**PUBLIC HEARING FOR THE CONSIDERATION OF PERMANENT RULEMAKING UNDER THE OKLAHOMA AMINISTRATIVE PROCEDURES ACT**

**PLACE OF HEARING:** This meeting will occur via videoconference. Please register for the meeting here: https://okhca.zoom.us/webinar/register/WN_1WXZ7_pATdukbJ8jCh7x1w

**TIME OF HEARING:** 1:00 PM

**DATE OF HEARING:** February 23, 2021

**AGENDA FOR THE MEETING**

**1. INTRODUCTIONS AND PURPOSE OF MEETING**

**2. RULES TO BE CONSIDERED**

A. **APA WF # 20-04 Electronic Visit Verification —** ADDING agency rules at ***Oklahoma Administrative Code (OAC) 317:30-3-34*** to comply with the 21st Century Cures Act which requires providers of personal care services to utilize an electronic visit verification (EVV) system where visit details are documented in real time. The revisions will require that certain details of the visit including 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 are entered into the EVV system. Further revisions outline personal care provider requirements and claims reimbursement as it applies to EVV use. Finally, revisions will include minor cleanup to fix grammatical and formatting errors.

B. **APA WF # 20-06C Durable Medical Equipment (DME) and Supplies Benefit Moved under the Scope of the Home Health Benefit —** AMENDING agency rules at ***OAC 317:40-5-104*** to 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.

C. **APA WF # 20-13 Child Support Cooperation Exemption for Recipients of Indian Health Services —** AMENDING agency rules at ***OAC 317:35-5-7 and 317:35-5-44*** to 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.

D-1. **APA WF # 20-15A Residential Substance Use Disorder (SUD) Treatment Coverage —** AMENDING agency rules at ***OAC 317:25-7-13*** to support the changes being made in APA 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. Lastly, the proposed revisions will also remove "family planning" references as the program is terminating due to Medicaid expansion.

D-2. **APA WF # 20-15B Residential Substance Use Disorder (SUD) Treatment Coverage —** AMENDING agency rules at ***OAC 317:30-5-95, 317:30-5-95.1, 317:30-5-95.42, 317:30-5-96.3, 317:30-5-241.6 and 317:30-5-268*** and ADDING agency rules at ***OAC 317:30-5-95.43 through 317:30-5-95.50*** to 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.

E. **APA WF # 20-16 SUPPORT Act Medication-Assisted Treatment and Opioid Treatment Programs —** AMENDING agency rules at ***OAC 317:30-5-9*** and ADDING agency rules at ***OAC 317:30-5-241.7*** to 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.

F-1. **APA WF # 20-19A Appeals Language Cleanup —** AMENDING agency rules at ***OAC 317:2-1-2, 317:2-1-2.5, 317:2-1-13, and 317:2-1-14*** to 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.

F-2. **APA WF # 20-19B Appeals and Incorrect References Language Cleanup —** AMENDING agency rules at ***OAC 317:30-3-90, 317:30-3-91, 317:30-5-22.1, 317:30-5-131.2, 317:30-5-221, 317:30-5-261, 317:30-5-641.1, and 317:30-5-1020*** 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.

G. **APA WF # 20-20 Pay-for-Performance (PFP) Program —** AMENDING agency rules at ***OAC 317:30-5-136.1*** to 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 PFP program quality measures to align with the most recent metrics modified by the Centers for Medicare and Medicaid (CMS). Additional changes will specify the timeline in which a nursing facility can submit its quality of care documentation to be eligible for reimbursement each quarter.

H. **APA WF # 20-21 Employment Services Offered through Developmental Disabilities Services —** AMENDING agency rules **at** ***OAC 317:40-7-7 and 317:40-7-15*** to promote small group placements of up to three (3) members in an integrated work site who are paid at more than minimum wage. Policy changes will also create small groups between four (4) to five (5) members in an integrated work site, who may earn less than minimum wage. Additional changes will create provisions to authorize remote supports for individual placements, remove the specific limit that the cost of member's employment services, excluding transportation and state-funded services, cannot exceed limits specified in OKDHS Appendix D-26. Finally, 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 not to exceed limits specified in OKDHS Appendix D-26 per Plan of Care year and changes will also clarify/update terminology used. Revisions will also align policy with current practice and correct grammatical errors.

