Oklahoma Health Care Authority

The Oklahoma Health Authority (OHCA) values your feedback and input. It is very important that you provide your comments regarding the proposed rule change by the comment due date. Comments can be submitted on the OHCA's Proposed Changes Blog.

OHCA COMMENT DUE DATE: May 13, 2020

Reference: APA WF 20-06A

SUMMARY:
Durable medical equipment (DME) and supplies benefit moved under the scope of home health benefit — The proposed revisions are needed 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. Prosthetics and orthotics are under a separate regulation and remain an optional benefit. Finally, revisions will remove language that refers to the family planning program since the program will be terminated and that eligibility group will be eligible for full benefits as a part of the new adult group.

LEGAL AUTHORITY
The Oklahoma Health Care Authority Act, Section 5007 (C)(2) of Title 63 of Oklahoma Statutes; The Oklahoma Health Care Authority Board; Section 6407 of the Affordable Care Act; Section 504 of the Medicare Access and CHIP Reauthorization Act of 2015; CMS-2348-F Final Rule; Public Law 114-10; 42 Code of Federal Regulations (C.F.R.) § 440.70; and 42 C.F.R. § 440.120

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

SUBJECT: Rule Impact Statement
APA WF # 20-06

A. Brief description of the purpose of the rule:

The proposed revisions to medical supplier, home health agency, long-term care facilities, hospitals, and general provider policies are needed 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. Prosthetics and orthotics are under a separate regulation and remain an optional benefit. Durable medical equipment was changed to medical supplies, equipment and appliances to match language in federal regulation. Policy references which indicated limitations on coverage of medical supplies, equipment, and appliances were removed. Revisions require long term care facilities to provide certain medical supplies, equipment, and appliances as part of their daily per diem payment. Revisions update the place of service for which medical supplies, equipment, and appliances may be received to any setting in which normal life activities take place except for inpatient settings. Revisions require and define a face-to-face encounter between a patient and a practitioner before the provision of medical supplies, equipment, and appliances. Revisions define medical supplies, equipment, and appliances, orthotics, and prosthetics. Revisions establish specific pricing methodology for enteral food; medical supplies, equipment, and appliances; oxygen; supplies; and parenteral equipment and food. Revisions clarify when manual pricing of medical supplies, equipment, and appliances is required and outlines two types of manual pricing: Invoice pricing and fair market pricing. Also, the proposed revisions will update organ transplant requirements and guidelines to reflect current practice. Finally, a reference regarding the new adult eligibility group (ages 19 to 64) will be added, family planning references will be removed, and other changes will be made to shift policy to more appropriate sections as well as grammar and language clean-up.

B. A description of the classes of persons who most likely will be affected by the proposed rule, including classes that will bear the cost of the proposed rule, and any information on cost impacts received by the agency from any private or public entities:

SoonerCare long-term care providers will be affected by the proposed rule changes as all medical supplies, equipment, and appliances will be included in their per diem rate. Other SoonerCare providers will also be affected by the required face-to-face encounter between a patient and a practitioner before the provision of medical supplies, equipment, and appliances.

C. A description of the classes of persons who will benefit from the proposed rule:

The proposed rule changes will benefit some SoonerCare members as a result of the medical supplies, equipment, and appliances benefit being moved under the scope of the home health benefit as a mandatory benefit.

D. A description of the probable economic impact of the proposed rule upon the affected classes of persons or political subdivisions, including a listing of all fee changes and, whenever possible, a separate justification for each fee change:

The proposed rule may have an economic impact on long-term care providers as stated in item B above. There are no fee changes associated with the rule change.

E. The probable costs and benefits to the agency and to any other agency of the implementation and enforcement of the proposed rule, the source of revenue to be used for implementation and enforcement of the proposed rule, and any anticipated effect on state revenues, including a projected net loss or gain in such revenues if it can be projected by the agency:

The estimated budget impact for SFY2021 and SFY2022 will be an increase in the total amount of $2,615,007, which is $1,702,631 federal share and $912,376 state share.

F. A determination of whether implementation of the proposed rule will have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the rule:

The proposed rule changes will not have an economic impact on any political subdivision or require their cooperation in implementing or enforcing the rule changes.

G. A determination of whether implementation of the proposed rule will have an adverse effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act:

The agency does not anticipate that the proposed rule changes will have an adverse effect on small businesses.

H. An explanation of the measures the agency has taken to minimize compliance costs and a determination of whether there are less costly or non-regulatory methods or less intrusive methods for achieving the purpose of the proposed rule:

The agency has taken measures to determine that there are no other legal methods to achieve the purpose of the proposed rule. Measures included a formal public comment period and tribal consultation.

I. A determination of the effect of the proposed rule on the public health, safety and environment and, if the proposed rule is designed to reduce significant risks to the public health, safety and environment, an explanation of the nature of the risk and to what extent the proposed rule will reduce the risk:

The proposed rule changes are not designed to reduce any significant risks to the public health, safety, and environment.

J. A determination of any detrimental effect on the public health, safety and environment if the proposed rule is not implemented:

The agency anticipates that in the absence of these rule changes, there would not be any detrimental effect on the public health, safety, and environment, however, the agency would be out of compliance with federal regulations.

K. The date the rule impact statement was prepared and if modified, the date modified:

Prepared: March 25, 2020
Modified: April 15, 2020

RULE TEXT:

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-ELIGIBILITY

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 3. GENERAL MEDICAL PROGRAM INFORMATION

317:30-3-40. Home and ~~Community-Based Services Waivers (HCBS)~~community-based services (HCBS) waivers for persons with intellectual disabilities or certain persons with related conditions

(a) **Introduction to HCBS waivers for persons with intellectual disabilities.** The Medicaid HCBS waiver programs are authorized per Section 1915(c) of the Social Security Act.

(1) The Oklahoma Department of Human Services (OKDHS) Developmental Disabilities Services Division (DDS) operates

HCBS waiver programs for persons with intellectual disabilities and certain persons with related conditions. The Oklahoma Health Care Authority (OHCA), is the State's Medicaid agency, retains and exercises administrative authority over all HCBS waiver programs.

(2) Each waiver allows for the provision of specific SoonerCare-compensable services that assist members to reside in the community and avoid institutionalization.

(3) HCBS waiver services:

(A) ~~complement~~Complement and supplement services available to members through the Medicaid State Plan or other federal, state, or local public programs, as well as informal supports provided by families and communities;

(B) ~~are~~Are only provided to persons who are Medicaid eligible, outside of a nursing facility, hospital, or institution;

(C) ~~are~~Are not intended to replace other services and supports available to members; and

(D) ~~are~~Are authorized based solely on current need.

(4) HCBS waiver services must be:

(A) ~~appropriate~~Appropriate to the member's needs; and

(B) ~~included~~Included in the member's ~~Individual Plan~~individual plan (IP).

(i) The IP:

(I) ~~is~~Is developed annually by the member's ~~Personal Support Team,~~personal support team, per Oklahoma Administrative Code (OAC) 340:100-5-52; and

(II) ~~contains~~Contains detailed descriptions of services provided, documentation of amount and frequency of services, and types of providers to provide services.

(ii) Services are authorized, per OAC 340:100-3-33 and 340:100-3-33.1.

(5) DDS furnishes case management, targeted case management, and services to members as a Medicaid State Plan services, per Section 1915(g)(1) of the Social Security Act and per OAC 317:30-5-1010 through 317:30-5-1012.

(b) **Eligible providers.** All providers must have entered into contractual agreements with OHCA to provide HCBS for persons with an intellectual disability or related conditions.

(1) All providers, except pharmacy, ~~specialized medical supplies~~ and durable medical equipment (DME) providers must be reviewed by ~~DHS~~OKDHS DDS. The review process verifies that:

(A) ~~the~~The provider meets the licensure, certification or other standards specified in the approved HCBS waiver documents; and

(B) ~~organizations~~Organizations that do not require licensure wanting to provide HCBS services meet program standards, are financially stable and use sound business management practices.

(2) Providers who do not meet program standards in the review process are not approved for a provider agreement.

(3) Provider agreements with providers that fail to meet programmatic or financial requirements may not be renewed.

(c) **Coverage.** All services must be included in the member's IP and arranged by the member's case manager.

317:30-3-57. General SoonerCare coverage - categorically needy

The following are general SoonerCare coverage guidelines for the categorically needy and adult group, nineteen (19) to sixty-four (64) years of age, as per Section (§) 435.119 of Title 42 of the Code of Federal Regulations (C.F.R.):

(1) Inpatient hospital services other than those provided in an institution for mental diseases (IMD).

(A) Adult coverage for inpatient hospital stays as described at ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-5-41.

(B) Coverage for members under twenty-one (21) years of age is not limited. All admissions must be medically necessary. All psychiatric admissions require prior authorization for an approved length of stay.

(2) Emergency department services.

(3) Dialysis in an outpatient hospital or free standing dialysis facility.

(4) Outpatient therapeutic radiology or chemotherapy for proven malignancies or opportunistic infections.

(5) Outpatient surgical services - facility payment for selected outpatient surgical procedures to hospitals which have a contract with ~~OHCA~~the Oklahoma Health Care Authority (OHCA).

(6) Outpatient mental health services for medical and remedial care including services provided on an outpatient basis by certified ~~hospital based~~hospital-based facilities that are also qualified mental health clinics.

(7) Rural health clinic (RHC) services and other ambulatory services furnished by ~~rural health clinic~~an RHC.

(8) Optometrists' services - only as listed in Subchapter 5, Part 45, Optometrist specific rules of this Chapter.

(9) Maternity clinic services.

(10) Outpatient diagnostic x-rays and lab services. Other outpatient services provided to adults, not specifically addressed, are covered only when prior authorized by the agency's Medical Authorization Unit.

(11) Medically necessary screening mammography. Additional follow-up mammograms are covered when medically necessary.
(12) ~~Nursing~~Long-term care facility services (other than services in an institution for tuberculosis or mental diseases).
(13) Early and Periodic Screening, ~~Diagnosis~~Diagnostic and Treatment Services (EPSDT) are available for members under twenty-one (21) years of age to provide access to regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth. Federal regulations also require that diagnosis and treatment be provided for conditions identified during a screening whether or not they are covered under the State Plan, as long as federal funds are available for these services. These services must be necessary to ameliorate or correct defects and physical or mental illnesses or conditions and require prior authorization. EPSDT/OHCA ~~Child Health~~child-health services are outlined in OAC 317:30-3-65.2 through ~~317:30-3-65.4~~317:30-3-65.12.

(A) ~~Child health screening examinations~~EPSDT screenings examinations for eligible children by a medical or osteopathic physician, physician assistant, or advanced practice nurse practitioner.

(B) Diagnostic x-rays, lab, and/or injections when prescribed by a provider.

(C) Immunizations.

(D) Outpatient care.

(E) Dental services as outlined in OAC 317:30-3-65.8.

(F) Optometrists' services. The EPSDT periodicity schedule provides for at least one (1) visual screening and glasses each twelve (12) months. In addition, payment is made for glasses for children with congenital aphakia or following cataract removal. Interperiodic screenings and glasses at intervals outside the periodicity schedule for optometrists are allowed when a visual condition is suspected. Payment is limited to two (2) glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.

(G) Hearing services as outlined in OAC 317:30-3-65.9.

(H) Prescribed drugs.

(I) Outpatient-psychological services as outlined in OAC 317:30-5-275 through 317:30-5-278.

(J) Inpatient-psychiatric services as outlined in OAC 317:30-5-95 through 317:30-5-97.

(K) Transportation. Provided when necessary in connection with examination or treatment when not otherwise available.

(L) Inpatient-hospital services.

(M) Medical supplies, equipment, appliances and prosthetic devices beyond the normal scope of SoonerCare.

(N) EPSDT services furnished in a qualified child health center.

~~(14) Family planning services and supplies for members of child-bearing age, including counseling, insertion of intrauterine device, implantation of subdermal contraceptive device, and sterilization for members twenty-one (21) years of age and older who are legally competent, not institutionalized and have signed the "Consent Form" at least thirty (30) days prior to procedure. Reversal of sterilization procedures for the purposes of conception is not covered. Reversal of sterilization procedures are covered when medically indicated and substantiating documentation is attached to the claim.~~

~~(15)~~(14) Physicians' services whether furnished in the office, the member's home, a hospital, a ~~nursing~~long-term care facility, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), or elsewhere. For adults, payment is made for compensable hospital days described at OAC 317:30-5-41. Office visits for adults are limited to four (4) per month except when in connection with conditions as specified in OAC 317:30-5-9(b).

~~(16)~~(15) Medical care and any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law. See applicable provider ~~section~~Section for limitations to covered services for:

(A) Podiatrists' services;

(B) Optometrists' services;

(C) Psychologists' services;

(D) Certified ~~Registered Nurse Anesthetists~~registered nurse anesthetists;

(E) Certified ~~Nurse Midwives~~nurse midwives;

(F) Advanced ~~Practice Nurses~~practice registered nurses; and

(G) Anesthesiologist ~~Assistants~~assistants.

~~(17)~~(16) Free-standing ambulatory surgery centers.

~~(18)~~(17) Prescribed drugs not to exceed a total of six (6) prescriptions with a limit of two (2) brand name prescriptions per month. Exceptions to the six (6) prescription limit are:

(A) ~~unlimited~~Unlimited medically necessary monthly prescriptions for:

(i) ~~members~~Members under the age of twenty-one (21) years; and

(ii) ~~residents~~Residents of ~~nursing~~long-term care facilities or ICF/IID.

(B) ~~seven~~Seven (7) medically necessary generic prescriptions per month in addition to the six (6) covered under the State Plan (including three (3) brand name prescriptions) are allowed for adults receiving services under the 1915(c) ~~Home and Community Based Services Waivers~~home and community-based services (HCBS) waivers. These additional medically necessary prescriptions beyond the three (3) brand name or thirteen (13) total prescriptions are covered with prior authorization.

~~(19)~~(18) Rental and/or purchase of ~~durable medical equipment~~medical supplies, equipment, and appliances.

~~(20)~~(19) Adaptive equipment, when prior authorized, for members residing in private ICF/IID's.

~~(21)~~(20) Dental services for members residing in private ICF/IID's in accordance with the scope of dental services for members under age twenty-one (21).

~~(22) Prosthetic devices limited to catheters and catheter accessories, colostomy and urostomy bags and accessories, tracheostomy accessories, nerve stimulators, hyperalimentation and accessories, home dialysis equipment and supplies, external breast prostheses and support accessories, oxygen/oxygen concentrator equipment and supplies, respirator or ventilator equipment and supplies, and those devices inserted during the course of a surgical procedure.~~(21) Orthotic and prosthetic devices for members under age twenty-one (21). For adults, orthotics and prosthetics are limited to breast prosthesis and support accessories. See OAC 317:30-5-210.1 and OAC 317:30-5-211.13.

~~(23)~~(22) Standard medical supplies.

~~(24)~~(23) Eyeglasses under EPSDT for members under age twenty-one (21). Payment is also made for glasses for children with congenital aphakia or following cataract removal. Payment is limited to two (2) glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.

~~(25)~~(24) Blood and blood fractions for members when administered on an outpatient basis.

~~(26)~~(25) Inpatient services for members age sixty-five (65) or older in institutions for mental diseases, limited to those members whose Medicare, Part A benefits are exhausted for this particular service and/or those members who are not eligible for Medicare services.

~~(27) Nursing~~(26) Long-term care facility services, limited to members preauthorized and approved by OHCA for such care.

~~(28)~~(27) Inpatient psychiatric facility admissions for members under twenty-one (21) are limited to an approved length of stay

effective July 1, 1992, with provision for requests for extensions.

