate facilities.~~

**"Non-ambulance"** means a carrier that is not an ambulance.

**"Non-emergency"** means all reasons for transportation that are not an emergency as defined above.

**"Service animal"** means an animal individually trained to work or perform tasks for an individual with a disability. The work or task an animal has been trained to provide must be directly related to the individual's disability.

**"SoonerRide Non-Emergency Transportation ~~(NET)~~ (NEMT)"** means non-emergency non-ambulance transportation provided statewide within the geographical boundaries of the State of Oklahoma.

**"Standing appointments"** means recurring appointments that are scheduled over a significant period of time. Examples include, but are not limited to, dialysis and chemotherapy.

**317:30-5-327.1. ~~SoonerRide NET Coverage~~SoonerRide NEMT coverage and exclusions**

~~(a) SoonerRide NET is available for SoonerCare covered admission and discharge into inpatient hospital care, outpatient hospital care, services from physicians/approved practitioners, diagnostic services, clinic services, pharmacy services, eye care and dental care under the following conditions:~~

~~(1) Transportation is to the nearest appropriate facility or medical provider capable of providing the necessary services.~~

~~(A) The nearest appropriate facility or provider is not considered appropriate if the member's condition requires a higher level of care or specialized services available at the more distant facility. However, a legal impediment barring a member's admission would mean that the institution did not have "appropriate facilities". For example, the nearest transplant center may be in another state and that state's law precludes admission of nonresidents.~~

~~(B) The nearest appropriate facility is not considered appropriate if no bed or provider is available. However, the medical records must be properly documented.~~

~~(C) Services should be available within 45 miles of the members' residence with exceptions. The OHCA has discretion and the final authority to approve or deny travel greater than 45 miles to access services.~~

~~(i) Members seeking self-referred services are limited to the 45 mile radius.~~

~~(ii) Native Americans seeking services at a tribal or I.H.S facility may be transported to any facility within a 45 mile radius equipped for their medical needs with exceptions. Trips to out-of-state facilities require prior approval.~~

~~(iii) Duals may be transported to any facility within a 45 mile radius equipped for their medical needs with exceptions. Trips to out-of-state facilities require prior approval.~~

~~(2) The service provided must be a SoonerCare covered service provided by a medical provider who is enrolled in the SoonerCare program; and~~

~~(3) Services requiring prior authorization must have been authorized (e.g. travel that exceeds the 45 mile radius, out-of-state travel, meals and lodging services).~~

~~(b) SoonerRide NET is available on a statewide basis to all eligible members.~~

~~(c) SoonerRide NET may also be provided for eligible members to providers other than SoonerCare providers if the transportation is to access medically necessary services covered by SoonerCare.~~
~~(d) SoonerRide NET is available if a member is being discharged from a facility to their home. The facility is responsible for scheduling the transportation.~~
~~(e) In documented medically necessary instances, a medical escort may accompany the member.~~
~~(1) SoonerRide NET is not required to transport any additional individuals other than the one approved individual providing the escort services. In the event that additional individuals request transportation, the SoonerRide broker may charge those family members according to the SoonerRide broker's policies which have been approved by the OHCA.~~
~~(2) A medical escort is not eligible for direct compensation by the SoonerRide broker or SoonerCare.~~

(a) **SoonerRide NEMT coverage.** SoonerRide NEMT is available for SoonerCare compensable services under the following conditions:

(1) **Nearest appropriate facility.**

(A) Transportation is to the nearest appropriate facility or medical provider that is capable of providing the necessary services.

(B) SoonerRide NEMT services to a more distant hospital, clinic, practitioner or physicians' office solely to avail a member of the service of a specific physician or physician assistant does not make the institution in which the physician has staff privileges the nearest institution with appropriate facilities.

(C) The nearest facility is not considered appropriate if:

(i) The member's condition requires a higher level of care or specialized services available at a more distant facility; or

(ii) There are no beds or providers available. Medical records must be properly documented in this circumstance.

(2) **Radius.** Primary care and specialty SoonerCare compensable services should be available within forty-five (45) miles of the member's residence. The Oklahoma Health Care Authority (OHCA) has the final authority to approve or deny travel greater than forty-five (45) miles to access these services.

(A) **Residency change.** Should a member change residence then care will be established within forty-five (45) miles of the new residence.

(B) **American Indians/Alaska Natives (AI/AN).** AI/AN members that are seeking services at a Tribal or Indian Health Services (I.H.S.) facility may be transported to any Tribal or I.H.S. facility equipped for their medical needs. All trips to out-of-state facilities require prior authorization

and approval.

(3) **Services requiring prior authorization.**

(A) Travel that exceeds the forty-five (45) mile radius, as mentioned in Oklahoma Administrative Code (OAC) 317:30-5-327.1 (a) (2), must be authorized and approved; and

(B) Out-of-state travel for prior authorized out-of-state medically necessary services, must also be authorized and approved.

(b) **Discharge coverage.** SoonerRide NEMT is available if a member is being discharged from a facility to their home. The facility is responsible for scheduling the transportation. SoonerRide NEMT is only responsible for transporting the member.

(1) Personal belongings and/or durable medical equipment (with the exception of portable oxygen or a wheelchair that is medically necessary for transportation) will not be transported through SoonerRide NEMT.

(2) Wheelchairs must be provided by the medical escort/member. This item is not provided by the SoonerRide NEMT transport.

(c) **Medical escorts/service animals/additional passengers.** In instances where there is documented medical necessity, a medical escort or service animal may accompany the member.

(1) **Medical escort.** A medical escort is not eligible for direct compensation by the SoonerRide NEMT broker or SoonerCare.

(2) **Service animal.** The SoonerRide NEMT broker may request additional information regarding the service animal, including but not limited to, if the animal is required because of a disability and what work or task the animal has been trained to perform.

(3) **Removal of the service animal.** The SoonerRide NEMT broker may ask for the service animal to be removed if it is not under the control of the handler or if it is not housebroken/trained. Additionally, the SoonerRide NEMT broker and the OHCA are not responsible for the care and supervision of the service animal.

(4) **Additional passengers.** SoonerRide NEMT is not required to transport any additional individuals other than the one (1) approved individual providing the escort services.

(A) **Additional passengers request.** In the event that additional individuals request transportation, it is the responsibility of the member to contact the transportation provider directly to request allotment of additional passengers. The SoonerRide NEMT broker will not facilitate this request.

(B) **Exceptions for urgent appointments.** Exceptions may be granted if the medical appointment is urgent in nature and meets the criteria outlined in Oklahoma Administrative Code (OAC) 317:30-5-327.1 (d) (1)- (3).

(d) **Urgent appointments and additional passengers.** An urgent

appointment can be for either a sick child or sick parent/guardian. The member must make the request for additional child passengers when making the trip reservation. A maximum of three (3) children can ride with the parent/guardian. The total number of passengers, including the driver, cannot exceed more than five (5) persons for any vehicle. In addition, the following conditions must be met:

(1) **Urgent medical appointment.** The medical appointment must be urgent (for a sick child or sick parent) as determined by the member's doctor. The SoonerRide NEMT broker will confirm that the medical appointment is urgent with the member's doctor;

(2) **Children.** All children must be the member's by birth, marriage, legal adoption, foster child, or legal guardianship. Further, the additional children passengers must be younger than thirteen (13) years of age. Exception will be granted if a child has complex, medical, intellectual, or physical disabilities that requires constant care and supervision; and

(3) **Car seats for children.** Each child must have his or her own car seat, provided by the member, if required by Oklahoma state law.

(e) **Forms of transportation.** SoonerRide NEMT can include one (1) of the following forms of transportation:

(1) **Authorization for transportation by private vehicle or bus.** Transportation by private vehicle or bus is administered through the broker when it is necessary for an eligible member to receive medical services.

(2) **Authorization for transportation by taxi.** Taxi service may be authorized at the discretion of the broker.

(3) **Transportation by ambulance.** Transportation by ambulance is only provided for non-emergency scheduled stretcher service.

(4) **Transportation by airplane.** When an individual's medical condition is such that transportation out-of-state by a commercial airline is required, approval for airfare must be secured by telephoning the OHCA who will make the necessary flight arrangements.

(f) **Exclusions for SoonerRide NEMT.** SoonerRide NEMT coverage excludes the following:

(1) **Emergency services.** Transportation of members to access emergency services;

(2) **Ambulance.** Transportation of members by ambulance for any reason, except for non-emergency scheduled stretcher service per OAC 317:30-5-327.1 (e) (3);

(3) **Non-compensable services.** Transportation of members to services that are not covered by SoonerCare; and

(4) **Non-medically necessary services.** Transportation of members to services that are not medically necessary.

**317:30-5-327.3. Coverage for residents of ~~nursing facilities~~long-**

**term care facilities**

(a) An attendant must accompany members during SoonerRide ~~Non-Emergency Transportation (NET)~~NEMT. An attendant must be at least at the level of a nurse's aide, and must have the appropriate training necessary to provide any and all assistance to the member, including physical assistance needed to seat the member in the vehicle. The attendant must have the ability to interface with health care providers as appropriate. An attendant must be of an age of legal majority recognized under Oklahoma State law.

(1) The ~~nursing facility~~long-term care facility must provide an attendant to accompany members receiving ~~NET~~NEMT services.

(2) The attendant will be responsible for any care needed by the member(s) during transport and any assistance needed by the member(s) to assure the safety of all passengers and the driver of the vehicle. An attendant leaves the vehicle at its destination and remains with the member(s).

(3) When multiple members residing in the same ~~nursing facility~~long-term care facility are being transported to the same provider for health care services, the ~~nursing facility~~long-term care facility may provide one (1) qualified attendant for ~~each~~ three (3) members unless other circumstances indicate the need for additional attendants. Such circumstances might include, but are not limited to:

(A) ~~the~~The physical and/or mental status of the member(s)~~,~~;

(B) ~~difficulty~~Difficulty in getting the member(s) in and out of the vehicle~~,~~;

(C) ~~the~~The amount of time that a member(s) would have to wait unattended, etc.

(4) SoonerRide NEMT is not responsible for arranging for an attendant. The services of the attendant are not directly reimbursable by the SoonerRide program or SoonerCare. The cost for the attendant is included in the SoonerCare ~~nursing facility~~long-term care facility per diem rate.

(5) In certain instances, a family member or legal guardian may wish to accompany the member for health care services. In such instances, the family member or legal guardian may accompany the member in place of the attendant. Only one (1) medical escort may accompany a member and it must be declared, upon reservation, that the medical escort is accompanying the member. The medical escort must be able to provide any services and assistance necessary to assure the safety of the member in the vehicle.

(A) When ~~an~~a medical escort wishes to accompany the member in place of an attendant provided by the ~~nursing facility~~long-term care facility, the medical escort and the ~~nursing facility~~long-term care facility must sign a release form stating that ~~an~~a medical escort will be traveling with

the member and performing the services which would normally be performed by the attendant. This release must be faxed to the SoonerRide broker's business office prior to the date of the transport.

(B) If ~~an~~a medical escort is used in place of an attendant provided by the n~~ursing facility~~long-term care facility, that medical escort cannot be counted as ~~an~~a medical escort for any other member who is traveling in the same vehicle.

(C) ~~SoonerRide is not required to transport any additional family members other than the one family member providing escort services. In the event that additional family members request transportation, the SoonerRide broker may charge those family members according to the SoonerRide broker's policies approved by the OHCA.~~ In the event that additional individuals request transportation, it is the responsibility of the member to contact the transportation provider directly to request allotment of additional passengers. The SoonerRide NEMT broker will not facilitate this request.

(D) ~~An escort~~A medical escort or attendant is not eligible for direct compensation by the SoonerRide NEMT broker or SoonerCare.

(b) For members who require ~~non-emergency transportation~~SoonerRide NEMT for dialysis, one (1) attendant is required to accompany a group of up to three (3) dialysis patients when they are being transported for dialysis services. The attendant must remain with the patient(s) unless the provider of the dialysis treatment and the ~~nursing facility~~long-term care facility sign a release form stating that the presence of the attendant is not necessary during the dialysis treatment. The release must be faxed to the SoonerRide NEMT broker's business office prior to the date of the dialysis service.

(1) In instances when an attendant does not remain with the member(s) during dialysis treatment, SoonerRide NEMT is not responsible for transporting the attendant back to the ~~nursing facility~~long-term care facility.

(2) In instances when an attendant does not remain with the member(s) during dialysis treatment, the ~~nursing facility~~long-term care facility is responsible for providing an attendant to accompany the member(s) on the return trip from the dialysis center. The ~~nursing facility~~long-term care facility is also responsible for transporting that attendant to the dialysis center in order to accompany the member(s) on the return trip.

(c) In the event that a member is voluntarily moving from one (1) ~~nursing facility~~long-term care facility to another, SoonerRide will provide ~~NET~~NEMT to the new facility. The ~~nursing facility~~long-term care facility that the member is moving from will be responsible for scheduling the transportation and providing an

attendant for the member.
(d) In the event that a ~~nursing facility's~~long-term care facility's license is terminated, SoonerRide will provide ~~NET~~NEMT to a new ~~nursing facility~~long-term care facility. The ~~nursing facility~~long-term care facility that the member is moving from will be responsible for scheduling the ~~NET~~NEMT through SoonerRide and providing an attendant to accompany the member. SoonerRide is only responsible for transporting the member. Personal belongings and/or durable medical equipment (with the exception of portable oxygen or a wheelchair that is medically necessary for transportation) will not be transported through SoonerRide NEMT.
(e) The long-term care facility is responsible for providing a wheelchair when needed. This item is not provided by the SoonerRide NEMT transport.

**317:30-5-327.5. Exclusions from SoonerRide NET [REVOKED]**

~~SoonerRide NET excludes:~~
~~(1) transportation of members to access emergency services;~~
~~(2) transportation of members by ambulance for any reason;~~
~~(3) transportation of members to services that are not covered by SoonerCare; and~~
~~(4) transportation of members to services that are not medically necessary.~~

**317:30-5-327.6. Denial of SoonerRide ~~NET~~NEMT services by the SoonerRide broker**

(a) In addition to the exclusions listed in ~~317:30-5-327.5~~Oklahoma Administrative Code (OAC) 317:30-5-327.1 (f) (1) – (4) of this Part, the SoonerRide NEMT broker may deny ~~NET~~NEMT services if:

(1) ~~the nursing facility/member~~The long-term care facility/member refuses to cooperate in determining the member's eligibility;
(2) ~~the nursing facility/member~~The long-term care facility/member refuses to provide the documentation required to determine the medical necessity for ~~NET~~NEMT services;
(3) ~~the member or attendant~~The member, medical escort, attendant, or service animal exhibits uncooperative behavior or misuses/abuses ~~NET~~NEMT services;
(4) ~~the~~The member is not ready to board ~~NET~~the NEMT transport at the scheduled time or within ~~10~~fifteen (15) minutes after the scheduled pick up time; ~~and~~
(5) The member has not shown or cancelled previous appointments less than twenty-four (24) hours prior to the appointment, or has cancelled three (3) times within a ninety (90) day period, upon the SoonerRide NEMT transport's arrival at the member's residence; or
~~(5)~~ (6) ~~the nursing facility/member~~The long-term care

facility/member fails to request a reservation at least three (3) days in advance of a health care appointment without good cause. Good cause is created by factors such as, but not ~~limit~~limited to, any of the following:

(A) ~~urgent~~Urgent care;

(B) ~~post-surgical~~Post-surgical and/or medical follow up care specified by a health care provider to occur in fewer than three (3) days;

(C) ~~imminent~~Imminent availability of an appointment with a specialist when the next available appointment would require a delay of two (2) weeks or more; and

(D) ~~the~~The result of administrative or technical delay caused by SoonerRide and requiring that an appointment be rescheduled.

(7) All requests, provided with or without good cause, are subject to availability and resources.

(b) Pursuant to Federal law, SoonerRide will provide notification in writing to ~~nursing facilities/member~~long-term care facilities/members when ~~members have been denied services~~services have been denied. This notification must include the specific reason for the denial and the member's right to appeal.

(1) An appeal must be filed with the Oklahoma Health Care Authority (OHCA) in accordance with OAC 317:2-1-2.

(2) The appropriateness of transportation may be appealed only to the extent that the transportation does not meet the medical needs of the member. Dissatisfaction with the use of public transportation, shared rides, type of vehicle, etc., is not appropriate grounds for appeal.

(3) The OHCA's decision is final. This decision may be appealed to the chief executive officer of the OHCA pursuant to OAC 317:2-1-13.

(c) The agency contracts directly with ambulance and air providers for all other transportation needs for eligible members not approved by SoonerRide NEMT. Please refer to Subchapter 5, Part 33, Transportation by Ambulance, of this Chapter.

**317:30-5-327.8. Type of services provided and duties of the SoonerRide NEMT driver**

(a) ~~The SoonerRide NET program is limited to curb-to-curb services. Curb-to-curb services are defined as services for which the vehicle picks up and discharges the passengers at the curb or driveway in front of their place of residence or destination. The SoonerRide NET driver does not provide assistance to passengers along walkways or steps to the door or the residence or other destination. The SoonerRide NET driver will open and close the vehicle doors, load or provide assistance with loading adaptive equipment. Additionally, the SoonerRide NET driver may fasten and unfasten~~

~~safety restraints when that service is requested by the rider or on behalf of the rider.~~

(a) The SoonerRide NEMT program shall not exceed curb-to-curb services. This service will be determined by the SoonerRide NEMT broker.

(1) Curb-to-curb services are defined as services for which the vehicle picks up and discharges the passengers at the curb or driveway in front of their place of residence or destination.

(A) The SoonerRide NEMT driver will open and close the vehicle doors, load or provide assistance with loading adaptive equipment.

(B) The SoonerRide NEMT driver may fasten and unfasten safety restraints when that service is requested by the rider or on behalf of the rider.

(2) Curb-to-curb services are limited to the first thirty (30) days of NEMT eligibility. After thirty (30) days, the member may be required to utilize public transportation. Exceptions to this include:

(A) The member's residence is outside of three-fourths (3/4) of a mile from the public transportation stop; or

(B) The medical appointment is outside of three-fourths (3/4) of a mile from the transportation stop.

(3) If a letter of medical necessity is provided by the member's medical provider as to the need of curb-to-curb services, when the exceptions listed in Oklahoma Administrative Code 317:30-5-327.8 (a) (2) (A) and (B) are applicable, the approval must be confirmed by the Oklahoma Health Care Authority (OHCA).

(b) If the member is traveling by lift van, the SoonerRide ~~NET~~NEMT driver will load and unload the member according to established protocols for such procedures approved by the ~~Oklahoma Health Care Authority~~OHCA.

(c) The SoonerRide ~~NET~~NEMT driver will deliver the member to the scheduled destination, and is not required to remain with the member.

(d) The SoonerRide NEMT driver does not provide assistance to passengers along walkways or steps to the door of the residence or other destination.

**317:30-5-327.9. Scheduling ~~NET~~NEMT services through SoonerRide**

(a) The ~~nursing facility/member~~long-term care facility/member will schedule SoonerRide ~~NET~~NEMT services for transportation to covered services. SoonerRide ~~NET~~NEMT services may be scheduled by calling the toll free SoonerRide number or by faxing a request to SoonerRide.

(b) All SoonerRide ~~NET~~NEMT routine services must be scheduled by advance appointment. Appointments must be made at least three (3) business days in advance of the health care appointment, but may

be scheduled up to fourteen (14) business days in advance. Scheduling for members with standing appointments may be scheduled for those appointments beyond the ~~14~~fourteen (14) days.

(c) ~~NET~~NEMT services for eligible members will be scheduled and obtained through the SoonerRide ~~NET~~NEMT program. The ~~nursing facility/member~~long-term care facility/member will be financially responsible for ~~NET~~NEMT services which are not scheduled for eligible members through the SoonerRide program. The ~~nursing facility~~long-term care facility may not charge the member or member's family for ~~NET~~NEMT services which were not paid for by SoonerRide because they were not scheduled through SoonerRide in the appropriate manner.

(d) The long-term care facility/member must provide wheelchairs or car seats when needed. These items will not be provided by the SoonerRide NEMT transport.

~~(d)~~(e) Whenever possible SoonerRide will give consideration for members who request ~~NET~~NEMT for routine care and the request is made less than three (3) business days in advance of the appointment. However, such requests for service are not guaranteed and will depend on the ~~available space and resources~~availability of space and resources, as well as, the distance to the medical appointment.

~~(e)~~(f) If SoonerRide cannot provide ~~NET~~NEMT for urgent care, the ~~nursing facility/member~~long-term care facility/member may provide the ~~NET~~NEMT transportation and submit proper documentation to SoonerRide for reimbursement. In such cases the ~~nursing facility/member~~long-term care facility/member must attempt to schedule the service through SoonerRide first, and obtain a reference number or the service must have become necessary during a time that SoonerRide scheduling was unavailable, such as after hours or weekends. For ~~NET~~NEMT for urgent services provided after hours or on weekends, the ~~nursing facility/member~~long-term care facility/member must notify SoonerRide within two (2) business days of the date of service.

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

**SUBCHAPTER 3. COVERAGE AND EXCLUSIONS**

## 317:35-3-2. SoonerCare transportation and subsistence [REVOKED]

~~(a) The Oklahoma Health Care Authority (OHCA) is responsible for assuring that necessary transportation is available to all eligible SoonerCare members who are in need of SoonerCare medical services in accordance with 42 CFR 431.53. The agency contracts with a broker to provide statewide curb to curb coverage for non-emergency transportation under the SoonerRide program. The broker provides the most appropriate and least costly mode of transportation necessary to meet the individual needs of SoonerCare members. As the Medicaid Agency, OHCA is the payer of last resort, with few exceptions. When other resources are available, those resources must first be utilized. Exceptions to this policy are those receiving medical treatment through Indian Health Services and those eligible for the Crime Victims Compensation Act. The agency contracts directly with ambulance and air providers for all other transportation needs for eligible members not provided by SoonerRide. SoonerRide excludes those individuals who are categorized as:~~

- ~~(1) Qualified Medicare Beneficiaries(QMB)when SoonerCare pays only the Medicare premium, deductible, and co-pay;~~
- ~~(2) Specified Low Income Medicare Beneficiaries (SLMB)only;~~
- ~~(3) Qualifying Individuals-1;~~
- ~~(4) individuals who are in an institution for mental disease (IMD);~~
- ~~(5) inpatient;~~
- ~~(6) institutionalized;~~
- ~~(7) Home and Community Based Waiver members with the exception of the In-home Supports Waiver for Children, the ADvantage Waiver, the Living Choice demonstration, and the Medically Fragile Waiver.~~

~~(b) Members seeking medically necessary non-emergency transportation will be required to contact the SoonerRide reservation center. Contact will be made via a toll-free phone number which is answered Monday through Saturday, 8 a.m. to 6 p.m. Whenever possible, the member is required to notify SoonerRide at least 72 hours prior to the appointment. The member is asked to furnish the SoonerRide reservation center their SoonerCare member number, home address, the time and date of the medical appointment, the address and phone number of the medical provider, and any physical/mental limitations which will impact the type of~~

~~transportation needed. SoonerRide makes arrangements for the most appropriate, least costly transportation. SoonerRide verifies appointments when appropriate. If the member disagrees with the transportation arranged or denied by SoonerRide, an appeal must be filed with OHCA according to OAC 317:2-1-2. The appropriateness of transportation may be appealed only to the extent that the transportation does not meet the medical needs of the member. Dissatisfaction with the use of public transportation, shared rides, type of vehicle, etc., is not appropriate grounds for appeal. The Oklahoma Health Care Authority's decision is final.~~

~~(1)~~ **~~Authorization for transportation by private vehicle or bus.~~** ~~Transportation by private vehicle or bus is administered through the broker when it is necessary for an eligible member to receive medical services.~~

~~(2)~~ **~~Authorization for transportation by taxi.~~** ~~Taxi service may be authorized at the discretion of the broker.~~

~~(3)~~ **~~Transportation by ambulance (ground, air ambulance or helicopter).~~** ~~Transportation by ambulance is compensable for individuals eligible for SoonerCare benefits when other available transportation does not meet the medical needs of the individual. Payment is made for ambulance transportation to and/or from a medical facility for medical care compensable under SoonerCare.~~

~~(4)~~ **~~Transportation by airplane.~~** ~~When an individual's medical condition is such that transportation out-of-state by a commercial airline is required, approval for airfare must be secured by telephoning the OHCA who will make the necessary flight arrangements.~~

~~(5)~~ **~~Subsistence (lodging and meals).~~** ~~Payment for lodging and/or meals assistance for an eligible member and/or an approved medical escort is provided only when medically necessary in connection with transportation to and from SoonerCare compensable services. The member and/or medical escort must make a reasonable effort to secure lodging at a hospital or non-profit organization. The Oklahoma Health Care Authority (OHCA) has discretion and final authority to approve or deny any lodging and/or meal services.~~

~~(A) Lodging and/or meals are reimbursable when prior approved. Payment for lodging and/or meals is limited to a period of up to 24 hours prior to the start of the member's medical services and up to 24 hours after the services end. Lodging is approved for the member and/or one approved medical escort. The following factors may be considered by OHCA when approving reimbursement for a member and/or one medical escort:~~

~~(i) travel is to obtain specialty care; and~~

~~(ii) the trip cannot be completed during SoonerRide operating hours;~~

~~(iii) the trip is 100 miles or more from the member's residence, as listed in the OHCA system, to the medical facility; and/or~~

~~(iv) the member's medical treatment requires an overnight stay, or the condition of the member discourages traveling.~~

~~(B) When a member is not required to have a PCP or when a PCP referral is not required to obtain a SoonerCare covered service, a member may go to any provider they choose but SoonerCare will not reimburse for transportation, lodging, or meals if the distance is beyond what is considered the nearest appropriate facility.~~

~~(C) Meals will be reimbursed if lodging criteria is met, and duration of trip is or exceeds 18 hours.~~

~~(D) Reimbursement for meals is based on a daily per diem and may be used for breakfast, lunch or dinner, or all three meals, whichever is required.~~

~~(E) During inpatient or outpatient medical stays, lodging and/or meals services are reimbursed for a period of up to 14 days without prior approval; stays exceeding the 14 day period must be prior approved. A member may not receive reimbursement for lodging and/or meals services for days the member is an inpatient in a hospital or medical facility.~~

~~(F) For eligible members in the Neonatal Intensive Care Unit (NICU) a minimum visitation of 6 hours per day for the medical escort is required for reimbursement of lodging and/or meals services. Non-emergency transportation services for medically necessary visitation may be provided for eligible medical escorts.~~

~~(G) Lodging must be with a SoonerCare contracted Room and Board provider, when available, before direct reimbursement to a member and/or medical escort can be approved. If the lodging provider provides meals the member and/or medical escort is not eligible for separate reimbursement and may not seek assistance for meals obtained outside of the contracted Room and Board provider facility. If lodging and/or meal assistance with contracted Room and Board providers is not available, the member and/or medical escort may request reimbursement assistance by submitting the appropriate travel reimbursement forms. The travel reimbursement forms may be obtained by contacting SoonerCare Care Management division. Any lodging and/or meal expenses claimed on the travel reimbursement forms must be documented with the required receipts and medical records to document~~

~~the lodging and/or meals criteria have been met. Reimbursement will not exceed established state per diem amounts. The OHCA has discretion and the final authority to approve or deny lodging and/or meals reimbursement.~~

~~(6) **Escort assistance required.** Payment for transportation and lodging and/or meals of one medical escort may be approved if the service is required. If the Oklahoma Department of Human Services (OKDHS) removes a child from his/her home, a court must appoint a temporary guardian. During this time the temporary guardian is eligible for escort related lodging and/or meals services. It is the responsibility of the OHCA to determine this necessity. The decision should be based on the following circumstances:~~

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

~~(B) when the individual seeking medical services is a minor child.~~

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

**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**

**PART 1. PHYSICIANS**

**317:30-5-22. Obstetrical care**

(a) Obstetrical (OB) care is billed using the appropriate CPT codes for Maternity Care and Delivery. The date of delivery is used as the date of service for charges for total ~~obstetrical~~OB care. Inclusive dates of care should be indicated on the claim form as part of the description. Payment for total ~~obstetrical~~OB care includes all routine care, and any ultrasounds performed by the attending physician provided during the maternity cycle unless otherwise specified in this Section. For payment of total OB care, a physician must have provided care for more than one (1) trimester. To bill for prenatal care only, the claim is filed after the member leaves the provider's care. Payment for routine or minor medical problems will not be made separately to the OB physician outside of the antepartum visits. The antepartum care during the prenatal care period includes all care by the OB attending physician except major illness distinctly unrelated to the pregnancy.

(b) Procedures paid separately from total ~~obstetrical~~OB care are listed in (1) - (8) of this subsection.

(1) The completion of an American College of Obstetricians and Gynecologist (ACOG) assessment form or form covering same elements as ACOG and the most recent version of the Oklahoma Health Care Authority's (OHCA) Prenatal Psychosocial Assessment are reimbursable when both documents are included in the prenatal record. SoonerCare allows one (1) assessment per provider and no more than two (2) per pregnancy.

(2) Medically necessary real time antepartum diagnostic ultrasounds will be paid in addition to antepartum care, delivery and postpartum ~~obstetrical~~OB care under defined circumstances. To be eligible for payment, all ultrasound reports must meet the guideline standards published by the American Institute of Ultrasound Medicine (AIUM).

(A) One (1) ~~abdominal or vaginal~~ ultrasound will be covered in the first trimester of an uncomplicated pregnancy. Both an abdominal and vaginal ultrasound may be allowed when clinically appropriate and medically necessary. The ultrasound must be performed by a Board Eligible/Board Certified Obstetrician-Gynecologist (OB-GYN), Radiologist, or a Board Eligible/Board Certified Maternal-Fetal Medicine specialist. In addition, this ultrasound may be performed by

a Certified Nurse Midwife, Family Practice Physician or Advance Practice Nurse Practitioner in Obstetrics with a certification in ~~obstetrical~~OB ultrasonography.

(B) One (1) ultrasound after the first trimester will be covered. This ultrasound must be performed by a Board Eligible/Board Certified OB-GYN, Radiologist, or a Board Eligible/Board Certified Maternal-Fetal Medicine specialist. In addition, this ultrasound may be performed by a Certified Nurse Midwife, Family Practice Physician or Advance Practice Nurse Practitioner in Obstetrics with certification in ~~obstetrical~~OB ultrasonography.

(C) One (1) additional detailed ultrasound is allowed by a Board Eligible/Board Certified Maternal Fetal Specialist or general obstetrician with documented specialty training in performing detailed ultrasounds. This additional ultrasound is allowed to identify or confirm a suspected fetal/maternal anomaly. This additional ultrasound does not require prior authorization. Any subsequent ultrasounds will require prior authorization.