I-1. **APA WF # 20-24A ADvantage Waiver Revisions —** AMENDING agency rules at ***OAC 317:30-5-764, 317:30-5-950, and 317:30-5-953*** will align waiver policy with the Oklahoma Health Care Authority's overarching Electronic Visit Verification rules. Additional revisions will involve eliminating or updating outdated policy and correcting grammatical errors.

I-2. **APA WF # 20-24B ADvantage Waiver Revisions —** AMENDING agency rules at ***OAC 317:35-17-22*** will align waiver policy with the

Oklahoma Health Care Authority's overarching Electronic Visit Verification rules. Additional revisions will involve eliminating or updating outdated policy and correcting grammatical errors.

J. **APA WF # 20-25 Peer Recovery Support Specialist (PRSS) Services in Indian Health Services, Tribal Programs and Urban Indian Clinics (I/T/Us) —** AMENDING agency rules at ***OAC 317:30-5-1094*** will add coverage and reimbursement of PRSS services in Indian Health Services, Tribal Programs and Urban Indian Clinics (I/T/Us). The proposed revisions will also support WF 20-15A&B in adding coverage and reimbursement of residential substance use disorder (SUD) treatment services in I/T/Us. Other revisions will reorganize policy for clarity and correct grammatical errors.

K. **APA WF # 20-26 Applied Behavior Analysis (ABA) Services Revisions —** AMENDING agency rules at ***OAC 317:30-3-65.12*** 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 also allow licensed psychologists to render ABA services without additional ABA-related certification requirements. Other revisions will involve limited rewriting aimed at clarifying policy language.

L. **APA WF # 20-27 Specialty PRTF Staffing and Admission Revisions —** AMENDING agency rules at ***OAC 317:30-5-95.24*** to 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.

M. **APA WF # 20-31 State Treasurer's Achieving a Better Life Experience (STABLE) Accounts —** AMENDING agency rules at ***OAC 317:35-5-41.9*** 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.

N. **APA WF # 20-34 Dental Revisions —** AMENDING agency rules at ***OAC 317:30-5-696 and 317:30-5-698*** 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.

O-1. **APA WF # 20-36A Lodging, Meals, and SoonerRide —** AMENDING agency rules at ***OAC 317:30-3-92*** will change the allowed mileage radius, for lodging and meals, 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 organize the existing policy in order to provide better clarity on how the approval process works for the lodging and meals benefit.

AMENDING agency rules at ***OAC 317:30-5-326, 317:30-5-326.1, 317:30-5-327.1, 317:30-5-327.3, 317:30-5-327.6, 317:30-5-327.8, 317:30-5-327.9*** and REVOKING agency rules at ***OAC 317:30-5-327.5*** will update and reformat the SoonerRide Non-Emergency Transportation (NEMT) policy to provide more clarity to providers and members. 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.

O-2. **APA WF # 20-36B Lodging, Meals, and SoonerRide —** REVOKING agency rules at ***OAC 317:35-3-2*** 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.

P. **APA WF # 20-37 Obstetrical (OB) Ultrasound —** AMENDING agency rules at ***OAC 317:30-5-22*** 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. Policy currently only allows for either an abdominal or vaginal ultra sound.

Q. **APA WF # 20-38 Clinical Trials —** ADDING agency rules at ***OAC 317:30-3-57.1*** and AMENDING agency rules at ***OAC 317:30-3-60, 317:30-3-65.5, 317:30-5-2, 317:30-5-14.1, 317:30-5-20, 317:30-5-41.2, 317:30-5-42.18, 317:30-5-72.1, 317:30-5-105, 317:30-5-321, 317:30-5-327.4, 317:30-5-337, and 317:30-5-567*** will add guidelines for coverage of clinical trials, medical necessity criteria for coverage of routine care services during a clinical trial, and clarifying that other

experimental and investigational treatment is not covered.