~~(29)~~(28) Transportation and subsistence (room and board) to and from providers of medical services to meet member's needs (ambulance or bus, etc.), to obtain medical treatment.

~~(30)~~(29) Extended services for pregnant women including all pregnancy-related and postpartum services to continue to be provided, as though the women were pregnant, for sixty (60) days after the pregnancy ends, beginning on the last date of pregnancy.

~~(31) Nursing~~(30) Long-term care facility services for members under twenty-one (21) years of age.

~~(32)~~(31) Personal care in a member's home, prescribed in accordance with a plan of treatment and rendered by a qualified person under supervision of a Registered Nurse (RN).

~~(33)~~(32) Part A deductible and Part B Medicare Coinsurance and/or deductible.

~~(34)~~(33) ~~Home and Community-Based Waiver Services~~HCBS for the intellectually disabled.

~~(35)~~(34) Home-health services limited to thirty-six (36) visits per year and standard supplies for one (1) month in a twelve (12) month period. The visits are limited to any combination of ~~Registered Nurse~~an RN and nurse aide visits, not to exceed thirty-six (36) per year.

~~(36)~~(35) Medically necessary solid organ and bone marrow/stem cell transplantation services for children and adults are covered services based upon the conditions listed in (A)-(D) of this paragraph:

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

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

~~(C) 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.~~

~~(D) Finally, procedures considered experimental or investigational are not covered.~~

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

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

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

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

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

~~(37)~~(36) HCBS for intellectually disabled members who were determined to be inappropriately placed in a ~~nursing~~long-term care facility (Alternative Disposition Plan - ADP).

~~(38)~~(37) Case management services for the chronically and/or severely mentally ill.

~~(39)~~(38) Emergency medical services including emergency labor and delivery for illegal or ineligible aliens.

~~(40)~~(39) Services delivered in Federally Qualified Health Centers (FQHCs). Payment is made on an encounter basis.

~~(41)~~(40) Early ~~Intervention~~intervention services for children ages zero (0) to three (3).

~~(42)~~(41) Residential behavior management in therapeutic foster care setting.

~~(43)~~(42) Birthing center services.

~~(44)~~(43) Case management services through the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS).

~~(45)~~(44) HCBS for aged or physically disabled members.

~~(46)~~(45) Outpatient ambulatory services for members infected with tuberculosis.

~~(47)~~(46) Smoking and tobacco use cessation counseling for children and adults.

~~(48)~~(47) Services delivered to American Indians/Alaskan Natives (AI/AN) in ~~I/T/Us~~Indian Health Services, Tribal Programs, and Urban Indian Clinics (I/T/Us). Payment is made on an encounter basis.

~~(49)~~(48) OHCA contracts with designated agents to provide disease state management for individuals diagnosed with certain chronic conditions. Disease state management treatments are based on protocols developed using evidence-based guidelines.

317:30-3-59. General program exclusions - adults

The following are excluded from SoonerCare coverage for adults:

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

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

(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) Refractions and visual aids.

(5) 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).
(6) 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.
(7) Non-therapeutic hysterectomies.
(8) 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.)~~
(9) Medical services considered experimental or investigational.
(10) Services of a ~~Certified Surgical Assistant~~certified surgical assistant.
(11) Services of a ~~Chiropractor~~chiropractor. Payment is made for ~~Chiropractor~~chiropractor services on ~~Crossover~~crossover claims for coinsurance and/or deductible only.
(12) Services of an independent licensed ~~Physical~~physical and/or ~~Occupational Therapist~~occupational therapist.
(13) Services of a ~~Psychologist~~psychologist.
(14) Services of an independent licensed ~~Speech and Hearing Therapist~~speech and hearing therapist.
(15) Payment for more than four (4) outpatient visits per month (home or office) per member, except those visits ~~in connection with family planning or~~ related to emergency medical conditions.
(16) Payment for more than two (2) ~~nursing~~long-term care facility visits per month.
(17) More than one (1) inpatient visit per day per physician.
(18) Payment for removal of benign skin lesions.
(19) 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.
(20) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.
(21) Payment for the services of social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in ~~OHCA~~the Oklahoma Health Care Authority (OHCA) rules.

(22) Mileage.
(23) A routine hospital visit on the date of discharge unless the member expired.
(24) Direct payment to perfusionist as this is considered part of the hospital reimbursement.
(25) Inpatient chemical dependency treatment.
(26) Fertility treatment.
(27) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.
~~(28) Sleep studies.~~

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 3. HOSPITALS

317:30-5-42.16. Related services

(a) **Ambulance.** Ambulance services furnished by the facility are covered separately if otherwise compensable under the ~~Authority's Medical Programs~~SoonerCare program.

(b) **Home health care.** ~~Hospital based~~Hospital-based home health providers must be Medicare certified and have a current Home Health Agency contract with the ~~OHCA~~Oklahoma Health Care Authority (OHCA). For home health services, a qualified provider must conduct and document a face-to-face encounter with the member in accordance with provisions of ~~42 CFR §440.70~~42 Code of Federal Regulations (C.F.R.) § 440.70. Refer to Oklahome Administrative Code (OAC) 317:30-5-546 and OAC 317:30-5-547 for additional policy related to coverage and reimbursement for home health care services.

~~(1) Payment is made for home health services provided in a member's residence to all categorically needy individuals.~~
~~(2) Payment is made for a maximum of 36 visits per year for eligible members 21 years of age or older. Payment for any combination of skilled and home health aide visits can not exceed 36 visits per year.~~
~~(3) Payment is made for standard medical supplies.~~
~~(4) Payment is made on a rental or purchase basis for equipment and appliances suitable for use in the home.~~
~~(5) Non-covered items include sales tax, enteral therapy and nutritional supplies, and electro-spinal orthosis systems (ESO).~~
~~(6) Payment may be made to home health agencies for prosthetic devices.~~
~~(A) Coverage of oxygen includes rental of liquid oxygen systems, gaseous oxygen systems and oxygen concentrators when prior authorized. Purchase of oxygen systems may be made where unusual circumstances exist and purchase is~~

considered most appropriate.

(B) Payment is made for permanent indwelling catheters, drain bags, insert trays and irrigation trays. Male external catheters are also covered.

(C) Sterile tracheotomy trays are covered.

(D) Payment is made for colostomy and urostomy bags and accessories.

(E) Payment is made for hyperalimentation, including supplements, supplies and equipment rental on behalf of persons having permanently inoperative internal body organ dysfunction. Information regarding the member's medical condition that necessitates the hyperalimentation and the expected length of treatment, should be attached when requesting prior authorization.

(F) Payment is made for ventilator equipment and supplies when prior authorized.

(G) Payment for medical supplies, oxygen, and equipment is made when using appropriate HCPCS codes which are included in the HCPCS Level II Coding Manual.

(c) **Hospice Services.** Hospice is defined as palliative and/or comfort care provided to the member family when a physician certifies that the member has a terminal illness and has a life expectancy of six months or less. A hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional and spiritual stresses which are experienced during the final stages of illness and death. Hospice services must be related to the palliation and management of the member's illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills.

(1) Payment is made for home based hospice services for terminally ill individuals under the age of 21 with a life expectancy of six months or less when the member and/or family has elected hospice benefits. Hospice services are available to eligible members without forgoing any other service to which the member is entitled under SoonerCare for curative treatment of the terminal illness. Once the member has elected hospice care, the hospice medical team assumes responsibility for the member's medical care for the terminal illness in the home environment. Hospice providers are not responsible for curative treatments for members that elect such services while on hospice. Hospice care includes nursing care, physician services, medical equipment and supplies, drugs for symptom control and pain relief, home health aide and personal care, physical, occupational and/or speech therapy, medical social services, dietary counseling and grief and bereavement counseling to the member and/or family.

~~(2) Hospice care is available for two initial 90-day periods and an unlimited number of subsequent 60-day periods during the remainder of the member's lifetime. Beginning January 1, 2011, a hospice physician or nurse practitioner must have a face to face encounter with the member to determine if the member's terminal illness necessitates continuing hospice care services. The encounter must take place prior to the 180th day recertification and each subsequent recertification thereafter; and attests that such visit took place. The member and/or the family may voluntarily terminate hospice services.~~

~~(3) Hospice services must be reasonable and necessary for the palliation or management of a terminal illness or related conditions. A certification that the member is terminally ill must be completed by the member's attending physician or the Medical Director of an Interdisciplinary Group. Nurse practitioners serving as the attending physician may not certify the terminal illness; however, effective January 1, 2011, nurse practitioners may re-certify the terminal illness.~~

~~(4) Services must be prior authorized. A written plan of care must be established before services are provided. The plan of care should be submitted with the prior authorization request.~~

317:30-5-42.17. Non-covered services

In addition to the general program exclusions [~~OAC~~Oklahoma Administrative Code (OAC) 317:30-5-2(a)(2)] the following are excluded from coverage:

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

(2) Procedures that result in sterilization which do not meet the guidelines set forth in this Chapter~~ of rules~~.

(3) Reversal of sterilization procedures for the purposes of conception are not covered.

(4) Medical services considered experimental or investigational.

(5) Payment for removal of benign skin lesions for adults.

(6) Visual aids.

(7) Charges incurred while the member is in a skilled nursing or swing bed.

~~(8) Sleep studies for adults.~~

PART 9. LONG-TERM CARE FACILITIES

317:30-5-133.1. Routine services

(a) ~~Nursing~~Long-term care facility care includes routine items and services that must be provided directly or through appropriate arrangement by the facility when required by SoonerCare residents.

Charges for routine services may not be made to resident's personal funds or to resident family members, guardians, or other parties who have responsibility for the resident. If reimbursement is available from Medicare or another public or private insurance or benefit program, those programs are billed by the facility. In the absence of other available reimbursement, the facility must provide routine services from the funds received from the regular SoonerCare vendor payment and the SoonerCare resident's applied income, or spend down amount.

(b) The ~~OHCA~~Oklahoma Health Care Authority (OHCA) will review the listing periodically for additions or deletions, as indicated. Routine services are member specific and provided in accordance with standard medical care. Routine services include, but are not limited to:

(1) Regular room.

(2) Dietary ~~Services~~services:

(A) ~~regular~~Regular diets;

(B) ~~special~~Special diets;

(C) ~~salt~~Salt and sugar substitutes;

(D) ~~supplemental~~Supplemental feedings;

(E) ~~special~~Special dietary preparations;

(F) ~~equipment~~Equipment required for preparing and dispensing tube and oral feedings; and

(G) ~~special~~Special feeding devices (furnished or arranged for).

(3) Medically related social services to attain or maintain the highest practicable physical, mental and psycho-social well-being of each resident, nursing care, and activities programs (costs for a private duty nurse or sitter are not allowed).

(4) Personal services - personal laundry services for residents (does not include dry cleaning).

(5) Personal hygiene items (personal care items required to be provided does not include electrical appliances such as shavers and hair dryers, or individual personal batteries), to include:

(A) ~~shampoo~~Shampoo, comb, and brush;

(B) ~~bath~~Bath soap;

(C) ~~disinfecting~~Disinfeting soaps or specialized cleansing agents when indicated to treat or prevent special skin problems or to fight infection;

(D) ~~razor~~Razor and/or shaving cream;

(E) ~~nail~~Nail hygiene services; and

(F) ~~sanitary~~Sanitary napkins, douche supplies, perineal irrigation equipment, solutions, and disposable douches.

(6) Routine oral hygiene items, including:

(A) ~~toothbrushes~~Toothbrushes;

(B) ~~toothpaste~~Toothpaste;

(C) ~~dental~~Dental floss;

(D) ~~lemon~~Lemon glycerin swabs or equivalent products; and

(E) ~~denture~~Denture cleaners, denture adhesives, and containers for dental prosthetic appliances such as dentures and partial dentures.

(7) Necessary items furnished routinely as needed to all members, e.g., water pitcher, cup and tray, towels, wash cloths, hospital gowns, emesis basin, bedpan, and urinal.

(8) The facility will furnish as needed items such as alcohol, applicators, cotton balls, tongue depressors and, first aid supplies, including small bandages, ointments and preparations for minor cuts and abrasions, and enema supplies, disposable enemas, gauze, 4 x 4's ABD pads, surgical and micropore tape, telfa gauze, ace bandages, etc.

(9) Over the counter drugs (non-legend) not covered by the prescription drug program (PRN or routine). In general, ~~nursing~~long-term care facilities are not required to provide any particular brand of non-legend drugs, only those items necessary to ensure appropriate care.

(A) If the physician orders a brand specific non-legend drug with no generic equivalent, the facility must provide the drug at no cost to the member. If the physician orders a brand specific non-legend drug that has a generic equivalent, the facility may choose a generic equivalent, upon approval of the ordering physician;

(B) If the physician does not order a specific type or brand of non-legend drug, the facility may choose the type or brand;

(C) If the member, family, or other responsible party (excluding the ~~nursing~~long-term care facility) prefers a specific type or brand of non-legend drug rather than the ones furnished by the facility, the member, family or responsible party may be charged the difference between the cost of the brand the resident requests and the cost of the brand generally provided by the facility. (Facilities are not required to provide an unlimited variety of brands of these items and services. It is the required assessment of resident needs, not resident preferences, that will dictate the variety of products facilities need to provide);

(D) Before purchasing or charging for the preferred items, the facility must secure written authorization from the member, family member, or responsible party indicating his or her desired preference, as well as the date and signature of the person requesting the preferred item. The signature may not be that of an employee of the facility. The authorization is valid until rescinded by the maker of the

instrument.
(10) The facility will furnish or obtain any necessary equipment to meet the needs of the member upon physician order. Examples include: trapeze bars and overhead frames, foot and arm boards, bed rails, cradles, wheelchairs and/or geriatric chairs, foot stools, adjustable crutches, canes, walkers, bedside commode chairs, hot water bottles or heating pads, ice bags, sand bags, traction equipment, IV stands, etc.
(11) Physician prescribed lotions, ointments, powders, medications and special dressings for the prevention and treatment of decubitus ulcers, skin tears and related conditions, when medications are not covered under the Vendor Drug Program or other third party payer.
(12) Supplies required for dispensing medications, including needles, syringes including insulin syringes, tubing for IVs, paper cups, medicine containers, etc.
(13) Equipment and supplies required for simple tests and examinations, including scales, sphygmomanometers, stethoscopes, clinitest, acetest, dextrostix, pulse oximeters, blood glucose meters and test strips, etc.
(14) Underpads and diapers, waterproof sheeting and pants, etc., as required for incontinence or other care.
(A) If the assessment and care planning process determines that it is medically necessary for the resident to use diapers as part of a plan to achieve proper management of incontinence, and if the resident has a current physician order for adult diapers, then the facility must provide the diapers without charge;
(B) If the resident or the family requests the use of disposable diapers and they are not prescribed or consistent with the facility's methods for incontinent care, the resident/family would be responsible for the expense.
(15) ~~Oxygen for emergency use, or intermittent use as prescribed by the physician for medical necessity~~Members in long-term care facilities requiring oxygen will be serviced by oxygen kept on hand by the long-term care facility as part of the per diem rate.
(16) Other physician ordered equipment to adequately care for the member and in accordance with standard patient care~~, including infusion pumps and supplies, and nebulizers and supplies, etc~~.
(17) Dentures and ~~Related Services~~and related services. Payment for the cost of dentures and related services is included in the daily rate for routine services. The projected schedule for routine denture services must be documented on the Admission Plan of Care and on the Annual Plan of Care. The medical records

must also contain documentation of steps taken to obtain the services. When the provision of denture services is medically appropriate, the ~~nursing~~long-term care facility must make timely arrangements for the provision of these services by licensed dentists. In the event denture services are not medically appropriate, the treatment plan must reflect the reason the services are not considered appropriate, e.g., the member is unable to ingest solid nutrition or is comatose, etc. When the need for dentures is identified, one set of complete dentures or partial dentures and one dental examination is considered medically appropriate every three years. One rebase and/or one reline is considered appropriate every three years. It is the responsibility of the ~~nursing~~long-term care facility to ensure that the member has adequate assistance in the proper care, maintenance, identification and replacement of these items. The ~~nursing~~long-term care facility cannot set up payment limits which result in barriers to obtaining denture services. However, the ~~nursing~~long-term care facility may restrict the providers of denture services to providers who have entered into payment arrangements with the facility. The facility may also choose to purchase a private insurance dental coverage product for each SoonerCare member. At a minimum, the policy must cover all denture services included in routine services. The member cannot be expected to pay any co-payments and/or deductibles. If a difference of opinion occurs between the ~~nursing~~long-term care facility, member, and/or family regarding the provision of dentures services, the OHCA will be the final authority. All members and/or families must be informed of their right to appeal at the time of admission and yearly thereafter. The member cannot be denied admission to a facility because of the need for denture services.