(3) Standby attendance at Cesarean Section (C-Section), for the purpose of attending the baby, is compensable when billed by a physician or qualified health care provider not participating in the delivery.

(4) Anesthesia administered by the attending physician is a compensable service and may be billed separately from the delivery.

(5) Amniocentesis is not included in routine ~~obstetrical~~OB care and is billed separately. Payment may be made for an evaluation and management service and a medically indicated amniocentesis on the same date of service. This is an exception to general information regarding surgery found at ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-5-8.

(6) Additional payment is not made for the delivery of multiple gestations. If one (1) fetus is delivered vaginally and additional fetus(es)are delivered by C-section by the same physician, the higher level procedure is paid. If one (1) fetus is delivered vaginally and additional fetus(es)are delivered by C-Section, by different physicians, each should bill the appropriate procedure codes without a modifier. Payment is not made to the same physician for both standby and assistant at C-Section.

(7) Reimbursement is allowed for nutritional counseling in a group setting for members with gestational diabetes. Refer to OAC 317:30-5-1076(5).

(c) Assistant surgeons are paid for C-Sections which include only in-hospital post-operative care. Family practitioners who provide prenatal care and assist at C-Section bill separately for the

prenatal and the six (6) weeks postpartum office visit.

(d) Procedures listed in (1) - (5) of this subsection are not paid or not covered separately from total ~~obstetrical~~OB care.

(1) Non stress test, unless the pregnancy is determined medically high risk. See OAC 317:30-5-22.1.

(2) Standby at C-Section is not compensable when billed by a physician participating in delivery.

(3) Payment is not made for an assistant surgeon for ~~obstetrical~~OB procedures that include prenatal or postpartum care.

(4) An additional allowance is not made for induction of labor, double set-up examinations, fetal stress tests, or pudendal anesthetic. Providers must not bill separately for these procedures.

(5) Fetal scalp blood sampling is considered part of the total OB care.

(e) ~~Obstetrical~~OB coverage for children is the same as for adults. Additional procedures may be covered under ~~EPSDT~~Early and Periodic Screening, Diagnostic and Treatment (EPSDT) provisions if determined to be medically necessary.

(1) Services deemed medically necessary and allowable under federal Medicaid regulations are covered by the EPSDT/OHCA Child Health Program even though those services may not be part of the ~~Oklahoma Health Care Authority~~OHCA SoonerCare program. Such services must be prior authorized.

(2) Federal Medicaid regulations also require the State to make the determination as to whether the service is medically necessary and do not require the provision of any items or services that the State determines are not safe and effective or which are considered experimental. For more information regarding experimental or investigational and clinical trials see OAC 317:30-3-57.1.

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

**SUBCHAPTER 3. GENERAL PROVIDER POLICIES**

**PART 3. GENERAL MEDICAL PROGRAM INFORMATION**

**317:30-3-57.1. Clinical trials**

(a) **Definition.** A clinical trial is a federally funded study that is either being conducted under an Investigational New Drug (IND) application or is exempt from having an IND application and helps to prevent, detect, or treat cancer or a life-threatening illness, injury, or disease.

(b) **Medical necessity.** Clinical trials must be determined to be medically necessary for the individual affected member. Documentation in the member's plan of care should support the medical necessity of the clinical trial for the affected individual member and that the clinical trial is for the medical purposes only. Requests for clinical trials in and of itself shall not constitute medical necessity. The Oklahoma Health Care Authority (OHCA) shall serve as the final authority pertaining to all determinations of medical necessity. Refer to Oklahoma Administrative Code (OAC) 317:30-3-1(f) for policy on medical necessity.

(c) **Documentation/requirements.** All documentation submitted to request services must demonstrate, through adequate objective medical records, evidence sufficient to justify the member's need for the service, in accordance with OAC 317:30-3-1(f)(2). An OHCA approved clinical trial must include the following:

(1) The clinical trial does one (1) of the following for the treatment of cancer or a life-threatening illness, injury, or disease:

(A) Tests how to administer a health care service;

(B) Tests responses to a health care service;

(C) Compares effectiveness of a health care service; or

(D) Studies new uses of a health care service.

(2) The clinical trial is approved and funded by one (1) of the following:

(A) Research facilities that have an established peer review program that has been approved by the National Institutes of Health Center (NIH);

(B) The Centers for Disease Control and Prevention;

(C) The Agency for Health Care Research and Quality (AHRQ);

(D) The Centers for Medicare and Medicaid Services (CMS);

(E) The United State Department of Veterans Affairs (VA);

(F) The United States Department of Defense (DOD);

(G) The Food and Drug Administration;

(H) The United States Department of Energy; or

(I) Research entities that meet the eligibility criteria for a support grant from a NIH center.

(3) Is conducted in a facility where the personnel have training and expertise needed to provide the type of care required and there is written protocol for the approved clinical trial;

(4) Complies with appropriate federal regulations regarding the protection of human subjects; and

(5) For full guidelines, please refer to www.okhca.org/mau.

(d) **Routine care costs.**

(1) The following are included in routine care costs for approved clinical trials and by a SoonerCare contracted provider:

(A) Costs that are required for the administration of the investigational item or service and are not a covered benefit of the clinical trial;

(B) Costs regarding the appropriate monitoring of the effects from the item or service; and

(C) Costs that are necessary for the prevention, diagnosis or treatment of medical complications for a non-covered item or service that was provided in the clinical trial.

(2) The following are excluded from routine care costs in approved clinical trials:

(A) The investigational item or service;

(B) Items or services that the study gives for free;

(C) Items or services that are only utilized when determining if the individual is eligible for the clinical trial;

(D) Items or services that are used only for data collection or analysis;

(E) Evaluations that are designed to only test toxicity or disease pathology;

(F) Experimental, investigational, and unproven treatments or procedures and all related services provided outside of an approved clinical trial; and

(G) Any non-FDA approved drugs that were provided or made available to the member during the approved clinical trial will not be covered after the trial ends.

(3) Applicable plan limitations for coverage for out-of-network and out-of-state providers will apply to routine care costs in an approved clinical trial.

(4) Applicable utilization management guidelines will apply to routine care costs in an approval clinical trial.

(e) **Experimental and investigational.** SoonerCare does not cover for medical, surgical, or other health care procedures, which are considered experimental or investigational in nature.

**317:30-3-60. General program exclusions - children**

(a) The following are excluded from SoonerCare coverage for children:

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

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

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

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

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

(6) Non-therapeutic hysterectomies.

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

(8) Medical services considered experimental or investigational. For more information regarding experimental or investigational including clinical trials, see OAC 317:30-3-57.1.

(9) Services of a Certified Surgical Assistant.

(10) Services of a Chiropractor.

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

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

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

(14) Payment for the services of social workers, licensed family counselors, registered nurses or other ancillary staff, except

as specifically set out in ~~OHCA~~Oklahoma Health Care Authority (OHCA) rules.

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

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

(17) Mileage.

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

(b) Not withstanding the exclusions listed in (1)-(18) of subsection (a), the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) provides for coverage of needed medical services normally outside the scope of the medical program when performed in connection with an EPSDT screening and prior authorized.

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

### 317:30-3-65.5. Diagnosis and treatment

When a screening indicates the need for further evaluation of an individual's health, a referral for appropriate diagnostic studies or treatment services must be provided without delay. Diagnostic services are defined as those services necessary to fully evaluate defects, physical or behavioral health illnesses or conditions discovered by the screening.

(1) Health care, treatment, or other measures to correct or ameliorate defects, physical or mental illnesses or conditions must also be provided and will be covered by the EPSDT/OHCA Child Health Program as medically necessary. The defects, illnesses and conditions must have been discovered during the screening or shown to have increased in severity.

(2) Services, deemed medically necessary and allowable under federal Medicaid regulations, may be covered by the EPSDT/OHCA Child Health program even though those services may not be part of the Oklahoma Health Care Authority Medicaid program. However, such services must be prior authorized and must be allowable under federal Medicaid regulations.

(3) Federal Medicaid regulations also require the State to make the determination as to whether the service is medically necessary and do not require the provision of any items or services that the State determines are not safe and effective or which are considered experimental. For more information regarding experimental or investigational including clinical trials, see Oklahoma Administrative Code 317:30-3-57.1.

## SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

## PART 1. PHYSICIANS

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

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

(1) Coverage includes, but is not limited to, the following medically necessary services:

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

(B) Inpatient psychotherapy by a physician.

(C) Inpatient psychological testing by a physician.

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

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

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

(G) Physician services on an outpatient basis include:

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

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

(H) Direct physician services in a nursing facility.

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

(ii) To receive payment for a second nursing facility visit in a month denied by Medicare for a Medicare/SoonerCare member, attach the explanation of

Medicare benefits (EOMB) showing denial and mark "carrier denied coverage."

(I) Diagnostic x-ray and laboratory services.

(J) Mammography screening and additional follow-up mammograms as per current guidelines.

(K) Obstetrical care.

(L) Pacemakers and prostheses inserted during the course of a surgical procedure.

(M) Prior authorized examinations for the purpose of determining medical eligibility for programs administered by OHCA. A copy of the authorization, Oklahoma Department of Human Services (OKDHS) form 08MA016E, Authorization for Examination and Billing, must accompany the claim.

(N) If a physician renders direct care to a member on the same day as a dialysis treatment, payment is allowed for a separately identifiable service unrelated to the dialysis.

(O) Family planning includes sterilization procedures for legally competent members twenty-one (21) years of age and over who voluntarily request such a procedure and execute the federally mandated consent form with his/her physician. A copy of the consent form must be attached to the claim form. Separate payment is allowed for the insertion and/or implantation of contraceptive devices during an office visit. Certain family planning products may be obtained through the Vendor Drug Program. Reversal of sterilization procedures for the purposes of conception is not allowed. Reversal of sterilization procedures are allowed when medically indicated and substantiating documentation is attached to the claim.

(P) Genetic counseling.

(Q) Laboratory testing.

(R) Payment for ultrasounds for pregnant women as specified in Oklahoma Administrative Code (OAC) 317:30-5-22.

(S) Payment to the attending physician in a teaching medical facility for compensable services when the physician signs as claimant and renders personal and identifiable services to the member in conformity with federal regulations.

(T) Payment to the attending physician for the services of a currently Oklahoma licensed physician in training when the following conditions are met:

(i) Attending physician performs chart review and signs off on the billed encounter;

(ii) Attending physician is present in the clinic/or hospital setting and available for consultation; and

(iii) Documentation of written policy and applicable training of physicians in the training program regarding when to seek the consultation of the attending physician.

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

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

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

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

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

(X) Medically necessary organ and tissue transplantation services for children and adults are covered services based upon the conditions listed in (i)-(v) of this subparagraph:

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

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

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

(iv) Procedures considered experimental or investigational are not covered~~; and~~. For more information regarding experimental or investigational including clinical trials, see OAC 317:30-3-57.1; and

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

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

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

(AA) Ventilator equipment.

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

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

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

(ii) Up to eight (8) sessions are covered per year per individual.
(iii) Smoking and tobacco use cessation counseling is a covered service when performed by physicians, physician assistants (PA), advanced registered nurse practitioners (ARNP), certified nurse midwives (CNM), dentists, Oklahoma State Health Department (OSDH) and Federally Qualified Health Center (FQHC) nursing staff, and maternal/child health licensed clinical social worker trained as a certified tobacco treatment specialist (CTTS). It is reimbursed in addition to any other appropriate global payments for obstetrical care, primary care provider (PCP) care coordination payments, evaluation and management codes, or other appropriate services rendered. It must be a significant, separately identifiable service, unique from any other service provided on the same day.
(iv) Chart documentation must include a separate note that addresses the 5A's and office note signature along with the member specific information addressed in the five (5) steps and the time spent by the practitioner performing the counseling. Anything under three (3)

minutes is considered part of a routine visit and not separately billable.

(EE) Immunizations as specified by the Advisory Committee on Immunization Practices (ACIP) guidelines.

(FF) Genetic testing and other molecular pathology services are covered when medically necessary. Genetic testing may be considered medically necessary when the following conditions are met:

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

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

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

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

(2) General coverage exclusions include, but is not limited to, the following:

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

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

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

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

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

(F) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.
(G) Sterilization of members who are under twenty-one (21) years of age, mentally incompetent, or institutionalized or reversal of sterilization procedures for the purposes of conception.
(H) Non-therapeutic hysterectomies.
(I) Medical services considered experimental or investigational. For more information regarding experimental or investigational including clinical trials, see OAC 317:30-3-57.1.
(J) Payment for more than four (4) outpatient visits per member (home or office) per month, except visits in connection with family planning, services related to emergency medical conditions, or primary care services provided to SoonerCare Choice members.
(K) Payment for more than two (2) nursing facility visits per month.
(L) More than one (1) inpatient visit per day per physician.
(M) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing, tumor board review or multidisciplinary opinion, dictation, and similar functions.
(N) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.
(O) Payment for the services of social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in OHCA rules.
(P) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or that the pregnancy is the result of an act of rape or incest. (Refer to OAC 317:30-5-6 or 317:30-5-50).
(Q) Speech and hearing services.
(R) Mileage.
(S) A routine hospital visit on the date of discharge unless the member expired.
(T) Direct payment to perfusionist as this is considered part of the hospital reimbursement.
(U) Inpatient chemical dependency treatment.
(V) Fertility treatment.
(W) Payment for removal of benign skin lesions.

~~(X) Sleep studies.~~

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

(1) **Pre-authorization of inpatient psychiatric services.** All inpatient psychiatric services for members under twenty-one (21) years of age must be prior authorized by an agency designated by the OHCA. All psychiatric services are prior authorized for an approved length of stay. Non-authorized inpatient psychiatric services are not SoonerCare compensable.

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

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

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

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

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

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

(6) **Reporting suspected abuse and/or neglect.** Instances of child abuse and/or neglect are to be reported in accordance with state law, including, but not limited to, Section 1-2-101 of Title 10A of the Oklahoma Statutes and 43A O.S. ' 10-104. Any person suspecting child abuse or neglect shall immediately report it to the Oklahoma Department of Human Services (OKDHS) hotline, at 1-800-522-3511; any person suspecting abuse, neglect, or exploitation of a vulnerable adult shall immediately report it to the local OKDHS county office, municipal or county law enforcement authorities, or, if the report occurs after normal business hours, the OKDHS hotline. Health care professionals who are requested to report incidents of domestic abuse by adult victims with legal capacity shall promptly make a report to the nearest law enforcement agency, per 22 O.S. ' 58.

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

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

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

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

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

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

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

(G) Non-therapeutic hysterectomies.

(H) Medical services considered experimental or investigational. For more information regarding experimental

or investigational including clinical trials, see OAC 317:30-3-57.1.

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

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

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

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

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

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

(O) Mileage.

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

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

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

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

**317:30-5-14.1. Allergy services**

(a) **Allergy testing.** Allergy testing is the process of identifying allergen(s) that may cause an allergic or anaphylactic reaction

and the degree of the reaction. By identifying the allergen(s), the member can avoid exposures and the allergic reaction can be managed appropriately. Treatment options for allergies are avoidance of the allergen(s), pharmacological therapy, and/or immunotherapy. ~~OHCA~~Oklahoma Health Care Authority (OHCA) may consider allergy testing medically necessary when a complete medical, immunological history, and physical examination is performed and indicates symptoms are suggestive of a chronic allergy. Allergy testing may also be determined medically necessary if diagnosis indicates an allergy and simple medical treatment and avoidance of the allergen(s) were tried and showed inadequate response.

(1) **Coverage.** OHCA will provide reimbursement for allergy testing when the following conditions are met:

(A) Testing is done in a hospital or providers office under direct supervision of an eligible provider;

(B) The diagnostic testing is based on the member's immunologic history and physical examination, which document that the antigen(s) being used for testing have a reasonable probability of exposure in the members environment;

(C) The member has significant life-threatening symptomatology or a chronic allergic state (e.g., asthma) which has not responded to conservative measures;

(D) The member's records document the need for allergy testing and the justification for the number of tests performed;

(E) The complete report of the test results, as well as controls, will be kept as part of the medical record; and

(F) The member is observed for a minimum of ~~20~~twenty (20) minutes following allergy testing to monitor for signs of allergic or anaphylactic reactions.

(2) **Provider requirements.** Only contracted providers (a physician (MD or DO), physician's assistant, or advanced practice nurse) who are board certified or board eligible in allergy and immunology or have received training in allergy and immunology in an accredited academic institution for a minimum of one (1) month clinical rotation (authenticated by supporting letter from institution or mentor).

(A) Follow-up administration of medically indicated allergy immunotherapy can be done by a practitioner other than an allergist.

(B) Allergy testing and/or immunotherapy for SoonerCare members younger than five (5) years of age preferably should be performed by an allergy specialist.

(3) **Description of services.** There are a variety of tests to identify the allergen(s) that may be responsible for the

member's allergic response. OHCA covers the following allergy test(s) for SoonerCare members:

(A) Direct skin tests:

(i) Percutaneous (i.e., scratch, prick, or puncture) tests are performed for inhalant allergies, suspected food allergies, hymenoptera allergies, or specific drug allergies.

(ii) Intra-cutaneous (i.e., intradermal) tests are performed commonly when a significant allergic history is obtained and results of the percutaneous test are negative or equivocal.

(B) Patch or application tests;

(C) Photo or photo patch skin tests;

(D) Inhalant bronchial challenge testing (not including necessary pulmonary function tests);

(E) Ingestion challenge tests (this test is used to confirm an allergy to a food or food additives); and

(F) Double-blind food challenge testing.

(G) Ophthalmic mucous membrane or direct nasal membrane tests, serum allergy tests, serial dilution endpoint tests, or any unlisted allergy procedure not stated above will require prior authorization.

(4) **Reimbursement.** Reimbursement for allergy testing is limited to a total of 60 tests every three years. Repeat allergy testing for the same allergen(s) within three years will require prior authorization. Any service related to allergy testing beyond predetermined limits must be submitted with the appropriate documentation to OHCA for prior authorization consideration.

(5) **Non-covered services.** OHCA does not cover allergy testing determined to be investigational or experimental in nature. For more information regarding experimental or investigational including clinical trials, see OAC 317:30-3-57.1.

(b) **Allergy immunotherapy.** Allergy immunotherapy involves administration of allergenic extracts at periodic intervals, with the goal of reducing symptoms, including titrating to a dosage that is maintained as maintenance therapy. Allergy immunotherapy is initiated once the offending allergen(s) has been identified through exposure and/or allergy testing. The documented allergy should correspond to the allergen planned for immunotherapy. OHCA may consider allergy immunotherapy medically necessary for members who have significant life-threatening symptomology or a chronic allergic state that cannot be managed by medication, avoidance, or environmental control measures. Before beginning allergy immunotherapy, consideration must be given to other common medical conditions that could make allergy immunotherapy more risky.

(1) **Coverage requirements.** Allergy immunotherapy is covered when the following criteria are met and documented in the medical record:

(A) The member has allergic asthma, or

(B) Allergic rhinitis and/or conjunctivitis, or

(C) Life-threatening allergy to hymenoptera (stinging insect allergy), or

(D) There is clinical evidence of an inhalant allergen(s) sensitivity; and

(E) Documentation supports that the member's symptoms are not controlled with medications and avoidance of the allergen(s) are impractical.

(2) **Provider qualifications.** See OAC ~~317:30-5-14.1(A)(2)~~317:30-5-14.1 (a)(2) for provider qualifications.

(3) **Administering sites.** Allergy immunotherapy should be administered in a medical facility with trained staff and proper medical equipment available in the case of significant reaction. Should home administration be necessary, the following requirements must be met:

(A) Adequate documentation must be present in the member's record indicating why home administration is medically necessary;

(B) Documentation must indicate the member and/or family member have been properly trained in recognizing and treating anaphylactic and/or allergic reactions to allergy immunotherapy administration;

(C) Epinephrine kits must be available to the member and the family and the member and/or family have been instructed in its use;

(D) Documentation of member and/or family member having been properly trained in antigen(s) dosing plan, withdrawing of correct amount of antigen(s) from the vial and administration of allergy immunotherapy;

(E) The signed consent by the member or family member to administer allergy immunotherapy at home;

(F) The provider initiated allergy immunotherapy in their office and is planning to continue therapy at the member's home; and

(G) Signed acknowledgement by the member or family member of receiving antigen vial(s) as per treatment protocol.

(4) **Treatment period.** A "treatment period" is generally 90 days, and adequate documentation must be available for continuation of therapy after each treatment period. The length of allergy immunotherapy treatment depends on the demonstrated clinical efficacy of the treatment.

(5) **Reimbursement.** Payment is made for the administration of allergy injections as well as supervision and provision of antigen(s) for adults and children, with the following considerations:

(A) When a contracted provider actually administers or supervises administration of the allergy injections, the administration fee is compensable;

(B) Reimbursement for the administration only codes is limited to one per member, per day;

(C) No reimbursement is made for administration of allergy injections when the allergy injection is self-administered by the member; and

(D) For antigens purchased by the provider for supervision, preparation and provision for allergy immunotherapy, an invoice reflecting the purchase should be made available upon request for post-payment review.

(6) **Limitations.** The following limitations and restrictions apply to immunotherapy:

(A) A presumption of failure can be assumed if, after ~~12~~twelve (12) months of allergy immunotherapy, the member does not experience any signs of improvement, and all other reasonable factors have been ruled out.

(B) Documented success of allergy immunotherapy treatment is evidenced by:

(i) A noticeable decrease of hypersensitivity symptoms, or

(ii) An increase in tolerance to the offending allergen(s), or

(iii) A reduction in medication usage.

(C) Very low dose immunotherapy or continued submaximal dose has not been shown to be effective and will be denied as not medically necessary.

(D) Liquid antigen(s) prepared for sublingual administration are not covered as they have not been proven to be safe and effective.

(E) Food and Drug Administration (FDA) approved oral desensitization therapies may be covered as part of the member's pharmacy benefits and requires prior authorization.

(F) If a provider is preparing single dose vials of antigens to be administered by a different provider, member or family member, only ~~30~~thirty (30) units per treatment period of ~~90~~ninety (90) days with a limit of ~~120~~one hundred and twenty (120) units per year is allowed. Additional units above the stated limits will require prior authorization.

(G) If using multi-dose vials, there is a limitation of 10 units per vial, with a maximum of ~~20~~twenty (20) units allowed

per ~~90~~ninety (90) day treatment period. There is a limit of 80 units allowed per year. Additional units above the stated limits will require prior authorization.

(7) **Non-covered services.** Allergy immunotherapy determined by OHCA to be investigational or experimental will not be covered. For more information regarding experimental or investigational including clinical trials, see OAC 317:30-3-57.1.

**317:30-5-20. Laboratory services**

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

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

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

(B) Only medically necessary laboratory services are compensable.

(i) Testing must be medically indicated as evidenced by patient-specific indications in the medical record.

(ii) Testing is only compensable if the results will affect patient care and are performed to diagnose conditions and illnesses with specific symptoms.

(iii) Testing is only compensable if the services are performed in furtherance of the diagnosis and/or treatment of conditions that are covered under SoonerCare.

(C) Laboratory testing must be ordered by the physician or non-physician provider, and must be individualized to the patient and the patient's medical history or assessment indicators as evidenced in the medical documentation.

(D) Laboratory testing for routine diagnostic or screening

tests following clinical guidelines such as those found in the American Academy of Pediatrics (AAP) Bright Futures' periodicity schedule, the United States Preventive Services Task Force (USPSTF) A and B recommendations, the American Academy of Family Practitioners (AAFP), or other nationally recognized medical professional academy or society standards of care, is compensable. Additionally, such sources as named in this subdivision should meet medical necessity criteria as outlined in Oklahoma Administrative Code (OAC) 317:30-3-1(f).

(2) **Non-compensable laboratory services.**

(A) Laboratory testing for routine diagnostic or screening tests not supported by the clinical guidelines of a nationally recognized medical professional academy or society standard of care, and/or testing that is performed without apparent relationship to treatment or diagnosis of a specific illness, symptom, complaint or injury is not covered.

(B) Non-specific, blanket panel or standing orders for laboratory testing, custom panels particular to the ordering provider, or lab panels which have no impact on the patient's plan of care are not covered.

(C) Split billing, or dividing the billed services for the same patient for the same date of service by the same rendering laboratory into two (2) or more claims is not allowed.

(D) Separate payment is not made for blood specimens obtained by venipuncture or urine specimens collected by a laboratory. These services are considered part of the laboratory analysis.

(E) Claims for inpatient full service laboratory procedures are not covered since this is considered a part of the hospital rate.

(F) Billing multiple units of nucleic acid detection for individual infectious organisms when testing for more than one (1) infectious organism in a specimen is not permissible. Instead, OHCA considers it appropriate to bill a single unit of a procedure code indicated for multiple organism testing.

(G) Billing multiple Current Procedural Terminology (CPT) codes or units for molecular pathology tests that examine multiple genes or incorporate multiple types of genetic analysis in a single run or report is not permissible. Instead, OHCA considers it appropriate to bill a single CPT code for such test. If an appropriate code does not exist, then one (1) unit for an unlisted molecular pathology procedure may be billed.

(3) **Covered services by a pathologist.**

(A) A pathologist may be paid for the interpretation of inpatient surgical pathology specimen when the appropriate CPT procedure code and modifier is used.

(B) Full service or interpretation of surgical pathology for outpatient surgery performed in an outpatient hospital or ambulatory surgery center setting.

(4) **Non-compensable services by a pathologist.** The following are non-compensable pathologist services:

(A) Experimental or investigational procedures. For more information regarding experimental or investigational including clinical trials, see OAC 317:30-3-57.1.

(B) Interpretation of clinical laboratory procedures.

## PART 3. HOSPITALS

### 317:30-5-41.2. Organ transplants

Solid organ and bone marrow/stem cell transplants are covered when appropriate and medically necessary.

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

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

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

(4) Procedures considered experimental or investigational are not covered. For more information regarding experimental or investigational including clinical trials, see OAC 317:30-3-57.1.

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

### 317:30-5-42.18. Coverage for children

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

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

investigational including clinical trials, see Oklahoma Administrative Code 317:30-3-57.1.

## PART 5. PHARMACIES

### 317:30-5-72.1. Drug benefit

~~OHCA~~The Oklahoma Health Care Authority (OHCA) administers and maintains an Open Formulary subject to the provisions of 42 U.S.C. ' 1396r-8. The OHCA covers a drug that has been approved by the Food and Drug Administration (FDA) and whose manufacturers have entered into a drug rebate agreement with the Centers for Medicare and Medicaid Services (CMS), subject to the following exclusions and limitations.

(1) The following drugs, classes of drugs, or their medical uses are excluded from coverage:

(A) Agents used to promote fertility.

(B) Agents primarily used to promote hair growth.

(C) Agents used for cosmetic purposes.

(D) Agents used primarily for the treatment of anorexia or weight gain. Drugs used primarily for the treatment of obesity, such as appetite suppressants are not covered. Drugs used primarily to increase weight are not covered unless otherwise specified.

(E) Agents that are investigational, experimental or whose side effects make usage controversial including agents that have been approved by the FDA but are being investigated for additional indications. For more information regarding experimental or investigational including clinical trials see, OAC 317:30-3-57.1.

(F) Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or designee.

(G) Agents when used for the treatment of sexual or erectile dysfunction, unless such agents are used to treat a condition, other than sexual or erectile dysfunction, for which the agents have been approved by the FDA.

(H) Agents used for the symptomatic relief of cough and colds.

(2) The drug categories listed in (A) through (D) of this paragraph are covered at the option of the state and are subject to restrictions and limitations. An updated list of products in each of these drug categories is included on the OHCA's public website.

(A) Vitamins and Minerals. Vitamins and minerals are not

covered except under the following conditions:

(i) ~~prenatal~~Prenatal vitamins are covered for pregnant women;

(ii) ~~fluoride~~Flouride preparations are covered for persons under sixteen (16) years of age or pregnant;

(iii) ~~vitamin~~Vitamin D, metabolites, and analogs when used to treat chronic kidney disease or end stage renal disease are covered;

(iv) ~~iron~~Iron supplements may be covered for pregnant women if determined to be medically necessary;

(v) ~~vitamin~~Vitamin preparations may be covered for children less than twenty-one (21) years of age when medically necessary and furnished pursuant to EPSDT protocol; and

(vi) ~~some~~Some vitamins are covered for a specific diagnosis when the FDA has approved the use of that vitamin for a specific indication.

(B) Coverage of non-prescription or over the counter drugs is limited to:

(i) Insulin;

(ii) ~~certain~~Certain smoking cessation products;

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

(iv) OTC products may be covered for children if the particular product is both cost-effective and clinically appropriate; and

(v) ~~prescription~~Prescription and non-prescription products which do not meet the definition of outpatient covered drugs, but are determined to be medically necessary.

(C) Coverage of food supplements is limited to PKU formula and amino acid bars for members diagnosed with PKU, other certain nutritional formulas and bars for children diagnosed with certain rare metabolic conditions when medically necessary and prior authorized.

(3) All covered outpatient drugs are subject to prior authorization as provided in OAC 317:30-5-77.2 and 317:30-5-77.3.

(4) All covered drugs may be excluded or coverage limited if:

(A) ~~the~~The prescribed use is not for a medically accepted indication as provided under 42 U.S.C. ' 1396r-8; or

(B) ~~the~~The drug is subject to such restriction pursuant to the rebate agreement between the manufacturer and CMS.

## PART 7. CERTIFIED LABORATORIES

**317:30-5-105. Non-covered procedures**

The following procedures by certified laboratories are not covered:

(1) Tissue examinations of teeth and foreign objects.

(2) Tissue examination of lens after cataract surgery except when the patient is under 21 years of age.

(3) Charges for autopsy.

(4) Hair analysis for trace metal analysis.

(5) Procedures deemed experimental or investigational. For more information regarding experimental or investigational including clinical trials, see Oklahoma Administrative Code 317:30-3-57.1.

(6) Professional component charges for inpatient clinical laboratory services.

(7) Inpatient clinical laboratory services.

## PART 31. ROOM AND BOARD PROVIDERS

**317:30-5-321. Coverage by category**

Payment is made to Room and Board Providers as set forth in this Section.

(1) **Adults.** Payment is made to Room and Board Providers for room and board of an eligible adult and an escort, if necessary, when authorized by ~~OHCA.~~the Oklahoma Health Care Authority (OHCA). Room and Board is authorized by, Room and Board Order form, for Adults and Children. A copy of the authorization must be attached to each claim along with the dates of stay and signature of authorized escort.

(2) **Children.** Coverage for children is the same as for adults.

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

(B) Federal Medicaid regulations also require the State to make the determination as to whether the service is medically necessary and do not require the provision of any items or services that the State determines are not safe and effective or which are considered experimental. For more information regarding experimental or investigational including clinical trials see, Oklahoma Administrative Code 317:30-3-57.1.