R. **APA WF # 20-39 Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Policy Revisions —** REVOKING agency rules at ***OAC 317:30-5-660.5, 317:30-5-661, 317:30-5-661.2, and 317:30-5-661.6***; ADDING agency rules at ***OAC 317:30-5-354, 317:30-5-355.2, and 317:30-5-659***; AMENDING agency rules at ***OAC 317:30-5-355, 317:30-5-355.1, 317:30-5-356, 317:30-5-357, 317:30-5-361, 317:30-5-660, 317:30-5-660.1, 317:30-5-660.2, 317:30-5-661.1, 317:30-5-661.3, 317:30-5-661.5 , 317:30-5-664.1, 317:30-5-664.3, and 317:30-5-664.7*** will align RHC/FQHC policy language with the Oklahoma Medicaid State Plan, federal regulations and OHCA's current business practice. Other revisions will involve limited rewriting aimed at clarifying policy language, including basic laboratory services that may be reimbursed at a RHC; mid-level professional staff requirements in RHCs; and claims' requirements to indicate the setting in which a service was provided.

S. **APA WF # 20-40 Medicaid-Funded Abortion Certification Requirements —** AMENDING agency rules at ***OAC 317:30-5-6 and 317:30-5-50*** to align with 63 Oklahoma Statutes § 1-741.1 and require the Certification for Medicaid Funded Abortion form to be completed by the physician and the patient

T. **APA WF # 20-41 Sunsetting of Behavioral Health Homes —** REVOKING agency rules at ***OAC 317:30-5-250, 317:30-5-251, 317:30-5-252, 317:30-5-253, 317:30-5-254*** and AMENDING agency rules at ***OAC 317:30-5-1207*** to remove language and references to behavioral 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.

**A.**
**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 [NEW]**
**(REFERENCE APA WF # 20-04)**

**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.

**B**.

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**
**CHAPTER 40. DEVELOPMENTAL DISABILITIES SERVICES**
**SUBCHAPTER 5. MEMBER SERVICES**
**PART 9. SERVICE PROVISIONS**
**317:40-5-104 [AMENDED]**
**(REFERENCE APA WF # 20-06C)**

**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.

**C**.

**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 [AMENDED]**
**PART 5. COUNTABLE INCOME AND RESOURCES**
**317:35-5-44 [AMENDED]**
**(REFERENCE APA WF # 20-13)**

**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 42 C.F.R. § 533.152; 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 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 42 Code of Federal Regulations (CFR) § 433.152, 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 (U.S.C.) § 1603(12)), including through the Purchased/Referred Care program, to a child who is eligible for health care services from the Indian Health Services (IHS). 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.

**D-1.**
**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**
**CHAPTER 25. SOONERCARE CHOICE**
**SUBCHAPTER 7. SOONERCARE**
**PART 3. ENROLLMENT CRITERIA**
**317:25-7-13 [AMENDED]**
**(REFERENCE APA WF # 20-15A)**

**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.

**D-2.**
**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 [AMENDED]**
**317:30-5-95.1 [AMENDED]**
**317:30-5-95.42 [AMENDED]**
**317:30-5-95.43 [NEW]**
**317:30-5-95.44 [NEW]**
**317:30-5-95.45 [NEW]**
**317:30-5-95.46 [NEW]**
**317:30-5-95.47 [NEW]**
**317:30-5-95.48 [NEW]**
**317:30-5-95.49 [NEW]**
**317:30-5-95.50 [NEW]**
**317:30-5-96.3 [AMENDED]**
**PART 21. OUTPATIENT BEHAVIORAL HEALTH AGENCY SERVICES**
**317:30-5-241.6 [AMENDED]**
**PART 24. CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS**
**317:30-5-268 [AMENDED]**
**(REFERENCE APA WF # 20-15B)**

**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) **"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.

(9) **"Substance use disorder (SUD)"** means alcohol or drug dependence or psychoactive SUD as defined by the most recent DSM criteria.