(18) Vision ~~Services~~services. Routine eye examinations for the purpose of medical screening or prescribing or changing glasses and the cost of glasses are included in the daily rate for routine services. This does not include follow-up or treatment of known eye disease such as diabetic retinopathy, glaucoma, conjunctivitis, corneal ulcers, iritis, etc. Treatment of known eye disease is a benefit of the member's medical plan. The projected schedule for routine vision care must be documented on the Admission Plan of Care and on the Annual Plan of Care. The medical record must contain documentation of the steps that have been taken to access the service. When vision services are not appropriate, documentation of why vision services are not medically appropriate must be included in the treatment plan. For example, the member is comatose, unresponsive, blind, etc. Nursing Home providers may contract with individual eye care

providers, providers groups or a vision plan to provide routine vision services to their members. The member cannot be expected to pay any co-payments and/or deductibles.

(A) The following minimum level of services must be included:

(i) Individuals ~~21~~twenty-one (21) to ~~40~~forty (40) years of age are eligible for one (1) routine eye examination and one (1) pair of glasses every ~~36~~thirty-six (36) months (three (3) years).

(ii) Individuals ~~41~~forty-one (41) to ~~64~~sixty-four (64) years of age are eligible for one (1) routine eye examination and one (1) pair of glasses every ~~24~~twenty-four (24) months (~~2~~two (2) years).

(iii) Individuals ~~65~~sixty-five (65) years of age or older are eligible for one (1) routine eye examination and one (1) pair of glasses every ~~12~~twelve (12) months (yearly).

(B) It is the responsibility of the ~~nursing~~long-term care facility to ensure that the member has adequate assistance in the proper care, maintenance, identification and replacement of these items. When vision services have been identified as a needed service, ~~nursing~~long-term care facility staff will make timely arrangements for provision of these services by licensed ophthalmologists or optometrists. If a difference of opinion occurs between the ~~nursing~~long-term care facility, member, and/or family regarding the provision of vision services, the OHCA will be the final authority. All members and/or families must be informed of their right to appeal at admission and yearly thereafter. The member cannot be denied admission to the facility because of the need for vision services.

(19) An attendant to accompany SoonerCare eligible members during SoonerRide ~~Non-Emergency Transportation~~non-emergency transportation (NET). Please refer to ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-5-326 through OAC 317:30-5-327.9 for SoonerRide rules regarding members residing in a ~~nursing~~long-term care facility~~. And~~; and

(20) Influenza and pneumococcal vaccinations.

317:30-5-133.2. Ancillary services [REVOKED]

~~(a) Ancillary services are those items which are not considered routine services. Ancillary services may be billed separately to the SoonerCare program, unless reimbursement is available from Medicare or other insurance or benefit programs. Coverage criteria, utilization controls and program limitations are specified in Part 17 of OAC 317:30-5. Ancillary services are limited to the following services:~~

~~(1) Services requiring prior authorization:~~

~~(A) External breast prosthesis and support accessories.~~
~~(B) Ventilators and supplies.~~
~~(C) Total Parenteral Nutrition (TPN), and supplies.~~
~~(D) Custom seating for wheelchairs.~~
~~(2) Services not requiring prior authorization:~~
~~(A) Permanent indwelling or male external catheters and catheter accessories.~~
~~(B) Colostomy and urostomy supplies.~~
~~(C) Tracheostomy supplies.~~
~~(D) Catheters and catheter accessories.~~
~~(E) Oxygen and oxygen concentrators.~~
~~(i) PRN Oxygen. Members in nursing facilities requiring oxygen PRN will be serviced by oxygen kept on hand as part of the per diem rate.~~
~~(ii) Billing for Medicare eligible members. Oxygen supplied to Medicare eligible nursing home members may be billed directly to OHCA. It is not necessary to obtain a denial from Medicare prior to filing the claim with OHCA.~~
~~(b) Items not considered ancillary, but considered routine and covered as part of the routine rate include but are not limited to:~~
~~(1) Diapers.~~
~~(2) Underpads.~~
~~(3) Medicine cups.~~
~~(4) Eating utensils.~~
~~(5) Personal comfort items.~~

PART 17. MEDICAL SUPPLIERS

317:30-5-210. Eligible providers

All eligible medical suppliers must have a current contract with the Oklahoma Health Care Authority (OHCA). The supplier must comply with all applicable ~~State and Federal~~state and federal laws. Effective January 1, 2011, all suppliers of ~~durable~~ medical ~~equipment, prosthetics, orthotics and~~ supplies, equipment, and appliances ~~(DMEPOS)~~ must be accredited by a Medicare deemed accreditation organization for quality standards for ~~DMEPOS~~durable medical equipment (DME) suppliers in order to bill the SoonerCare program. For coverage of orthotics and prosthetics, refer to Oklahoma Administrative Code (OAC) 317:30-5-211.13. OHCA may make exceptions to this standard based on the exemptions provided by the Centers for Medicare and Medicaid Services (CMS) for Medicare accreditation, if the provider is a government-owned entity, or at a provider's request and at the discretion of OHCA based on access issues and/or agency needs for SoonerCare members. Additionally,

unless an exception is granted from the OHCA, all ~~DMEPOS~~DME providers must meet the following criteria:

(1) ~~DMEPOS~~DME providers are required to have a physical location in the State of Oklahoma, or within a designated range of the Oklahoma State border, as determined by the OHCA. The OHCA may make exceptions to this requirement if a ~~DMEPOS~~DME provider provides a specialty item, product, or service, which is not otherwise available to SoonerCare members within the State of Oklahoma. Provider contracts for out-of-state ~~DMEPOS~~DME providers will be reviewed on a case-by-case basis for specialty items only. The OHCA has discretion and the final authority to approve or deny any provider contract.

(2) ~~DMEPOS~~DME providers are required to comply with Medicare ~~DMEPOS~~DME Supplier Standards for ~~DMEPOS~~medical supplies, equipment, and appliances provided to SoonerCare members, except the requirement to meet surety bond requirements, as specified in 42 C.F.R. 424.57(c).

(3) Complex ~~Rehabilitation Technology~~rehabilitation technology (CRT) suppliers are considered ~~DMEPOS~~DME providers. Only CRT suppliers may bill CRT procedure codes. A CRT supplier means a company or entity that:

(A) Is accredited by a recognized accrediting organization as a supplier of CRT;

(B) Is an enrolled Medicare supplier and meets the supplier and quality standards established for DME suppliers, including those for CRT, under the Medicare program;

(C) Employs as a W-2 employee at least one qualified CRT professional, also known as assistive technology professional, for each location to:

(i) Analyze the needs and capacities of complex-needs patients in consultation with qualified health care professionals;

(ii) Participate in selecting appropriate CRT items for such needs and capacities; and

(iii) Provide the complex-needs patient technology related training in the proper use and maintenance of the CRT items.

(D) Requires a qualified CRT professional be physically present for the evaluation and determination of the appropriate CRT;

(E) Has the capability to provide service and repair by qualified technicians for all CRT items it sells; and

(F) Provides written information to the complex-needs patient prior to ordering CRT as to how to access service and repair.

317:30-5-210.1. Coverage for adults

Coverage of ~~durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS)~~medical supplies, equipment, and appliances for adults ~~is specified in~~complies with 42 Code of Federal Regulations (C.F.R.) § 440.70 and is specified in ~~OAC~~ Oklahoma Administrative Code (OAC) 317:30-5-211.1 through OAC ~~317:30-5-211.18~~317:30-5-211.19. Orthotics and prosthetics are not a covered service for adults with the exception of breast prosthetics and support acessories (Refer to OAC 317:30-5-211.13).

317:30-5-210.2. Coverage for children

(a) **Coverage.** ~~Coverage of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS)~~Medical supplies, equipment, and appliances are covered for children.~~ includes the specified coverage for adults found in OAC 317:30-5-210.2 through OAC 317:30-5-211.18. In addition the following are covered items for children only:~~

~~(1) Orthotics and prosthetics.~~

~~(2) Enteral nutrition is considered medically necessary for certain conditions in which, without the products, the member's condition would deteriorate to the point of severe malnutrition.~~

~~(A) Enteral nutrition must be prior authorized. PA requests must include:~~

~~(i) the member's diagnosis;~~

~~(ii) the impairment that prevents adequate nutrition by conventional means;~~

~~(iii) the member's weight history before initiating enteral nutrition that demonstrates oral intake without enteral nutrition is inadequate;~~

~~(iv) the percentage of the member's average daily nutrition taken by mouth and by tube; and~~

~~(v) prescribed daily caloric intake.~~

~~(B) Enteral nutrition products that are administered orally and related supplies are not covered.~~

~~(3) Continuous positive airway pressure devices (CPAP).~~

In addition, orthotics and prosthetics are covered items for children only, except as specified in OAC 317:30-5-211.3.

(b) **EPSDT.** ~~Services deemed medically necessary and allowable under federal regulations may be covered by the EPSDT Child Health program even though those services may not be part of the SoonerCare program. These services must be prior authorized.~~Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, supplies, or equipment that are determined to be medically necessary for a child, and which are included within the categories of mandatory and optional services in Section 1905(a) of Title

XIX, are covered regardless of whether such services, supplies, or equipment are listed as covered in Oklahoma's State Plan.

(c) **Medical necessity.** Federal regulations require ~~OHCA~~the Oklahoma Health Care Authority (OHCA) 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 that are considered experimental.

317:30-5-211.1. Definitions

The following words and terms, when used in this Part, have the following meaning, unless the context clearly indicates otherwise.

"Activities of daily living-basic" means a series of activities performed on a day-to-day basis that are necessary to care for oneself (e.g., personal hygiene, dressing, eating, maintaining continence and transferring).

"Activities of daily living-instrumental" means activities that are not necessarily required on a daily basis, but are important to being able to live independently (e.g., basic communication skills, transportation, meal preparation, shopping, housework, managing medication and managing personal finances).

~~**"Adaptive equipment"** means devices, aids, controls, appliances or supplies of either a communication or adaptive type, determined necessary to enable the person to increase his or her ability to function in a home and community based setting or private Intermediate Care Facilities for Individuals with Intellectual Disabilities (IFC/IID) with independence and safety~~.

~~**"Basic activities of daily living"** means a series of activities performed on a day-to-day basis that are necessary to care for oneself (e.g., personal hygiene, dressing, eating, maintaining continence and transferring).~~

"Capped rental" means monthly payments for the use of the ~~Durable Medical Equipment (DME)~~medical supplies, equipment, and appliances for a limited period of time not to exceed ~~13~~thirteen (13) months. Items are considered purchased and owned by the Oklahoma Health Care Authority (OHCA) after ~~13~~thirteen (13) months of continuous rental.

"Certificate of medical necessity (CMN)" means a certificate which is required to help document the medical necessity and other coverage criteria for selected items. Those items are defined in this Chapter. The ~~physician's certification~~CMN must include the member's diagnosis, the reason the equipment is required, and the physician's, non-physician provider's (NPP's), or dentist's estimate, in months, of the duration of its need.

"Complex-needs patient" means an individual with a diagnosis or medical condition that results in significant physical or functional needs and capacities.

"Complex rehabilitation technology" means medically necessary durable medical equipment and items that are individually configured to meet specific and unique medical, physical, and functional needs and capacities for basic activities of daily living and instrumental activities of daily living of a complex needs patient. Such equipment and items include, but are not limited to, individually configured power wheelchairs and accessories, individually configured manual wheelchairs and accessories, adaptive seating and positioning systems and accessories, and other specialized equipment such as standing frames and gait trainers.

"Customized ~~DME~~equipment and/or appliances" means items of ~~DME~~equipment and/or appliances which have been uniquely constructed or substantially modified for a specific member according to the description and orders of the member's treating physician or other qualified medical professional. For instance, a wheelchair would be considered "customized" if it has been:

(A) measured, fitted, or adapted in consideration of the the member's body size, disability, period of need, or intended use;

(B) assembled by a supplier or ordered from a manufacturer who makes available customized features, modifications, or components for wheelchairs; and

(C) intended for an individual member's use in accordance with instructions from the member's physician.

"~~Durable medical equipment (DME)~~Equipment and/or appliances" means ~~equipment that can withstand repeated use (e.g. a type of item that could normally be rented), is used to serve a medical purpose, is not useful to a person in the absence of an illness or injury, and is used in the most appropriate setting, including the home or workplace~~items that are primarily and customarily used to serve a medical purpose, generally are not useful to an individual in the absence of a disability, illness or injury, can withstand repeated use, can be reusable or removable, and are suitable for use in any setting in which normal life activities take place other than a hospital, long-term care facility, intermediate care facility for individuals with intellectual disabilities, or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board. Refer to 42 Code of Federal Regulations (C.F.R.) 440.70(b).

"Face-to-face encounter" means a patient visit in which a practitioner, as defined by 42 C.F.R. 440.70(f), completes a face-to-face assessment related to the primary reason the beneficiary requires durable medical equipment. The face-to-face encounter must occur no more than six (6) months prior to the start of services. The ordering physician must document the face-to-face

encounter, including the practitioner who conducted the encounter and the date of the encounter. Clinical findings must be incorporated into a written or electronic document included in the beneficiary's medical record. The face-to-face encounter may occur through telehealth.

~~**"Instrumental activities of daily living"** means activities that are not necessarily required on a daily basis, but are important to being able to live independently (e.g., basic communication skills, transportation, meal preparation, shopping, housework, managing medication and managing personal finances).~~

"Invoice" means a document that provides the following information when applicable: the description of product, quantity, quantity in box, purchase price, NDC, strength, dosage, provider, seller's name and address, purchaser's name and address, and date of purchase. At times, visit notes will be required to determine how much of the supply was expended. When possible, the provider should identify the SoonerCare member receiving the equipment or supply on the invoice.

"Medical supplies" means ~~an article used in the cure, mitigation, treatment, prevention, or diagnosis of illnesses. Disposable medical supplies are medical supplies consumed in a single usage and do not include skin care creams or cleansers~~health care related items that are consumable or disposable, or cannot withstand repeated use by more than one individual, that are required to address an individual medical disability, illness, or injury. Medical supplies do not include skin care creams, cleansers, surgical supplies, or medical or surgical equipment.

"OHCA CMN" means a certificate required to help document the medical necessity and other coverage criteria for selected items. Those items are defined in this ~~chapter~~Chapter. The ~~physician's certification~~CMN must include the member's diagnosis, the reason equipment is required, and the physician's, NPP's, or dentist's estimate, in months, of the duration of its need. This certificate is used when the OHCA requires a CMN and one has not been established by CMS.