## PART 32. SOONERRIDE NON-EMERGENCY TRANSPORTATION

**317:30-5-327.4. Coverage for children**

(a) Services, deemed medically necessary and allowable under federal Medicaid regulations, may be covered by the EPSDT/OHCA

Child Health program even though the services may not be part of the OHCA SoonerCare program. Such services must be prior authorized.
(b) Federal Medicaid regulations also require the State to make the determination as to whether the service is medically necessary and do not require the provision of any items or services that the State determines are not safe and effective or which are considered experimental. For more information regarding experimental or investigational including clinical trials, see Oklahoma Administrative Code 317:30-3-57.1.

## PART 33. TRANSPORTATION BY AMBULANCE

### 317:30-5-337. Coverage for children

(a) Services, deemed medically necessary and allowable under federal Medicaid regulations, may be covered by the EPSDT/OHCA Child Health program even though those services may not be part of the OHCA SoonerCare program. Such services must be prior authorized.
(b) Federal Medicaid regulations also require the State to make the determination as to whether the service is medically necessary and do not require the provision of any items or services that the State determines are not safe and effective or which are considered experimental. For more information regarding experimental or investigational including clinical trials, see Oklahoma Administrative Code 317:30-3-57.1.

## PART 63. AMBULATORY SURGICAL CENTERS (ASC)

### 317:30-5-567. Coverage by category

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

(1) **Children.** Payment is made for children for medically necessary surgical procedures which are included on Medicare's list of covered ASC surgical procedures and dental procedures in certain circumstances. Services not covered as Medicare ASC procedures and otherwise covered under SoonerCare may be reimbursed as determined by the ~~OHCA.~~Oklahoma Health Care Authority (OHCA).

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

(B) Federal regulations also require the State to make the

determination as to whether the service is medically necessary and do not require the provision of any items or services that the State determines are not safe and effective or which are considered experimental. For more information regarding experimental or investigational including clinical trials, see Oklahoma Administrative Code 317:30-3-57.1.

(2) **Adults.** Payment is made for adults for medically necessary surgical procedures which are included on Medicare's list of covered ASC surgical procedures. Services not covered as Medicare ASC procedures and otherwise covered under SoonerCare may be reimbursed as determined by the OHCA.

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

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

**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**

**PART 35. RURAL HEALTH CLINICS**

**317:30-5-354. Definitions**

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

**"APRN"** means advanced practice registered nurse.

**"C.F.R."** means the U.S. Code of Federal Regulations.

**"CLIA"** means the Clinical Laboratory Improvement Amendments.

**"CMS"** means the Centers for Medicare and Medicaid Services.

**"CNM"** means certified nurse midwife.

**"Core services"** means outpatient services that may be covered when furnished to a patient at the rural health clinic (RHC) or other location, including the patient's place of residence.

**"CP"** means clinical psychologist.

**"CPT"** means current procedural terminology.

**"CSW"** means clinical social worker.

**"EPSDT"** means the Early and Periodic Screening, Diagnostic and Treatment program for members under twenty-one (21).

**"FFS"** means the current OHCA's fee-for-service reimbursement rate.

**"HCPCS"** means Healthcare Common Procedure Coding System.

**"OAC"** means the Oklahoma Administrative Code.

**"OHCA"** means the Oklahoma Health Care Authority.

**"Other ambulatory services"** means other outpatient health services covered under the Oklahoma Medicaid State Plan other than core services.

**"PA"** means physician assistant.

**"Physician"** means:

(A) A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which the function is performed or who is a licensed physician employed by the Public Health Service;

(B) Within limitations as to the specific services furnished, a doctor of dentistry or dental, a doctor of optometry, or a doctor of podiatry.

**"Physicians' services"** means professional services that are performed by a physician at the RHC (or are performed away from the Center, excluding inpatient hospital services) whose agreement with the RHC provides that he or she will be paid by the RHC for such services.

**"PPS"** means prospective payment system all-inclusive per visit rate method specified in the Oklahoma Medicaid State Plan.

**"RHC"** means rural health clinic.

**"Visit"** means a face-to-face encounter between a clinic patient and a physician, PA, APRN, CNM, CP or CSW whose services are reimbursed under the RHC payment method. Encounters with more than one (1) health care professional and multiple encounters with the same health care professional that take place on the same day and at a single location constitute a single visit, except when the patient, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

**317:30-5-355. Eligible providers and staffing requirements**

~~Rural Health Clinics (RHCs) certified for participation in the Medicare Program are considered eligible for participation in the Medicaid Program. RHCs may be provider-based (i.e., clinics that are an integral part of a hospital, skilled nursing facility, or home health agency that participates in Medicare) or independent (freestanding), and may include Indian Health Clinics. To participate, a RHC must have a current contract on file with the Oklahoma Health Care Authority (OHCA).~~

(a) **Eligible providers.** RHCs certified for participation in the Medicare Program are considered eligible for participation in the Medicaid Program. RHC conditions for certification are found in 42 C.F.R. Part 491. RHCs may be provider-based (i.e., clinics that are an integral part of a hospital, skilled nursing facility, or home health agency that participates in Medicare) or independent (freestanding) and may include Indian Health Clinics. To participate, an RHC must have a current contract on file with the OHCA.

(b) **Staffing requirements.** Eligible providers must follow all staffing and staff responsibilities in accordance with 42 C.F.R. § 491.8. Additional requirements for mid-level practitioners at the clinic include:

(1) A nurse practitioner, a physician assistant, or certified nurse-midwife must be available to furnish patient care services at least fifty percent (50%) of the time the clinic operates.

(2) An existing clinic may request a temporary waiver of these staffing requirements for a one (1) year period, if it demonstrates that it has been unable to hire a physician assistant, nurse-practitioner, or a certified nurse-midwife in the previous ninety (90) day period.

(3) A subsequent request for a waiver cannot be made less than six (6) months after the expiration date of any previous waiver of the mid-level staffing requirements for the clinic.

**317:30-5-355.1. ~~Definition of services~~RHC professional staff**

~~The Rural Health Clinic (RHC) benefit package, as described in Title 42 of the Code of Federal Regulations (C.F.R.), ' 440.20,~~

consists of two (2) components: RHC services and other ambulatory services.

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

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

(i) Physician's services;

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

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

(iv) Services and supplies incident to the services of APRNs and PAs (including services furnished by CNMs);

(v) Visiting nurse services to the homebound;

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

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

(B) **Physicians' services.** In addition to the professional services of a physician, and services provided by an APRN, PA, and CNM which would be covered as RHC services under Medicare, certain primary preventive services are covered under the SoonerCare RHC benefit. The services must be furnished by or under the direct supervision of an RHC practitioner who is a clinic employee:

(i) Prenatal and postpartum care;

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

(iii) Family planning services;

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

(C) **Services and supplies "incident to".** Services and supplies incident to the service of a physician, PA, APRN, CP, or CSW are covered if the service or supply is:

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

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

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

(iv) Drugs and biologicals which cannot be self-administered or are specifically covered by Medicare law, are included within the scope of RHC services. Drugs and biologicals commonly used in life saving procedures, such

as analgesics, anesthetics (local), antibiotics, anticonvulsants, antidotes and emetics, serums and toxoids are not billed separately.

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

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

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

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

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

(E) **RHC encounter.** RHC "core" services (including preventive services, i.e., prenatal, EPSDT, or family planning) are part of an all-inclusive visit. A "visit" means a face-to-face encounter between a clinic patient and an RHC health professional (physicians, PAs, APRNs, CNMs, CPs, and CSWs). Encounters with more than one (1) health professional and multiple encounters with the same health professional that takes place on the same day and a single location, constitute a single visit except when the member, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment. Payment is made for one (1) encounter per member per day. Medical review will be required for additional visits for children. Payment is also limited to four (4) visits per member per month for adults.

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

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

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

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

~~(ii) Optometric services;~~

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

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

~~(v) Durable medical equipment;~~

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

~~(vii) Prescribed drugs;~~

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

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

~~(x) Inpatient services;~~

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

~~(xii) Applied behavior analysis (ABA) [refer to OAC 317:30-3-65.12].~~

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

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

~~(i) **EPSDT dental screening**. An EPSDT dental screening includes oral examination, prophylaxis and fluoride treatment, charting of needed treatment, and, if necessary, x-rays (including two bite wing films). This service must be filed on claim form ADM-36-D for EPSDT reporting purposes.~~

~~(ii) **Dental encounter**. A dental encounter consists of all dental treatment other than a dental screening. This service must be billed on the ADM-36-D.~~

~~(iii) **Visual analysis**. Visual analysis (initial or yearly) for a child with glasses, or a child who needs glasses, or a medical eye exam. This includes the refraction and medical eye health evaluation. Glasses must be billed separately. Payment is limited to two (2) glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.~~

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

~~(D) Other ambulatory services provided off-site by independent practitioners (through subcontracting agreements or arrangements for services not available at the clinic) must be billed to the SoonerCare program by the provider rendering the service. Independent practitioners must meet provider eligibility criteria and must have a current contract with the OHCA.~~

(a) RHCs must either directly employ or contract the services of professional staff who is licensed or certified and in good standing in the state in which services are provided. Services must be within the scope of the professional's license or certification for which claims are submitted to OHCA or its designated agent.

(b) Professional staff contracted or employed by the RHC recognized by the OHCA for direct reimbursement are required to individually enroll with the OHCA and will be affiliated with the organization which contracts or employs them. Participating RHCs are required to submit a list of names upon request of all practitioners working within the RHC and a list of all individual OHCA provider numbers. Reimbursement for services rendered at or on behalf of the RHC is made to the organization. Practitioners eligible for direct reimbursement for providing services to a clinic patient outside of the clinic may bill with their individual assigned number if they are not compensated under agreement by the RHC.

(c) Other providers who are not eligible for direct reimbursement may be recognized by the OHCA for the provision and payment of RHC services to an RHC as long as they are licensed or certified in good standing and meet OHCA enrollment requirements.

**317:30-5-355.2. Covered services**

The RHC benefit package, as described in 42 C.F.R. § 440.20, consists of RHC services and other ambulatory services.

(1) **RHC services.** RHC services are covered when medically necessary and furnished at the clinic or other outpatient setting, including the member's place of residence.

(A) **Core services.** RHC "core" services include, but are not limited to:

(i) Services furnished by a physician, PA, APRN, CNM, CP, or CSW.

(ii) Services and supplies incident to services provided by a physician, PA, APRN, CNM, CP, or CSW are covered in

accordance with 42 C.F.R §§ 405.2413 and 405.2415, if the service or supply is:

(I) Furnished in accordance with State law;

(II) A type commonly furnished in physicians' offices;

(III) A type commonly rendered either without charge or included in the RHC's bill;

(IV) Furnished as an incidental, although integral, part of a physician's professional services, PA, APRN, CNM, CP or CSW; or

(V) Furnished under the direct supervision of a contracted physician PA, APRN, or CNM; and

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

(iii) Visiting nurse services to the homebound are covered if:

(I) The RHC is located in an area in which the Secretary of Health and Human Services has determined there is a shortage of home health agencies;

(II) The services are rendered to members who are homebound;

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

(IV) The services are furnished under a written plan of treatment as required by 42 C.F.R § 405.2416.

(iv) Certain virtual communication services.

(B) **Preventive services.** In addition to the professional services of a physician, and services provided by an APRN, PA, and CNM which would be covered as RHC services under Medicare, certain primary preventive services are covered under the SoonerCare RHC benefit. The services must be furnished by or under the direct supervision of an RHC practitioner who is a clinic employee:

(i) Prenatal and postpartum care;

(ii) Screening examination under the EPSDT program for members under twenty-one (21);

(iii) Family planning services; and

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

(C) **Off-site services.** RHC services provided off-site of the clinic are covered if the RHC has a compensation

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

(2) **Other ambulatory services.** Other ambulatory services that may be provided by an RHC include non-primary care services covered by the Oklahoma Medicaid State Plan but are not included in the RHC's core services. These services are separately billable and may be provided by the RHC if the RHC meets the same standards as other contracted providers of those services.

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

(i) Dental services for members under the age of twenty-one (21) provided by other than a licensed dentist;

(ii) Optometric services provided by other than a licensed optometrist;

(iii) Laboratory tests performed in the RHC lab, including the lab tests required for RHC certification;

(I) Chemical examinations of urine by stick or tablet method or both (including urine ketones);

(II) Hemoglobin or hematocrit;

(III) Blood glucose;

(IV) Examination of stool specimens for occult blood;

(V) Pregnancy tests; and

(VI) Primary culturing for transmittal to a certified laboratory.

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

(v) Durable medical equipment;

(vi) Transportation by ambulance;

(vii) Prescribed drugs;

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

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

(x) Inpatient services;

(xi) Outpatient hospital services; and

(xii) Applied behavior analysis (ABA); and

(xiii) Diabetes self-management education and support (DSMES) services.

(B) Services listed in (2)(A) of this Section, furnished on-site, require a separate provider agreement(s) with the OHCA. Service item (2)(A)(iii) does not require a separate contract when furnished on-site, however, certain conditions of participation apply. (Refer to OAC 317:30-5-361 for conditions.)

**317:30-5-356. Coverage for adults**

Payment is made to ~~rural health clinics~~RHCs for adult services as set forth in this Section.

(1) **RHC services.** Payment is made for one (1) encounter per member per day. Payment is also limited to four (4) visits per member per month. ~~Refer to OAC 317:30-1, General Provisions, and OAC 317:30-3-65.2 for exceptions to the four visit limit for children under the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT). Additional preventive~~Preventive service exceptions include:

(A) **Obstetrical care.** ~~A Rural Health Clinic~~An RHC should have a written contract with its physician, ~~certified nurse midwife, advanced practice nurse, or physician assistant~~PA, APRN, or CNM that specifically identifies how obstetrical care will be billed to SoonerCare, in order to avoid duplicative billing situations. The agreement should also specifically identify the physician's compensation for ~~rural health and non-rural health clinic (other ambulatory) services~~RHC and other ambulatory services.

(i) If the clinic compensates the physician, ~~certified nurse midwife or advanced practice nurse~~PA, APRN, or CNM to provide obstetrical care, then the clinic must bill the SoonerCare program for each prenatal visit using the appropriate CPT evaluation and management codes.

(ii) If the clinic does not compensate its practitioners to provide obstetrical care, then the independent practitioner must bill the OHCA for prenatal care according to the global method described in the SoonerCare provider specific rules for physicians, ~~certified nurse midwives, physician assistants, and advanced practice nurses~~PAs, APRNs and CNMs (refer to OAC 317:30-5-22).

(iii) Under both billing methods, payment for prenatal care includes all routine or minor medical problems. No additional payment is made to the prenatal provider except in the case of a major illness distinctly unrelated to pregnancy.

(B) **Family planning services.** Family planning services are available only to members with reproductive capability. Family planning visits do not count as one (1) of the four (4) RHC visits per month.

(2) **Other ambulatory services.** ~~Services defined as "other ambulatory" services are not considered a part of a RHC visit and are therefore billable to the SoonerCare program by the RHC or provider of service on the appropriate claim forms~~These services are not considered a part of an RHC visit; therefore, these may be billed to the SoonerCare program by the RHC or service provider on the appropriate claim form. ~~Other ambulatory services are subject to the same scope of coverage as other SoonerCare services billed to the program, i.e., limited adult services and some services for under 21 subject to same prior authorization process.~~ Refer to OAC 317:30-1, General Provisions, and OAC 317:30-3-57, 317:30-5-59, and 317:30-3-60 for general coverage and exclusions under the SoonerCare program. Some specific limitations are applicable to other ambulatory services as set forth in specific provider rules and excerpted as follows: ~~Coverage under optometrists for adults is limited to treatment of eye disease not related to refractive errors. There is no coverage for eye exams for the purpose of prescribing eyeglasses, contact lenses or other visual aids. (See OAC 317:30-5-431.)~~

(A) Coverage under optometrists for adults is limited to treatment of eye disease not related to refractive errors.

(B) There is no coverage for eye exams for the purpose of prescribing eyeglasses, contact lenses or other visual aids. (See OAC 317:30-5-431.)

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

~~Coverage for rural health clinic (RHC) services and other ambulatory services for children include the same services as for adults in addition to the following:~~RHC services and other ambulatory services for children include the same services as for adults. Medical review will be required for additional visits for children. Additional services for children include:

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

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

(3) An EPSDT screening is considered a comprehensive examination. A provider billing the Medicaid program for an EPSDT screening may not bill any other visits for that patient on that same day. It is expected that the screening provider will perform necessary treatment as part of the screening charge. Additional services such as tests, immunizations, etc., required at the time of screening may be billed independently from the screening.
(4) The administration fee for immunizations should be billed if provided at the same time as a scheduled EPSDT examination.
(5) Payment may be made directly to the RHC for the professional services of physician assistants performing EPSDT screenings within the certified RHC. The claim form must include the signature of the supervising physician.

**317:30-5-361. Billing**

~~(a) **Encounters.** Payment is made for one encounter per member per day. Medical review will be required for additional visits for children. Payment is also limited to four visits per member per month for adults. Rural health clinics must bill the combined fees of all "core" services provided during an encounter on the appropriate claim form. Claims must include reasonable and customary charges.~~

~~(1) **RHC.** The appropriate revenue code is required. No HCPC or CPT code is required.~~

~~(2) **Mental health.** Mental health services must include a revenue code and a HCPCS code.~~

~~(3) **Obstetrical care.** The appropriate revenue code and HCPCS code are required. The date the member is first seen is required. The primary pregnancy diagnosis code is also required. Secondary diagnosis codes are used to describe complications of pregnancy. Delivery must be billed by the independent practitioner who has a contract with the OHCA.~~

~~(4) **Family planning.** Family planning encounters require a revenue code, HCPCS code, and a family planning diagnosis.~~

~~(5) **EPSDT screening.** EPSDT screenings must be billed by the attending provider using the appropriate Preventative Medicine procedure code from the Current Procedural Terminology Manual (CPT).~~

~~(6) **Dental.** Dental services for children must be billed on the appropriate dental claim form.~~

~~(7) **Visual analysis.** Optometric services for children are billed using the appropriate revenue code and a HCPCS code.~~

~~(b) **Services billed separately from encounters.** Other ambulatory services and preventive services itemized separately from encounters must be billed using the appropriate revenue, HCPC and/or CPT codes. Claims must include reasonable and customary charges.~~

~~(1) **Laboratory**. The rural health clinic must be CLIA certified for specialized laboratory services performed. Laboratory services must be itemized separately using the appropriate CPT or HCPCS code.~~

~~(2) **Radiology**. Radiology must be identified using the appropriate CPT or HCPC code with the technical component modifier. Radiology services are paid at the technical component rate. The professional component is included in the encounter rate.~~

~~(3) **Immunizations**. The administration fee for immunizations provided on the same day as the EPSDT exam is billed separately.~~

~~(4) **Contraceptives**. Contraceptives are billed independently from the family planning encounter. A revenue code and the appropriate CPT or HCPC codes are required. The following are examples:~~

~~(A) DepoProvera 150 mg. (Medroxyprogesterone Acetate).~~

~~(B) Insertion and implantation of a subdermal contraceptive device.~~

~~(C) Removal, implantable contraceptive devices.~~

~~(D) Removal, with reinsertion, implantable contraceptive device.~~

~~(E) Insertion of intrauterine device (IUD).~~

~~(F) Removal of intrauterine device.~~

~~(G) ParaGard IUD.~~

~~(H) Progestasert IUD.~~

~~(5) **Eyeglasses**. Eyeglasses prescribed by a licensed optometrist are billed using the appropriate revenue code and HCPCS code. Payment is limited to two eyeglasses per year. Any eyeglasses beyond this limit must be prior authorized and determined to be medically necessary.~~

(a) **Encounters**. Payment is made for one (1) encounter per member per day. Encounters with more than one (1) health professional and multiple encounters with the same health professional that takes place on the same day and a single location, constitute a single visit except when the member, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment. Medical review will be required for additional visits for children. Payment is also limited to four (4) visits per member per month for adults. RHCs must bill the combined fees of all "core" services provided during an encounter on the appropriate claim form. Claims must include reasonable and customary charges.

(1) **RHC.** The appropriate revenue code is required. No HCPCS or CPT code is required.

(2) **Mental health.** Mental health services must include a revenue code and a HCPCS code.

(3) **Obstetrical care.** The appropriate revenue code and HCPCS code are required. The date the member is first seen is required. The primary pregnancy diagnosis code is also

required. Secondary diagnosis codes are used to describe complications of pregnancy. Delivery must be billed by the independent practitioner who has a contract with the OHCA.

(4) **Family planning.** Family planning encounters require a revenue code, HCPCS code, and a family planning diagnosis.

(5) **EPSDT screening.** EPSDT screenings must be billed by the attending provider using the appropriate Preventative Medicine procedure code from the CPT Manual. Payment is made directly to the RHC on an encounter basis for on-site dental services by a licensed dentist for members under the age of twenty-one (21).

(6) **Dental.** Dental services for children must be billed on the appropriate dental claim form.

(A) **EPSDT dental screening.** An EPSDT dental screening includes oral examination, prophylaxis and fluoride treatment, charting of needed treatment, and, if necessary, x-rays (including two bite wing films). This service must be filed on claim form ADM-36-D for EPSDT reporting purposes.

(B) **Dental encounter.** A dental encounter consists of all dental treatment other than a dental screening. This service must be billed on the ADM-36-D.

(7) **Visual analysis.** Visual analysis services for a child with glasses, or a child who needs glasses, or a medical eye exam. This includes the refraction and medical eye health evaluation. Visual analysis services are billed using the appropriate revenue code and a HCPCS code. Payment is made directly to the RHC on an encounter basis for on-site optometric services by a licensed optometrist for members under the age of twenty-one (21).

(b) **Services billed separately from encounters.**

(1) Other ambulatory services and preventive services itemized separately from encounters must be billed using the appropriate revenue, HCPC and/or CPT codes. Claims must include reasonable and customary charges from the physical location where services were rendered/performed.

(A) **Laboratory.** The RHC must be CLIA certified for specialized laboratory services performed. Laboratory services must be itemized separately using the appropriate CPT or HCPCS code.

(B) **Radiology.** Radiology must be identified using the appropriate CPT or HCPC code with the technical component modifier. Radiology services are paid at the technical component rate. The professional component is included in the encounter rate.

(C) **Immunizations.** The administration fee for immunizations provided on the same day as the EPSDT exam is billed separately.

(D) **Contraceptives.** Contraceptives are billed independently from the family planning encounter. A revenue code and the

appropriate CPT or HCPC codes are required.

(E) **Eyeglasses.** Eyeglasses prescribed by a licensed optometrist are billed using the appropriate revenue code and HCPCS code. Payment is limited to two eyeglasses per year. Any eyeglasses beyond this limit must be prior authorized and determined to be medically necessary.

(2) Other ambulatory services provided off-site by independent practitioners (through subcontracting agreements or arrangements for services not available at the clinic) must be billed to the SoonerCare program by the provider rendering the service. Independent practitioners must meet provider eligibility criteria and must have a current contract with the OHCA.

## PART 75. FEDERALLY QUALIFIED HEALTH CENTERS

### 317:30-5-659. Definitions

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

**"APRN"** means advanced practice registered nurse.

**"C.F.R"** means the U.S. Code of Federal Regulations.

**"CLIA"** means the Clinical Laboratory Improvement Amendments.

**"CMS"** means the Centers for Medicare and Medicaid Services.

**"CNM"** means certified nurse midwife.

**"Core services"** means outpatient services that may be covered when furnished to a patient at the Center or other location, including the patient's place of residence.

**"CPT"** means current procedural terminology.

**"CSW"** means clinical social worker.

**"Encounter or visit"** means a face-to-face contact between an approved health care professional as authorized in the FQHC pages of the Oklahoma Medicaid State Plan and an eligible SoonerCare member for the provision of defined services through a Health Center within a twenty-four (24) hour period ending at midnight, as documented in the patient's medical record.

**"FFS"** means the current OHCA's fee-for-service reimbursement rate.

**"FQHC"** means Federally Qualified Health Center.

**"HHS"** means the U.S. Department of Health and Human Services.

**"HRSA"** means the Health Resources and Services Administration.

**"Licensed behavioral health professional (LBHP)** means any of the following practitioners:

(A) An allopathic or osteopathic physician with a current license and board certification in psychiatry or board eligible in the state in which services are provided, or a current resident in psychiatry practicing as described in OAC 317:30-5-2.

(B) A practitioner with a current license to practice in the state in which services are provided, within one (1) of the areas of practice listed in (i) through (vi).

(i) Psychology;

(ii) Social work (clinical specialty only);

(iii) Professional counselor;

(iv) Marriage and family therapist;

(v) Behavioral practitioner; or

(vi) Alcohol and drug counselor.

(C) An advanced practice registered nurse certified in a psychiatric mental health specialty, and licensed as a registered nurse (RN) with a current certification of recognition from the board of nursing in the state in which services are provided.

(D) A physician assistant who is licensed and in good standing in the state and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or counseling functions.

**"OAC"** means the Oklahoma Administrative Code.

**"OHCA"** means the Oklahoma Health Care Authority.

**"Other ambulatory services"** means other health services covered under the Oklahoma Medicaid State Plan other than core services.

**"PA"** means physician assistant.

**"Physician"** means:

(A) A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which the function is performed or who is a licensed physician employed by the Public Health Service;

(B) Within limitations as to the specific services furnished, a doctor of dentistry or dental, a doctor of optometry, or a doctor of podiatry.

**"Physicians' services"** means professional services that are performed by a physician at the Health Center (or are performed away from the Center, excluding inpatient hospital services) whose agreement with the Center provides that he or she will be paid by the Health Center for such services.

**"PPS"** means prospective payment system all-inclusive per visit rate method specified in the Oklahoma Medicaid State Plan.

**317:30-5-660. Eligible providers**

~~(a) Federally Qualified Health Centers (FQHC) are entities or programs more commonly known as Community Health Centers, Migrant Health Centers, and Health Care for the Homeless Programs. The facilities in this Part are hereafter referred to as "Health Centers" or "Centers".~~

~~(b) For purposes of providing covered services under SoonerCare, Health Centers may qualify by one of the following methods:~~

~~(1) The entity receives a grant under Section 330 of the Public Health Service (PHS) Act (Public Law 104-229), receives funding from such grants under a contract with the recipient of such a grant and includes an outpatient health program or entity operated by a tribe or tribal organization under the Indian Self-Determination Act (Public Law 93-638);~~

~~(2) The Health Resources and Services Administration (HRSA) within the PHS recommends, and the Centers for Medicare and Medicaid Services (CMS) determines that, the entity meets the requirements for receiving such a grant and is designated a FQHC look-alike; or~~

~~(3) The Secretary of Health and Human Services (Secretary) determines that an entity may, for good cause, qualify through waiver of requirements. Such a waiver cannot exceed a period of two years.~~

~~(c) Any entity seeking to qualify as a FQHC should contact the U.S. Public Health Service.~~

(a) FQHCs are community-based health care providers that receive federal funds to provide primary care services in underserved areas. FQHCs may be Community Health Centers, Migrant Health Centers, Health Care for the Homeless, and Health Centers for Residents of Public Housing. The facilities in this Part may also be referred to as "Health Centers" or "Centers".

(b) To qualify as an FQHC SoonerCare provider, Health Centers must meet one (1) of the following requirements:

(1) Received a grant under Section 330 of the Public Health Service (PHS) Act or is funded by the same grant contracted to the recipient;

(2) Based on the recommendation of the Health Resources and Services Administration within the Public Health Service, is determined by the Secretary to meet the requirements for receiving such a grant, which qualifies the entity as an "FQHC look-alike";

(3) Treated by the Secretary of HHS as a comprehensive federally funded health center; or

(4) Operating as an outpatient health program or facility of a tribe or tribal organization under the Indian Self-Determination Act or as an urban Indian organization getting funds under Title V of the Indian Health Care Improvement Act.

(c) Any entity seeking to qualify as a FQHC should contact the U.S. Public Health Service.

**317:30-5-660.1. Health Center multiple sites contracting**

(a) Health Centers may contract as SoonerCare Traditional providers and as a PCP~~/CM~~ under SoonerCare Choice (Refer to OAC 317:25-7-5).

(b) Health Centers are required to submit a list of all entities affiliated or owned by the Center including any programs that do

not have Health Center status, along with all OHCA provider numbers.
(c) Payment for FQHC services is based on a ~~Prospective Payment System (PPS)~~PPS reimbursement. (Refer to OAC 317:30-5-664.10) In order to be eligible for reimbursement under this method for covered services, in traditional primary care settings, each site must submit an approval copy of the ~~Health Resource and Service Administration (HRSA)~~HRSA Notice of Grant Award Authorization for Public Health Services Funds under Section 330, (or a copy of the ~~letter from CMS~~recommendation letter from the HRSA designating the facility as a "Look Alike" FQHC) at the time of enrollment.

**317:30-5-660.2. Health Center professional staff**
(a) ~~Health Centers must either directly employ or contract the services of legally credentialed professional staff that are authorized within their scope of practice under state law to provide the services for which claims are submitted to OHCA or its designated agent.~~Health Centers must either directly employ or contract the services of professional staff who is licensed or certified and in good standing in the state in which services are provided. Services must be within the scope of the professional's license or certification for which claims are submitted to OHCA or its designated agent.
(b) Professional staff contracted or employed by the Health Center recognized by the OHCA for direct reimbursement are required to individually enroll with the OHCA and will be affiliated with the organization which contracts or employs them. Participating Health Centers are required to submit a list of names upon request of all practitioners working within the Center and a list of all individual OHCA provider numbers. Reimbursement for services rendered at or on behalf of the Health Center is made to the organization. Practitioners eligible for direct reimbursement for providing services to a clinic patient outside of the clinic may bill with their individual assigned number if they are not compensated under agreement by the Health Center.
(c) Other providers who are not eligible for direct reimbursement may be recognized by OHCA for the provision and payment of FQHC services to a health center as long as they are ~~legally credentialed under state law and OHCA enrollment requirements~~licensed or certified in good standing and meet OHCA enrollment requirements.