(10) **"Therapeutic services"** means professional services during which members engage in identifying, addressing and/or resolving issues identified in the member's service plan.

(11) **"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 skill development, 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. Skill development 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 skill development, care management, crisis intervention, and community recovery support services. Group therapy is limited to a total of eight (8) individuals. Skill development 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, skill development 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. Skill development 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, skill development 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. Skill development 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 skill development services. A week begins on Sunday and ends on Saturday.

(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, skill development 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. Skill development 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 skill development services. 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, skill development services, crisis intervention, care management, and community recovery support services. Group therapy is limited to a total of eight (8) individuals. Skill development 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 skill development services. 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, skill development services, crisis intervention, care management, and community recovery support services. Group therapy is limited to a total of eight (8) individuals. Skill development 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 skill development services. 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, skill development 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. Skill development 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 skill development services. 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, skill development 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. Skill development 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 skill development services. 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, skill development 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. Skill development 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 skill development services. 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 skill development 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. Transition/discharge plans and discharge summaries shall be completed by an LBHP or licensure candidate. Licensure candidate signatures must be co-signed by a fully-licensed LBHP in good standing.

(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.~~

**E.**

**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 [AMENDED]**
**PART 21. OUTPATIENT BEHAVIORAL HEALTH AGENCY SERVICES**
**317:30-5-241.7 [NEW]**
**(REFERENCE APA WF # 20-16)**

**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.

**F-1.**

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**
**CHAPTER 2. GRIEVANCE PROCEDURES AND PROCESS**
**317:2-1-2 [AMENDED]**
**317:2-1-2.5 [AMENDED]**
**317:2-1-13 [AMENDED]**
**317:2-1-14 [AMENDED]**
**(REFERENCE APA WF # 20-19A)**

**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.

**F-2.**
**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 [AMENDED]**
**317:30-3-91 [AMENDED]**
**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**
**PART 1. PHYSICIANS**
**317:30-5-22.1 [AMENDED]**
**PART 9. LONG-TERM CARE FACILITIES**
**317:30-5-131.2 [AMENDED]**
**PART 18. GENETIC COUNSELORS**
**317:30-5-221 [AMENDED]**
**PART 23. PODIATRISTS**
**317:30-5-261 [AMENDED]**
**PART 73. EARLY INTERVENTION SERVICES**
**317:30-5-641.1 [AMENDED]**
**PART 103. QUALIFIED SCHOOLS AS PROVIDERS OF HEALTH-RELATED SERVICES**
**317:30-5-1020 [AMENDED]**
**(REFERENCE APA WF # 20-19B)**

**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. 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 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.

**G.**

**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 [AMENDED]**
**(REFERENCE APA WF # 20-20)**

**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.

**H.**

**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 [AMENDED]**
**317:40-7-15 [AMENDED]**
**(REFERENCE APA WF # 20-21)**

**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.

**I-1.**
**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 [AMENDED]**
**PART 95. AGENCY PERSONAL CARE SERVICES**
**317:30-5-950 [AMENDED]**
**317:30-5-953 [AMENDED]**
**(REFERENCE APA WF # 20-24A)**

**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) - (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 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.

**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.~~

**I-2.**
**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**
**CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY**
**SUBCHAPTER 17. ADVANTAGE WAIVER SERVICES**
**317:35-17-22 [AMENDED]**
**(REFERENCE APA WF # 20-24B)**

**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.~~

**J.**
**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 [AMENDED]**
**(REFERENCE APA WF # 20-25)**

**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.

**K.**

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**
**CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**
**SUBCHAPTER 3. GENERAL PROVIDER POLICIES**
**PART 4. EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) PROGRAM/CHILD-HEALTH SERVICES**
**317:30-3-65.12 [AMENDED]**
**(REFERENCE APA WF # 20-26)**

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

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

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

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

(3) At an initial assessment, target symptoms are identified. A treatment plan is developed ~~that identifies~~to identify core deficits and aberrant behaviors, and includes designated interventions intended to address these deficits and behaviors and ~~achieve individualized goals~~that are functional, meaningful and connected to the member's daily activities routines.