"Orthotics" means ~~an item used for the correction or prevention of skeletal deformities~~a device used to support, align, prevent or correct deformities, protect a body function, improve the function of movable body parts or to assist a dysfunctional joint.

~~**"Prosthetic devices"**~~**"Prosthetics"** means ~~a replacement, corrective, or supportive device (including repair and replacement parts of the same) worn on or in the body to artificially replace a missing portion of the body, prevent or correct physical deformity or malfunction, or support a weak or deformed portion of the body~~an artificial substitute which replaces all or part of a

body organ or replaces all or part of the function of a permanently inoperative, absent, or malfunctioning body part.

"Provider" refers to the treating provider and must be a physician (Medical Doctor (MD), or Doctor of Osteopathy, (DO)), a NPP (Physician Assistant (PA), or Advanced Practice Registered Nurse (APRN)), or a dentist (Doctor of Dental Surgery (DDS), or Doctor of Medicine in Dentistry (DMD)).

~~**"Qualified complex rehabilitation technology professional"** means an individual who is certified as an Assistive Technology Professional (ATP) by the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA).~~

317:30-5-211.2. Medical necessity

(a) **Coverage.** Coverage is subject to the requirement that the equipment be necessary and reasonable for the treatment of an illness or injury, or to improve the functioning of a malformed body member, in accordance with state and federal Medicaid law, including, but not limited to, Oklahoma Administrative Code (OAC) 317:30-3-1(f). The member's diagnosis must warrant the type of equipment or supply being purchased or rented. Items that are used for the following are not a benefit to a member of any age:

(1) Routine personal hygiene;

(2) Education;

(3) Exercise;

(4) Convenience, safety, or restraint of the member, or his or her family or caregiver;

(5) Participation in sports; and/or

(6) Cosmetic purposes.

(b) **Ordering requirements.** All medical supplies, equipment, and appliances as defined by 42 Code of Federal Regulations (C.F.R.) § 440.70 (b)(3) and OAC 317:30-5-211.1, nursing services, and home health aide services provided by a home health agency, must be ordered by a physician as part of a written plan of care.

(1) The plan of care must be reviewed in accordance with 42 C.F.R. § 440.70. Medical supplies, equipment, and appliances must be reviewed annually by the ordering physician. Nursing services and home health aide services provided by a home health agency must be reviewed every sixty (60) days by the ordering physician.

(2) A face-to-face encounter must occur and be documented, in accordance with 42 C.F.R. § 440.70 and OAC 317:30-5-211.1.

~~(b)~~(c) **Prescription requirements.** All ~~DME~~prosthetics and orthotics, as those terms are defined by 42 C.F.R. § 440.120 and OAC 317:30-5-211.1, except for hearing aid batteries and equipment repairs with a cost per item of less than ~~$250.00~~$1,000.00 total parts and labor ~~and hearing aid batteries~~, require a prescription

signed by a physician, a physician assistant, or an advanced practice nurse. Except as otherwise stated in state or federal law, the prescription must be in writing, or given orally and later reduced to writing by the provider filling the order. Prescriptions are valid for no more than one (1) year from the date written. The prescription must include the following information:

~~(1) date of the order;~~
~~(2) name and address of the prescriber;~~
~~(3) name and address of the member;~~
~~(4) name or description and quantity of the prescribed item;~~
~~(5) diagnosis for the item requested;~~
~~(6) directions for use of the prescribed item; and~~
~~(7) prescriber's signature.~~

(1) The member's name;
(2) The prescribing practitioner's name;
(3) The date of the prescription;
(4) All items, options, or additional features that are separately billed. The description can be either a narrative description (e.g. lightweight wheelchair base), a Healthcare Common Procedure Coding System (HCPCS) code, a HCPCS code narrative, or a brand name/model number; and
(5) The prescribing practitioner's signature and signature date.

~~(c)~~(d) **Certificate of medical necessity (CMN).** For certain items or services, the supplier must receive a signed CMN/OHCA CMN from the treating physician, non-physician practitioner, or dentist. The supplier must have a signed CMN/OHCA CMN in their records before they submit a claim for payment. The CMN/OHCA CMN may be ~~faxed, copied~~ faxed copy, electronic copy, or the original hardcopy.

~~(d)~~(e) **Place of service.**

(1) ~~OHCA~~The Oklahoma Health Care Authority (OHCA) covers ~~DMEPOS~~medical supplies, equipment, and appliances for use in the member's place of residence ~~except if the member's place of residence is a nursing facility~~and in any setting in which normal life activities take place except for a hospital, long-term care facility, intermediate care facility for individuals with intellectual disabilities, or any other setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

(2) For members residing in a hospital, ~~nursing~~long-term care facility, intermediate care facility for individuals with intellectual disabilities, or any other setting in which payment is or could be made under Medicaid for inpatient services that include room and board, ~~most~~ medical supplies,

equipment, and appliances ~~and/or DME~~ are considered part of the facility's per diem rate. ~~Refer to coverage for nursing facility residents at OAC 317:30-5-211.16.~~

(f) **Contracting requirements.** Per 42 C.F.R. 455.410(b), medical supplies, equipment, and appliances may only be ordered or prescribed by a SoonerCare contracted provider.

317:30-5-211.3. Prior authorization (PA)

(a) **General.** Prior authorization is the electronic or written authorization issued by ~~OHCA~~ the Oklahoma Health Care Authority (OHCA) to a provider prior to the provision of a service. Providers should obtain a PA before providing services.

(b) **Requirements.** Billing must follow correct coding guidelines as promulgated by CMS or per uniquely and publicly promulgated OHCA guidelines. ~~DME~~Medical supplies, equipment, and appliances claims must include the most appropriate ~~HCPCS~~Healthcare Common Procedure Coding System (HCPCS) code as assigned by the Medicare Pricing, Data, Analysis, and Coding (PDAC) or its successor. Authorizations for services not properly coded will be denied. **The following services require prior authorization (PA):**

(1) services that exceed quantity/frequency limits;

(2) medical need for an item that is beyond OHCA's standards of coverage;

(3) use of a Not Otherwise Classified (NOC) code or miscellaneous codes;

(4) services for which a less costly alternative may exist; and

(5) procedures indicating that a PA is required on the OHCA fee schedule.

(c) **Prior authorization (PA) requests.** ~~Refer to OAC 317:30-5-216.~~

(1) **PA requirements.** Requirements vary for different types of services. Providers should refer to the service-specific sections of policy or the OHCA website for services requiring a PA. Also refer to OAC 317:30-3-31.

(A) **Required forms.** All required forms are available on the OHCA website.

(B) **Certificate of medical necessity (CMN).** The prescribing physician, non-physician practitioner (NPP), or dentist must complete the medical necessity section of the CMN. This section cannot be completed by the supplier. The medical necessity section can be completed by any health care clinician; however, only the member's physician, NPP, or dentist may sign the CMN. By signing the CMN, the physician, NPP, or dentist is validating the completeness and accuracy of the medical necessity section. The member's medical records must contain documentation substantiating that the member's condition meets the coverage criteria and the

answers given in the medical necessity section of the CMN. These records may be requested by OHCA or its representatives to confirm concurrence between the medical records and the information submitted with the PA request.

(2) **Submitting PA requests.** Contact information for submitting PA requests may be found in the OHCA Provider Billing and Procedures Manual. An electronic version of this manual is located on the OHCA website.

(3) **PA review.** Upon verifying the completeness and accuracy of clerical items, the PA request is reviewed by OHCA staff to evaluate whether or not each service being requested meets SoonerCare's definition of "medical necessity" [see OAC 317:30-3-1 (f)] as well as other criteria.

(4) **PA decisions.** After the PA request is processed, a notice will be issued regarding the outcome of the review.

(5) **PA does not guarantee reimbursement.** Provider status, member eligibility, and medical status on the date of service, as well as all other SoonerCare requirements, must be met before the claim is reimbursed.

(6) **PA of manually-priced items.** Manually-priced items must be prior authorized. For reimbursement of manually priced items, see OAC 317:30-5-218.

317:30-5-211.5. Repairs, maintenance, replacement and delivery

(a) **Repairs.** Repairs to equipment that either the Oklahoma Health Care Authority or a member owns are covered when they are necessary to make the equipment usable. The repair charge includes the use of "loaner" equipment as required. If the expense for repairs exceeds the estimated expense of purchasing or renting another item of equipment for the remaining period of medical need, payment cannot be made for the amount in excess. Repairs of rented equipment are not covered.

(b) **Maintenance.** Routine periodic servicing, such as testing, cleaning, regulating, and checking the member's equipment is considered maintenance and not a separate covered service. ~~DMEPOS~~DME suppliers must provide equipment-related services consistent with the manufacturer's specifications and in accordance with all federal, state, and local laws and regulations. Equipment-related services may include, but are not limited to, checking oxygen system purity levels and flow rates, changing and cleaning filters, and assuring the integrity of equipment alarms and back-up systems. However, more extensive maintenance, as recommended by the manufacturer and performed by authorized technicians, is considered repairs. This may include breaking down sealed components and performing tests that require specialized testing equipment not available to the member. The supplier of a

capped rental item that supplied the item the ~~13th~~thirteenth (13th) month must provide maintenance and service for the item. In very rare circumstances of malicious damage, culpable neglect, or wrongful disposition, the supplier may document the circumstances and be relieved of the obligation to provide maintenance and service.

(c) **Replacement.**

(1) ~~If a capped rental item of equipment has been in continuous use~~If equipment that has met the capped rental period and has been in continued use by the member for the equipment's useful life or if the item is irreparably damaged, lost, or stolen, a prior authorization must be submitted to obtain new equipment. The reasonable useful lifetime for capped rental equipment cannot be less than five (5) years. Useful life is determined by the delivery of the equipment to the member, not the age of the equipment.

(2) Replacement parts must be billed with the appropriate ~~HCPCS~~Healthcare Common Procedure Coding System (HCPCS) code that represents the item or part being replaced along with a pricing modifier and replacement modifier. If a part that has not been assigned a HCPCS code is being replaced, the provider should use a miscellaneous HCPCS code to bill each part. Each claim that contains miscellaneous codes for replacement parts must include a narrative description of the item, the brand name, model name/number of the item, and an invoice.

(d) **Delivery.** ~~DMEPOS~~Medical supplies, equipment, and appliance products are set with usual maximum quantities and frequency limits. Suppliers are not expected to provide these amounts routinely, nor are members required to accept ~~DMEPOS~~medical supplies, equipment, and appliance products at frequencies or in quantities that exceed the amount the member would typically use. Suppliers must not dispense a quantity of any ~~DMEPOS~~medical supplies, equipment, and appliance product exceeding a member's expected utilization. The reordering or refilling of ~~DMEPOS~~medical supplies, equipment, and appliance products should always be based on actual member usage. Suppliers should stay attuned to atypical utilization patterns on behalf of their members and verify with the ordering physician that the atypical utilization is warranted. Suppliers must exercise the following guidelines in regard to the delivery of ~~DMEPOS~~medical supplies, equipment, and appliance products:

(1) For ~~DMEPOS~~medical supplies, equipment, and appliance products that are supplied as refills to the original order, suppliers must contact the member prior to dispensing the refill. This shall be done to ensure that the refilled item is necessary and to confirm any changes/modifications to the

order. Contact with the member regarding refills should take place no sooner than ~~7~~seven (7) days prior to the delivery/shipping date. For subsequent deliveries of refills, the supplier must deliver the ~~DMEPOS~~medical supplies, equipment, and appliance product no sooner than ~~5~~five (5) days prior to the end of the usage for the current product. This is regardless of which delivery method is utilized. A member must specifically request the refill before a supplier dispenses the product. Suppliers must not automatically dispense a quantity of supplies on a predetermined basis, even if the member has authorized this in advance. The supplier must have member contact documentation on file to substantiate that the ~~DMEPOS~~medical supplies, equipment, and appliance product was refilled in accordance with this section.

(2) For ~~DMEPOS~~medical supplies, equipment, and appliance products that are supplied via mail order, suppliers must bill using the appropriate modifier which indicates that the ~~DMEPOS~~medical supplies, equipment, and appliance product was delivered via the mail. Reimbursement for ~~DMEPOS~~medical supplies, equipment, and appliance products supplied and delivered via mail may be at a reduced rate.

(3) For ~~DMEPOS~~medical supplies, equipment, and appliance products that are covered in the scope of the SoonerCare program, the cost of delivery is always included in the rate for the covered item(s).

317:30-5-211.6. General documentation requirements

(a) Section 1833(e) of the Social Security Act precludes payment to any provider of service unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider" ~~[42 U.S.S. Section 13951(e)]~~[42 United States Code (U.S.C. Section 1395l(e)]. The member's medical records will reflect the need for the care provided. The member's medical records should include the physician's office records, hospital records, nursing home records, home health agency records, records from other health care professionals and test reports. This documentation must be provided for prior authorization requests and available to the ~~OHCA~~Oklahoma Health Care Authority or its designated agent upon request.

(b) Payment is made for Durable Medical Equipment as set forth in this section when a face-to-face encounter has occurred in accordance with provisions of 42 CFR 440.70 and Oklahoma Administrative Code 317:30-5-211.1.

317:30-5-211.9. Adaptive equipment [REVOKED]

~~(a) **Residents of ICF/IID facilities.** Payment is made for customized adaptive equipment for persons residing in private Intermediate~~

~~Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). This means customized equipment or devices to assist in ambulation. Standard wheelchairs, walkers, eyeglasses, etc., would not be considered customized adaptive equipment. All customized adaptive equipment must be prescribed by a physician and requires prior authorization.~~

~~(b) **Members in home and community-based waivers.** Refer to OAC 317:40-5-100.~~

317:30-5-211.10. ~~Durable medical equipment (DME)~~Medical supplies, equipment, and appliances

(a) **~~DME~~Medical supplies, equipment, and appliances**. ~~DME includes, but is not limited to: medical supplies, orthotics and prosthetics, custom braces, therapeutic lenses, respiratory equipment, and other qualifying items when acquired from a contracted DME provider.~~ See the definition for medical supplies, equipment, and appliances at Oklahoma Administrative Code 317:30-5-211.1.

(b) **Certificate of medical necessity (CMN)**. Certain items of ~~DME~~medical supplies, equipment, and appliances require a CMN/OHCA CMN which should be submitted with the request for prior authorization. These items ~~(with form numbers)~~ include, but are not limited to:

~~(1) hospital beds;~~
~~(2) support surfaces;~~
~~(3) patient lift devices;~~
~~(4) external infusions pumps;~~
~~(5) enteral and parenteral nutrition;~~
~~(6) Oxygen and oxygen related products; and~~
~~(7) pneumatic compression devices.~~
(1) External infusion pumps;
(2) Hospital beds;
(3) Oxygen and oxygen related products;
(4) Pneumatic compression devices;
(5) Support surfaces;
(6) Enteral and parenteral nutrition; and
(7) Osteogenesis stimulator.

(c) **~~Prior authorization~~Rental**. Several medical supplies, equipment, and appliance products are classified as either a capped rental or a continuous rental. Payment for a capped rental is capped at thirteen (13) months and a continuous rental is paid monthly for as long as it is medically necessary. Both require documentation showing that the product is medically necessary.

~~(1) **Rental.** Rental of hospital beds, support surfaces, oxygen and oxygen related products, continuous positive airway pressure devices (CPAP and BiPAP), pneumatic compression devices, and lifts require prior authorization and, except for CPAP and BiPAP devices, a completed CMN/OHCA CMN; medical~~

~~necessity must be documented in the member's medical record, signed by the physician, and attached to the PA.~~

~~(2) **Purchase.** Equipment may be purchased when a member requires the equipment for an extended period of time. During the prior authorization review, the OHCA may change the authorization from a rental to a purchase or a purchase to a rental based on the documentation submitted. The provider must indicate whether the DME item provided is new or used.~~

(d) **Purchase.** Medical supplies, equipment, and appliances may be purchased when a member requires the product for an extended period of time. During the prior authorization review, the Oklahoma Health Care Authority (OHCA) may change the authorization from a rental to a purchase or a purchase to a rental based on the documentation submitted.