**317:30-5-660.5. Health Center service definitions [REVOKED]**
~~The following words and terms, when used in this Subchapter, shall have the following meaning, unless the context clearly indicates otherwise:~~

~~**"Core Services"** means outpatient services that may be covered when furnished to a patient at the Center or other location, including the patient's place of residence.~~

~~**"Encounter or Visit"** means a face-to-face contact between an approved health care professional as authorized in the FQHC state plan pages and an eligible SoonerCare member for the provision of defined services through a Health Center within a 24-hour period ending at midnight, as documented in the patient's medical record.~~

~~**"Licensed Behavioral Health Professional (LBHP)"** means licensed psychologists, licensed clinical social workers (LCSWs), licensed marital and family therapists (LMFTs), licensed professional counselors (LPCs), licensed behavioral practitioners (LBPs), and licensed alcohol and drug counselors (LADCs).~~

~~**"Other ambulatory services"** means other health services covered under the State plan other than core services.~~

~~**"Physician"** means:~~

~~(A) a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which the function is performed or who is a licensed physician employed by the Public Health Service;~~

~~(B) within limitations as to the specific services furnished, a doctor of dentistry or dental or oral surgery, a doctor of optometry, or a doctor of podiatry;~~

~~**"Physicians' services"** means professional services that are performed by a physician at the Health Center (or are performed away from the Center, excluding inpatient hospital services) whose agreement with the Center provides that he or she will be paid by the Health Center for such services.~~

~~**"PPS"** means prospective payment system all-inclusive per visit rate method specified in the State plan.~~

**317:30-5-661. Coverage by category [REVOKED]**

~~Health Center services are covered for SoonerCare adults and children as set forth in this Part, unless otherwise specified.~~

**317:30-5-661.1. ~~Health Center core services~~Coverage of core services**

~~Health Center "core" services include:~~

~~(1) Physicians' services and services and supplies incident to a physician's services;~~

~~(2) Services of advanced practice nurse (APNs), physician assistants (PAs), certified nurse midwives (CNMs), or specialized advanced practice nurse practitioners;~~

~~(3) Services and supplies incident to the services of APNs, certified nurse midwives, and PAs;~~

~~(4) Visiting nurse services to the homebound;~~

~~(5) Behavior health professional services as authorized under the FQHC State Plan pages and services and supplies incident thereto;~~

~~(6) Preventive primary care services;~~

~~(7) Preventive primary dental services.~~

Health Center services are covered for SoonerCare adults and children as set forth in this Part, unless otherwise specified.

(1) Services furnished by a physician, PA, APRN, CNM, CP, or CSW.

(2) Services and supplies incident to services provided by a physician, PA, APRN, CNM, CP, or CSW are covered in accordance with 42 C.F.R §§ 405.2413 and 405.2415, if the service or supply is:

(A) Furnished in accordance with State law;

(B) A type commonly furnished in physicians' offices;

(C) A type commonly rendered either without charge or included in the FQHC's bill;

(D) Furnished as an incidental, although integral, part of a physician, PA, APRN, CNM, CP or CSW services; or

(E) Furnished under the direct supervision of a physician PA, APRN, or CNM; and

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

(G) "Services and supplies incident to" include but are not limited to services such as minor surgery, reading x-rays, setting casts or simple fractures and other activities that involve evaluation or treatment of a patient's condition. They also include laboratory services performed by the Health Center, specimen collection for laboratory services furnished by an off-site CLIA certified laboratory and injectable drugs.

(3) Visiting nurse services to the homebound are covered if:

(A) The FQHC is located in an area in which the Secretary of Health and Human Services has determined there is a shortage of home health agencies;

(B) The services are rendered to members who are homebound;

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

(D) The services are furnished under a written plan of treatment as required by 42 C.F.R § 405.2416.

(4) Preventive primary services in accordance with 42 C.F.R § 405.2448;
(5) Medical nutrition services in accordance with OAC 317:30-5-1075 through 317:30-5-1076; and
(6) Preventive primary dental services.

**317:30-5-661.2. Services and supplies "incident to" Health Center encounters [REVOKED]**

~~(a) Services and supplies incident to the service of covered health center providers may be covered if the service or supply is:~~
~~(1) of a type commonly furnished in physician offices;~~
~~(2) of a type commonly rendered either without charge or included in the Health Center's bill;~~
~~(3) furnished as an incidental, although integral, part of professional services furnished by a physician, advanced practice nurse, physician assistant, certified nurse midwife, or specialized advanced practice nurse;~~
~~(4) furnished under the direct, personal supervision of an advanced practice nurse, physician assistant, certified nurse midwife, specialized advanced practice nurse or a physician; and~~
~~(5) in the case of a service, furnished by a member of the Health Center's health care staff who is an employee or contractor of the organization.~~
~~(b) "Services and supplies incident to" include services such as minor surgery, reading x-rays, setting casts or simple fractures and other activities that involve evaluation or treatment of a patient's condition. They also include laboratory services performed by the Health Center, specimen collection for laboratory services furnished by an off-site CLIA certified laboratory and injectable drugs.~~

**317:30-5-661.3. Visiting Nurse services [REVOKED]**

~~Visiting Nurse services may be covered if the Health Center is located in an area in which the Secretary of Health and Human Services has determined that there is a shortage of home health agencies.~~

**317:30-5-661.5. Health Center preventive primary care services**

(a) Preventive primary care services, as described in 42 C.F.R § 405.2448, are those health services that:
(1) ~~a~~A Health Center is required to provide as preventive primary health services under section 330 of the Public Health Service Act;
(2) ~~are~~Are furnished by or under the direct supervision of ~~an APN, PA, CNMW, specialized advanced practice nurse practitioner, licensed psychologist, LCSW ,a physician,~~a physician, PA, APRN, CNM, CP, CSW or other approved health care

professional as authorized in the approved FQHC ~~state plan~~State Plan pages;

(3) ~~are~~Are furnished by a member of the Health Center's health care staff who is an employee of the Center or provides services under arrangements with the Center; and

(4) ~~includes~~Includes only drugs and biologicals that cannot be self-administered.

(b) Preventive primary care services which may be paid for when provided by Health Centers include:

(1) ~~medical~~Medical social services;

(2) ~~nutritional~~Nutritional assessment and referral;

(3) ~~preventive~~Preventive health education;

(4) ~~children's~~Children's eye and ear examinations;

(5) ~~prenatal~~Prenatal and post-partum care;

(6) ~~perinatal~~Perinatal services;

(7) ~~well~~Well child care, including periodic screening (refer to OAC 317:30-3-65);

(8) ~~immunizations~~Immunizations, including tetanus-diphtheria booster and influenza vaccine;

(9) ~~voluntary family~~Family planning services;

(10) ~~taking~~Taking patient history;

(11) ~~blood~~Blood pressure measurement;

(12) ~~weight~~Weight;

(13) ~~physical~~Physical examination targeted to risk;

(14) ~~visual~~Visual acuity screening;

(15) ~~hearing~~Hearing screening;

(16) ~~cholesterol~~Cholesterol screening;

(17) ~~stool~~Stool testing for occult blood;

(18) ~~dipstick~~Dipstick urinalysis;

(19) ~~risk~~Risk assessment and initial counseling regarding risks;

(20) ~~tuberculosis~~Tuberculosis testing for high risk patients;

(21) ~~clinical~~Clinical breast exam;

(22) ~~referral~~Referral for mammography; and

(23) ~~thyroid~~Thyroid function test~~; and~~.

(24) ~~dental~~Dental services (specified procedure codes).

(c) Primary care services do not include:

(1) Health education classes, or group education activities, including media productions and publications, group or mass information programs;

(2) Eyeglasses, hearing aids or preventive dental services (except under EPSDT);

(3) Screening mammography provided at a Health Center unless the Center meets the requirements as specified in OAC 317:30-5-900; and

(4) Vaccines covered by the Vaccines for Children program (refer to OAC 317:30-5-14).

**317:30-5-661.6. Health Center preventive and primary care exclusions [REVOKED]**

~~Preventive primary care Health Center services do not include:~~
~~(1) health education classes, or group education activities, including media productions and publications, group or mass information programs;~~
~~(2) eyeglasses or hearing aids (except under EPSDT);~~
~~(3) screening mammography provided at a Health Center unless the Center meets the requirements as specified in OAC 317:30-5-900; and~~
~~(4) vaccines covered by the Vaccines For Children program (refer to OAC 317:30-5-14).~~

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

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

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

(1) Dental services (refer to OAC 317:30-5-696) except for primary preventive dental services;
(2) Eyeglasses (refer to OAC 317:30-5-431, 317:30-5-432.1 and 317:30-5-451);
(3) Clinical lab tests performed in the Center lab (other than the specific laboratory tests set out for Health Centers' certification and covered as Health Center services);
(4) Technical component of diagnostic tests such as x-rays and EKGs (interpretation of the test provided by the Center physician is included as physician professional services);
(5) Durable medical equipment (refer to OAC 317:30-5-210);
(6) Transportation by ambulance (refer to OAC 317:30-5-335);
(7) Prescribed drugs (refer to OAC 317:30-5-70);
(8) Prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags) and supplies directly related to colostomy care and the replacement of such devices;
(9) Specialized laboratory services furnished away from the clinic;
(10) Psychosocial rehabilitation services (refer to OAC 317:30-5-241.3);

(11) Behavioral health related case management services (refer to OAC 317:30-5-241.6); and
(12) Applied behavior analysis (ABA) (refer to OAC 317:30-3-65.12).
(13) Diabetes self-management ~~training (DSMT)~~education and support (DSMES) services (refer to OAC 317:30-5-1080 through 317:30-5-1084).

**317:30-5-664.3. ~~Federally Qualified Health Center (FQHC)~~FQHC encounters**

(a) FQHC encounters that are billed to the ~~Oklahoma Health Care Authority (OHCA)~~OHCA must meet the definition in this Section and are limited to services covered by OHCA. Only encounters provided by ~~the~~an authorized health care professional ~~on~~listed in the approved FQHC ~~state plan~~State Plan pages within the scope of their licensure trigger a ~~prospective payment system~~PPS encounter rate.
(b) An encounter is defined as a face-to-face contact between a health care professional and a member for the provision of defined services through a FQHC within a ~~24-hour~~twenty-four (24) hour period ending at midnight, as documented in the member's medical record.
(c) An FQHC may bill for one (1) medically necessary encounter per ~~24~~twenty-four (24) hour period when the appropriate modifier is applied. Medical review will be required for additional visits for children. For information about multiple encounters, refer to ~~Oklahoma Administrative Code (OAC)~~OAC 317:30-5-664.4. Payment is limited to four (4) visits per member per month for adults.
(d) Services considered reimbursable encounters (including any related medical supplies provided during the course of the encounter) include:
(1) ~~medical~~Medical;
(2) ~~diagnostic~~Diagnostic;
(3) ~~dental~~Dental, medical and behavioral health screenings;
(4) ~~vision~~Vision;
(5) ~~physical~~Physical therapy;
(6) ~~occupational~~Occupational therapy;
(7) ~~podiatry~~Podiatry;
(8) ~~behavioral~~Behavioral health;
(9) ~~speech~~Speech;
(10) ~~hearing~~Hearing;
(11) ~~medically~~Medically necessary FQHC encounters with a registered nurse or licensed practical nurse and related medical supplies (other than drugs and biologicals) furnished on a part-time or intermittent basis to home-bound members (refer to OAC 317:30-5-661.3); and
(12) ~~any~~Any other medically necessary health services (i.e. optometry and podiatry) are also reimbursable as permitted within the FQHCs scope of services when medically reasonable

and necessary for the diagnosis or treatment of illness or injury, and must meet all applicable coverage requirements.

(e) ~~Services and supplies incident to a physician's professional service are reimbursable within the encounter if the service or supply is:~~

~~(1) of a type commonly furnished in physicians' offices;~~

~~(2) of a type commonly rendered either without a charge or included in the health clinic's bill;~~

~~(3) furnished as an incidental, although integral, part of a physician's professional services;~~

~~(4) furnished under the direct, personal supervision of a physician; and~~

~~(5) in the case of a service, furnished by a member of the clinic's health care staff who is an employee of the clinic.~~Services and supplies incident to the services of a physician, PA, APRN, CNM, CP and CSW are reimbursable within the encounter, as described in 42 C.F.R § 405.2413 and OAC 317:30-5-661.1.

(f) Only drugs and biologicals which cannot be self-administered are included within the scope of this benefit.

**317:30-5-664.7. Dental services provided by Health Centers**

(a) **Adults.** The Health Center core service benefit to adults is intended to provide services requiring immediate treatment, relief of pain and/or extraction and is not intended to restore teeth as described in OAC 317:30-5-696. ~~For scope of services for individuals eligible under other program categories, refer to OAC 317:30-5-696.~~ Core services are limited to treatment for conditions such as:

(1) Acute infection;

(2) Acute abscesses;

(3) Severe tooth pain; and

(4) Tooth re-implantation, when clinically appropriate.

(b) **Children.** Medically necessary dental services for ~~children~~members under twenty-one (21) are covered.

(c) **Exclusions and ~~Limitations~~limitations.** Other medically necessary dental services which are not considered core services may be billed by the Health Center utilizing the current SoonerCare fee schedule, including but not limited to smoking and tobacco use cessation.

~~(1) Smoking and tobacco use cessation is a covered service for adults and children and is separately reimbursable. Refer to OAC 317:30-5-2.~~

~~(2) Refer to OAC 317:30-5-695 for other specific coverage, exclusions and prior authorization requirements.~~

(d) Health Centers must submit all claims for SoonerCare reimbursement for dental services on the American Dental Association (ADA) form.

(e) For additional coverage, medical necessity criteria, exclusions, billing, and prior authorization requirements, refer to OAC 317:30-5-695 through 317:30-5-705.

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

**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**

**PART 1. PHYSICIANS**

**317:30-5-6. Abortions**

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

(1) For abortions necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, the physician must complete the Certification for Medicaid Funded Abortion and certify in writing that the abortion is being performed due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed. The ~~mother's~~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 ~~patient~~physician must fully complete the ~~Patient~~ Certification ~~For~~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 ~~mother's~~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 ~~client's~~patient's inability to file a report, the Authority will perform a prepayment review of all records to ensure there is sufficient documentation to support the physician's certification.

(b) The Oklahoma Health Care Authority performs a "look-behind" procedure for abortion claims paid from Medicaid funds. This procedure will require that this Agency obtain the complete medical records for abortions paid under Medicaid. On a post-payment basis, this Authority will obtain the complete medical records on all claims paid for abortions.
(c) Claims for spontaneous abortions, including dilation and curettage do not require certification. The following situations also do not require certification:
(1) If the physician has not induced the abortion, counseled or otherwise collaborated in inducing the abortion; and
(2) If the process has irreversibly commenced at the point of the physician's medical intervention.
(d) Claims for the diagnosis "incomplete abortion" require medical review.
(e) The appropriate diagnosis codes should be used indicating spontaneous abortion, etc., otherwise the procedure will be denied.

## 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 ~~mother's~~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 ~~patient~~physician must fully complete the ~~Patient~~ Certification ~~For~~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 ~~mother's~~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 ~~client's~~patient's inability to file a report, the ~~Authority~~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 ~~Oklahoma Health Care Authority~~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.

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

**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**

**PART 22. HEALTH HOMES [REVOKED]**

**317:30-5-250. Purpose [REVOKED]**

~~Health Homes for Individuals with Chronic Conditions are created to promote enhanced integration and coordination of primary, acute, behavioral health, and long-term services and supports for persons across the lifespan with chronic illness. The purpose of the Health Home is to improve the health status of SoonerCare members with Serious Mental Illness or Serious Emotional Disturbance by promoting wellness and prevention and to improve access and continuity in health care for these members by supporting coordination and integration of primary care services in specialty behavioral health settings.~~

**317:30-5-251. Eligible providers [REVOKED]**

~~(a) **Agency requirements.** Providers of Health Home (HH) services are responsible for providing HH services to qualifying individuals within the provider's specified service area. Qualifying providers must be:~~

~~(1) Certified by the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) as a Community Mental Health Center under OAC 450:17; or~~

~~(2) Accredited as a provider of outpatient behavioral health services from one of the national accrediting bodies; or~~

~~(3) Certified by ODMHSAS as a Mental Illness Service Program pursuant to OAC 450:27; or~~

~~(4) Certified by ODMHSAS as a Program of Assertive Community Treatment (PACT) pursuant to OAC 450:55.~~

~~(5) In addition to the accreditation/certification requirements in (1) B (4), providers must also have provider specific credentials from ODMHSAS for Health Home Services (OAC 450:17; OAC 450:27; OAC 450:55).~~

~~(b) **Health Home team.** Health Homes will utilize an interdisciplinary team of professionals and paraprofessionals to identify an individual's strengths and needs, create a unified plan to empower persons toward self-management and coordinate the individual's varied healthcare needs. HH teams will vary in size depending on the size of the member panel and acuity of members. HH team composition will vary slightly between providers working with adults and children.~~

~~(1) Health Homes working with adults with Serious Mental Illness (SMI) will utilize a multidisciplinary team consisting of the following:~~

~~(A) Health Home Director;~~

~~(B) Nurse Care Manager (RN or LPN);~~

~~(C) Consulting Primary Care Practitioner (PCP);~~

~~(D) Psychiatric Consultant (317:30-5-11);~~

~~(E) Certified Behavioral Health Case Manager(CM)(OAC 450:50; 317:30-5-595);~~

~~(F) Wellness Coach credentialed through ODMHSAS; and~~

~~(G) Administrative support.~~

~~(2) In addition to the individuals listed in (1) (A) through (G) above, teams working with adults with SMI (PACT teams only) will also have at least one of the following team members:~~

~~(A) Licensed Behavioral Health Professional or Licensure Candidate (317:30-5-240.3);~~

~~(B) Substance abuse treatment specialist (Licensed Alcohol and Drug Counselor (LADC) or Certified Alcohol and Drug Counselor (CADC); or~~

~~(C) Employment specialist.~~

~~(3) Health Homes working with children with Serious Emotional Disturbance (SED) will utilize a multidisciplinary team consisting of the following:~~

~~(A) Health Home Director;~~

~~(B) Nurse Care Manager (RN or LPN);~~

~~(C) Consulting Primary Care Practitioner (PCP);~~

~~(D) Psychiatric Consultant (317:30-5-11);~~

~~(E) Care Coordinator (CM II Wraparound Facilitator as defined in 317:30-5-595(2) (C);~~

~~(F)Family Support Provider (317:30-5-240.3);~~

~~(G) Youth/Peer Support Specialist (OAC 450:53; 317:30-5-240.3);~~

~~(H) Children's Health Home Specialist(Behavioral Health Aide or higher, with additional training in WellPower or credentialed as a Wellness Coach through ODMHSAS); and~~

~~(I) Administrative Support.~~

**317:30-5-252. Covered Services [REVOKED]**

~~Health Home services are covered for adults with Serious Mental Illness (SMI) and children with Serious Emotional Disturbance (SED) as set forth in this Section unless specified otherwise, and when provided in accordance with a documented care plan. The care plan must be client directed, integrated, and reflect the input of the team (including the involvement of the consulting primary care physician or APRN in managing the medical component of the plan), as well as others the client chooses to involve. Coverage includes the following services:~~

(1) **Comprehensive Care Management.**

(A) **Definition.** Comprehensive care management services consist of developing a Comprehensive Care Plan to address needs of the whole person and involves the active participation of the Nurse Care Manager, certified Behavioral Health Case Manager, Primary Care Practitioner, the Health Home clinical support staff with participation of other team members, family and caregivers.

(B) **Service requirements.** Comprehensive care management services include the following, but are not limited to:

(i) Identifying high-risk members and utilizing member information to determine level of participation in care management services;

(ii) Assessing preliminary service needs; participating in comprehensive person-centered service plan development; responsible for member physical health goals, preferences and optimal clinical outcomes;

(iii) Developing treatment guidelines that establish clinical pathways for health teams to follow across risk levels or health conditions;

(iv) Monitoring individual and population health status and service use to determine adherence to or variance from best practice guidelines; and

(v) Developing and disseminating reports that indicate progress toward meeting outcomes for member satisfaction, health status, service delivery and cost.

(C) **Qualified professionals.** Comprehensive care management services are provided by a health care team with participation from the client, family and caregivers. The following team members are eligible to provide comprehensive care management:

(i) Nurse Care Manager (RN or LPN within scope of practice);

(ii) Certified Behavioral Health Case Manager;

(iii) Primary Care Practitioner;

(iv) Psychiatric consultant; and

(v) Licensed Behavioral Health Professional (LBHP).

(2) **Care coordination.**

(A) **Definition.** Care coordination is the implementation of the Comprehensive Care Plan with active member involvement through appropriate linkages, referrals, coordination, and follow-up to needed services and supports.

(B) **Service requirements.** Care coordination services include the following, but are not limited to:

(i) Care coordination for primary health care, specialty health care, and transitional care from emergency

departments, hospitals and Psychiatric Residential Treatment Facilities (PRTFs);

(ii) Ensuring integration and compatibility of mental health and physical health activities;

(iii) Providing on-going service coordination and link members to resources;

(iv) Tracking completion of mental and physical health goals in member's Comprehensive Care Plan;

(v) Coordinating with all team members to ensure all objectives of the Comprehensive Care Plan are progressing;

(vi) Appointment scheduling;

(vii) Conducting referrals and follow-up monitoring;

(viii) Participating in hospital discharge processes; and

(ix) Communicating with other providers and members/family.

(C) **Qualified professionals.** Team members are responsible to ensure implementation of the Comprehensive Care Plan, which includes mental health goals, physical health goals, and other life domain goals for achievement of clinical outcomes. Care coordination services are provided by a primary care practitioner-led team which includes the following professionals and paraprofessionals:

(i) Nurse Care Manager (RN or LPN);

(ii) Certified Behavioral Health Case Managers;

(iii) Health Home Director;

(iv) Family Support Provider;

(v) Peer/Youth Support Provider; and

(vi) Health Home Specialist/Hospital Liaison.

(3) **Health promotion.**

(A) **Definition.** Health promotion consists of providing health education specific to the member's chronic condition.

(B) **Service requirements.** Health promotion will minimally consist of the following, but is not limited to:

(i) Providing health education specific to member's condition;

(ii) Developing self-management plans with the member;

(iii) Providing support for improving social networks and providing health promoting lifestyle interventions including:

(I) Substance use prevention;

(II) Smoking prevention and cessation;

(III) Obesity reduction and prevention;

(IV) Nutritional counseling; and

(V) Increasing physical activity.

(C) **Qualified professionals.** Health promotion services must be provided by the Primary Care Practitioner, Registered

~~Nurse Care Manager (or LPN within full scope of practice) and the Wellness Coach or Health Home Specialist at the direction of the Health Home Director.~~

~~(4) **Comprehensive transitional care.**~~

~~(A) **Definition.** Care coordination services for comprehensive transitional care are designed to streamline plans of care, reduce hospital admissions and interrupt patterns of frequent hospital emergency department use.~~

~~(B) **Service requirements.** The duties of the qualified team members providing transitional care services include, but are not limited to the following:~~

~~(i) Developing contracts or Memorandums of Understanding (MOUs) with regional hospitals or system(s) to ensure a formalized structure for transitional care planning, to include communication of inpatient admissions and discharges of Health Home members;~~

~~(ii) Maintaining a mutual awareness and collaboration to identify individuals seeking emergency department services that may benefit from connection with a Health Home site; and~~

~~(iii) Motivate hospital staff to notify the Health Home staff of such opportunities.~~

~~(C) **Qualified individuals.** Comprehensive transitional care services can be provided by the following team members:~~

~~(i) Nurse Care Manager;~~

~~(ii) Certified behavioral health case manager; and~~

~~(iii) Family Support provider.~~

~~(5) **Individual and family support services.**~~

~~(A) **Definition.** Individual and family support services assist individuals in accessing services that will reduce barriers and improve health outcomes, with a primary focus on increasing health literacy, the ability of the member to self- manage their care, and facilitate participation in the ongoing revision of their Comprehensive Care Plan.~~

~~(B) **Service requirements.** Individual and family support services include, but are not limited to:~~

~~(i) Teaching individuals and families self-advocacy skills;~~

~~(ii) Providing peer support groups;~~

~~(iii) Modeling and teaching how to access community resources;~~

~~(iv) Assisting with obtaining and adhering to medications and other prescribed treatments; and~~

~~(v) Identifying resources to support the member in attaining their highest level of health and functioning in their families and in the community, including transportation to medically necessary services.~~

(C) **Qualified individuals.** Individual and family support service activities must be provided by one of the following:

(i) Wellness Coaches, Recovery support specialist, Children's Health Home specialist; or

(ii) Care coordinators; or

(iii) Family Support Providers; or

(iv) Nurse Care Manager.

(6) **Referral to community and social support services.**

(A) **Definition.** Provide members with referrals to community and social support services in the community.

(B) **Service requirements.** Providing assistance for members to obtain and maintain eligibility for the following services as applicable, including but not limited to:

(i) Healthcare;

(ii) Disability benefits;

(iii) Housing;

(iv) Transportation;

(v) Personal needs; and

(vi) Legal services.

(C) **Limitations.** For members with Developmental Disabilities, the Health Home will refer to and coordinate with the approved Developmental Disabilities case management entity for these services.

(D) **Qualified individuals.** Referral to community and social support services may be provided by a certified behavioral health case manager, Family Support Provider or a nurse care manager.

**317:30-5-253. Reimbursement [REVOKED]**

(a) In order to be eligible for payment, HHs must have an approved Provider Agreement on file with OHCA. Through this agreement, the HH assures that OHCA's requirements are met and assures compliance with all applicable Federal and State regulations. These agreements are renewed annually with each provider.

(b) A Health Home may bill up to three months for outreach and engagement to a member attributed to but not yet enrolled in a Health Home. The reimbursement for outreach and engagement is limited to once per month and is not reimbursable in the same month that the HH receives reimbursement for qualified HH services.

(c) The HH will be reimbursed a monthly care coordination payment upon successful submission of a claim for one or more of the covered services listed in 317:30-5-251.

**317:30-5-254. Limitations [REVOKED]**

(a) Children/families for whom case management services are available through OKDHS/OJA staff are not eligible for concurrent Health Home services.

~~(b) The following services will not be reimbursed separately for individuals enrolled in a Health Home:~~

~~(1) Targeted case management;~~
~~(2) Service Plan Development, low complexity;~~
~~(3) Medication training and support;~~
~~(4) Peer to Peer support (family support);~~
~~(5) Medication management and support and coordination linkage when provided within a Program of Assertive Community Treatment (PACT);~~
~~(6) Medication reminder;~~
~~(7) Medication administration;~~
~~(8) Outreach and engagement.~~

## PART 113. LIVING CHOICE PROGRAM

**317:30-5-1207. Benefits for members ages sixteen (16) through eighteen (18) in a psychiatric residential treatment facility**

(a) Living Choice program participants, ages sixteen (16) through eighteen (18), may receive a range of necessary home and community based services for one (1) year after transitioning to the community from a psychiatric residential treatment facility (PRTF) setting. In order to be eligible for the Living Choice program, the member must:

(1) Have been in a PRTF facility for ninety (90) or more days during an episode of care; and

(2) Meet Level 3 criteria on the Individual Client Assessment Record; or

(3) Meet the criteria for Serious Emotional Disturbance as defined in OAC 317:30-5-240.1; or

(4) Show critical impairment on a caregiver rated Ohio Scales (score of 25 and above on the Problems Subscale or a score of 44 and below on the Functioning Subscales).

(b) Services must be billed using the appropriate Healthcare Common Procedure Code System and must be medically necessary.

(c) All services must be necessary for the individual to live successfully in the community, must be documented in the individual care plan and require prior authorization.

(d) Services that may be provided to members transitioning from a PRTF are found in OAC ~~317:30-5-252~~317:30-5-241.6(1)(B).

(e) Reimbursement will be for a monthly care coordination payment upon successful submission of a claim for one (1) or more of the covered services listed in OAC ~~317:30-5-252~~317:30-5-96.3(e)(2).

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**Oklahoma Health Care Authority Board Meeting – Drug Summary**

Drug Utilization Review Board Meeting – February 16, 2021

| Recommendation/ Vote | Drug | Used for | Cost* | Notes |
|---|---|---|---|---|
| **1** | Blenrep | • Multiple Myeloma | • $16,554 per 3 weeks | • ≥ 4 prior therapies |
| | Darzalex® | | • $6,668 per dose | • IV infusion |
| | Darzalex Faspro™ | | • $7,573 per dose | • Sub-Q injection |
| | Empliciti® | | • $9,062 every 28 days | • ≥ 1 prior therapy |
| | Hemady™ | | • $49.70 per dose | • Branded 20 mg dexamethasone tabs; cheaper options available |
| | Ninlaro® | | • $10,475 per 28 days | • ≥ 1 prior therapy |
| | Sarclisa® | | • $9,100 per 28 days | • ≥ 2 prior therapies |
| | Xpovio® | | • $22,000 per 28 days | • ≥ 2 prior therapies |
| **2** | Lenvima® | • Thyroid Cancer | • $19,000 per 30 days | • ≥ 1 prior therapy |
| **3** | AirDuo®Digihaler® | • Asthma | • $5,388 per year | • Cheaper options available |
| | ArmonAir®Digihaler® | • Asthma | • $3,588 per year | • Cheaper options available |
| | Breztri Aerosphere™ | • COPD | • $7,084 per year | • Cheaper options available |

**Oklahoma Health Care Authority Board Meeting – Drug Summary**

| | | | | |
|---|---|---|---|---|
| 4 | Enspryng™<br><br>Uplizna™ | • Neuromyelitis Optica Spectrum Disorder (NMOSD) | • $219,230 1st year; $190,000 yearly<br><br>• $393,000 1st year; $262,000 yearly | • Autoimmune disease involving chronic inflammation of optic nerve and spinal cord |
| 5 | Ortikos™ | • Crohn's Disease | • $1,200 per 30 days | • Cheaper options available |
| 6 | Pizensy™ | • Chronic Idiopathic Constipation | • N/A | • Adults |
| 7 | Oriahnn™ | • Heavy menstrual bleeding assoc. with fibroids | • $11,796 per year | • Other options should be used first line |
| 8 | Nexletol®<br><br>Nexlizet™ | • Familial hyper-cholesterolemia | • $3,833 per year<br><br>• $3,840 per year | • Need additional therapy to lower LDL-C<br>• Combination product |
| 9 | Durysta™ | • Glaucoma or ocular hypertension | • $1,950 | • Implant |
| 10 | Imcivree™ | • Weight loss for specific genetic conditions | • Up to $361,000 per year | • Dosing based on age and desired effect |

*Costs do not reflect rebated prices or net costs. Costs based on National Average Drug Acquisition Costs (NADAC) or Wholesale Acquisition Costs (WAC) if NADAC unavailable. N/A = not available at the time of publication.