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

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

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

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

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

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

(D) Consequence analysis; and

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

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

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

(c) **Eligible providers.** Eligible ABA provider types include:
(1) Board certified behavior analyst® (BCBA®) – A master's or doctoral level independent practitioner who is certified by the national-accrediting Behavior Analyst Certification Board, Inc.® (BACB®) and licensed by the Oklahoma Department of Human Services' (OKDHS) Developmental Disabilities Services Division (DDS) to provide behavior analysis services. A BCBA may supervise the work of board certified assistant behavior analysts and registered behavior technicians implementing behavior analytic interventions;
(2) Board certified assistant behavior analyst® (BCaBA®) – A bachelor's level practitioner who is certified by the national-accrediting BACB and certified by OKDHS DDS to provide behavior analysis services under the supervision of a BCBA;
(3) Registered behavior technician™ (RBT®) – A high school level or higher paraprofessional who is certified by the national-accrediting BACB and practices under the close and ongoing supervision of a BCBA. The RBT works under the license number of a BCBA and is primarily responsible for the direct implementation of BCBA designed and prescribed behavior-analytic services; ~~and~~
(4) Licensed psychologist – An individual who is licensed and in good standing with the Oklahoma State Board of Examiners of Psychologists may render behavior analysis services. Refer to OAC 317:30-5-275; and

~~(4)~~(5) Human services professional - A practitioner who is licensed by the State of Oklahoma pursuant to (A) - (H), and certified by the national-accrediting BACB, and who is working within the scope of his or her practice, to include:

(A) A licensed physical therapist;

(B) A licensed occupational therapist;

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

~~(D) A licensed psychologist;~~

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

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

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

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

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

(1) A BCBA shall:

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

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

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

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

(2) A BCaBA shall:

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

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

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

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

(3) An RBT shall:

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

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

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

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

(4) A human services professional shall:

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

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

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

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

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

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

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

(5) The member exhibits atypical or disruptive behavior within the most recent thirty (30) calendar days that significantly

interferes with daily functioning and activities. Such atypical or disruptive behavior may include, but is not limited to:

(A) Impulsive aggression toward others;

(B) Self-injury behaviors; ~~or~~

(C) Intentional property destruction~~.~~; or

(D) Severe disruption in daily functioning (e.g. the individual's inability to maintain in school, child care settings, social settings, etc.) due to changes in routine activities that have not been helped by other treatments such as occupational, speech therapy, additional psychotherapy and/or school/ daycare interventions.

(6) The focus of treatment is not custodial in nature (which is defined as care provided when the member "has reached maximum level of physical or mental function and such person is not likely to make further significant improvement" or "any type of care where the primary purpose of the type of care provided is to attend to the member's daily living activities which do not entail or require the continuing attention of trained medical or paramedical personnel.") Interventions are intended to strengthen the individual's/parent's/legal guardian's capacity for self care and self sufficiency to decrease interventions in the home by those other than the parent(s)/legal guardian(s).

(7) It has been determined that there is no ~~other appropriate service~~less intensive or more appropriate level of service which can be safely and effectively provided.

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

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

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

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

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

(D) Functional assessment of problem behavior that includes antecedent factors, skill deficits, and consequences contributing to the problem behavior. The treatment plan should address all three (3) areas, including antecedent interventions, teaching replacement skills, and modification of consequences.

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

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

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

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

(D) Clearly define in measurable and objective terms the intervention plan so it can address ~~the~~ specific target behaviors ~~that are linked to the function of (or reason for) the behavior;~~. The intervention plan should be clearly linked to the function of the maladaptive behavior and include antecedent interventions, replacement skills to be taught, and modification of consequences. Additional goals may be identified that are related to the core deficits of ASD and are prioritized based on current research and social significance for the individual.

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

(F) Set quantifiable criteria for progress;

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

(H) Specify strategies for generalization of learned skills beyond the clinical settings such as in the home or other community settings;

(I) Document planning for transition through the continuum of interventions, services, and settings, as well as discharge criteria~~;~~. Treatment (behavioral training) will be individualized and documentation will support the identified atypical or disruptive behavior.