~~(d)~~(e) **Backup equipment.** Backup equipment is considered part of the rental cost and is not a covered service without prior authorization.

~~(e)~~(f) **Home modification.** ~~Equipment used for home modification is not a covered service~~Home modifications that require permanent installation are not covered services as they are not removable and therefore do not meet the definition of ~~DME~~medical supplies, equipment, and appliances per 42 CFR 440.70.Refer to Title 317, Chapters 40 and 50 for home modifications covered under ADvantage Waiver and Home and Community Based Services Waivers.

317:30-5-211.12. Oxygen rental

A monthly rental payment is made for rental of liquid oxygen systems, gaseous oxygen systems and oxygen concentrators. The rental payment for a stationary system includes all contents and supplies, such as, regulators, tubing, masks, etc., that are medically necessary. An additional monthly payment may be made for a portable liquid or gaseous oxygen system based on medical necessity.

(1) Stationary oxygen systems and portable oxygen systems are covered items for members residing in their home ~~or in a nursing facility~~and in any setting in which normal life activities take place except for a hospital, long-term care facility, intermediate care facility for individuals with intellectual disabilities, or any other setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

(2) For members who meet medical necessity criteria, SoonerCare covers portable liquid or gaseous oxygen systems. ~~Portable oxygen contents are not covered for adults.~~Payment for both oxygen contents used with stationary oxygen equipment and oxygen contents used with portable oxygen equipment is included in the monthly payments for oxygen and oxygen equipment. The

need for a portable oxygen system must be stated on the CMN. A portable system that is used as a backup system only is not a covered item.

(3) When four or more liters of oxygen are medically necessary, an additional payment will be paid up to ~~150%~~one hundred and fifty percent (150%) of the allowable for a stationary system when billed with the appropriate modifier.

317:30-5-211.13. ~~Prosthetics and orthotics~~Orthotics and prosthetics

(a) Orthotics and prosthetics are classified as an optional benefit by the Center for Medicare and Medicaid Services (CMS) and are administered as per 42 CFR §440.120. Refer to Oklahoma Administrative Code (OAC) 317:30-5-211.1 for definitions of orthotics and prosthetics.

~~(b) Coverage of prosthetics for adults is limited to (1) home dialysis equipment and supplies, (2) nerve stimulators, (3) external breast prosthesis and support accessories, and (4) implantable devices inserted during the course of a surgical procedure. Prosthetics prescribed by an appropriate medical provider and as specified in this section are covered items for adults. There is no coverage of orthotics for adults.~~

~~(1) **Home dialysis.** Equipment and supplies are covered items for members receiving home dialysis treatments only.~~

~~(2) **Nerve stimulators.** Payment is made for transcutaneous nerve stimulators, implanted peripheral nerve stimulators, and neuromuscular stimulators.~~

~~(3) **Breast prosthesis, bras, and prosthetic garments.**~~

~~(A) Payment is limited to:~~

~~(i) one prosthetic garment with mastectomy form every 12 months for use in the postoperative period prior to a permanent breast prosthesis or as an alternative to a mastectomy bra and breast prosthesis;~~

~~(ii) two mastectomy bras per year; and~~

~~(iii) one silicone or equal breast prosthetic per side every 24 months; or~~

~~(iv) one foam prosthetic per side every six months.~~

~~(B) Payment will not be made for both a silicone and a foam prosthetic in the same 12 month period.~~

~~(C) Breast prostheses, bras, and prosthetic garments must be purchased from a Board Certified Mastectomy Fitter.~~

~~(D) A breast prosthesis can be replaced if:~~

~~(i) lost;~~

~~(ii) irreparably damaged (other than ordinary wear and tear); or~~

~~(iii) the member's medical condition necessitates a different type of item and the physician provides a new~~

~~prescription explaining the need for a different type of prosthesis.~~

~~(E) External breast prostheses are not covered after breast reconstruction is performed except in instances where a woman with breast cancer receives reconstructive surgery following a mastectomy, but the breast implant fails or ruptures and circumstances are such that an implant replacement is not recommended by the surgeon and/or desired by the member.~~

~~(4)~~ **~~Prosthetic devices inserted during surgery~~**~~. Separate payment is made for prosthetic devices inserted during the course of surgery when the prosthetic devices are not integral to the procedure and are not included in the reimbursement for the procedure itself.~~

(b) There is no coverage of orthotics for adults.

(c) Coverage of prosthetics for adults is limited to one (1) breast prosthesis and support accessories and two (2) prosthetic devices insurted during surgery.

(1) **Breast prosthesis and support accessories.**

(A) Payment is limited to:

(i) one (1) prosthetic garment with mastectomy form every twelve (12) months for use in the postoperative period prior to a permanent breast prosthesis or as an alternative to a mastectomy bra and breast prosthesis;

(ii) two (2) mastectomy bras per year; and

(iii) one (1) silicone or equal breast prosthetic per side every twenty-four (24) months; or

(iv) one (1) foam prosthetic per side every six (6) months.

(B) Payment will not be made for both a silicone and a foam prosthetic in the same twelve (12) month period.

(C) Breast prostheses, bras, and prosthetic garments must be purchased from a Board Certified Mastectomy Fitter.

(D) A breast prosthesis can be replaced if:

(i) lost;

(ii) irreparably damaged (other than ordinary wear and tear); or

(iii) the member's medical condition necessitates a different type of item and the physician provides a new prescription explaining the need for a different type of prosthesis.

(E) External breast prostheses are not covered after breast reconstruction is performed except in instances where a woman with breast cancer receives reconstructive surgery following a mastectomy, but the breast implant fails or ruptures and circumstances are such that an implant

replacement is not recommended by the surgeon and/or desired by the member.

(2) **Prosthetic devices inserted during surgery.** Separate payment is made for prosthetic devices inserted during the course of surgery when the prosthetic devices are not integral to the procedure and are not included in the reimbursement for the procedure itself.

317:30-5-211.14. Nutritional support

(a) **Enteral nutrition.** Enteral nutrition administered only via gravity, syringe, or pump is covered for children and adults at home. Refer to pharmacy policy related to coverage of food supplements at Oklahoma Administrative Code (OAC) 317:30-5-72.1. For enteral nutrition authorization guidelines, see OAC 317:30-5-211.20.

~~(a)~~ **(b) Parenteral nutrition. The member must require intravenous** feedings to maintain weight and strength commensurate with the member's overall health status. Adequate nutrition must not be possible by dietary adjustment and/or oral supplements.

(1) The member must have a permanent impairment. Permanence does not require a determination that there is no possibility that the member's condition may improve sometime in the future. If the judgment of the attending physician, substantiated in the medical record, is that the condition is of long and indefinite duration (ordinarily at least three (3) months), the test of permanence is met. Parenteral nutrition will be denied as a non-covered service in situations involving temporary impairments.

(2) The member must have a condition involving the small intestine, exocrine glands, or other conditions that significantly impair the absorption of nutrients. Coverage is also provided for a disease of the stomach and/or intestine that is a motility disorder and impairs the ability of nutrients to be transported through the GI system, and other conditions as deemed medically necessary. There must be objective medical evidence supporting the clinical diagnosis.

(3) Re-certification of parenteral nutrition will be required as medically necessary and determined by the ~~OHCA~~Oklahoma Health Care Authority (OHCA) medical staff.

(c) **Long-term care facility enteral and parenteral nutrition.** Enteral and parenteral nutrition products supplied to long-term care facility residents will be included in the long-term care facility per diem rate.

~~(b)~~(d) ~~**Prior authorization**~~**Claim submission requirements.** A written signed and dated order must be received by the supplier before a claim is submitted to the OHCA. If the supplier bills an

item addressed in this policy without first receiving the completed order, the item will be denied as not medically necessary. The ordering physician is expected to see the member within ~~30~~thirty (30) days prior to the initial certification or required re-certification. If the physician does not see the member within this time frame, the physician must document the reason why and describe what other monitoring methods were used to evaluate the member's parenteral nutrition needs.

~~(c) **Enteral formulas.** Enteral formulas are covered for children only. See OAC 317:30-5-210.2.~~

317:30-5-211.15. ~~Supplies~~Medical Supplies

The ~~OHCA~~Oklahoma Health Care Authority (OHCA) provides coverage for medically necessary supplies that are prescribed by the appropriate medical provider and meet the ~~special requirements below:~~member's specific needs. Medical supplies include, but are not limited to, IV therapy supplies, diabetic supplies, catheters, colostomy and urostomy supplies, and incontinence supplies.

~~(1) **Intravenous therapy.** Supplies for intravenous therapy are covered items. Drugs for IV therapy are covered items only as specified by the Vendor Drug program.~~

~~(2) **Diabetic supplies.** Glucose test strips and lancets are covered when medically necessary and prescribed by a physician, physician assistant, or an advanced practice nurse. Testing supplies may be limited based on insulin use or type of diabetes. Prior authorization may be required for supplies beyond the standard allowance.~~

~~(3) **Catheters.** Permanent indwelling catheters, male external catheters, drain bags and irrigation trays are covered items. Single use self catheters when the member has a history of urinary tract infections is a covered item. The prescription from the attending physician must indicate such documentation is available in the member's medical record.~~

~~(4) **Colostomy and urostomy supplies.** Colostomy and urostomy bags and accessories are covered items.~~

317:30-5-211.16. Coverage for ~~nursing~~long-term care facility residents

~~(a)~~ For residents in a ~~nursing~~long-term care facility, ~~most DMEPOS~~ medical supplies, equipment and appliances are ~~considered part of~~included in the facility's per diem rate. Prosthetics and orthotics are paid separately from the per diem rate. Refer to Oklahoma Administrative Code (OAC) 317:30-5-211.13 for coverage. ~~The following are not included in the per diem rate and may be billed by the appropriate medical supplier:~~

~~(1) Services requiring prior authorization:~~

~~(A) ventilators and supplies;~~
~~(B) total parenteral nutrition (TPN), and supplies;~~
~~(C) custom seating for wheelchairs; and~~
~~(D) external breast prosthesis and support accessories.~~
~~(2) Services not requiring prior authorization:~~
~~(A) permanent indwelling or male external catheters and catheter accessories;~~
~~(B) colostomy and urostomy supplies;~~
~~(C) tracheostomy supplies;~~
~~(D) catheters and catheter accessories;~~
~~(E) oxygen and oxygen concentrators.~~
~~(i) **PRN oxygen.** Members in nursing facilities requiring oxygen PRN will be serviced by oxygen kept on hand as part of the per diem rate.~~
~~(ii) **Billing for Medicare eligible nursing home members.** Oxygen supplied to Medicare eligible nursing home members may be billed directly to OHCA. It is not necessary to obtain a denial from Medicare prior to filing the claim with OHCA.~~
~~(b) Items not covered include but are not limited to:~~
~~(1) diapers;~~
~~(2) underpads;~~
~~(3) medicine cups;~~
~~(4) eating utensils; and~~
~~(5) personal comfort items.~~

317:30-5-211.17. Wheelchairs

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

(1) **"Assistive technology professional"** or **"ATP"** means a for-service provider who is involved in analysis of the needs and training of a consumer in the use of a particular assistive technology device or is involved in the sale and service of rehabilitation equipment or commercially available assistive technology products and devices. All ATPs are required to be credentialed by Rehabilitation Engineering and Assistive Technology Society of North America (RESNA).

(2) **"Custom seating system"** means a wheelchair seating system which is individually made for a member using a plaster model of the member, a computer generated model of the member (e.g., CAD-CAM technology), or the detailed measurements of the member to create either:

(A) a molded, contoured, or carved (foam or other suitable material) custom-fabricated seating system that is incorporated into the wheelchair base; or

(B) a custom seating system made from multiple pre-fabricated components or a combination of custom fabricated materials and pre-fabricated components which have been configured and attached to the wheelchair base or incorporated into a wheelchair seat and/or back in a manner that the wheelchair could not be easily re-adapted for use by another individual.

~~(3) **"RESNA"** means the Rehabilitation Engineering and Assistive Technology Society of North America.~~

~~(4)~~(3) **"Specialty evaluation"** means the determination and documentation of the consumer's pathology, history and prognosis, and the physiological, functional, and environmental factors that impact the selection of an appropriate wheeled mobility system.

(b) **Medical Necessity.** Medical necessity, pursuant to ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-5-211.2, is required for a wheelchair to be covered and reimbursed by SoonerCare. Only one (1) wheelchair is covered as medically necessary during its reasonable useful lifetime, unless the member's documented medical condition indicates the current wheelchair no longer meets the member's medical need. Backup wheelchairs are not covered items.

(c) **Prior authorization.** Prior authorization, pursuant to OAC 317:30-5-211.3, is required for selected wheelchairs to be covered and reimbursed by SoonerCare. All prior authorization requests for the purchase of a wheelchair must indicate the length of the warranty period and what is covered under the warranty.

(1) Wheelchairs, wheelchair parts and accessories, and wheelchair modifications that are beneficial primarily in allowing the member to perform leisure or recreational activities are not considered medically necessary and will not be authorized.

(2) Wheelchair parts, accessories, and/or modifications that are distinctly and separately requested and priced from the original wheelchair request may require prior authorization.

(3) The ~~OHCA~~Oklahoma Health Care Authority will deny prior authorization requests when the required forms have not been fully completed or the member's medical record does not provide sufficient information to establish medical necessity or to determine that the criteria for coverage has been met.

(d) **Coverage and limitations.**

~~(1) For a member who resides in a personal residence, assisted living facility, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), or long term care facility, the following criteria must be met for the authorization to purchase a wheelchair.~~

~~(A) The member must have a prescription signed by a physician, a physician assistant, or an advanced registered nurse practitioner.~~

~~(B) The member must meet the requirements for medical necessity as determined and approved by the OHCA.~~

~~(C) The member must either have:~~

~~(i) a specialty evaluation that was performed by a licensed or certified medical professional, such as a physical therapist, occupational therapist, or a physician who has specific training and experience in rehabilitation wheelchair evaluations, and that documents the medical necessity for the wheelchair and its special features; or~~

~~(ii) a wheelchair provided by a supplier that employs a RESNA certified assistive technology professional who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the member.~~

~~(2) For members who reside in a long term care facility or ICF/IID, only custom seating systems for wheelchairs are eligible for direct reimbursement to DME providers.~~ For members who reside in a long-term careg facility or intermediate care facility for individuals with intellectual disabilities, ~~All~~all standard manual and power wheelchairs~~ are the responsibility of the facility and~~ are considered part of the facility's per diem rate. Repairs and maintenance~~, except for custom seating systems, are not covered items~~ for wheelchairs ~~and~~ are considered part of the facility's per diem rate.

(e) **Rental, repairs, maintenance, and delivery.** Refer to OAC 317:30-5-211.4 through 317:30-5-211.5.

(f) **Documentation.**

(1) The specialty evaluation or wheelchair selection documentation must be submitted with the prior authorization request.

(2) The specialty evaluation or wheelchair selection must be performed no longer than ~~90~~ninety (90) days prior to the submission of the prior authorization request.

(3) The results of the specialty evaluation or wheelchair selection documentation must be supported by the information submitted on the member's medical record.

(4) A copy of the dated and signed written specialty evaluation or wheelchair selection document must be maintained by the wheelchair provider. The results of the specialty evaluation or wheelchair selection must be written, signed, and dated by the medical professional who evaluated the member or the ATP who was involved in the wheelchair selection for the member.