# Recommendation 1: Vote to Prior Authorize Blenrep, Darzalex®, Darzalex Faspro™, Empliciti®, Hemady™, Ninlaro®, Sarclisa®, and Xpovio®

The Drug Utilization Review Board recommends the prior authorization of Blenrep (Belantamab Mafodotin-blmf), Darzalex® (Daratumumab), Darzalex Faspro™ (Daratumumab/Hyaluronidase-fihj), Empliciti® (Elotuzumab), Hemady™ (Dexamethasone 20mg Tablet), Ninlaro® (Ixazomib), Sarclisa® (Isatuximab-irfc), and Xpovio® (Selinexor) with the following criteria:

**Blenrep (Belantamab Mafodotin-blmf) Approval Criteria [Multiple Myeloma Diagnosis]:**

1. Diagnosis of relapsed or refractory multiple myeloma (RRMM) in adults; and
2. Member has received ≥4 prior therapies including an anti-CD38 monoclonal antibody, a proteasome inhibitor (PI), and an immunomodulatory agent; and
3. Prescriber must verify the member will receive eye exams, including visual acuity and slit lamp ophthalmic examinations, with each cycle (every 3 weeks).

**Darzalex® (Daratumumab) and Darzalex Faspro™ (Daratumumab/ Hyaluronidase-fihj) Approval Criteria [Light Chain Amyloidosis Diagnosis]:**

1. Relapsed/refractory light chain amyloidosis as a single agent; or
2. Newly diagnosed light chain amyloidosis in combination with bortezomib, cyclophosphamide, and dexamethasone.

**Darzalex® (Daratumumab) and Darzalex Faspro™ (Daratumumab/ Hyaluronidase-fihj) Approval Criteria [Multiple Myeloma Diagnosis]:**

1. Diagnosis of multiple myeloma; and
2. Used in 1 of the following settings:
    a. In combination with lenalidomide and dexamethasone as primary therapy in members who are ineligible for autologous stem cell transplant (ASCT) or in members who have received at least 1 prior therapy; or
    b. In combination with bortezomib, melphalan, and prednisone as primary therapy in members who are ineligible for ASCT; or
    c. In combination with bortezomib, thalidomide, and dexamethasone as primary therapy in members who are eligible for ASCT; or
    d. In combination with carfilzomib and dexamethasone in members with relapsed or progressive disease; or
    e. In combination with bortezomib and dexamethasone in members who have received at least 1 prior therapy; or

f. In combination with cyclophosphamide, bortezomib, and dexamethasone in members who have received at least 1 prior therapy; or
g. In combination with pomalidomide and dexamethasone in members who have received ≥2 prior therapies including a proteasome inhibitor (PI) and an immunomodulatory agent; or
h. As a single-agent in members who have received ≥3 prior therapies, including a PI and an immunomodulatory agent, or who are double refractory to a PI and an immunomodulatory agent.

**Empliciti® (Elotuzumab) Approval Criteria [Multiple Myeloma Diagnosis]:**

1. Diagnosis of previously treated multiple myeloma with relapsed or progressive disease; and
2. Used in combination with 1 of the following regimens:
   a. Lenalidomide and dexamethasone in members who have received 1 to 3 prior therapies; or
   b. Bortezomib and dexamethasone; or
   c. Pomalidomide and dexamethasone in members who have received ≥2 prior therapies, including an immunomodulatory agent and a proteasome inhibitor (PI).

**Hemady™ (Dexamethasone 20mg Tablet) Approval Criteria [Multiple Myeloma Diagnosis]:**

1. Diagnosis of multiple myeloma; and
2. A patient-specific, clinically significant reason (beyond convenience) why the member cannot use dexamethasone 4mg tablets to achieve the required dose in place of Hemady™ must be provided.

**Ninlaro® (Ixazomib) Approval Criteria [Multiple Myeloma Diagnosis]:**

1. Diagnosis of symptomatic multiple myeloma; and
2. Used as primary therapy; or
3. Used following disease relapse after 6 months following primary induction therapy with the same regimen; and
4. Used in combination with 1 of the following regimens:
   a. Lenalidomide and dexamethasone; or
   b. Cyclophosphamide and dexamethasone for transplant candidates only; or
   c. Pomalidomide and dexamethasone if member has failed ≥2 prior therapies and demonstrated disease progression within 60 days; or
5. Used as a single-agent for the maintenance treatment of disease.

**Sarclisa® (Isatuximab-irfc) Approval Criteria [Multiple Myeloma Diagnosis]:**

1. Diagnosis of relapsed or refractory multiple myeloma (RRMM) after ≥2 prior therapies; and

2. Previous treatment must have included lenalidomide and a proteasome inhibitor (PI); and
3. Used in combination with pomalidomide and dexamethasone.

**Xpovio® (Selinexor) Approval Criteria [Multiple Myeloma Diagnosis]:**

1. Diagnosis of relapsed or refractory multiple myeloma (RRMM); and
2. Used in 1 of the following settings:
    a. In combination with dexamethasone in members who have received ≥4 prior therapies including refractory disease to ≥2 proteasome inhibitors (PIs), ≥2 immunomodulatory agents, and an anti-CD38 monoclonal antibody; or
    b. Used in combination with bortezomib and dexamethasone in members who have failed at least 1 prior therapy.

**Xpovio® (Selinexor) Approval Criteria [Diffuse Large B-Cell Lymphoma (DLBCL) Diagnosis]:**

1. Diagnosis of relapsed/refractory DLBCL, not otherwise specified, including DLBCL arising from follicular lymphoma; and
2. Member has received ≥2 prior lines of systemic therapy.

## Recommendation 2: Vote to Prior Authorize Lenvima®

The Drug Utilization Review Board recommends the prior authorization of Lenvima® (Lenvatinib) with the following criteria:

**Lenvima® (Lenvatinib) Approval Criteria [Differentiated Thyroid Cancer (DTC) Diagnosis]:**

1. Locally recurrent or metastatic disease; and
2. Disease progression on prior treatment; and
3. Radioactive iodine-refractory disease.

**Lenvima® (Lenvatinib) Approval Criteria [Renal Cell Carcinoma (RCC) Diagnosis]:**

1. Advanced disease; and
2. Following 1 prior anti-angiogenic therapy; and
3. Used in combination with everolimus.

**Lenvima® (Lenvatinib) Approval Criteria [Hepatocellular Carcinoma (HCC) Diagnosis]:**

1. Unresectable disease; and
2. First-line treatment.

**Lenvima® (Lenvatinib) Approval Criteria [Endometrial Carcinoma Diagnosis]:**

1. Advanced disease with progression on prior systemic therapy; and
2. Member is not a candidate for curative surgery or radiation; and
3. Disease is not microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR); and
4. Used in combination with pembrolizumab.

## Recommendation 3: Vote to Prior Authorize AirDuo® Digihaler®, ArmonAir® Digihaler®, and Breztri Aerosphere™

The Drug Utilization Review Board recommends the prior authorization of AirDuo® Digihaler® (Fluticasone Propionate/Salmeterol), ArmonAir® Digihaler® (Fluticasone Propionate), and Breztri Aerosphere™ (Budesonide/Glycopyrrolate/Formoterol Fumarate) with the following criteria:

**AirDuo® Digihaler® (Fluticasone Propionate/Salmeterol Inhalation Powder) Approval Criteria:**

1. An FDA approved diagnosis of asthma; and
2. Member must be 12 years of age or older; and
3. A patient-specific, clinically significant reason why the member requires AirDuo® Digihaler® over AirDuo RespiClick® and all preferred Tier-1 inhaled corticosteroid and long-acting $beta_2$-agonist (ICS/LABA) products (Advair®, Dulera®, and Symbicort®) must be provided; and
4. Failure of Advair®, Dulera®, and Symbicort® or a reason why Advair®, Dulera®, and Symbicort® are not appropriate for the member must be provided; and
5. Member must have used an ICS for at least 1 month immediately prior; and
6. Member must be considered uncontrolled by provider [required rescue medication >2 days a week (not for prevention of exercise induced bronchospasms) and/or needed oral systemic corticosteroids]; or
7. A clinical situation warranting initiation with combination therapy due to severity of asthma; and
8. The prescriber agrees to closely monitor member adherence; and
9. The member should be capable and willing to use the Companion Mobile App and to follow the Instructions for Use, and member must ensure the Digihaler® Companion Mobile App is compatible with their specific smartphone; and
10. The member's phone camera must be functional and able to scan the inhaler QR code and register the AirDuo® Digihaler® inhaler; and
11. Approvals will be for the duration of 3 months. For continuation consideration, documentation demonstrating positive clinical response and member compliance >80% with prescribed maintenance therapy

must be provided. In addition, a patient-specific, clinically significant reason why the member cannot transition to Tier-1 medications must be provided. Tier structure rules continue to apply.

**ArmonAir® Digihaler® (Fluticasone Propionate Inhalation Powder) Approval Criteria:**

1. An FDA approved diagnosis of asthma; and
2. Member must be 12 years of age or older; and
3. A patient-specific, clinically significant reason why Flovent® (fluticasone propionate) and other preferred monotherapy inhaled corticosteroid (ICS) products are not appropriate for the member must be provided; and
4. The prescriber agrees to closely monitor member adherence; and
5. The member should be capable and willing to use the Companion Mobile App and to follow the Instructions for Use, and member must ensure the Digihaler® Companion Mobile App is compatible with their specific smartphone; and
6. The member's phone camera must be functional and able to scan the inhaler QR code and register the ArmonAir® Digihaler® inhaler; and
7. Approvals will be for the duration of 3 months. For continuation consideration, documentation demonstrating positive clinical response and member compliance >80% with prescribed maintenance therapy must be provided. In addition, a patient-specific, clinically significant reason why the member cannot transition to Tier-1 medications must be provided. Tier structure rules continue to apply.

**Breztri Aerosphere™ (Budesonide/Glycopyrrolate/Formoterol) Approval Criteria:**

1. An FDA approved diagnosis; and
2. Member must be 18 years of age or older; and
3. A 4-week trial of at least 1 long-acting $beta_2$ agonist (LABA) and a 4-week trial of 1 long-acting muscarinic antagonist (LAMA) within the past 90 days used concomitantly with an inhaled corticosteroid (ICS); and
4. A patient-specific, clinically significant reason why the member requires the triple combination therapy in place of the individual components or use of an ICS/LABA combination product with a LAMA must be provided.

## Recommendation 4: Vote to Prior Authorize Enspryng™ and Uplizna™

The Drug Utilization Review Board recommends the prior authorization of Enspryng™ (Satralizumab-mwge) and Uplizna™ (Inebilizumab-cdon) with the following criteria:

**Enspryng™ (Satralizumab-mwge) Approval Criteria:**

1. An FDA approved indication of neuromyelitis optica spectrum disorder (NMOSD) in adult members who are anti-aquaporin-4 (AQP4) antibody positive; and
2. Member must be 18 years of age or older; and
3. Member must have experienced at least 1 acute NMOSD attack in the prior 12 months; and
4. Member must have an Expanded Disability Severity Scale (EDSS) score ≤6.5; and
5. Prescriber must verify hepatitis B virus (HBV) and tuberculosis (TB) screening are negative before the first dose; and
6. Approvals will not be granted for members with active HBV infection or active or untreated latent TB; and
7. Prescriber must verify liver function tests have been assessed prior to initiation of treatment with Enspryng™ and levels are acceptable to prescriber; and
8. Prescriber must agree to counsel the member to monitor for clinically significant active infection(s) prior to each dose (for active infections, the dose should be delayed until the infection resolves); and
9. Prescriber must agree to monitor neutrophil counts 4 to 8 weeks after initiation of therapy and thereafter as clinically appropriate; and
10. Prescriber must verify member has not received any vaccinations within 4 weeks prior to initiation of therapy; and
11. Member and/or caregiver must be trained by a health care professional on subcutaneous administration and storage of Enspryng™; and
12. A quantity limit override for the loading dose will be approved upon meeting the Enspryng™ approval criteria. A quantity limit of 1 syringe per 28 days will apply for the maintenance dose, according to the package labeling; and
13. Initial approvals will be for the duration of 6 months. Reauthorization may be granted if the prescriber documents the member is responding well to treatment.

**Uplizna® (Inebilizumab-cdon) Approval Criteria:**

1. An FDA approved indication of neuromyelitis optica spectrum disorder (NMOSD) in adult members who are anti-aquaporin-4 (AQP4) antibody positive; and
2. Member must be 18 years of age or older; and

3. Member must have experienced at least 1 acute NMOSD attack in the prior 12 months, or at least 2 attacks in the prior 24 months, requiring rescue therapy; and
4. Member must have an Expanded Disability Severity Scale (EDSS) score ≤8; and
5. Prescriber must verify hepatitis B virus (HBV) and tuberculosis (TB) screening are negative before the first dose; and
6. Approvals will not be granted for members with active HBV infection or active or untreated latent TB; and
7. Prescriber must agree to monitor member for clinically significant active infection(s) prior to each dose (for active infections, the dose should be delayed until the infection resolves); and
8. Prescriber must verify testing for quantitative serum immunoglobulins has been performed before the first dose and levels are acceptable to prescriber; and
9. Prescriber must agree to monitor the level of serum immunoglobulins during and after discontinuation of treatment with Uplizna® until B-cell repletion; and
10. The infusion must be administered under the supervision of a health care professional with access to appropriate medical support to manage potential severe reactions, and the patient must be observed for at least 1 hour after the completion of each infusion; and
11. Female members of reproductive potential must not be pregnant and must have a negative pregnancy test prior to initiation of treatment; and
12. Female members of reproductive potential must use contraception while receiving Uplizna® and for 6 months after the last infusion; and
13. Prescriber must verify member has not received any vaccinations within 4 weeks prior to initiation of therapy; and
14. A quantity limit override for the loading dose will be approved upon meeting the Uplizna® approval criteria. A quantity limit of 30mL per 180 days will apply for the maintenance dose; and
15. Initial approvals will be for the duration of 6 months. Reauthorization may be granted if the prescriber documents the member is responding well to treatment.

## Recommendation 5: Vote to Prior Authorize Ortikos™

The Drug Utilization Review Board recommends the prior authorization of Ortikos™ [Budesonide Extended-Release (ER) Capsule] with the following criteria:

**Ortikos™ [Budesonide Extended-Release (ER) Capsule] Approval Criteria:**

1. An FDA approved indication of 1 of the following:
    a. For the treatment of mild-to-moderate active Crohn's disease (CD) involving the ileum and/or the ascending colon, in members 8 years of age or older; or
    b. For the maintenance of clinical remission of mild-to-moderate CD involving the ileum and/or the ascending colon for up to 3 months duration in adult members; and
2. Member must have previous failure of Entocort® EC (budesonide controlled ileal-release enteric coated capsules) within the last 3 months at recommended dosing and a reason for trial failure with Entocort® EC must be provided; or
3. A patient-specific, clinically significant reason (beyond convenience) why the member cannot use other oral corticosteroids, including Entocort® EC, that are available without prior authorization must be provided; and
4. Dosing regimen and duration of therapy must be in accordance with the Ortikos™ *Prescribing Information*; and
5. Approval length will be based on the manufacturer maximum recommended duration of therapy; and
6. A quantity limit of 30 capsules per 30 days will apply.

## Recommendation 6: Vote to Prior Authorize Pizensy™

The Drug Utilization Review Board recommends the prior authorization of Pizensy™ (Lactitol) with the following criteria:

**Pizensy™ (Lactitol) Approval Criteria:**

1. An FDA approved indication for the treatment of chronic idiopathic constipation (CIC) in members 18 years of age or older; and
2. Member must not have a known contraindication to Pizensy™ (i.e., suspected gastrointestinal obstruction, galactosemia); and
3. Documentation that constipation-causing therapies for other disease states have been discontinued (excluding opioid pain medications for cancer patients); and
4. Documented and updated colon screening for members older than 50 years of age; and
5. Documentation of hydration attempts and trials of at least 3 different types of products that failed to relieve constipation. Trials must be within the past 90 days. Products may be over-the-counter (OTC) or prescription (does not include fiber or stool softeners); and
    a. 1 of the 3 trials must be polyethylene glycol 3350 (PEG-3350); and
    b. Members with an oncology-related diagnosis are exempt from the trial requirements; and

6. A patient-specific, clinically significant reason why the member cannot use Linzess® (linaclotide), Amitiza® (lubiprostone), or Trulance® (plecanatide) must be provided; and
7. Use of the unit-dose packets will require a patient-specific, clinically significant reason why the member cannot use the multi-dose bottle; and
8. Approval will initially be for 12 weeks of therapy. Further approval may be granted if prescriber documents member is responding well to treatment; and
9. A quantity limit of 560 grams per 28 days will apply.

## Recommendation 7: Vote to Prior Authorize Oriahnn™

The Drug Utilization Review Board recommends the prior authorization of Oriahnn™ (Elagolix/Estradiol/Norethindrone and Elagolix) with the following criteria:

**Oriahnn™ (Elagolix/Estradiol/Norethindrone and Elagolix) Approval Criteria:**

1. An FDA approved diagnosis of heavy menstrual bleeding associated with uterine leiomyomas (fibroids) in premenopausal women; and
2. Member must be 18 years of age or older; and
3. Member must not have any contraindications to Oriahnn™ therapy including:
    a. Osteoporosis; and
    b. Pregnancy; and
        i. Female members must not be pregnant and must have a negative pregnancy test prior to initiation of therapy; and
        ii. Female members of reproductive potential must be willing to use effective non-hormonal contraception during treatment with Oriahnn™ and for at least 1 week after discontinuing treatment; and
    c. Hepatic impairment or disease; and
    d. Undiagnosed abnormal uterine bleeding; and
    e. High risk of arterial, venous thrombotic, or thromboembolic disease; and
    f. Current or history of breast cancer or other hormonally-sensitive malignancies; and
    g. Known hypersensitivity to ingredients in Oriahnn™; and
    h. Concomitant use with an organic anion transporting polypeptide (OATP) 1B1 inhibitor (e.g., cyclosporine, gemfibrozil); and
4. Oriahnn™ must be prescribed by, or in consultation with, an obstetrician/gynecologist or a specialist with expertise in the treatment of uterine leiomyomas (fibroids); and

5. A failed trial at least 1 month in duration with nonsteroidal anti-inflammatory drugs (NSAIDs) or a patient-specific, clinically significant reason why the member cannot use NSAIDs must be provided; and
6. A failed trial at least 3 months in duration of hormonal contraceptives or a patient-specific, clinically significant reason why the member cannot use hormonal contraceptives must be provided; and
7. A quantity limit of 56 capsules per 28 days will apply; and
8. Lifetime approval duration will be limited to a maximum of 24 months.

## Recommendation 8: Vote to Prior Authorize Nexletol® and Nexlizet™

The Drug Utilization Review Board recommends the prior authorization Nexletol® (Bempedoic Acid) and Nexlizet™ (Bempedoic Acid/Ezetimibe) with the following criteria:

**Nexletol® (Bempedoic Acid) and Nexlizet™ (Bempedoic Acid/Ezetimibe) Approval Criteria:**

1. An FDA approved indication as an adjunct to diet and maximally tolerated statin therapy for the treatment of 1 of the following:
    a. Heterozygous familial hypercholesterolemia (HeFH); and
        i. Documentation of definite HeFH using the Simon Broome Register criteria, the Dutch Lipid Network criteria, or via genetic testing; or
    b. Established atherosclerotic cardiovascular disease (ASCVD); and
        i. Supporting diagnoses/conditions and dates of occurrence signifying established ASCVD; and
2. Member must be 18 years of age or older; and
3. Member must be on a stable dose of maximally tolerated statin therapy for at least 4 weeks (dosing, dates, duration of treatment, and reason for discontinuation must be provided); and
    a. LDL-cholesterol (LDL-C) levels should be included following at least 4 weeks of treatment with each statin medication; and
    b. Member must not be taking simvastatin at doses >20mg or pravastatin at doses >40mg due to drug interactions with Nexletol® and Nexlizet™; and
    c. For statin intolerance due to myalgia, creatine kinase (CK) labs verifying rhabdomyolysis must be provided; and
4. Member requires additional lowering of LDL-cholesterol (LDL-C) (baseline, current, and goal LDL-C levels must be provided); and
5. A quantity limit of 30 tablets per 30 days will apply; and

6. Initial approvals will be for the duration of 3 months, after which time compliance and recent LDL-C levels to demonstrate the effectiveness of this medication will be required for continued approval. Subsequent approvals will be for the duration of 1 year.

## Recommendation 9: Vote to Prior Authorize Durysta™

The Drug Utilization Review Board recommends the prior authorization Durysta™ (Bimatoprost Implant) with the following criteria:

**Durysta™ (Bimatoprost Implant) Approval Criteria:**

1. An FDA approved indication to reduce intraocular pressure (IOP) in members with open-angle glaucoma (OAG) or ocular hypertension (OHT); and
2. Member must be 18 years of age or older; and
3. Durysta™ must be prescribed by, or in consultation with, an ophthalmologist; and
4. A patient-specific, clinically significant reason why the member requires Durysta™ and cannot utilize ophthalmic preparations, such as solution or suspension, to treat OAG or OHT must be provided; and
5. The affected eye(s) has not received prior treatment with Durysta™; and
6. The member has no contraindications to Durysta™; and
7. A quantity limit of (1) Durysta™ 10mcg implant per eye per lifetime will apply.

## Recommendation 10: Vote to Prior Authorize Imcivree™

The Drug Utilization Review Board recommends the prior authorization Imcivree™ (Setmelanotide) with the following criteria:

**Imcivree™ (Setmelanotide) Approval Criteria:**

1. An FDA approved indication of chronic weight management in adult and pediatric members 6 years of age and older with obesity due to proopiomelanocortin (POMC), proprotein convertase subtilisin/kexin type 1 (PCSK1), or leptin receptor (LEPR) deficiency; and
2. Molecular genetic testing to confirm variants in the *POMC*, *PCSK1*, or *LEPR* genes that are interpreted as pathogenic, likely pathogenic, or of uncertain significance; and
3. Requests for Imcivree™ for obesity due to suspected POMC-, PCSK1-, or LEPR-deficiency with *POMC, PCSK1, or LEPR* variants classified as

benign or likely benign, obesity associated with other genetic syndromes, or general obesity will not be approved; and
4. Member's baseline weight and body mass index (BMI) must be provided; and
5. Baseline BMI must be ≥30kg/$m^2$ for adults or ≥95$^{th}$ percentile on BMI-for-age growth chart assessment for children; and
6. Member must not be actively suicidal or have uncontrolled depression and prescriber must verify member will be monitored for depression prior to starting Imcivree™ therapy and throughout treatment; and
7. Prescriber must verify member has been counseled on potential sexual adverse reactions and when to seek emergency medical care; and
8. Prescriber must verify member does not have moderate, severe, or end stage renal disease [estimated glomerular filtration rate (eGFR) <60mL/min/1.73$m^2$]; and
9. Prescriber must verify female member is not pregnant or breastfeeding; and
10. Prescriber must confirm member or caregiver has been trained on the proper storage and administration of Imcivree™ prior to the first dose; and
11. Initial approvals will be for the duration of 16 weeks. Reauthorization may be granted if the prescriber documents the member's current weight or BMI and member has achieved weight loss of ≥5% of baseline body weight or ≥5% of BMI; and
12. A quantity limit of 9mL per 30 days will apply.

# OPERATIONAL METRICS

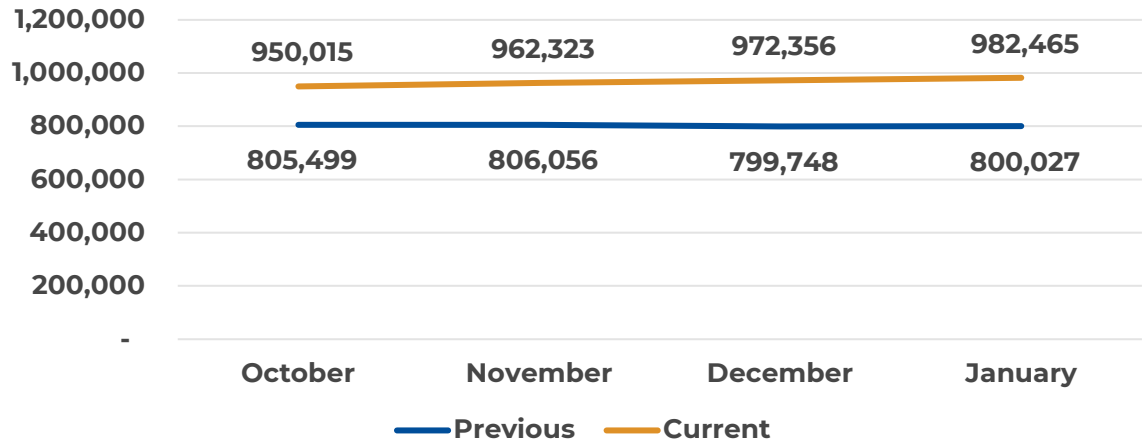
March 2021 Board Meeting

OKLAHOMA HEALTH CARE AUTHORITY

4345 N. LINCOLN BLVD. | OKHCA.ORG |

## Enrollment & Utilization

### Total Enrolled Members

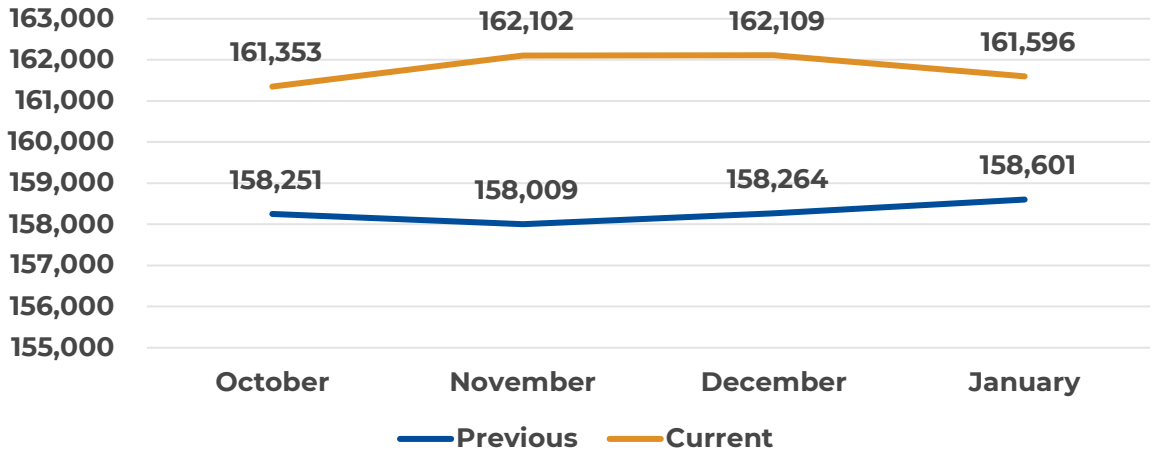



| Month | Previous | Current |
|---|---|---|
| October | 805,499 | 950,015 |
| November | 806,056 | 962,323 |
| December | 799,748 | 972,356 |
| January | 800,027 | 982,465 |

| Month | Count Change | Percent Change |
|---|---|---|
| October | 144,516 | 18% |
| November | 156,267 | 19% |
| December | 172,608 | 22% |
| January | 182,438 | 23% |

| Period Change | 18% |
|---|---|

### Aged/Blind/Disabled Enrolled



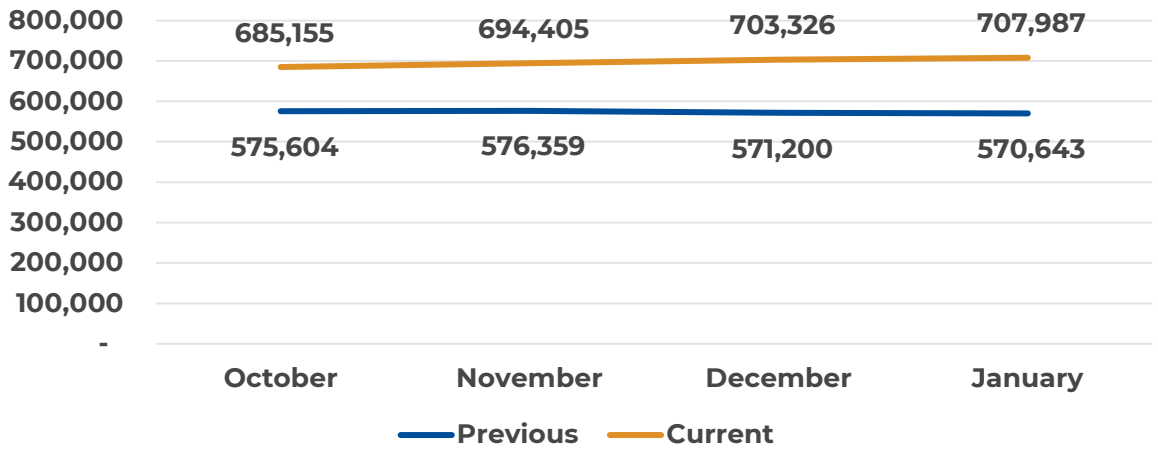

| Month | Previous | Current |
|---|---|---|
| October | 158,251 | 161,353 |
| November | 158,009 | 162,102 |
| December | 158,264 | 162,109 |
| January | 158,601 | 161,596 |

| Month | Count Change | Percent Change |
|---|---|---|
| October | 3,102 | 2% |
| November | 4,093 | 3% |
| December | 3,845 | 2% |
| January | 2,995 | 2% |

| Period Change | 0.4% |
|---|---|

## Enrollment & Utilization (Cont.)

### Children & Parent/Caretaker Enrolled

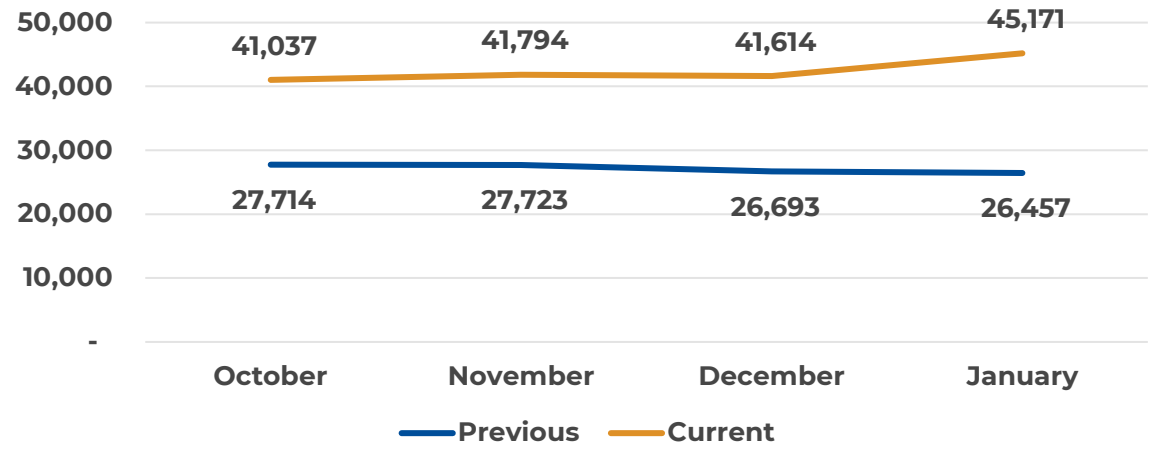



| Month | Previous | Current |
|---|---|---|
| October | 575,604 | 685,155 |
| November | 576,359 | 694,405 |
| December | 571,200 | 703,326 |
| January | 570,643 | 707,987 |