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

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

(L) Ensure that recommended ABA services do not duplicate or replicate services received in a member's primary academic education setting, or provided within an Individualized Education Plan (IEP), Individualized Service Plan (ISP), or any other individual plan of care. Documentation may be requested by the OHCA to support coordination of services with other providers and to prevent overlap and duplication of services including those in school settings.

(g) **ABA extension requests.** Extension requests for ABA services must be submitted to the OHCA or its designated agent. Extension requests must contain the appropriate documentation validating the need for continued treatment and establish the following:

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

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

(3) ~~If progress has not been measurable after two (2) extension requests, a functional analysis will be completed which records the member's maladaptive serious target behavioral symptom(s), and precipitants, as well as makes a determination of the function a particular maladaptive behavior serves for the member in the environmental context;~~A functional analysis shall be completed by the provider when no measurable progress has occurred, or it may be requested by the OHCA. The functional analysis should record the member's serious maladaptive target behavioral symptom(s) and precipitants, and document the modifications of the current treatment plan to address progress, as well as make a determination of the function a particular maladaptive behavior serves for the member in the environmental context;

(4) Appropriate consultations from other staff or experts have occurred ~~(psychiatric consults, pediatric evaluation for other conditions)~~(to optimize psychiatric medications and medical treatments to include but not limited to psychiatric consults, pediatric evaluation for other conditions, etc.) and interventions have been changed, including the number of hours per week of service or setting (higher level of care);

(5) The OHCA may suggest appropriate consultation from other staff or experts during the process of prior authorization;

~~(5)~~ (6) Parent(s)/legal guardian(s) have received re-training on these changed approaches; and

~~(6)~~ (7) The treatment plan documents a gradual tapering of higher intensities of intervention and ~~shifting~~transitioning to supports from other sources (i.e., schools) as progress ~~occurs~~allows.

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

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

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

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

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

**L.**

**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**
**317:30-5-95.24 [AMENDED]**
**(REFERENCE APA WF # 20-27)**

**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.

**M.**

**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 [AMENDED]**
**(REFERENCE APA WF # 20-31)**

**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) 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. 74-320 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).

**N.**

**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 [AMENDED]**
**317:30-5-698 [AMENDED]**
**(REFERENCE APA WF # 20-34)**

**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 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 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.

**O-1.**

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**
**CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**
**SUBCHAPTER 3. GENERAL PROVIDER POLICIES**
**PART 6. OUT-OF-STATE SERVICES**
**317:30-3-92 [AMENDED]**
**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**
**PART 32. SOONERRIDE NON-EMERGENCY TRANSPORTATION (NEMT)**
**317:30-5-326 [AMENDED]**
**317:30-5-326.1 [AMENDED]**
**317:30-5-327.1 [AMENDED]**
**317:30-5-327.3 [AMENDED]**
**317:30-5-327.5 [REVOKED]**
**317:30-327.6 [AMENDED]**
**317:30-5-327.8 [AMENDED]**
**317:30-5-327.9 [AMENDED]**
**(REFERENCE APA WF # 20-36A)**

**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 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 can be provided with approval. ~~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:

(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.~~Reimbursement for meals is based on a daily per diem rate. If meals or meal vouchers are provided by either the hospital or the lodging provider, additional reimbursement will not be provided.

~~(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) A member may not receive reimbursement for lodging and/or meals services for days the member is inpatient in a hospital or medical facility.

(7) During the first fourteen (14) days of a member's inpatient or outpatient stay, meals and lodging are reimbursed without prior approval. Additional lodging and/or meals beyond the fourteen (14) days must be prior approved by the OHCA.

(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 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 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 compensable service related to lodging/meals is not verifiable, reimbursement will be denied.

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

(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) 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. ~~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.

**"Urgent care"** means services furnished to an individual who requires services to be furnished within three (3) business days.