317:30-5-211.20. Enteral nutrition

(a) **Enteral Nutrition.** Enteral nutrition is the delivery of nutrients directly into the stomach, duodenum or jejunum.

(b) **Medical necessity.** Enteral nutrition supplies must be determined by a physician to be medically necessary and documented in the member's plan of care as medically necessary and used for medical purposes. Requests by medical providers for enteral nutrition supplies 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) 317:30-5-211.2 and OAC 317:30-3-1(f) for policy on medical necessity.

(c) **Documentation.** All documentation submitted to request services must demonstrate, through adequate objective medical records, evidence sufficient to justify the member's need for the service, in accordance with OAC 317:30-3-1(f)(2). Documentation must include:

(1) Diagnosis;
(2) Certificate of Medical Necessity (CMN);
(3) Ratio data;
(4) Route;
(5) Caloric intake; and
(6) Prescription.
(7) For full guidelines, please refer to www.okhca.org/mau.

(d) **Reimbursement.**

(1) Extension sets and Farrell bags are not covered when requested separately from the supply kits;
(2) Enteral nutrition for individuals in long-term care facilities is not separately reimbursed as this is included in the per diem rate.

(e) **Non-covered items.** The following are non-covered items:

(1) Orally administered enteral products and/or related supplies;
(2) Formulas that do not require a prescription unless administered by tube;
(3) Food thickeners, human breast milk, and infant formula;
(4) Pudding and food bars; and
(5) Nursing services to administer or monitor the feedings of enteral nutrition.

317:30-5-211.21. Incontinence supplies

(a) **Incontinence supplies and services.** Incontinence supplies and services are those supplies that are used to alleviate or prevent skin breakdown or excoriation associated with incontinence.

(b) **Medical necessity.** Incontinence supplies must be determined by a physician to be medically necessary and documented in the member's plan of care as medically necessary and used for medical

purposes. A request by a medical provider for incontinence supplies 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) 317:30-5-211.2 and OAC 317:30-3-1(f) for policy on medical necessity.

(c) **Documentation.** All documentation submitted to request services must demonstrate, through adequate objective medical records, evidence sufficient to justify the member's need for the service, in accordance with OAC 317:30-3-1(f)(2). Documentation must include:

(1) A signed provider prescription specifying the requested item;

(2) A documented diagnosis of an underlying chronic medical condition that involves loss of bladder or bowel control;

(3) Documentation must include the height and weight of the member, the type of incontinence (bowel/bladder/combined), and expected length of need;

(4) Requests submitted for underwear/pull-on(s) the member must be ambulatory or in a toilet training program;

(5) The member may qualify for incontinence supplies for a short period of time when the member has documented full-skin thickness injuries;

(6) When requesting wipes as incontinence supplies, documentation must be submitted specific to the supply being requested. Disposable wipes are only allowed when diapers have been approved;

(7) For full guidelines, please refer to www.okhca.org/mau.

(d) **Quantity limits.** There is a quantity limit to the products allowed as well as product combinations. For a listing of quantity limits on specific products, refer to the OHCA website, under the Durable Medical Equipment page, "Incontinence Supplies". Requests for quantities or combinations outside of the limits published will require additional medical review for approval.

(~~c~~) **Non-covered items.** The following are non-covered items:

(1) Incontinence supplies for members under the age of four (4) years;

(2) Reusable underwear and/or reusable pull-ons;

(3) Reusable briefs and/or reusable diapers;

(4) Diaper service for reusable diapers;

(5) Feminine hygiene products;

(6) Disposable penile wraps; and

(7) Shipping costs.

317:30-5-211.22. Pulse oximeter

(a) **Pulse oximeter.** Pulse oximeter is a device used for measuring blood oxygen levels in a non-invasive manner.

(b) **Medical necessity.** Pulse oximeters must be determined by a physician to be medically necessary and documented in the member's plan of care as medically necessary and used for medical purposes. A request by a medical provider for pulse oximeters 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) 317:30-5-211.2 and OAC 317:30-3-1(f) for policy on medical necessity.

(c) **Documentation.** All documentation submitted to request services must demonstrate, through adequate objective medical records, evidence sufficient to justify the member's need for the service, in accordance with OAC 317:30-3-1(f)(2). Documentation must include:

(1) A current oxygen order signed and dated by an OHCA-contracted physician, along with a certificate of medical necessity (CMN);

(2) Pertinent information relating to the member's underlying diagnosis and condition which results in the need for the oximeter and supplies, including documentation of unstable airway events and documentation of current monitor readings if available; and

(3) Documentation of an available trained caregiver in the home who is able to intervene and address changes in the member's oxygen saturation levels in a medically safe and appropriate manner.

(4) For full guidelines, please refer to www.okhca.org/mau.

(d) **Reimbursement.**

(1) Temporary probe covers are not reimbursed separately for rented oximeters as they are included in the price of the rental.

(2) Pulse oximeters are not reimbursed in conjunction with apnea monitors.

317:30-5-211.23. Continuous passive motion device for the knee

(a) **Continuous passive motion (CPM).** CPM is a postoperative treatment method designed to aid recovery of joint range of motion after joint surgery. CPM provides for early post-operative motion and is considered a substitute for active physical therapy (PT).

(b) **Medical necessity.** CPM must be determined by a provider to be medically necessary and documented in the member's plan of care as medically necessary and used for medical purposes. A request by a medical provider for CPM 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)

317:30-5-211.2 and OAC 317:30-3-1(f) for policy on medical necessity.

(1) A knee CPM device is covered for up to twenty-one (21) days and does not require a prior authorization (PA) for a patient in an early phase of rehabilitation.

(2) A knee CPM device required for more than twenty-one (21) days does require a PA of the additional days. These cases will be individually reviewed for medical necessity.

(c) **Documentation.** All documentation submitted to request services must demonstrate, through adequate objective medical records, evidence sufficient to justify the member's need for the service, in accordance with OAC 317:30-3-1(f)(2).

(1) Documentation must include:

(A) Type of surgery performed;

(B) Date of surgery;

(C) Date of application of CPM;

(D) Date of discharge from the hospital; and

(E) Written prescription issued by a licensed prescriber that is signed and dated no more than thirty (30) days prior to the first date of service and that defines the specific "from" and "to" dates that reflect the actual days the CPM device is to be utilized.

(2) For full guidelines, please refer to www.okhca.org/mau.

(d) **Reimbursement.**

(1) Separate reimbursement will not be made for use of device while member is hospitalized or in a long-term care facility.

(2) Billing for dates of service when the patient is no longer actively using the CPM device is not appropriate and is not reimbursable.

317:30-5-211.24. Parenteral nutrition

(a) **Parenteral nutrition (PN).** PN is the provision of giving nutritional requirements intravenously.

(b) **Medical necessity.** PN must be determined by a provider to be medically necessary and documented in the member's plan of care as medically necessary and used for medical purposes. A request by a medical provider for parenteral nutrition 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) 317:30-5-211.2 and OAC 317:30-3-1(f) for policy on medical necessity.

(c) **Documentation.** All documentation submitted to request services must demonstrate, through adequate objective medical records, evidence sufficient to justify the member's need for the service, in accordance with OAC 317:30-3-1(f)(2).

(1) Hospital records that have objective medical evidence supporting the clinical diagnosis; if applicable;
(2) A certificate of medical necessity;
(3) A prescription; and
(4) Caloric Intake.
(5) For full guidelines, please refer to www.okhca.org/mau.

(d) **Reimbursement.**
(1) Supply kits are all inclusive, unbundled supplies (e.g. gloves, tubing, etc.) are not reimbursable for parenteral nutrition.
(2) Pumps are rented as a capped rental.

317:30-5-211.25. Continuous glucose monitoring

(a) **Continuous Glucose Monitoring (CGM).** CGM means a minimally invasive system that measures glucose levels in subcutaneous or interstitial fluid. CGM provides blood glucose levels and can help members make more informed management decisions throughout the day.

(b) **Medical necessity.** CGM must be determined by a provider to be medically necessary and documented in the member's plan of care as medically necessary and used for medical purposes. A request by a medical provider for CGM 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) 317:30-5-211.2 and OAC 317:30-3-1(f) for policy on medical necessity. CGM devices must be approved by the U.S. Food and Drug Administration (FDA) as non-adjunctive and must be used for therapeutic purposes. Devices may only be used for members within the age range for which the devices have been FDA approved.

(c) **Documentation.** All documentation submitted to request services must demonstrate, through adequate objective medical records, evidence sufficient to justify the member's need for the service, in accordance with OAC 317:30-3-1(f)(2). Requests for CGM must include all of the following documentation:
(1) Prescription by a physician, physician assistant, or an advanced practice registered nurse;
(2) Member diagnosis that correlates to the use of CGM;
(3) Documentation of the member testing to include the frequency each day;
(4) Documentation member is insulin-treated to include frequency of daily or is using insulin pump therapy;
(5) Documentation member's insulin treatment regimen requires frequent adjustment;
(6) The member and/or family member has participated in age appropriate diabetes education, training, and support prior to beginning CGM; and

(7) In-person or telehealth visit [within the last six (6) months] between the treating provider, member and/or family to evaluate their diabetes control.
(8) For full guidelines please refer to www.okhca.org/mau.

317:30-5-211.26. Bathroom equipment

(a) **Bathroom equipment.** Bathroom equipment is used for bathing and toileting and may be considered primarily medical in nature if used in the presence of an illness and/or injury and if it is necessary for activities of daily living that are considered to be essential to health and personal hygiene.
(b) **Medical necessity.** Bathroom Equipment must be determined by a provider to be medically necessary and documented in the member's plan of care as medically necessary and used for medical purposes. A request by a medical provider for bathroom equipment 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) 317:30-5-211.2 and OAC 317:30-3-1(f) for policy on medical necessity.
(c) **Documentation.** All documentation submitted to request services must demonstrate, through adequate objective medical records, evidence sufficient to justify the member's need for the service, in accordance with OAC 317:30-3-1(f)(2).
(1) Current written prescription for specific medical supply, equipment, and appliance item;
(2) Letter of Medical Necessity;
(3) Product Information;
(4) Manufacturer's Suggested Retail Price (MSRP) for each item requested
(5) For full guidelines, please refer to www.okhca.org/mau.

317:30-5-211.27. Positive airway pressure (PAP) devices

(a) **PAP devices.** PAP devices are both a single level continuous positive airway pressure device (CPAP), and/or a bi-level respiratory assist device with or without back-up rate when it is used in the treatment of obstructive sleep apnea.
(b) **Medical Necessity.** PAP devices must be determined by a provider to be medically necessary and documented in the member's plan of care as medically necessary and used for medical purposes. A request by a medical provider for PAP devices 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) 317:30-5-211.2 and OAC 317:30-3-1(f) for policy on medical necessity.

(c) **Documentation.** All documentation submitted to request services must demonstrate, through adequate objective medical records, evidence sufficient to justify the member's need for the service, in accordance with OAC 317:30-3-1(f)(2).

(1) A face-to-face clinical evaluation by the treating qualified medical professional within six (6) months prior to receiving device;

(2) Qualifying polysomnogram, performed in a sleep diagnostic testing facility, that is dated within one (1) year of the prior authorization request submission;

(3) The patient and/or his or her caretaker have received instruction from the supplier of the device in the proper use and care of the equipment; and

(4) Medical records supporting the need for a PAP device.

(5) For full guidelines, please refer to www.okhca.org/mau.

317:30-5-211.28. Sleep studies

(a) **Sleep studies.** Sleep studies are the continuous and simultaneous monitoring and recording of specified physiological and pathophysiological parameters during a period of sleep for six (6) or more hours. The study is used to diagnose a variety of sleep disorders and to evaluate a patient's response to therapies such as continuous positive airway pressure (CPAP). A sleep study requires physician review, interpretation, and report.

(b) **Medical necessity.** Sleep studies must be determined by a provider to be medically necessary and documented in the member's plan of care as medically necessary and used for medical purposes. A request by a medical provider for sleep studies 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) 317:30-5-211.2 and OAC 317:30-3-1(f) for policy on medical necessity.

(c) **Documentation.** All documentation submitted to request services must demonstrate, through adequate objective medical records, evidence sufficient to justify the member's need for the service, in accordance with OAC 317:30-3-1(f)(2). Documentation requirements include:

(1) Legible signature of the physician or non-physician practitioner responsible for and providing the care to the patient;

(2) All pages in the prior authorization request must be clear and legible;

(3) Face-to-face evaluation by the ordering practitioner, the supervising physician, or the interpreting physician; and

(4) Medical records to support the medical indication for the sleep study including results of sleep scale.

(6) For full guidelines, please refer to www.okhca.org/mau.

(d) **Reimbursement.**

(1) Only sleep studies performed in a sleep diagnostic testing facility may be reimbursable.

(2) A split study beginning on a given date with the titration beginning after midnight on the subsequent date is one (1) study and may not be billed as two (2) consecutive studies.

317:30-5-216. Prior authorization requests [REVOKED]

~~(a) **Prior authorization requirements.** Requirements vary for different types of services. Providers should refer to the service-specific sections of policy or the OHCA website for services requiring PA.~~

~~(1) **Required forms.** All required forms are available on the OHCA web site at www.okhca.org.~~

~~(2) **Certificate of medical necessity.** The prescribing provider must complete the medical necessity section of the CMN. This section cannot be completed by the supplier. The medical necessity section can be completed by any health care clinician; however, only the member's treating provider may sign the CMN. By signing the CMN, the physician is validating the completeness and accuracy of the medical necessity section. The member's medical records must contain documentation substantiating that the member's condition meets the coverage criteria and the answers given in the medical necessity section of the CMN. These records may be requested by OHCA or its representatives to confirm concurrence between the medical records and the information submitted with the prior authorization request.~~

~~(b) **Submitting prior authorization requests.** Contact information for submitting prior authorization requests may be found in the OHCA Provider Billing and Procedures Manual. An electronic version of this manual is located on the OHCA web site.~~

~~(c) **Prior authorization review.** Upon verifying the completeness and accuracy of clerical items, the PA request is reviewed by OHCA staff to evaluate whether or not each service being requested meets SoonerCare's definition of "medical necessity" [see OAC 317:30-3-1 (f)] as well as other criteria.~~

~~(d) **Prior authorization decisions.** After the PA request is processed, a notice will be issued regarding the outcome of the review. If the request is approved the notice will include an authorization number, the appropriate date span and procedure codes approved.~~

~~(e) **Prior authorization does not guarantee reimbursement.** Provider status, member eligibility, and medical status on the date of service, as well as all other SoonerCare requirements, must be met before the claim is reimbursed.~~

~~(f) **Prior authorization of manually-priced items.** Manually-priced~~

~~items must be prior authorized. If manual pricing is used, the provider is reimbursed at the provider's documented Manufacturer's Suggested Retail Price (MSRP) minus 30% or invoice cost plus 30%, whichever is the lesser of two. OHCA may establish a fair market price through claims review and analysis.~~

317:30-5-218. Reimbursement

(a) **Medical ~~equipment and~~ supplies, equipment and appliances.**

(1) Reimbursement for ~~durable medical equipment and supplies~~medical supplies, equipment, and appliances will be made using an amount derived from the lesser of the ~~OHCA~~Oklahoma Health Care Authority (OHCA) maximum allowable fee or the provider's usual and customary charge. The maximum allowable fee is the maximum amount that the OHCA will pay a provider for an allowable procedure. When a code is not assigned a maximum allowable fee for a unit of service, a fee will be established. ~~The fee schedule will be reviewed annually and adjustments to the fee schedule may be made at any time based on efficiency, budget considerations, and quality of care as determined by the OHCA.~~

(2) The fee schedule will be reviewed annually. Adjustments to the fee schedule may be possible at any time based on efficiency, budget considerations, federal regulations, and quality of care as determined by the OHCA.