| Month | Count Change | Percent Change |
|---|---|---|
| October | 109,551 | 19% |
| November | 118,046 | 20% |
| December | 132,126 | 23% |
| January | 137,344 | 24% |

| Period Change | 17% |
|---|---|

### SoonerPlan Enrolled



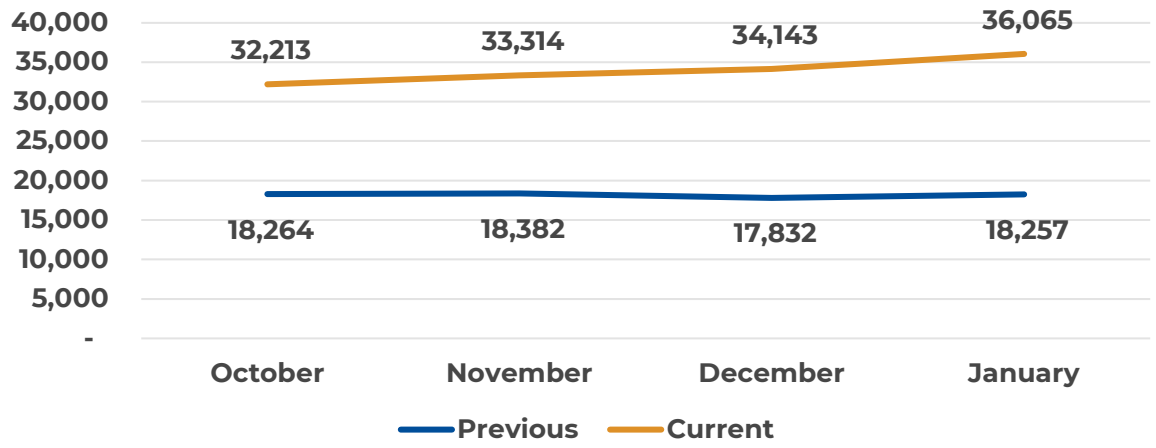

| Month | Previous | Current |
|---|---|---|
| October | 27,714 | 41,037 |
| November | 27,723 | 41,794 |
| December | 26,693 | 41,614 |
| January | 26,457 | 45,171 |

| Month | Count Change | Percent Change |
|---|---|---|
| October | 13,323 | 48% |
| November | 14,071 | 51% |
| December | 14,921 | 56% |
| January | 18,714 | 71% |

| Period Change | 42% |
|---|---|

## Enrollment & Utilization (Cont.)

### Insure Oklahoma Enrolled

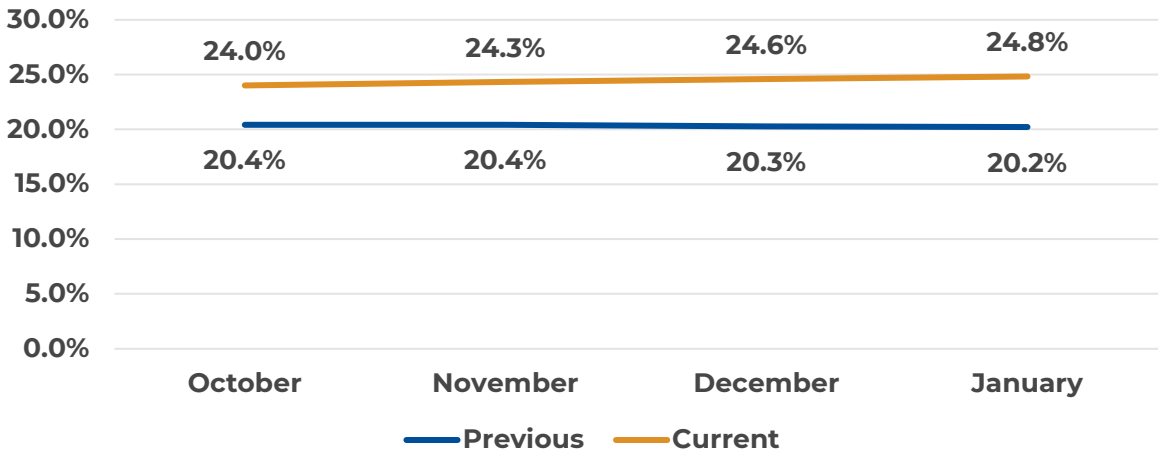



| Month | Previous | Current |
|---|---|---|
| October | 18,264 | 32,213 |
| November | 18,382 | 33,314 |
| December | 17,832 | 34,143 |
| January | 18,257 | 36,065 |

| Month | Count Change | Percent Change |
|---|---|---|
| October | 13,949 | 76% |
| November | 14,932 | 81% |
| December | 16,311 | 91% |
| January | 17,808 | 98% |

| Period Change | 76% |
|---|---|

### Percent of OK Population Enrolled



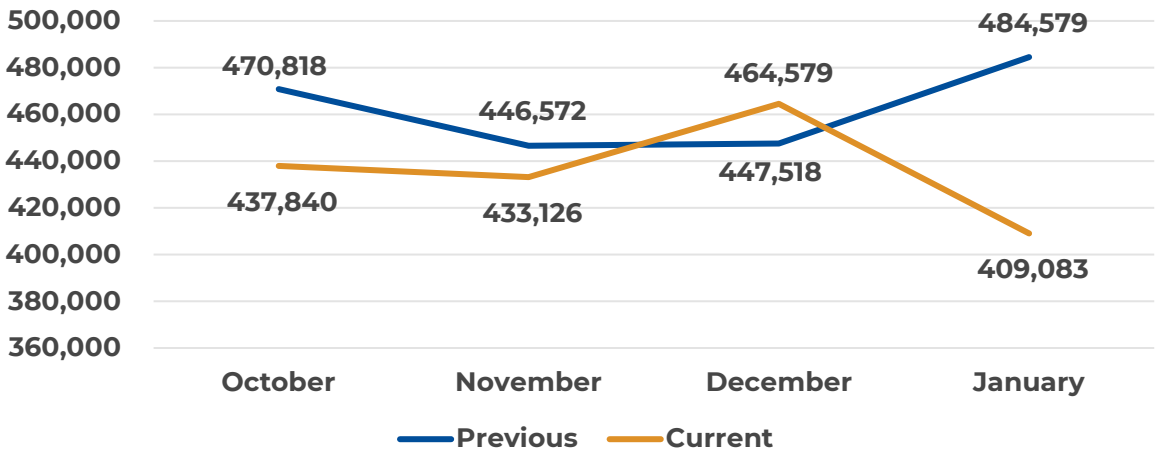

| Month | Previous | Current |
|---|---|---|
| October | 20.4% | 24.0% |
| November | 20.4% | 24.3% |
| December | 20.3% | 24.6% |
| January | 20.2% | 24.8% |

| Month | Count Change | Percent Change |
|---|---|---|
| October | 3.6% | 18% |
| November | 3.9% | 19% |
| December | 4.3% | 21% |
| January | 4.6% | 23% |

| Period Change | 17% |
|---|---|

## Enrollment & Utilization (Cont.)

### Total Members Utilization

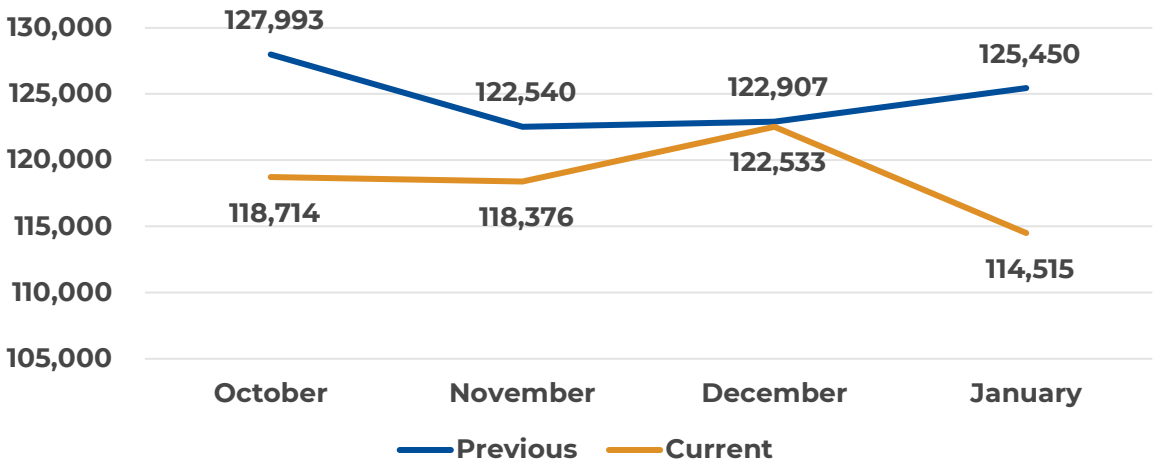



| Month | Previous | Current |
|---|---|---|
| October | 470,818 | 437,840 |
| November | 446,572 | 433,126 |
| December | 447,518 | 464,579 |
| January | 484,579 | 409,083 |

| Month | Count Change | Percent Change |
|---|---|---|
| October | (32,978) | -7% |
| November | (13,446) | -3% |
| December | 17,061 | 3.8% |
| January | (75,496) | -15.6% |

| Period Change | 0.1% |
|---|---|

### Aged/Blind/Disabled Utilization



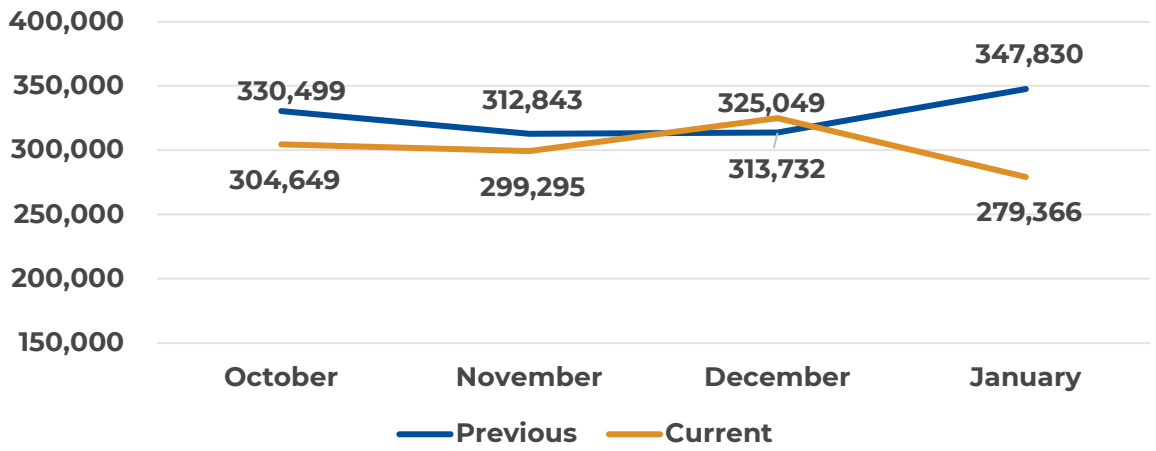

| Month | Previous | Current |
|---|---|---|
| October | 127,993 | 118,714 |
| November | 122,540 | 118,376 |
| December | 122,907 | 122,533 |
| January | 125,450 | 114,515 |

| Month | Count Change | Percent Change |
|---|---|---|
| October | (9,279) | -7% |
| November | (4,164) | -3% |
| December | (374) | -0.3% |
| January | (10,935) | -8.7% |

| Period Change | -4% |
|---|---|

## Enrollment & Utilization (Cont.)

### Children & Parent/Caretaker Utilization

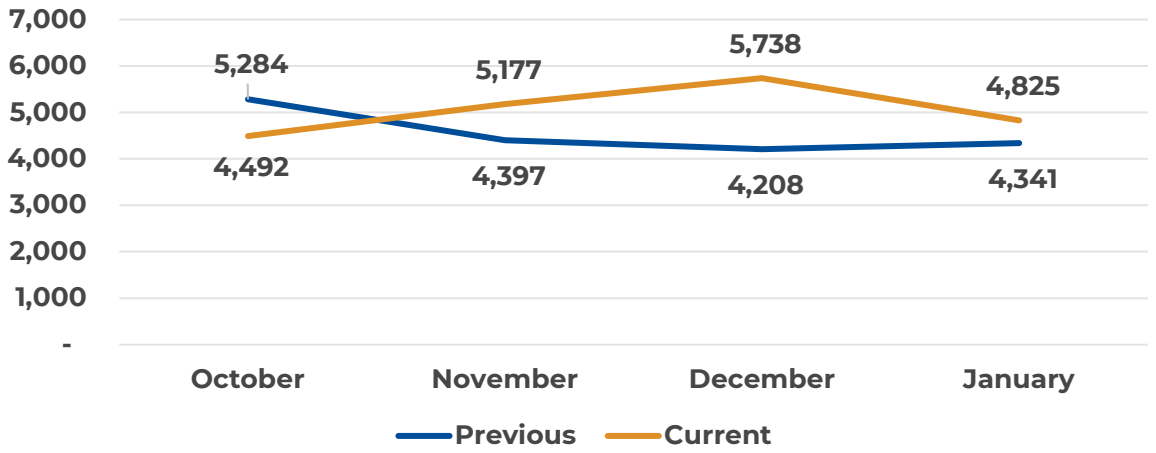



| Month | Previous | Current |
|---|---|---|
| October | 330,499 | 304,649 |
| November | 312,843 | 299,295 |
| December | 313,732 | 325,049 |
| January | 347,830 | 279,366 |

| Month | Count Change | Percent Change |
|---|---|---|
| October | (25,850) | -8% |
| November | (13,548) | -4% |
| December | 11,317 | 4% |
| January | (68,464) | -20% |

| Period Change | -0.1% |
|---|---|

### SoonerPlan Utilization



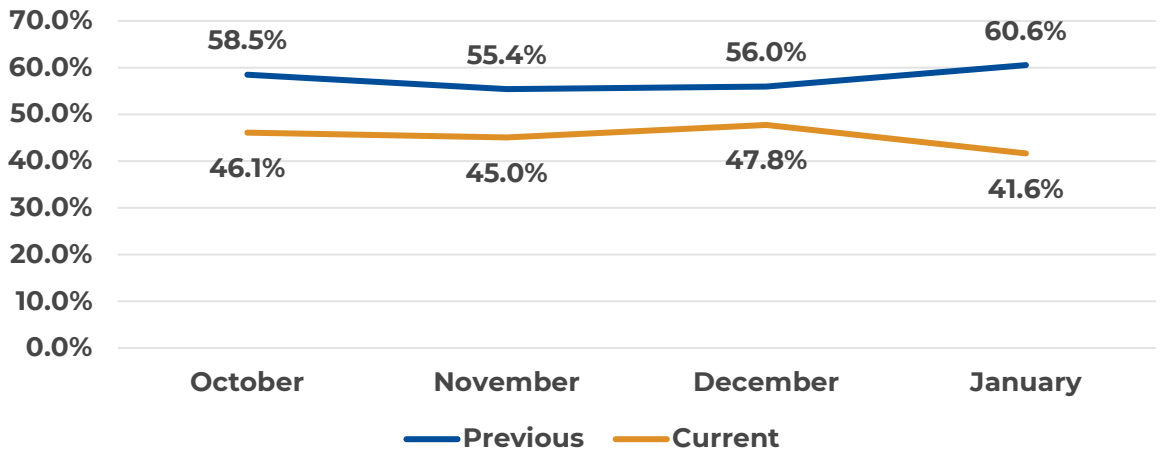

| Month | Previous | Current |
|---|---|---|
| October | 5,284 | 4,492 |
| November | 4,397 | 5,177 |
| December | 4,208 | 5,738 |
| January | 4,341 | 4,825 |

| Month | Count Change | Percent Change |
|---|---|---|
| October | (792) | -15% |
| November | 780 | 18% |
| December | 1,530 | 36% |
| January | 484 | 11% |

| Period Change | 11% |
|---|---|

## Enrollment & Utilization (Cont.)

### Percent of Total Enrolled Members Utilization

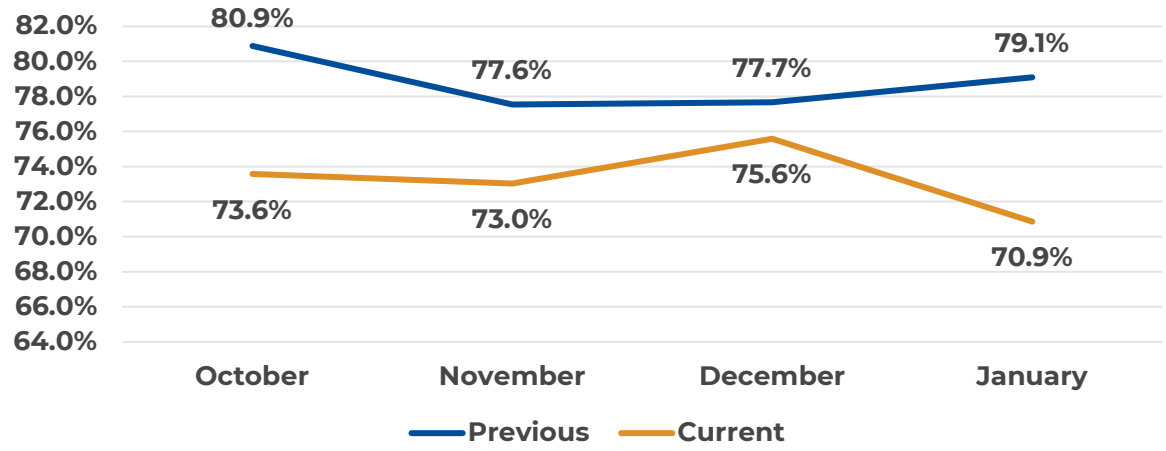



| Month | Previous | Current |
|---|---|---|
| October | 58.5% | 46.1% |
| November | 55.4% | 45.0% |
| December | 56.0% | 47.8% |
| January | 60.6% | 41.6% |

| Month | Count Change | Percent Change |
|---|---|---|
| October | -12.4% | -21% |
| November | -10.4% | -19% |
| December | -8.2% | -15% |
| January | -18.9% | -31% |

| Period Change | -15% |
|---|---|

### Percent of Aged/Blind/Disabled Enrolled Members Utilization



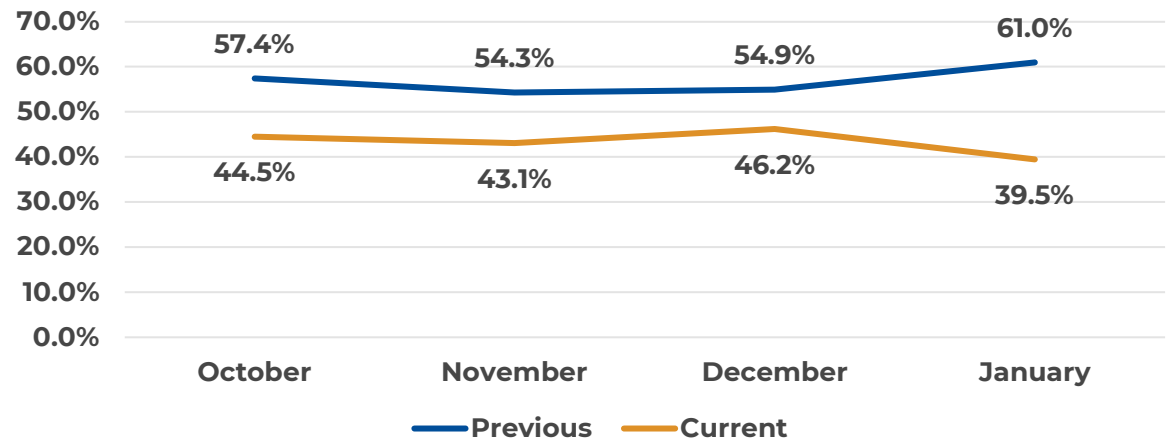

| Month | Previous | Current |
|---|---|---|
| October | 80.9% | 73.6% |
| November | 77.6% | 73.0% |
| December | 77.7% | 75.6% |
| January | 79.1% | 70.9% |

| Month | Count Change | Percent Change |
|---|---|---|
| October | -7.3% | -9% |
| November | -4.5% | -6% |
| December | -2.1% | -3% |
| January | -8.2% | -10% |

| Period Change | -4% |
|---|---|

## Enrollment & Utilization (Cont.)

### Percent of Children & Parent/Caretaker Enrolled Members Utilization

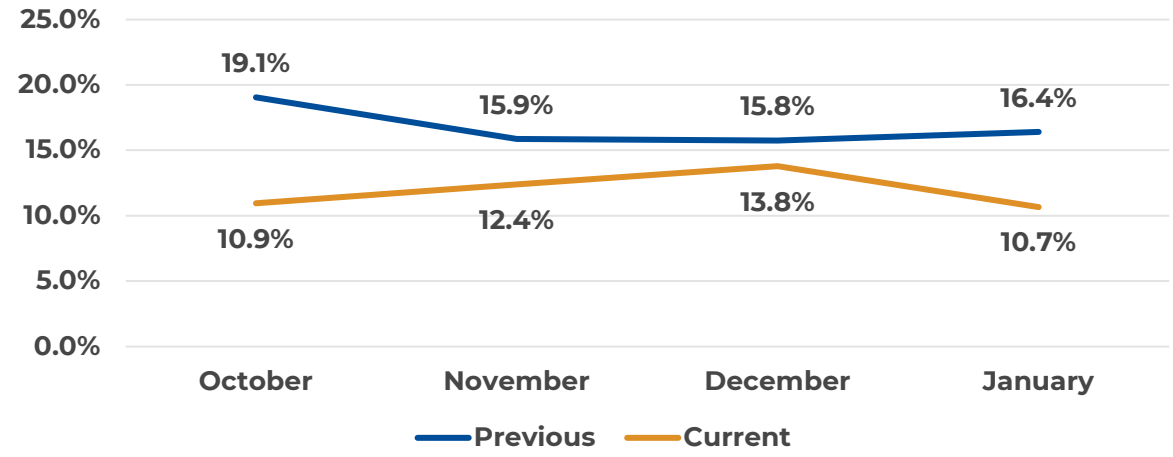



| Month | Previous | Current |
|---|---|---|
| October | 57.4% | 44.5% |
| November | 54.3% | 43.1% |
| December | 54.9% | 46.2% |
| January | 61.0% | 39.5% |

| Month | Count Change | Percent Change |
|---|---|---|
| October | -13.0% | -23% |
| November | -11.2% | -21% |
| December | -8.7% | -16% |
| January | -21.5% | -35% |

| Period Change | -15% |
|---|---|

### Percent of SoonerPlan Enrolled Members Utilization



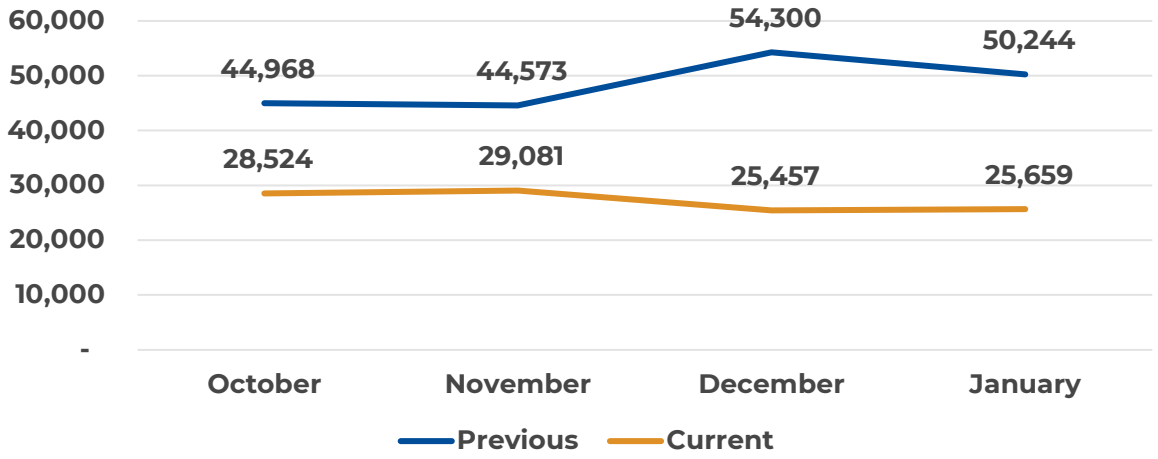

| Month | Previous | Current |
|---|---|---|
| October | 19.1% | 10.9% |
| November | 15.9% | 12.4% |
| December | 15.8% | 13.8% |
| January | 16.4% | 10.7% |

| Month | Count Change | Percent Change |
|---|---|---|
| October | -8.1% | -43% |
| November | -3.5% | -22% |
| December | -2.0% | -13% |
| January | -5.7% | -35% |

| Period Change | -22% |
|---|---|

## Utilization

### Emergency Department Visits (Claims)

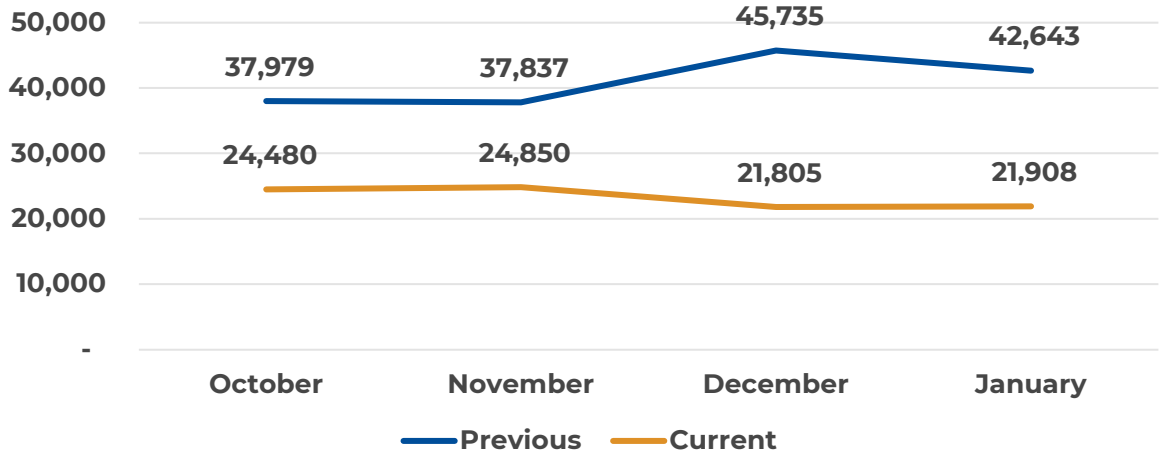



| Month | Previous | Current |
|---|---|---|
| October | 44,968 | 28,524 |
| November | 44,573 | 29,081 |
| December | 54,300 | 25,457 |
| January | 50,244 | 25,659 |

| Month | Count Change | Percent Change |
|---|---|---|
| October | (16,444) | -37% |
| November | (15,492) | -35% |
| December | (28,843) | -53% |
| January | (24,585) | -49% |

| Period Change | -37% |
|---|---|

### Members Using Emergency Department



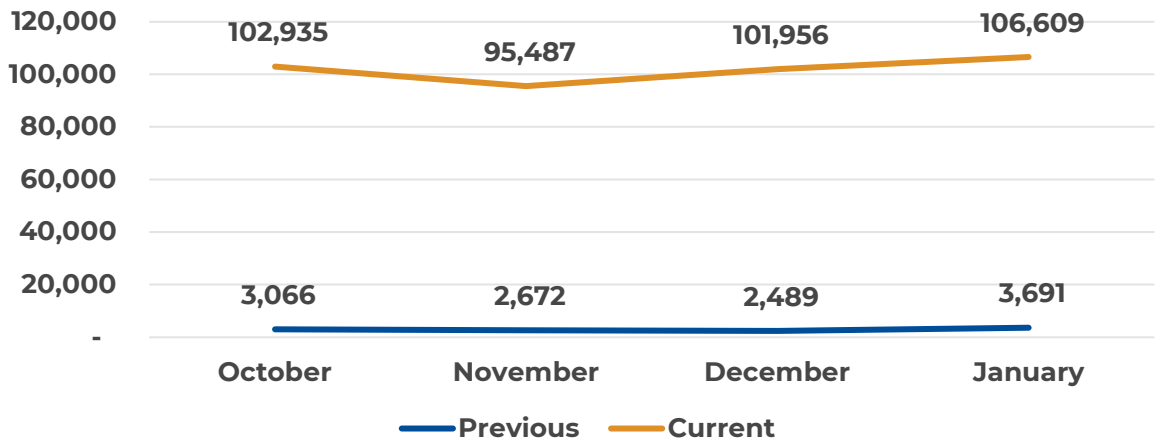

| Month | Previous | Current |
|---|---|---|
| October | 37,979 | 24,480 |
| November | 37,837 | 24,850 |
| December | 45,735 | 21,805 |
| January | 42,643 | 21,908 |

| Month | Count Change | Percent Change |
|---|---|---|
| October | (13,499) | -36% |
| November | (12,987) | -34% |
| December | (23,930) | -52% |
| January | (20,735) | -49% |

| Period Change | -35% |
|---|---|

## Utilization (Cont.)

### Telemedicine - Total Visits

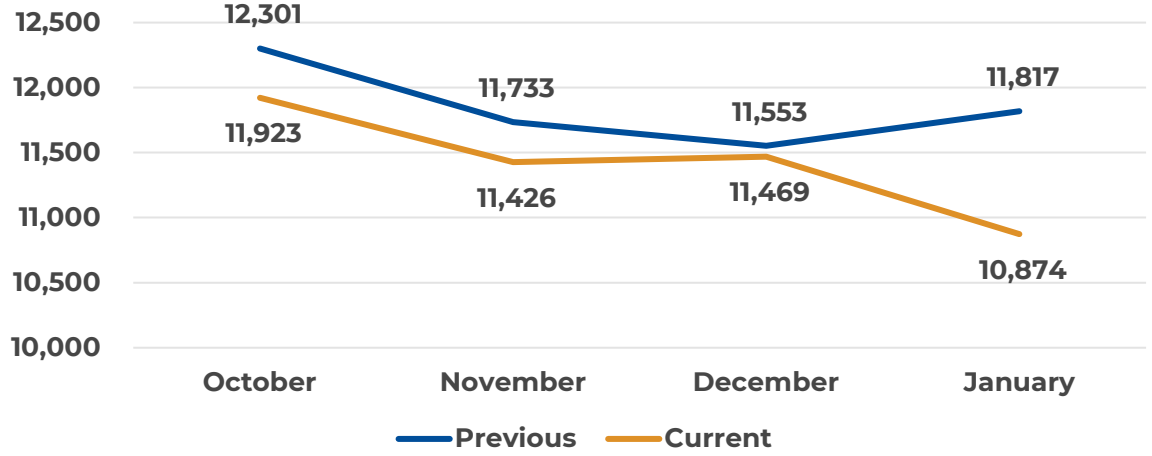



| Month | Previous | Current |
|---|---|---|
| October | 3,066 | 102,935 |
| November | 2,672 | 95,487 |
| December | 2,489 | 101,956 |
| January | 3,691 | 106,609 |