**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.** Travel that exceeds the forty-five (45) mile radius, as mentioned in Oklahoma Administrative Code (OAC) 317:30-5-327.1 (a) (2), and out-of-state travel for medically necessary services, that have been prior authorized, 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) Personable 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 documented medically necessary instances 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 not housebroken. 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.** SoonerRide NEMT will take up to three (3) children to urgent medical appointments. The 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. Personable 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.~~

**317:30-327.6. 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 no 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.

~~(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.

**O-2.**

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**
**CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY**
**SUBCHAPTER 3. COVERAGE AND EXCLUSIONS**
**317:35-3-2 [REVOKED]**
**(REFERENCE APA WF # 20-36B)**

**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.~~

**P.**
**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 [AMENDED]**
**(REFERENCE APA WF # 20-37)**

**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.

**Q.**

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**
**CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**
**SUBCHAPTER 3. GENERAL PROVIDER POLICIES**
**PART 3. GENERAL MEDICAL PROGRAM INFORMATION**
**30-3-57.1 [NEW]**
**317:30-3-60 [AMENDED]**
**PART 4. EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) PROGRAM/CHILD-HEALTH SERVICES**
**317:30-3-65.5 [AMENDED]**
**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**
**PART 1. PHYSICIANS**
**317:30-5-2 [AMENDED]**
**317:30-5-14.1 [AMENDED]**
**317:30-5-20 [AMENDED]**
**PART 3. HOSPITALS**
**317:30-5-41.2 [AMENDED]**
**317:30-5-42.18 [AMENDED]**
**PART 5. PHARMACIES**
**317:30-5-72.1 [AMENDED]**
**PART 7. CERTIFIED LABORATORIES**
**317:30-5-105 [AMENDED]**
**PART 31. ROOM AND BOARD PROVIDERS**
**317:30-5-321 [AMENDED]**
**PART 32. SOONERRIDE NON-EMERGENCY TRANSPORTATION**
**317:30-327.4 [AMENDED]**
**PART 33. TRANSPORTATION BY AMBULANCE**
**317:30-5-337 [AMENDED]**
**PART 63. AMBULATORY SURGICAL CENTERS (ASC)**
**317:30-5-567 [AMENDED]**
**(REFERENCE APA WF # 20-38)**

**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:

(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.

**R.**

**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 [NEW]**
**317:30-5-355 [AMENDED]**
**317:30-5-355.1 [AMENDED]**
**317:30-5-355.2 [NEW]**
**317:30-5-356 [AMENDED]**
**317:30-5-357 [AMENDED]**
**317:30-5-361 [AMENDED]**
**PART 75. FEDERALLY QUALIFIED HEALTH CENTERS**
**317:30-5-659 [NEW]**
**317:30-5-660 [AMENDED]**
**317:30-5-660.1 [AMENDED]**
**317:30-5-660.2 [AMENDED]**
**317:30-5-660.5 [REVOKED]**
**317:30-5-661 [REVOKED]**
**317:30-5-661.1 [AMENDED]**
**317:30-5-661.2 [REVOKED]**
**317:30-5-661.3 [AMENDED]**
**317:30-5-661.5 [AMENDED]**
**317:30-5-661.6 [REVOKED]**
**317:30-5-664.1 [AMENDED]**
**317:30-5-664.3 [AMENDED]**
**317:30-5-664.7 [AMENDED]**
**(REFERENCE APA WF # 20-39)**

**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 - 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) ParaCard 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 RHC'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 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.

(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 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;

(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 RHC; 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.

**S.**
**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 [AMENDED]**
**PART 3. HOSPITALS**
**317:30-5-50 [AMENDED]**
**(REFERENCE APA WF # 20-40)**

**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.

**T.**

**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 [REVOKED]**
**317:30-5-251 [REVOKED]**
**317:30-5-252 [REVOKED]**
**317:30-5-253 [REVOKED]**
**317:30-5-254 [REVOKED]**
**PART 113. LIVING CHOICE PROGRAM**
**317:30-5-1207 [AMENDED]**
**(REFERENCE APA WF # 20-41)**

**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) - (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).