(3) Payment for medical supplies, equipment, and appliances will be calculated using the rate methodologies found in the Oklahoma Medicaid state plan.

(4) Payment is not made for medical supplies, equipment, and appliances that are not deemed as medically necessary or considered over the counter.

(5) OHCA does not pay medical supplies, equipment, and appliances providers separately for services that are included as part of the payment for another treatment program. For example, all items required during inpatient stays are paid through the inpatient payment structure.

(6) Medical supplies, equipment, and appliance products purchased at a pharmacy are paid the equivalent to Medicare Part B, Average Sales Price (ASP) + six percent (6%). When ASP is not available, an equivalent price is calculated using Wholesale Acquisition Cost (WAC). If no Medicare, ASP, or WAC pricing is available, then the price will be calculated based on invoice cost.

(b) **Manually-priced medical equipment and supplies.**

There may be instances when manual pricing is required. When it is, the following pricing methods will be used:

(A) **Invoice pricing.** Reimbursement is at the provider's documented Manufacturer's Suggested Retail Price (MSRP) minus thirty percent (30%) or at the provider's invoice cost plus thirty percent (30%), whichever is the lesser of the two.

(B) **Fair market pricing.** OHCA may establish a fair market price through claims review and analysis. For a list of medical equipment and supplies that are fair market-priced, refer to the OHCA website at www.okhca.org for the Fair Market Value List (Selected medical supplies, equipment, and appliance items priced at Fair Market Price).

~~(b)~~(c) **Oxygen equipment and supplies.**

(1) Payment for stationary oxygen systems (liquid oxygen systems, gaseous oxygen systems, and oxygen concentrators) is based on continuous rental, i.e., a continuous monthly payment that is made as long as it is medically necessary. The rental payment includes all contents and supplies, e.g. regulators, tubing, masks, etc. Portable oxygen systems are considered continuous rental. Ownership of the equipment remains with the supplier.

(2) Separate payment will not be made for maintenance, servicing, delivery, or for the supplier to pick up the equipment when it is no longer medically necessary. In addition, the provider/supplier will not be reimbursed for mileage.

(3) Payment for oxygen and oxygen equipment and supplies will not exceed the Medicare fee for the same procedure code. ~~Reimbursement for members who reside in a nursing facility may be at a reduced rate. The fee schedule will be reviewed annually and adjustments to the fee schedule may be made at any time based on efficiency, budget considerations, and quality of care as determined by the OHCA.~~

(4) For residents in a long-term care facility, durable medical equipment products, including oxygen, are included in the facility's per diem rate.

PART 61. HOME HEALTH AGENCIES

317:30-5-545. Eligible providers

All eligible home health service providers must be Medicare certified, ~~accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO),~~ or have deemed status with Medicare, and have a current contract with the Oklahoma Health Care Authority (OHCA). Home ~~Health Agencies~~health agencies billing for ~~durable medical equipment (DME)~~medical supplies, equipment, and appliances must have a supplier contract and bill

equipment on claim form CMS-1500. Additionally, home health services providers that did not participate in Medicaid prior to January 1, 1998, must meet the "Capitalization Requirements" set forth in ~~42 CFR 489.28~~42 Code of Federal Regulations (C.F.R.) § 489.28. Home health services providers that do not meet these requirements will not be permitted to participate in the Medicaid program.

317:30-5-546. Coverage by category

Payment is made for home health services as set forth in this section when a ~~face to face~~face-to-face encounter has occurred in accordance with provisions of ~~42 CFR 440.70~~42 Code of Federal Regulations (C.F.R.) § 440.70. Payment is made for home health services provided in the member's residence and in any setting in which normal life activities take place except for a hospital, long-term care facility, or intermediate care facility for individuals with intellectual disabilities. For individuals eligible for Part B of Medicare, payment is made utilizing the Medicaid allowable for comparable services.

~~(1) **Adults.** Payment is made for home health services provided in the member's residence to all categorically needy individuals. Coverage for adults is as follows.~~

~~(A) **Covered items.**~~

~~(i) Part-time or intermittent nursing services;~~

~~(ii) Home health aide services;~~

~~(iii) Standard medical supplies;~~

~~(iv) Durable medical equipment (DME) and appliances; and~~

~~(v) Items classified as prosthetic devices.~~

~~(B) **Non-covered items.** The following are not covered:~~

~~(i) Sales tax;~~

~~(ii) Enteral therapy and nutritional supplies;~~

~~(iii) Electro-spinal orthosis system (ESO); and~~

~~(iv) Physical therapy, occupational therapy, speech pathology, or audiological services.~~

~~(2) **Children.** Home Health Services are covered for persons under age 21.~~

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

317:30-5-547. Reimbursement

(a) Nursing services and home health aide services are covered services on a per visit basis. ~~Reimbursement for any combination of nursing or home aid service shall not exceed 36 visits per calendar year per member. Additional visits for children must be prior authorized when medically necessary.~~Thirty-six (36) visits per calendar year of nursing and/or home health aide services for

any member do not require prior authorization; however, any visit surpassing thirty-six (36) would require prior authorization and medical review.

(b) Reimbursement for durable medical equipment and supplies will be made using the amount derived from the lesser of the ~~OHCA~~Oklahoma Health Care Authority (OHCA) fee schedule or the provider's usual and customary charge. ~~The maximum allowable fee is the maximum amount that OHCA will pay a provider for an allowable procedure code.~~ When a procedure code is not assigned a maximum allowable fee for a unit of service, a fee will be established. Once the service has been provided, the supplier is required to include a copy of the invoice documenting the supplier's cost of the item with the claim.

(c) Reimbursement for oxygen and oxygen supplies is as follows:

(1) Payment for oxygen systems (stationary, liquid and oxygen concentrators) is based on continuous rental, i.e., a continuous monthly payment is made as long as it is medically necessary. The rental payment includes all contents and supplies, i.e., regulators, tubing, masks, etc. Portable oxygen systems are also considered continuous rental. Ownership of the equipment remains with the supplier.

(2) Separate payment will not be made for maintenance, servicing, delivery, or for the supplier to pickup the equipment when it is no longer medically necessary.

(3) Payment for oxygen and oxygen equipment and supplies will not exceed the Medicare fee for the same procedure code. ~~Reimbursement for members who reside in a nursing facility may be at a reduced rate.~~ The fee schedule will be reviewed annually and adjustments to the fee schedule may be made at any time based on efficiency, budget considerations, and quality of care as determined by the OHCA.

(4) Physical therapy, occupational therapy, and/or speech pathology and audiology services, are not covered when provided by a home health agency.

317:30-5-548. Procedure codes

~~Procedure codes for home health services are assigned HCPCS codes for supplies and durable medical equipment.~~All home health services are billed using Healthcare Common Procedure Coding System (HCPCS) codes.

317:30-5-549. Prosthetic devices [REVOKED]

~~Payment may be made to home health agencies for prosthetic devices. Refer to the Medical Suppliers Provider Rules for further information.~~

PART 85. ADVANTAGE PROGRAM WAIVER SERVICES

317:30-5-763. Description of services

Services included in the ADvantage Program are:

(1) **Case management.**

(A) Case management services, regardless of payment source, assist a member to gain access to medical, social, educational, or other services that may benefit him or her to maintain health and safety. Case managers:

(i) ~~initiate~~Initiate and oversee necessary assessments and reassessments to establish or reestablish waiver program eligibility;

(ii) ~~develop~~Develop the member's comprehensive person-centered service plan, listing only the services necessary to prevent member institutionalization, ~~of the member,~~ as determined through the assessments;

(iii) ~~initiate~~Initiate the addition of necessary services or deletion of unnecessary services, as dictated by the member's condition and available support; and

(iv) ~~monitor~~Monitor the member's condition to ensure delivery and service appropriateness ~~of services~~ and initiate person-centered service plan reviews. Case managers submit an individualized ~~Form 02CB014, Services Backup Plan,~~services backup plan via electronic submission on all initial service plans, annually at reassessment, and on updates as appropriate throughout the year, reflecting risk factors and measures in place to minimize risks. When a member requires hospital or nursing facility (NF) services, the case manager:

(I) ~~assists~~Assists the member ~~in accessing~~to access institutional care and, as appropriate, periodically monitors the member's progress during the institutional stay;

(II) ~~helps~~Helps the member transition from institution to home by updating the person-centered service plan;

(III) ~~prepares~~Prepared services to start on the date the member is discharged from the institution; and

(IV) ~~must~~Must meet ADvantage Program minimum requirements for qualification and training prior to providing services to ADvantage members.

(B) Providers of ADvantage services for the member or for those who have an interest in or are employed by an ADvantage provider for the member must not provide case management or develop the person-centered service plan, except when the ADvantage Administration (AA) demonstrates the only willing and qualified entity to provide case management and/or

develop person-centered service plans in a geographic area, also provides other ADvantage services. Prior to providing services to members receiving Consumer-Directed Personal Assistance Services and Supports (CD-PASS), case manager supervisors, and case managers are required to receive training and demonstrate knowledge regarding the CD-PASS service delivery model, "Independent Living Philosophy," and demonstrate competency person-centered planning.

(C) ~~Providers may only claim time for billable case management activities, described as:~~

~~(i) any task or function, per Oklahoma Administrative Code (OAC) 317:30-5-763(1)(A) that only an ADvantage case manager because of skill, training, or authority can perform on behalf of a member; and~~

~~(ii) ancillary activities, such as clerical tasks including, but not limited to, mailing, copying, filing, faxing, driving time, or supervisory and administrative activities are not billable case management activities. The administrative cost of these activities and other normal and customary business overhead costs are included in the reimbursement rate for billable activities.~~

Providers may only claim time for billable case management activities, described as any task or function, per Oklahoma Administrative Code (OAC) 317:30-5-763(1)(A) that only an ADvantage case manager because of skill, training, or authority can perform on a member's behalf. Ancillary activities, such as clerical tasks including, but not limited to, mailing, copying, filing, faxing, driving time, or supervisory and administrative activities are not billable case management activities. The administrative cost of these activities and other normal and customary business overhead costs are included in the reimbursement rate for billable activities.

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

(i) Standard rate. ~~case~~Case management services are billed using a standard rate for reimbursement for billable service activities provided to a member who resides in a county with a population density greater than twenty-five (25) persons per square mile.

(ii) Very rural/difficult service area rate. ~~case~~Case management services are billed using a very rural/difficult service area rate for billable service activities provided to a member who resides in a county

with a population density equal to, or less than twenty-five (25) persons per square mile. ~~Exceptions are services to members who reside in Oklahoma Department of Human Services (DHS) Aging Services identified zip codes in Osage County adjacent to the metropolitan areas of Tulsa and Washington counties. Services to these members are prior authorized and billed using the standard rate. (iii) The latest United States Census, Oklahoma counties population data is the source for determination of whether a member resides in a county with a population density equal to, or less than twenty-five (25) persons per square mile, or resides in a county with a population density greater than twenty-five (25) persons per square mile.~~

(2) **Respite.**

~~(A)~~ Respite services are provided to members who are unable to care for themselves. Services are provided on a short-term basis due to the primary caregiver's absence or need for relief. Payment for respite care does not include room and board costs unless ~~more than seven (7)~~eight (8) or more hours are provided in a NF. Respite care is only utilized when other sources of care and support are exhausted. Respite care is only listed on the service plan when it is necessary to prevent ~~institutionalization of the~~ member~~.~~ Institutionalization. Units of services are limited to the number of units approved on the service plan. Respite services include:

~~(B)~~ (1) In-home respite services are billed per ~~fifteen-minute (15-minute)~~fifteen (15) minute units of service. Within any ~~one-day (1-day)~~one (1) day period, a minimum of eight (8) units [two (2) hours] must be provided with a maximum of ~~twenty-eight (28)~~thirty-one (31) units ~~[seven (7) hours]~~[less than eight (8) hours] provided. The service is provided in the member's home.

~~(C)~~ (2) ~~Facility-based extended respite is filed for a per diem rate when provided in a NF. Extended respite must be at least eight (8) hours in duration.~~In-home extended respite is filed for a per diem rate. A minimum of eight (8) hours must be provided in the member's home.

~~(D)~~ (3) ~~In-home extended respite is filed for a per diem rate. A minimum of eight (8) hours must be provided in the member's home.~~Facility-based extended respite is filed for a per diem rate when provided in a NF. Extended respite must be at least eight(8) hours in duration.

(3) **Adult day health (ADH) care.**

(A) ADH is furnished on a regularly-scheduled basis for one (1) or more days per week in an outpatient setting. It provides both health and social services necessary to ensure the member's optimal functioning. Most assistance with activities of daily living (ADLs), such as eating, mobility, toileting, and nail care are integral services to ADH care service and are covered by the ADH care basic reimbursement rate.
(B) ADH care is a ~~fifteen-minute (15-minute)~~fifteen (15) minute unit of service. No more than eight (8) hours, thirty-two (32) units [eight (8) hours] are authorized per day. The number of units of service a member may receive is limited to the number of units approved on the member's approved service plan.
(C) Physical, occupational, and speech therapies are only provided as an enhancement to the basic ADH care service when authorized by the service plan and are billed as a separate procedure. ADH care therapy enhancement is a maximum of one (1) session unit per day of service.
(D) Meals provided as part of this service do not constitute a full nutritional regimen. One (1) meal, that contains at least one-third (1/3) of the current daily dietary recommended intake (DRI) as established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences, is provided to those participants who are in the center for four (4) or more hours per day, and does not constitute a full nutritional regimen. Member's access to food at any time must also be available in addition to the required meal and is consistent with an individual not receiving Medicaid-funded services and supports.
(E) Personal-care service enhancement in ADH is assistance in bathing, hair care, or laundry service, authorized by the person-centered service plan and billed as separate procedures. This service is authorized when an ADvantage Waiver member who uses ADH requires assistance with bathing, hair care, or laundry to maintain health and safety. Assistance with bathing, hair care, or laundry service is not a usual and customary ADH care service. ADH personal care enhancement is a maximum of one (1) unit per day of bathing, hair care, or laundry service.
(F) ~~DHS~~Oklahoma Human Services (OKDHS) Home and Community-Based Services (HCBS) Waiver settings have qualities defined in federal regulation, per Section (§) 441.301 (c)(4) of Title 42 of Code of Federal Regulations ~~(CFR)~~(C.F.R.) based on the individual's needs, defined in the member's authorized service plan.

(i) The ADH center is integrated and supports full access of ADvantage members to the greater community, including opportunities to:

(I) ~~seek~~Seek employment and work in competitive integrated ADH Center, not a requirement for persons that are retirement age;

(II) ~~engage~~Engage in community life;

(III) ~~control~~Control personal resources; and

(IV) ~~receive~~Receive services in the community, to the same degree as individuals not receiving ADvantage Program or other Medicaid HBCS Waiver services.

(ii) The ADH is selected by the member from all available service options and given the opportunity to visit and understand the options.

(iii) The ADH ensures the member's rights of privacy, dignity, respect, and freedom from coercion and restraint.

(iv) The ADH optimizes the member's initiative, autonomy, and independence in making life choices including, but not limited to:

(I) ~~daily~~Daily activities;

(II) ~~the~~The physical environment; and

(III) ~~with~~With whom to interact.

(v) The ADH facilitates the member's choice regarding services and supports including the provider.

(vi) Each member has the freedom and support to control his or her own schedules, activities, and access to food at any time.

(vii) Each member may have visitors whenever he or she chooses.

(viii) The ADH center is physically accessible to the member.