| Month | Count Change | Percent Change |
|---|---|---|
| October | 99,869 | 3257% |
| November | 92,815 | 3474% |
| December | 99,467 | 3996% |
| January | 102,918 | 2788% |

| Period Change | 3550% |
|---|---|

### Members With Opioid Claims



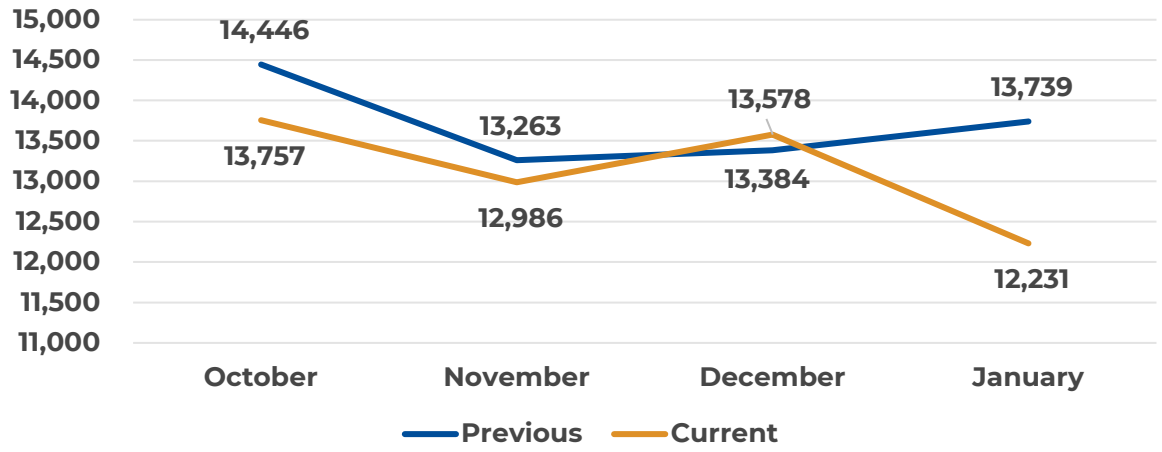

| Month | Previous | Current |
|---|---|---|
| October | 12,301 | 11,923 |
| November | 11,733 | 11,426 |
| December | 11,553 | 11,469 |
| January | 11,817 | 10,874 |

| Month | Count Change | Percent Change |
|---|---|---|
| October | (378) | -3% |
| November | (307) | -3% |
| December | (84) | -1% |
| January | (943) | -8% |

| Period Change | -4% |
|---|---|

## Utilization (Cont.)

### Total Opioid Claims

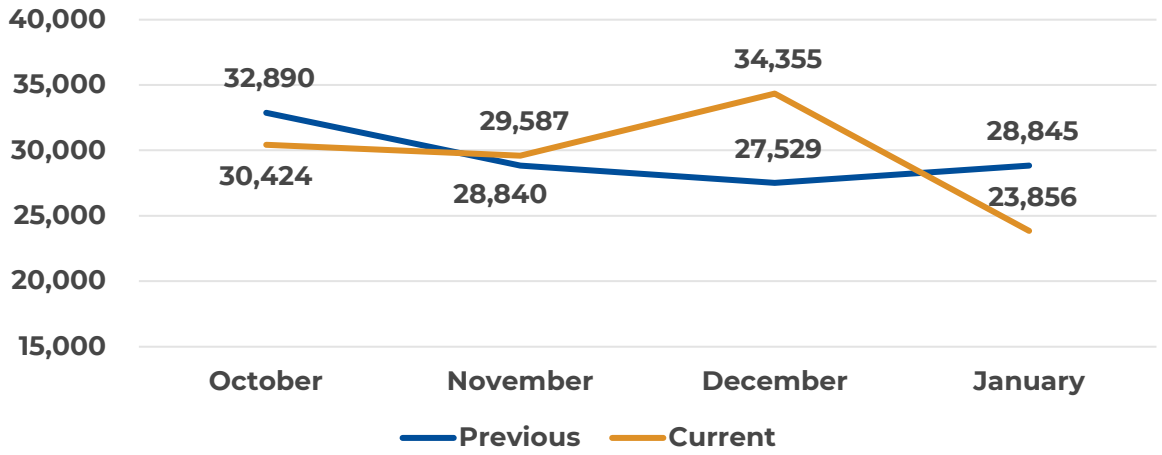



| Month | Previous | Current |
|---|---|---|
| October | 14,446 | 13,757 |
| November | 13,263 | 12,986 |
| December | 13,384 | 13,578 |
| January | 13,739 | 12,231 |

| Month | Count Change | Percent Change |
|---|---|---|
| October | (689) | -5% |
| November | (277) | -2% |
| December | 194 | 1% |
| January | (1,508) | -11% |

| Period Change | -2% |
|---|---|

### Out of State Services - Total Members Served



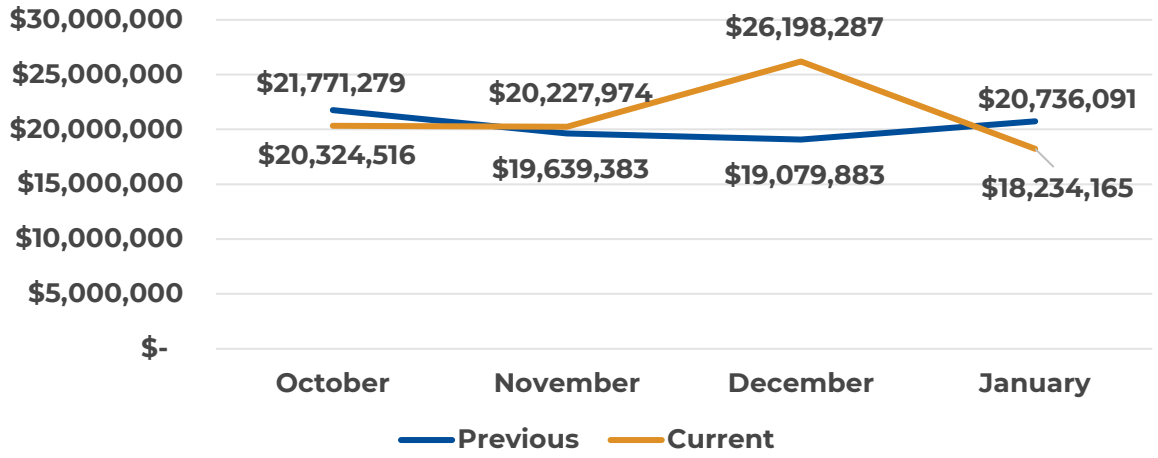

| Month | Previous | Current |
|---|---|---|
| October | 32,890 | 30,424 |
| November | 28,840 | 29,587 |
| December | 27,529 | 34,355 |
| January | 28,845 | 23,856 |

| Month | Count Change | Percent Change |
|---|---|---|
| October | (2,466) | -7% |
| November | 747 | 3% |
| December | 6,826 | 25% |
| January | (4,989) | -17% |

| Period Change | 7% |
|---|---|

## Utilization (Cont.)

### Out of State Services - Total Reimbursements

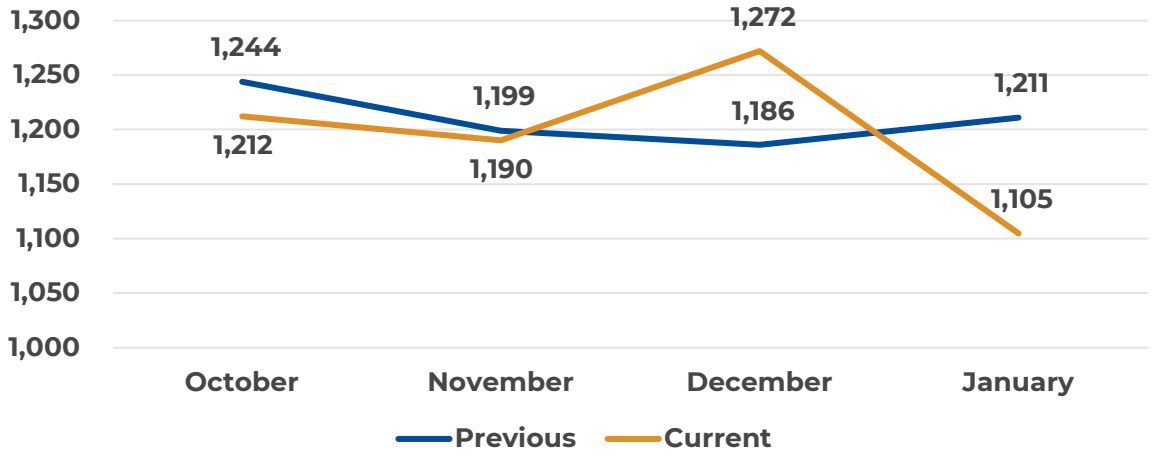



| Month | Previous | Current |
|---|---|---|
| October | $ 21,771,279 | $ 20,324,516 |
| November | $ 19,639,383 | $ 20,227,974 |
| December | $ 19,079,883 | $ 26,198,287 |
| January | $ 20,736,091 | $ 18,234,165 |

| Month | Count Change | Percent Change |
|---|---|---|
| October | (1,446,763) | -7% |
| November | 588,590 | 3% |
| December | 7,118,404 | 37% |
| January | (2,501,926) | -12% |

| Period Change | 10% |
|---|---|

### Out of State Services - Total Active Billing Providers



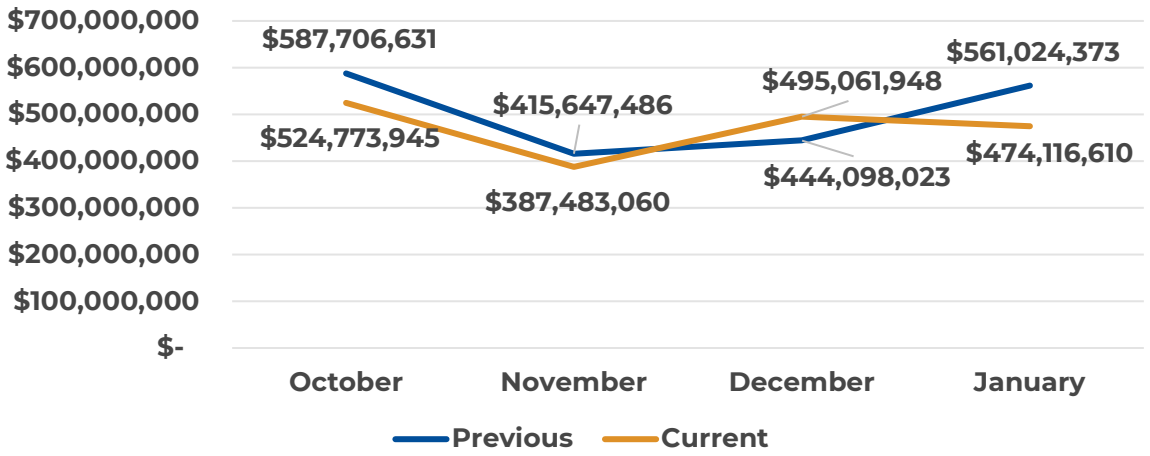

| Month | Previous | Current |
|---|---|---|
| October | 1,244 | 1,212 |
| November | 1,199 | 1,190 |
| December | 1,186 | 1,272 |
| January | 1,211 | 1,105 |

| Month | Count Change | Percent Change |
|---|---|---|
| October | (32) | -3% |
| November | (9) | -1% |
| December | 86 | 7% |
| January | (106) | -9% |

| Period Change | 1% |
|---|---|

## Financials

### Total Agency Expenditures

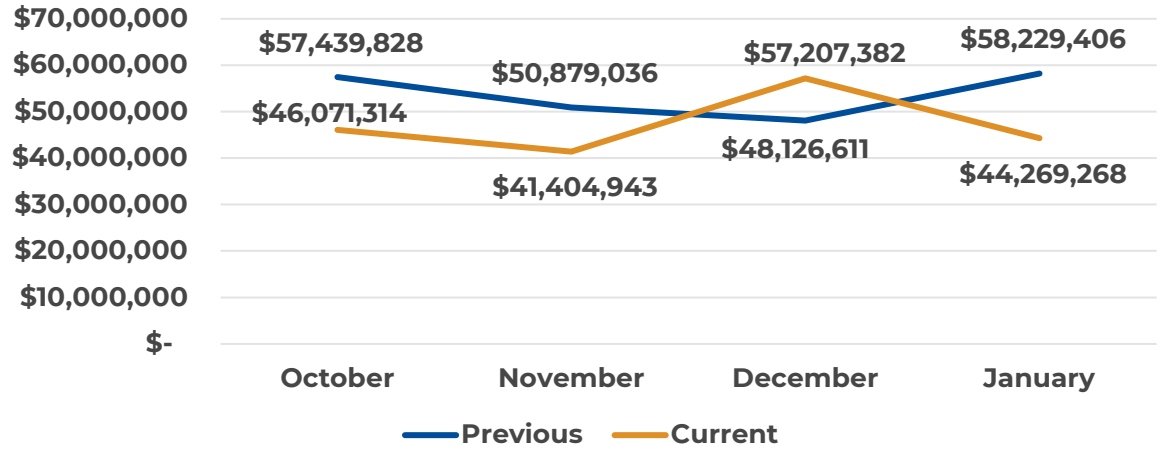



| Month | Previous | Current |
|---|---|---|
| October | $ 587,706,631 | $ 524,773,945 |
| November | $ 415,647,486 | $ 387,483,060 |
| December | $ 444,098,023 | $ 495,061,948 |
| January | $ 561,024,373 | $ 474,116,610 |

| Month | Count Change | Percent Change |
|---|---|---|
| October | $ (62,932,686) | -11% |
| November | $ (28,164,426) | -7% |
| December | $ 50,963,925 | 11% |
| January | $ (86,907,763) | -15% |

| Period Change | -3% |
|---|---|

### Inpatient Services Expenditures



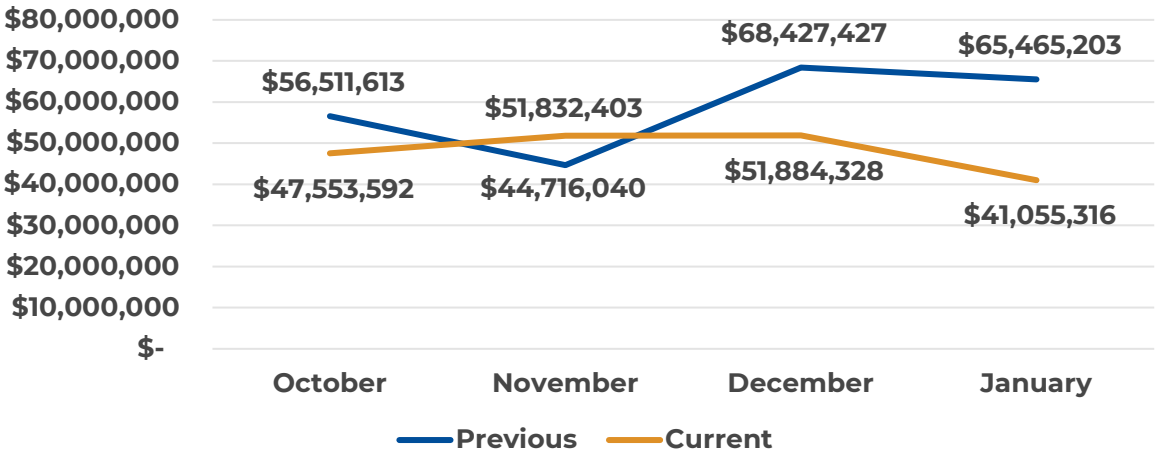

| Month | Previous | Current |
|---|---|---|
| October | $ 57,439,828 | $ 46,071,314 |
| November | $ 50,879,036 | $ 41,404,943 |
| December | $ 48,126,611 | $ 57,207,382 |
| January | $ 58,229,406 | $ 44,269,268 |

| Month | Count Change | Percent Change |
|---|---|---|
| October | $ (11,368,514) | -20% |
| November | $ (9,474,093) | -19% |
| December | $ 9,080,771 | 19% |
| January | $ (13,960,138) | -24% |

| Period Change | -8% |
|---|---|

## Financials (Cont.)

### Nursing Facility Expenditures

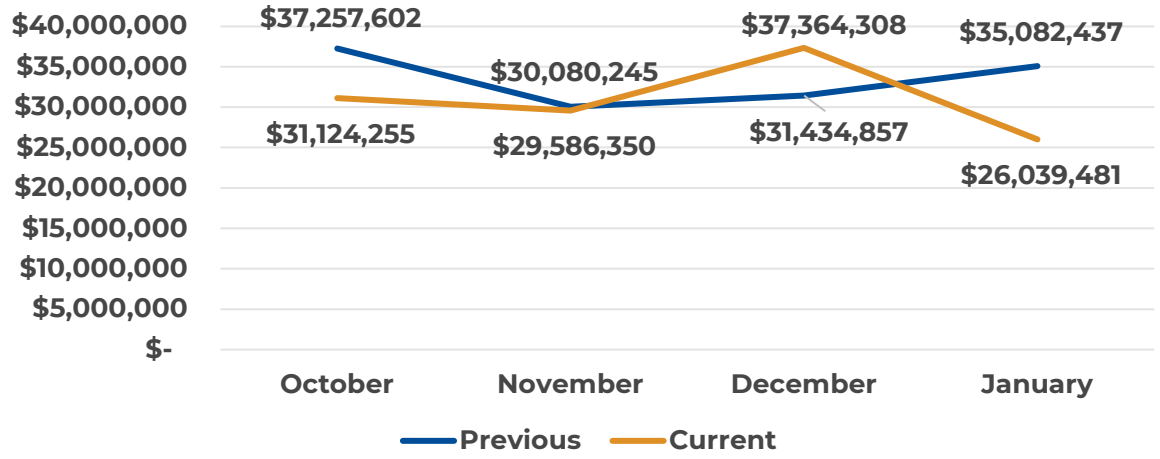



| Month | Previous | Current |
|---|---|---|
| October | $ 56,511,613 | $ 47,553,592 |
| November | $ 44,716,040 | $ 51,832,403 |
| December | $ 68,427,427 | $ 51,884,328 |
| January | $ 65,465,203 | $ 41,055,316 |

| Month | Count Change | Percent Change |
|---|---|---|
| October | $ (8,958,021) | -16% |
| November | $ 7,116,363 | 16% |
| December | $ (16,543,099) | -24% |
| January | $ (24,409,888) | -37% |

| Period Change | -11% |
|---|---|

### Outpatient Hospital Expenditures



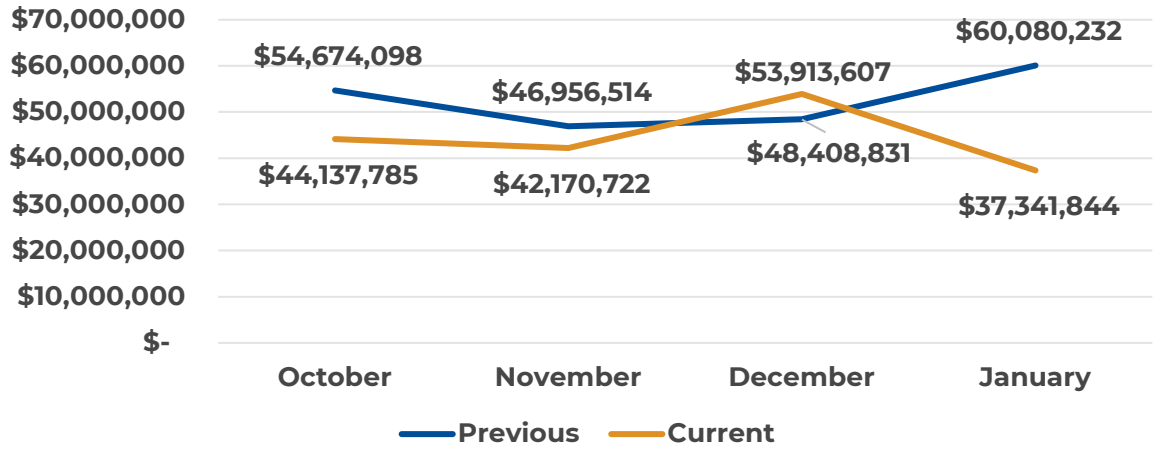

| Month | Previous | Current |
|---|---|---|
| October | $ 37,257,602 | $ 31,124,255 |
| November | $ 30,080,245 | $ 29,586,350 |
| December | $ 31,434,857 | $ 37,364,308 |
| January | $ 35,082,437 | $ 26,039,481 |

| Month | Count Change | Percent Change |
|---|---|---|
| October | $ (6,133,347) | -16% |
| November | $ (493,896) | -2% |
| December | $ 5,929,450 | 19% |
| January | $ (9,042,956) | -26% |

| Period Change | -1% |
|---|---|

## Financials (Cont.)

### Physician Expenditures

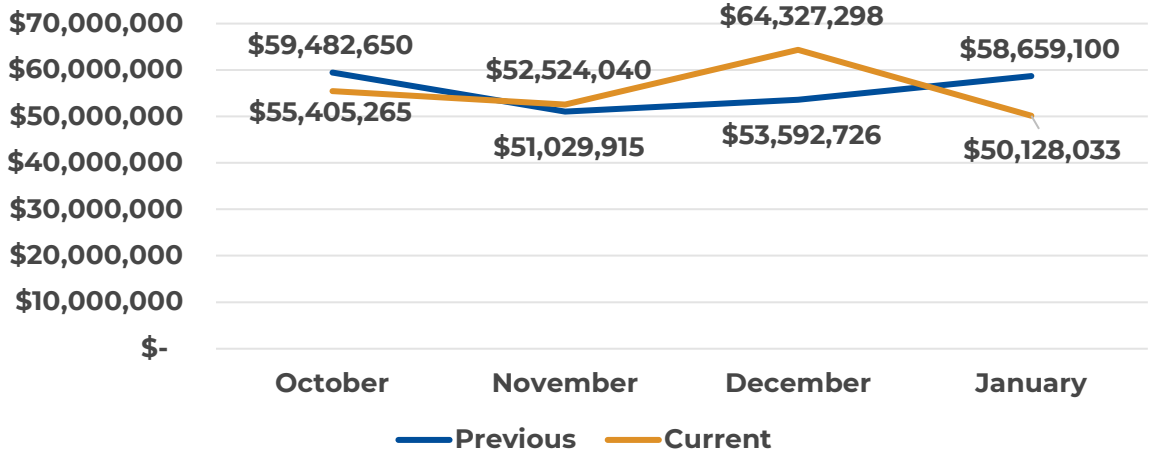



| Month | Previous | Current |
|---|---|---|
| October | $ 54,674,098 | $ 44,137,785 |
| November | $ 46,956,514 | $ 42,170,722 |
| December | $ 48,408,831 | $ 53,913,607 |
| January | $ 60,080,232 | $ 37,341,844 |

| Month | Count Change | Percent Change |
|---|---|---|
| October | $ (10,536,313) | -19% |
| November | $ (4,785,792) | -10% |
| December | $ 5,504,776 | 11% |
| January | $ (22,738,389) | -38% |

| Period Change | -7% |
|---|---|

### Prescribed Drugs Expenditures



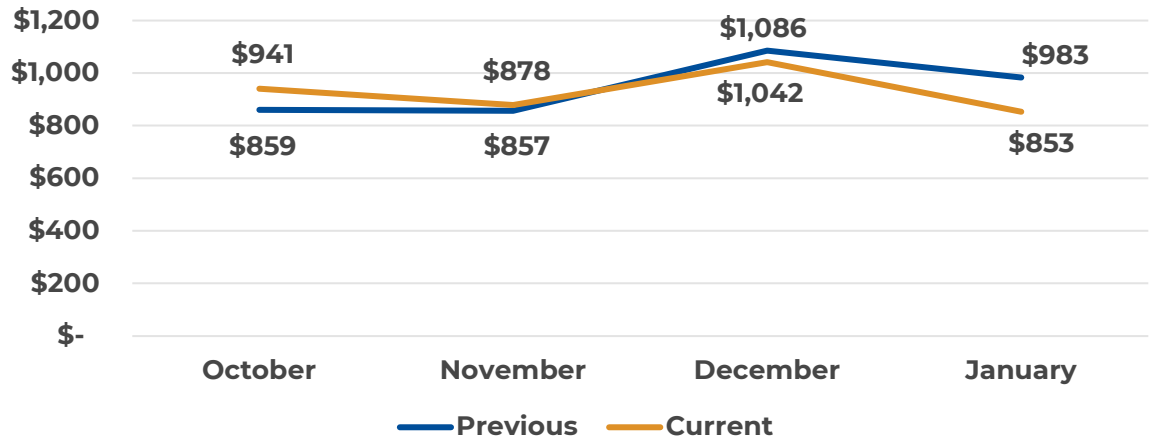

| Month | Previous | Current |
|---|---|---|
| October | $ 59,482,650 | $ 55,405,265 |
| November | $ 51,029,915 | $ 52,524,040 |
| December | $ 53,592,726 | $ 64,327,298 |
| January | $ 58,659,100 | $ 50,128,033 |

| Month | Count Change | Percent Change |
|---|---|---|
| October | $ (4,077,385) | -7% |
| November | $ 1,494,125 | 3% |
| December | $ 10,734,572 | 20% |
| January | $ (8,531,067) | -15% |

| Period Change | 5% |
|---|---|

## Financials (Cont.)

### Average Per Average Member Served

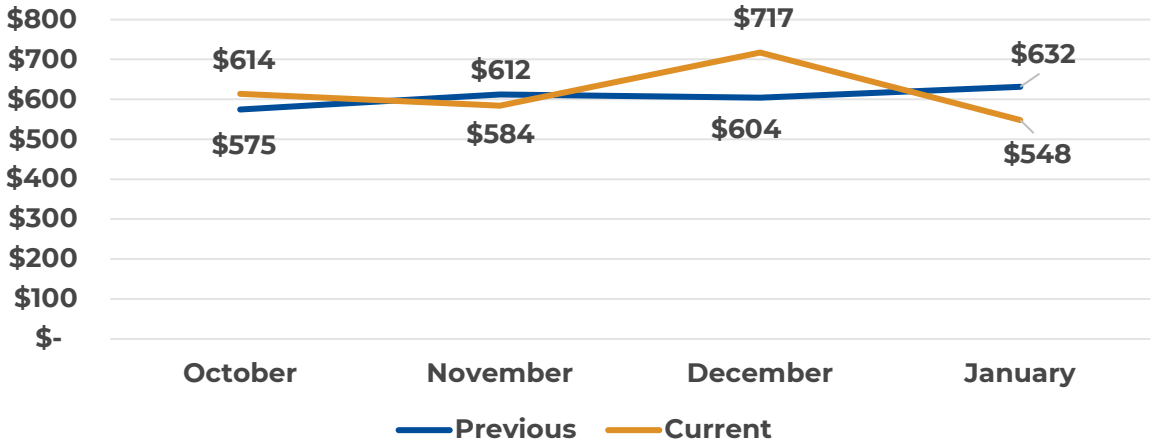



| Month | Previous | Current |
|---|---|---|
| October | $ 859 | $ 941 |
| November | $ 857 | $ 878 |
| December | $ 1,086 | $ 1,042 |
| January | $ 983 | $ 853 |

| Month | Count Change | Percent Change |
|---|---|---|
| October | $ 81 | 9% |
| November | $ 21 | 3% |
| December | $ (44) | -4% |
| January | $ (129) | -13% |

| Period Change | 0.2% |
|---|---|

### Average Per Child (Under 21) Member Served



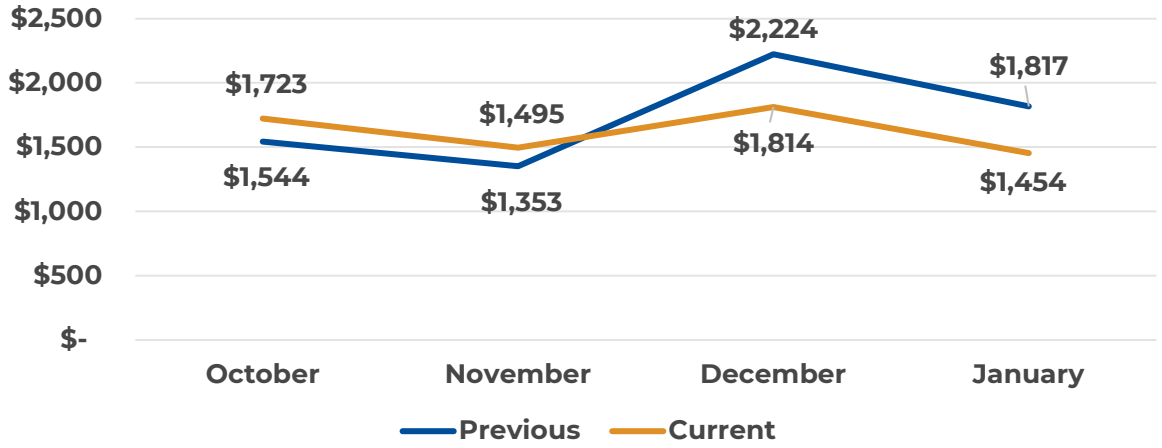

| Month | Previous | Current |
|---|---|---|
| October | $ 575 | $ 614 |
| November | $ 612 | $ 584 |
| December | $ 604 | $ 717 |
| January | $ 632 | $ 548 |

| Month | Count Change | Percent Change |
|---|---|---|
| October | $ 39 | 7% |
| November | $ (28) | -5% |
| December | $ 113 | 19% |
| January | $ (84) | -13% |

| Period Change | 3% |
|---|---|

## Financials (Cont.)

### Average Per Aged/Blind/Disabled Member Served

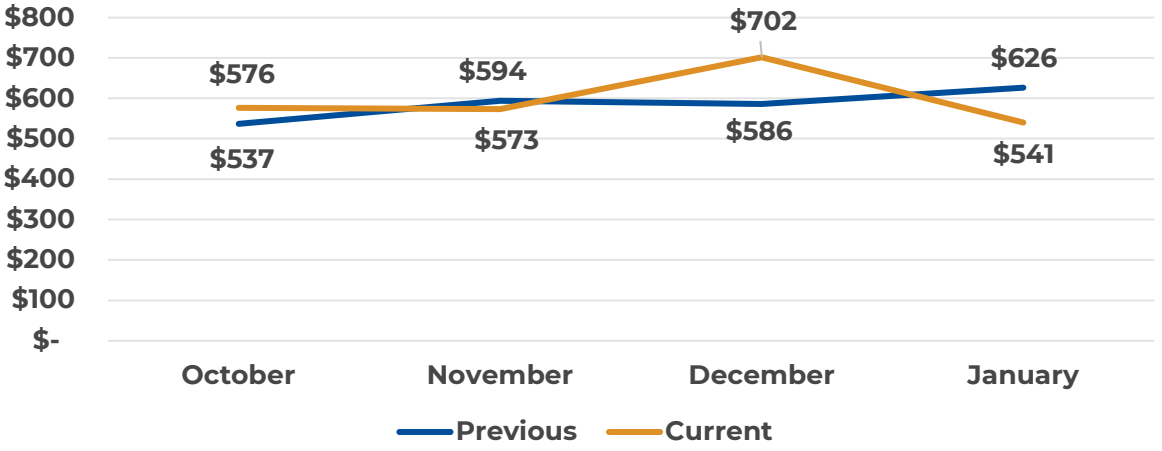



| Month | Previous | Current |
|---|---|---|
| October | $ 1,544 | $ 1,723 |
| November | $ 1,353 | $ 1,495 |
| December | $ 2,224 | $ 1,814 |
| January | $ 1,817 | $ 1,454 |

| Month | Count Change | Percent Change |
|---|---|---|
| October | $ 179 | 12% |
| November | $ 141 | 10% |
| December | $ (410) | -18% |
| January | $ (363) | -20% |

| Period Change | -2% |
|---|---|

### Average Per Children & Parent/Caretaker Member Served



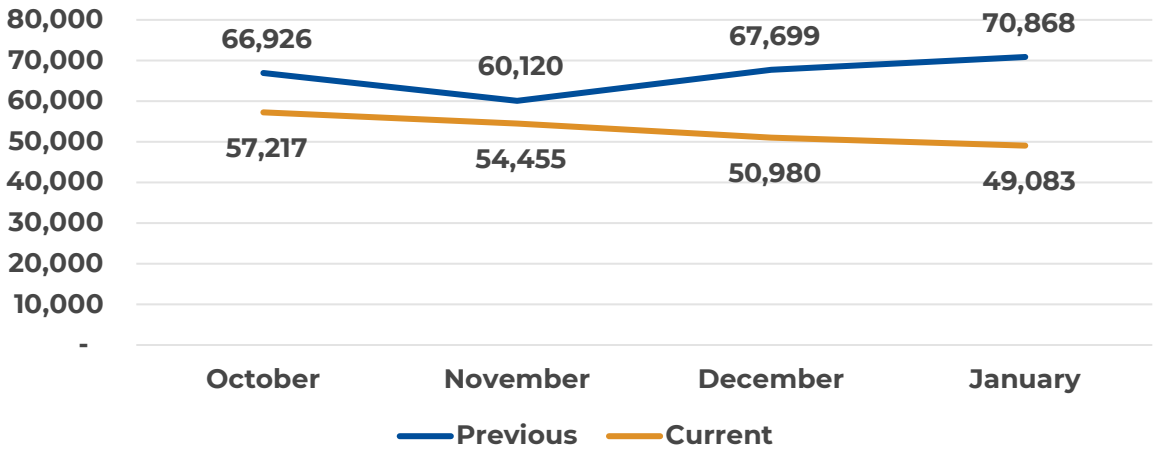

| Month | Previous | Current |
|---|---|---|
| October | $ 537 | $ 576 |
| November | $ 594 | $ 573 |
| December | $ 586 | $ 702 |
| January | $ 626 | $ 541 |

| Month | Count Change | Percent Change |
|---|---|---|
| October | $ 39 | 7% |
| November | $ (21) | -4% |
| December | $ 116 | 20% |
| January | $ (86) | -14% |

| Period Change | 5% |
|---|---|

## Call Center

### Call Center - Member Calls Answered

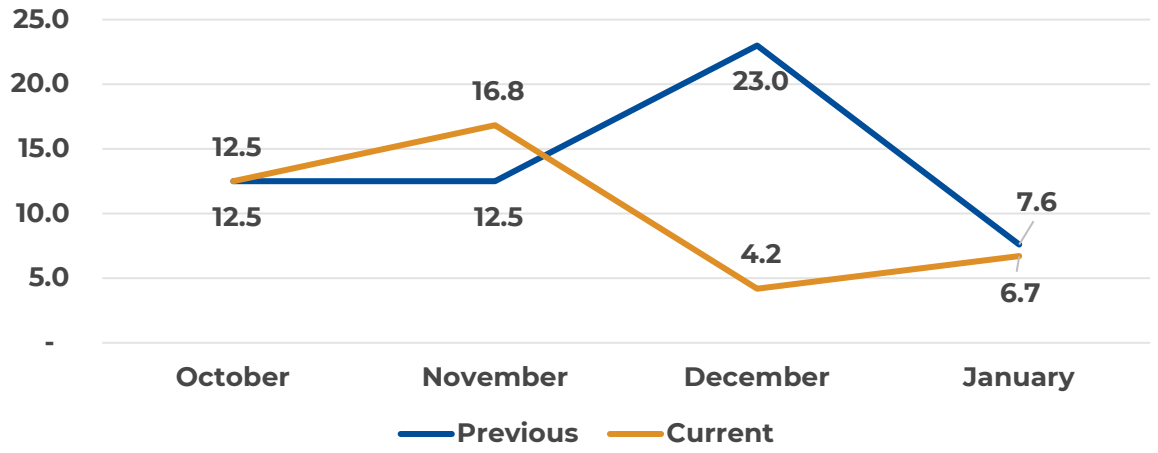



| Month | Previous | Current |
|---|---|---|
| October | 66,926 | 57,217 |
| November | 60,120 | 54,455 |
| December | 67,699 | 50,980 |
| January | 70,868 | 49,083 |

| Month | Count Change | Percent Change |
|---|---|---|
| October | (9,709) | -15% |
| November | (5,665) | -9% |
| December | (16,719) | -25% |
| January | (21,785) | -31% |

| Period Change | -16% |
|---|---|

### Call Center - Average Wait Time (In Seconds)



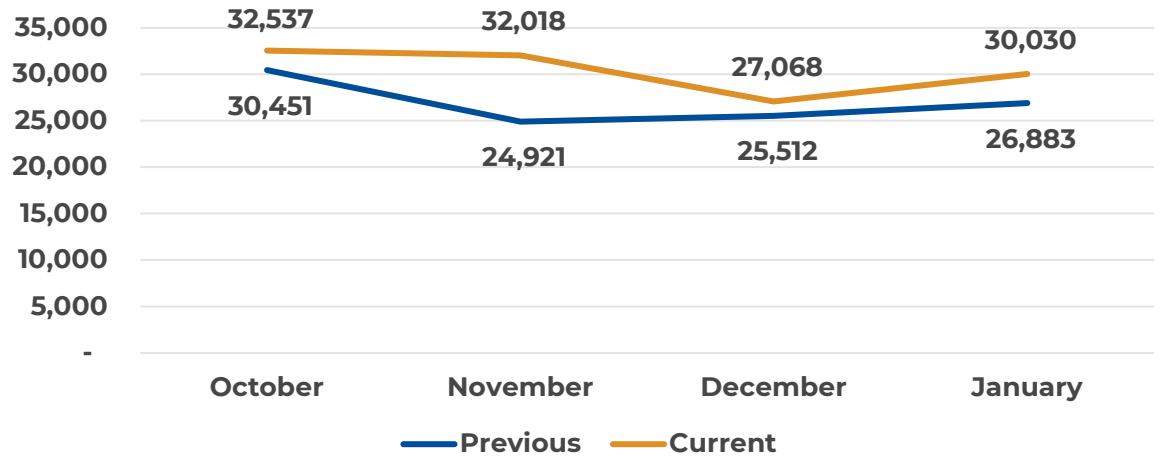

| Month | Previous | Current |
|---|---|---|
| October | 12.5 | 12.5 |
| November | 12.5 | 16.8 |
| December | 23.0 | 4.2 |
| January | 7.6 | 6.7 |

| Month | Count Change | Percent Change |
|---|---|---|
| October | - | 0.0% |
| November | 4 | 35% |
| December | (19) | -82% |
| January | (1) | -12% |

| Period Change | -30% |
|---|---|

## Prior Authorization

### Prior Authorization - Total Combined - Total Completed PA Volume

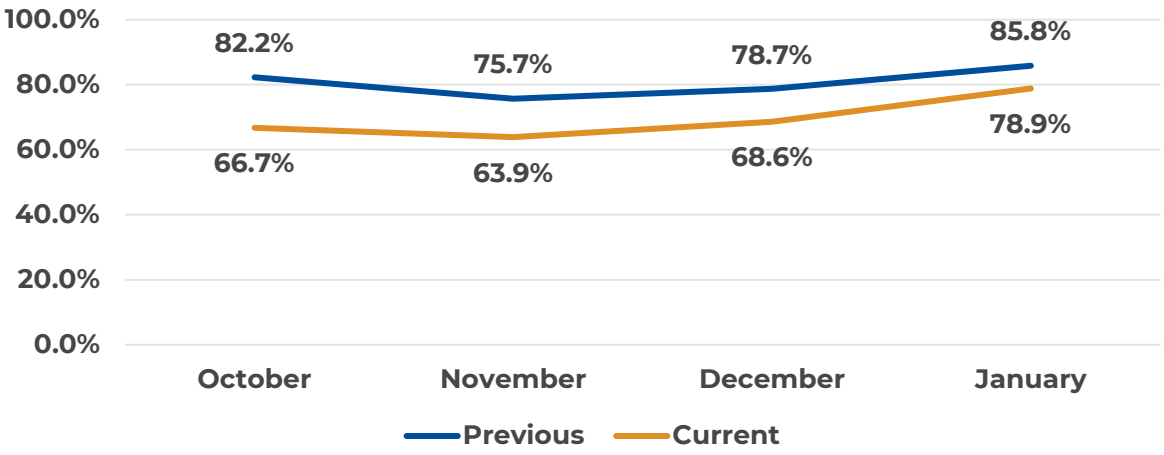



| Month | Previous | Current |
|---|---|---|
| October | 30,451 | 32,537 |
| November | 24,921 | 32,018 |
| December | 25,512 | 27,068 |
| January | 26,883 | 30,030 |

| Month | Count Change | Percent Change |
|---|---|---|
| October | 2,086 | 7% |
| November | 7,097 | 28% |
| December | 1,556 | 6% |
| January | 3,147 | 12% |

| Period Change | 18% |
|---|---|

### Prior Authorization - Total Combined - Total Percent Completed 0-6 Days



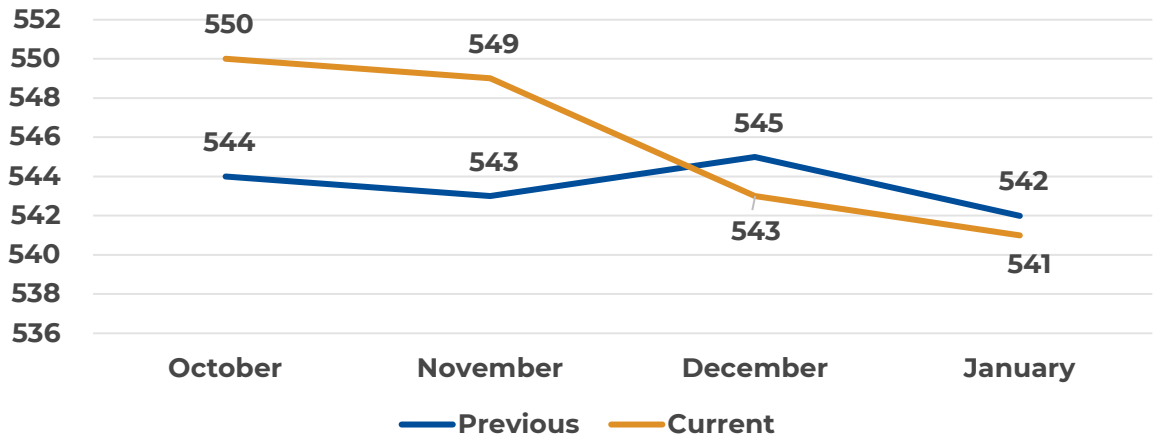

| Month | Previous | Current |
|---|---|---|
| October | 82.2% | 66.7% |
| November | 75.7% | 63.9% |
| December | 78.7% | 68.6% |
| January | 85.8% | 78.9% |

| Month | Count Change | Percent Change |
|---|---|---|
| October | -15.6% | -19% |
| November | -11.9% | -16% |
| December | -10.1% | -13% |
| January | -7.0% | -8% |

| Period Change | -17% |
|---|---|

## Agency Stats & Provider Network

### OHCA Admin - Number of FTEs

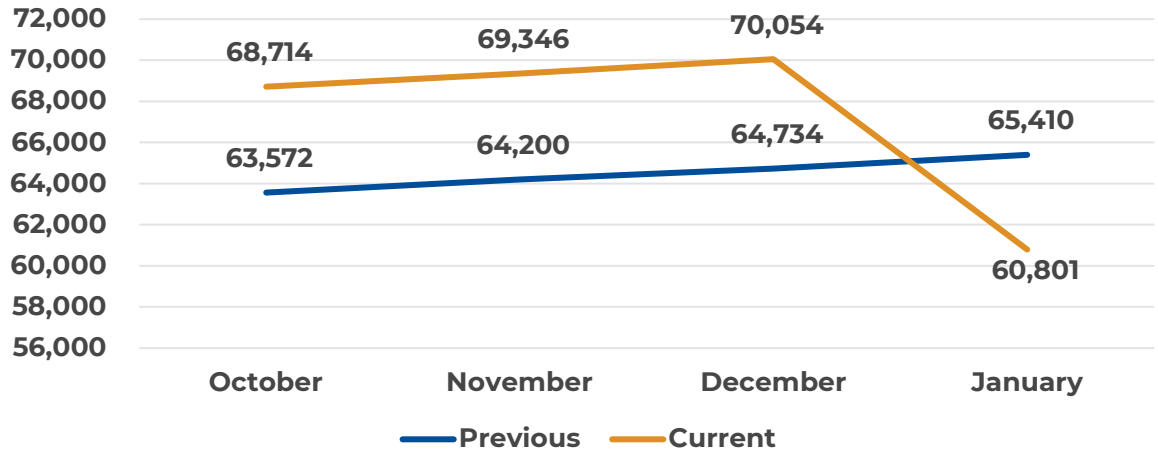



| Month | Previous | Current |
|---|---|---|
| October | 544 | 550 |
| November | 543 | 549 |
| December | 545 | 543 |
| January | 542 | 541 |

| Month | Count Change | Percent Change |
|---|---|---|
| October | 6 | 1% |
| November | 6 | 1% |
| December | (2) | -0.4% |
| January | (1) | -0.2% |

| Period Change | -0.4% |
|---|---|

### Total Providers



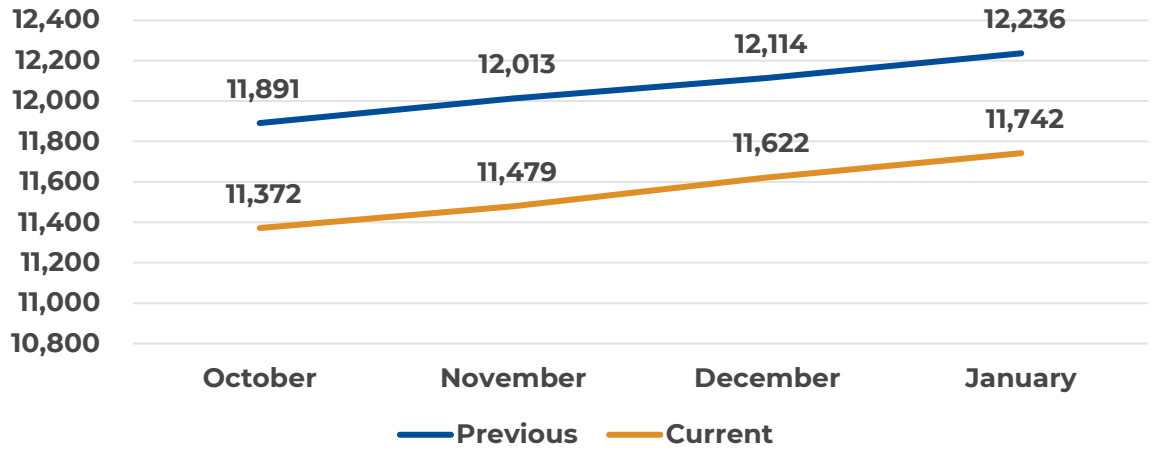

| Month | Previous | Current |
|---|---|---|
| October | 63,572 | 68,714 |
| November | 64,200 | 69,346 |
| December | 64,734 | 70,054 |
| January | 65,410 | 60,801 |

| Month | Count Change | Percent Change |
|---|---|---|
| October | 5,142 | 8% |
| November | 5,146 | 8% |
| December | 5,320 | 8% |
| January | (4,609) | -7% |

| Period Change | 9% |
|---|---|

## Agency Stats & Provider Network (Cont.)

### Mental Health Providers

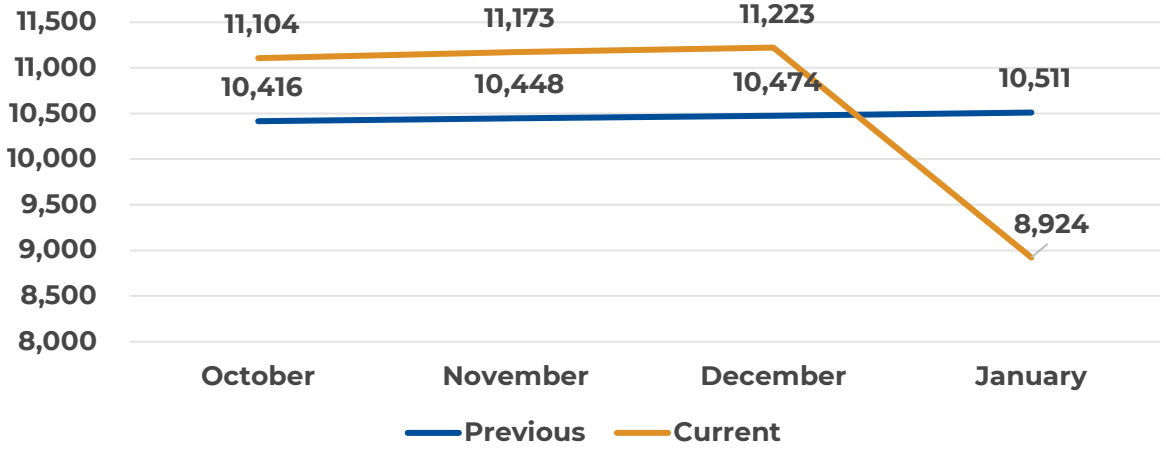



| Month | Previous | Current |
|---|---|---|
| October | 11,891 | 11,372 |
| November | 12,013 | 11,479 |
| December | 12,114 | 11,622 |
| January | 12,236 | 11,742 |

| Month | Count Change | Percent Change |
|---|---|---|
| October | (519) | -4% |
| November | (534) | -4% |
| December | (492) | -4% |
| January | (494) | -4% |

| Period Change | -1% |
|---|---|

### Physicians



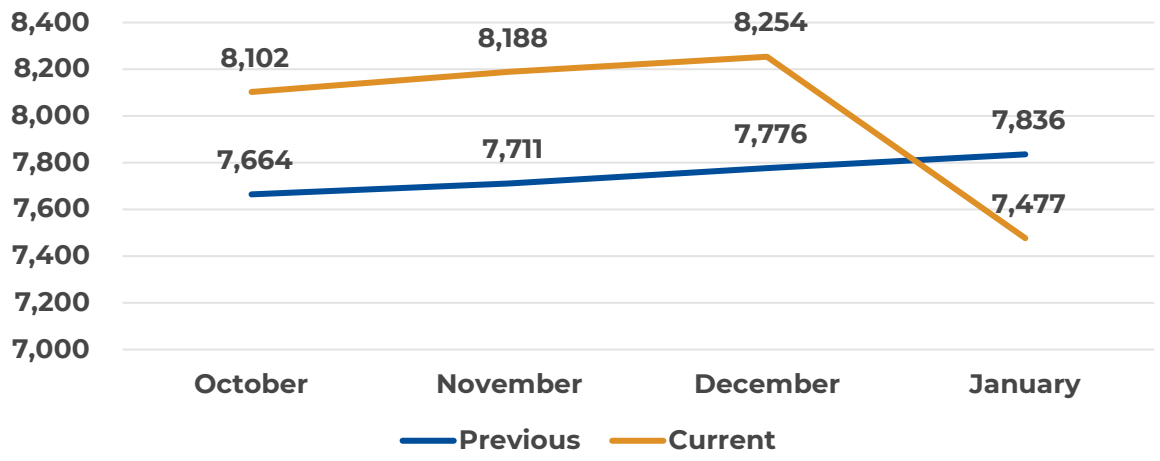

| Month | Previous | Current |
|---|---|---|
| October | 10,416 | 11,104 |
| November | 10,448 | 11,173 |
| December | 10,474 | 11,223 |
| January | 10,511 | 8,924 |

| Month | Count Change | Percent Change |
|---|---|---|
| October | 688 | 7% |
| November | 725 | 7% |
| December | 749 | 7% |
| January | (1,587) | -15% |

| Period Change | 7% |
|---|---|

## Agency Stats & Provider Network (Cont.)

### Primary Care Providers

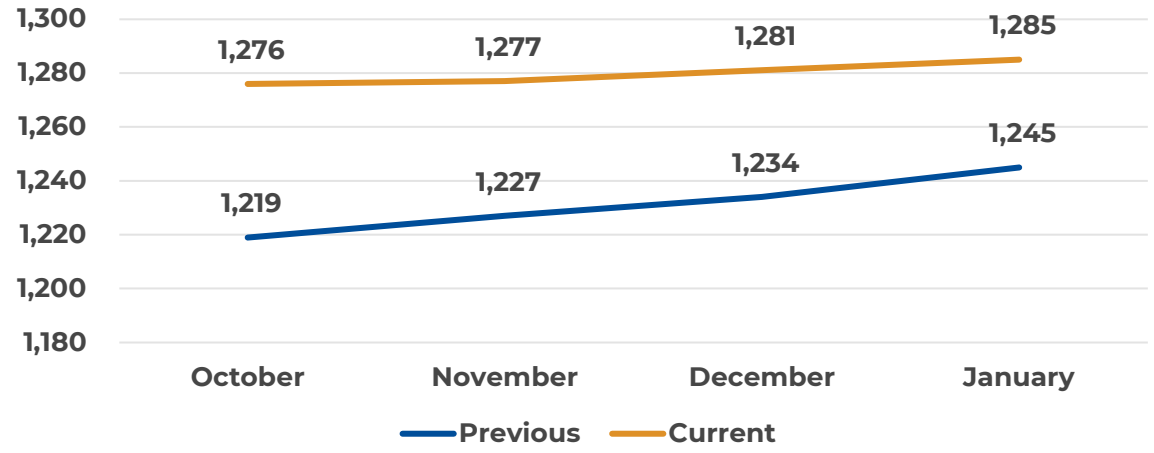



| Month | Previous | Current |
|---|---|---|
| October | 7,664 | 8,102 |
| November | 7,711 | 8,188 |
| December | 7,776 | 8,254 |
| January | 7,836 | 7,477 |

| Month | Count Change | Percent Change |
|---|---|---|
| October | 438 | 6% |
| November | 477 | 6% |
| December | 478 | 6% |
| January | (359) | -5% |

| Period Change | 7% |
|---|---|

### Dentists



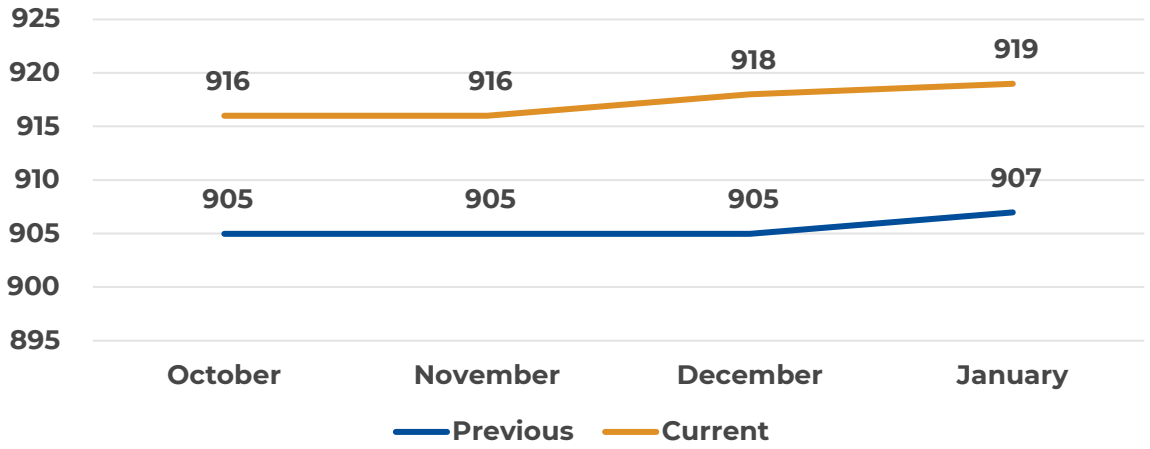

| Month | Previous | Current |
|---|---|---|
| October | 1,219 | 1,276 |
| November | 1,227 | 1,277 |
| December | 1,234 | 1,281 |
| January | 1,245 | 1,285 |

| Month | Count Change | Percent Change |
|---|---|---|
| October | 57 | 5% |
| November | 50 | 4% |
| December | 47 | 4% |
| January | 40 | 3% |

| Period Change | 5% |
|---|---|

## Agency Stats & Provider Network (Cont.)

### Pharmacy

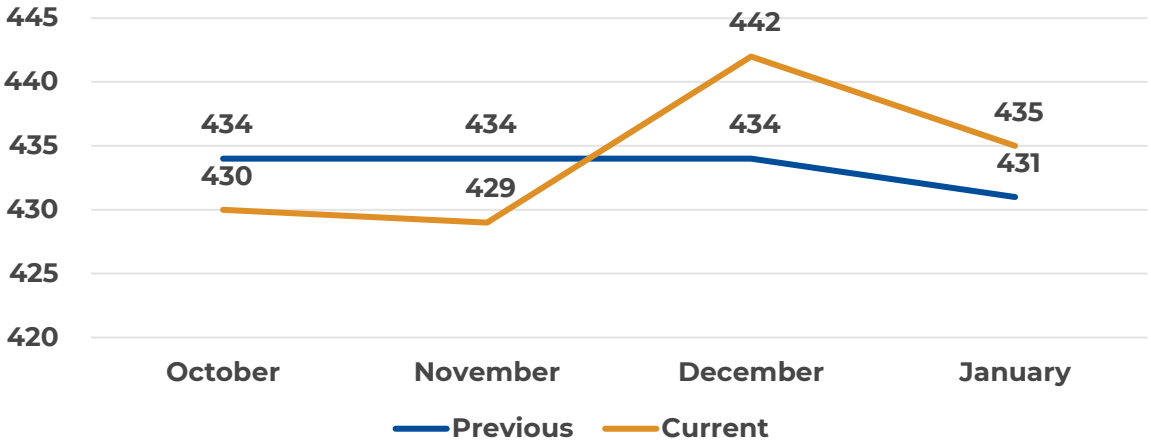



| Month | Previous | Current |
|---|---|---|
| October | 905 | 916 |
| November | 905 | 916 |
| December | 905 | 918 |
| January | 907 | 919 |

| Month | Count Change | Percent Change |
|---|---|---|
| October | 11 | 1% |
| November | 11 | 1% |
| December | 13 | 1% |
| January | 12 | 1% |

| Period Change | 1% |
|---|---|

### Extended Care Facilities



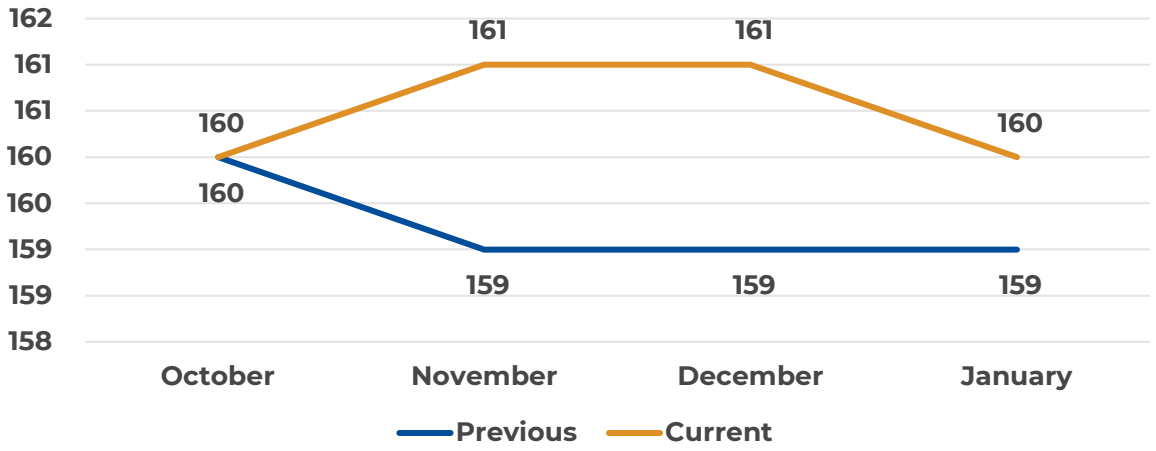

| Month | Previous | Current |
|---|---|---|
| October | 434 | 430 |
| November | 434 | 429 |
| December | 434 | 442 |
| January | 431 | 435 |

| Month | Count Change | Percent Change |
|---|---|---|
| October | (4) | -1% |
| November | (5) | -1% |
| December | 8 | 2% |
| January | 4 | 1% |

| Period Change | 2% |
|---|---|

## Agency Stats & Provider Network (Cont.)

### Hospitals




| Month | Previous | Current |
|---|---|---|
| October | 160 | 160 |
| November | 159 | 161 |
| December | 159 | 161 |
| January | 159 | 160 |

| Month | Count Change | Percent Change |
|---|---|---|
| October | - | 0.0% |
| November | 2 | 1% |
| December | 2 | 1% |
| January | 1 | 1% |

| Period Change | 1% |
|---|---|