(G) ADH centers that are presumed not to be HCBS settings per 42 ~~CFR~~C.F.R. § 441.301(c)(5)(v) include, ADH centers:

(i) in a publicly- or privately-owned facility providing inpatient treatment;

(ii) on the grounds of or adjacent to a public institution; and

(iii) with the effect of isolating individuals from the broader community of individuals not receiving ADvantage Program or another Medicaid HCBS;

(H) When the ADH is presumed not HCBS, according to 42 ~~CFR~~C.F.R. § 441.301(c)(5)(v), it may be subject to heightened scrutiny by AA, OHCA, and Centers for Medicare and Medicaid Services (CMS). The ADH must provide evidence that the ADH portion of the facility has clear

administrative, financial, programmatic, and environmental distinctions from the institution and comply with additional monitoring by the AA.

(4) **Environmental modifications.**

(A) Environmental modifications are physical adaptations to the home, required by the member's person-centered service plan that are necessary to ensure the member's health, welfare, and safety or enable the member to function with greater independence in the home, and that without such, the member would require institutionalization. Adaptations or improvements to the home not of direct medical or remedial benefit to the waiver member are excluded.

(B) All services require prior authorization.

(5) **Specialized medical equipment and supplies.**

(A) Specialized medical equipment and supplies are devices, controls, or appliances specified in the person-centered service plan that enable members to increase their abilities to perform ADLs, or to perceive, control, or communicate with the environment in which they live. Necessary items for life support, ancillary supplies, and equipment necessary for the proper functioning of such items, and durable and non-durable medical equipment and supplies not available under the Medicaid State Plan are also included. This service excludes any equipment and/or supply items not of direct medical or remedial benefit to the waiver member and necessary to prevent institutionalization.

(B) Specialized medical equipment and supplies are billed using the appropriate HealthCare Common Procedure Code (HCPC). Reoccurring supplies shipped and delivered to the member are compensable only when the member remains eligible for Waiver services, continues to reside in the home, and is not institutionalized in a hospital, skilled nursing facility, or nursing home. It is the provider's responsibility to verify the member's status prior to shipping and delivering these items. Payment for medical supplies, equipment, and appliances is ~~limited to the SoonerCare (Medicaid) rate when established, to the Medicare rate, or to actual acquisition cost, plus thirty (30) percent.~~consistent with OHCA rate methodology when available. Certain services, because of their variables, do not lend themselves to a fixed and uniform rate. Payments for these services are paid out at fair market price established through claims review and cost analysis or by selecting the lowest of three (3) bids. All services must have prior authorization.

(6) **Advanced supportive/restorative assistance.**

(A) Advanced supportive/restorative assistance services are maintenance services used to assist a member who has a chronic, yet stable condition. These services assist with ADLs that require devices and procedures related to altered body functions. These services are for maintenance only and are not utilized as treatment services.

(B) Advanced supportive/restorative assistance service is billed per ~~fifteen-minute (15-minute)~~fifteen (15) minute unit of service. The number of units of service a member may receive is limited to the number of units approved on the person-centered service plan.

(7) **Nursing.**

(A) Nursing services are services listed in the person-centered service plan~~ that are~~ within the scope of the Oklahoma Nursing Practice Act. These services are provided by a registered nurse (RN), a licensed practical nurse (LPN), or a licensed vocational nurse (LVN) under the supervision of an RN licensed to practice in the state. Nursing services may be provided on an intermittent or part-time basis or may be comprised of continuous care. The provision of the nursing service works to prevent or postpone the institutionalization of the member.

(B) Nursing services are services of a maintenance or preventative nature provided to members with stable, chronic conditions. These services are not intended to treat an acute health condition and may not include services reimbursable under either the Medicaid or Medicare Home Health Program. This service primarily provides nurse supervision to the personal care assistant or to the advanced supportive/restorative assistance aide and assesses the member's health and prescribed medical services to ensure they meet the member's needs as specified in the person-centered service plan. A nursing assessment/evaluation, on-site visit is made to each member, with additional visits for members with advanced supportive/restorative assistance services authorized to evaluate the condition of the member and medical appropriateness of services. An assessment/evaluation report is forwarded to the ADvantage Program case manager in accordance with review schedule determined between the case manager and outlined in the member's person-centered service plan, to report the member's condition or other significant information concerning each ADvantage member.

(i) The ADvantage Program case manager may recommend authorization of nursing services as part of the interdisciplinary team planning for the member's person-

centered service plan and/or assessment/evaluation of the:

(I) ~~member's~~Member's general health, functional ability, and needs; and/or

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

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

(I) ~~prepare~~Prepare a ~~one-week (1-week)~~one (1) week supply of insulin syringes for a person who is blind and has diabetes and can safely self-inject the medication but cannot fill his or her own syringe. This service includes monitoring the member's continued ability to self-administer the insulin;

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

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

(IV) ~~provide~~Provide nail care for the member with diabetes or member who has circulatory or neurological compromise; and

(V) ~~provide~~Provide consultation and education to the member, member's family, or other informal caregivers identified in the person-centered service plan, regarding the nature of the member's chronic condition. Skills training, including return skills demonstration to establish competency, to the member, family, or other informal caregivers as specified in the person-centered service plan for preventive and rehabilitative care procedures are also provided.

(C) Nursing service includes interdisciplinary team planning and recommendations for the member's person-centered service plan development and/or assessment/evaluation or for other services within the scope of the Oklahoma Nursing Practice

Act, including private duty nursing. Nursing services are billed per ~~fifteen-minute (15-minute)~~fifteen (15) minute unit of service. A specific procedure code is used to bill for interdisciplinary team planning and recommendations for the member's person-centered service plan other procedure codes may be used to bill for all other authorized nursing services. A maximum of eight (8) units, two (2) hours, per day of nursing for service plan development and assessment evaluation are allowed. An agreement by a provider to perform a nurse evaluation is also an agreement to provide the Medicaid in-home care services for which the provider is certified and contracted. Reimbursement for a nurse evaluation is denied when the provider that produced the nurse evaluation fails to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted.

(8) **Skilled nursing services.**

(A) Skilled nursing services listed in the person-centered service plan that are within the scope of the state's Nurse Practice Act and are ordered by a licensed physician, osteopathic physician, physician assistant, or an advanced practice nurse and are provided by an RN, LPN, or LVN under the supervision of an RN, licensed to practice in the state. Skilled nursing services provided in the member's home or other community setting are services requiring the specialized skills of a licensed nurse. The scope and nature of these services are intended for treatment of a disease or a medical condition and are beyond the scope of ADvantage nursing services. These intermittent nursing services are targeted toward a prescribed treatment or procedure that must be performed at a specific time or other predictable rate of occurrence. The RN contacts the member's physician to obtain necessary information or orders pertaining to the member's care. When the member has an ongoing need for service activities requiring more or less units than authorized, the RN must recommend, in writing, that the service plan be revised.

(B) Skilled nursing services are provided on an intermittent or part-time basis, and billed per ~~fifteen-minute (15-minute)~~fifteen (15) minute units of service. Skilled nursing services are provided when nursing services are not available through Medicare or other sources or when SoonerCare plan nursing services limits are exhausted. Amount, frequency, and duration of services are prior-authorized in accordance with the member's person-centered service plan.

(9) **Home-delivered meals.**

(A) Home-delivered meals provide one (1) meal per day. A home-delivered meal is a meal prepared in advance and brought to the member's home. Each meal must have a nutritional content equal to at least one-third of the dietary reference intakes as established by the Food and Nutrition Board of the National Academy of Sciences. Home-delivered meals are only provided to members who are unable to prepare meals and lack an informal provider to do meal preparation.

(B) Home-delivered meals are billed per meal, with one (1) meal equaling one (1) unit of service. The limit of the number of units a member is allowed to receive is in accordance with the member's person-centered service plan. The provider must obtain a signature from the member or the member's representative at the time the meal is delivered. In the event the member is temporarily unavailable, such as at a doctor's appointment and the meal is left at the member's home, the provider must document the reason a signature was not obtained. The signature logs must be available for review.

(10) **Occupational therapy services.**

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

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

(11) **Physical therapy services.**

(A) Physical therapy services are those services that maintain or improve physical disability through the evaluation and rehabilitation of members disabled by pain, disease, or injury. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Treatment involves the use of physical therapeutic means, such as massage, manipulation, therapeutic exercise, cold and/or heat therapy, hydrotherapy, electrical stimulation, and light therapy. Under a physician's order, a licensed physical therapist evaluates the member's rehabilitation potential and develops an appropriate, written, therapeutic regimen. Under the Oklahoma Physical Therapy Practice Act, a physical therapist may evaluate a member's rehabilitation potential and develop and implement an appropriate, written, therapeutic regimen without a referral from a licensed health care practitioner for a period not to exceed ~~thirty-calendar (30-calendar)~~thirty (30) calendar days. Any treatment required after the ~~thirty-calendar (30-calendar)~~thirty (30) calendar day period requires a prescription from a physician or the physician's assistant of the licensee. The regimen utilizes paraprofessional physical therapy assistant services, within the limitations of his or her practice, working under the supervision of the licensed physical therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services when appropriate. The licensed physical therapist ensures monitoring and documentation of the member's rehabilitative progress and reports to the member's case manager and physician to coordinate the necessary addition or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Physical therapy services are authorized as ADH care therapy enhancement and are a maximum of one (1) session unit per day of service. Payment is not allowed solely for written reports or record documentation.

(12) **Speech and language therapy services.**

(A) Speech and language therapy services are those that maintain or improve speech and language communication and swallowing disorders/disability through the evaluation and rehabilitation of members disabled by pain, disease, or

injury. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Services involve the use of therapeutic means, such as evaluation, specialized treatment, or development and oversight of a therapeutic maintenance program. Under a physician's order, a licensed speech and language pathologist evaluates the member's rehabilitation potential and develops an appropriate, written, therapeutic regimen. The regimen utilizes Speech Language Pathology Assistant services within the limitations of his or her practice, working under the supervision of the licensed Speech and Language Pathologist. The regimen includes education and training for informal caregivers to assist with, and/or maintain services when appropriate. The Speech and Language Pathologist ensures monitoring and documentation of the member's rehabilitative progress and reports to the member's case manager and physician to coordinate the necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Speech and language therapy services are authorized as ADH care-therapy enhancement and are a maximum of one (1) session unit per day of service. Payment is not allowed solely for written reports or record documentation.

(13) **Hospice services.**

(A) Hospice services are palliative and comfort care provided to the member and his or her family when a physician certifies the member has a terminal illness, with a life expectancy of six (6) months or less, and orders hospice care. ADvantage hospice care is authorized for a ~~six-month (6-month)~~six (6) month period and requires physician certification of a terminal illness and orders of hospice care. When the member requires more than six (6) months of hospice care, a physician or nurse practitioner must have a face-to-face visit with the member ~~thirty-calendar (30-calendar)~~thirty (30) calendar days prior to the initial hospice authorization end-date, and re-certify that the member has a terminal illness, has six (6) months or less to live, and orders additional hospice care. After the initial authorization period, additional periods of ADvantage hospice may be authorized for a maximum of ~~sixty-calendar (60-calendar)~~sixty (60) calendar day increments with physician certification that the member has a terminal illness and six (6) months or less to live. A member's person-centered service plan that includes hospice care must

comply with ~~Waiver~~waiver requirements to be within total person-centered service plan cost limits.

(B) A hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional, and spiritual stresses experienced during the final stages of illness, through the end of life, and bereavement. The member signs a statement choosing hospice care instead of routine medical care with the objective to treat and cure the member's illness. Once the member has elected hospice care, the hospice medical team assumes responsibility for the member's medical care for the illness in the home environment. Hospice care services include nursing care, physician services, medical equipment and supplies, drugs for symptom and pain relief, home health aide and personal care services, physical, occupational and speech therapies, medical social services, dietary counseling, and grief and bereavement counseling to the member and/or the member's family.

(C) A hospice person-centered service plan must be developed by the hospice team in conjunction with the member's ADvantage case manager before hospice services are provided. The hospice services must be related to the palliation or management of the member's terminal illness, symptom control, or to enable the member to maintain ADL and basic functional skills. A member who is eligible for Medicare hospice provided as a Medicare Part A benefit, is not eligible to receive ADvantage hospice services.

(D) Hospice services are billed per diem of service for days covered by a hospice person-centered service plan and while the hospice provider is responsible for providing hospice services as needed by the member or member's family. The maximum total annual reimbursement for a member's hospice care within a ~~twelve-month (12-month)~~twelve (12) month period is limited to an amount equivalent to eighty-five (85) percent of the Medicare hospice cap payment, and must be authorized on the member's person-centered service plan.

(14) **ADvantage personal care.**

(A) ADvantage personal care is assistance to a member in carrying out ADLs, such as bathing, grooming, and toileting or in carrying out instrumental activities of daily living (IADLs), such as preparing meals and laundry service, to ensure the member's personal health and safety, or to prevent or minimize physical health regression or deterioration. Personal care services do not include service provision of a technical nature, such as tracheal suctioning, bladder

catheterization, colostomy irrigation, or the operation and maintenance of equipment of a technical nature.

(B) ADvantage home care agency skilled nursing staff working in coordination with an ADvantage case manager is responsible for the development and monitoring of the member's personal care services.

(C) ADvantage personal care services are prior-authorized and billed per ~~fifteen-minute (15-minute)~~fifteen (15) minute unit of service, with units of service limited to the number of units on the ADvantage approved person-centered service plan.

(15) **Personal emergency response system (PERS).**

(A) PERS is an electronic device that enables members at high risk of institutionalization, to secure help in an emergency. Members may also wear a portable "help" button to allow for mobility. PERS is connected to the person's phone and programmed to signal, per member preference, a friend, relative, or a response center, once the "help" button is activated. For an ADvantage member to be eligible for PERS service, the member must meet all of the service criteria in (i) through (vi). ~~The:~~The member:

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

(ii) ~~member lives~~Lives alone and without a regular caregiver, paid or unpaid, and therefore is left alone for long periods of time;

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

(iv) ~~member has~~Has a health and safety plan detailing the interventions beyond the PERS to ensure the member's health and safety in his or her home;

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

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

(B) PERS services are billed using the appropriate Healthcare Common Procedure Coding System (HCPCS) procedure code for installation, monthly service, or PERS purchase. All services are prior authorized per the ADvantage approved service plan.

(16) **CD-PASS.**

(A) CD-PASS are personal services ~~assistance~~assistants (PSA) and advanced personal services ~~assistance~~assistants (APSA) that ~~enables~~enable a member in need of assistance to reside in his or her home and community of choice, rather than in an institution; and to carry out functions of daily living, self-care, and mobility. CD-PASS services are delivered as authorized on the person-centered service plan. The member becomes the employer of record and employs the PSA and the APSA. The member is responsible, with assistance from ADvantage Program Administrative Financial Management Services (FMS), for ensuring the employment complies with state and federal labor law requirements. The member/employer may designate an adult family member or friend, who is not a PSA or APSA to the member, as an "authorized representative" to assist in executing the employer functions. The member/employer:

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

(ii) ~~is~~Is solely responsible to provide instruction and training to the PSA or APSA on tasks and works with the consumer directed agent/case manager (CDA) to obtain ADvantage skilled nursing services assistance with training, when necessary. Prior to performing an APSA task for the first time, the APSA must demonstrate competency in the tasks in an on-the-job training session conducted by the member and the member must document the attendant's competency in performing each task in the APSA's personnel file;

(iii) ~~determines~~Determines where and how the PSA or APSA works, hours of work, what is to be accomplished and, within individual budget allocation limits, wages to be paid for the work;

(iv) ~~supervises~~Supervises and documents employee work time; and

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

(B) The services the PSA may provide include:

(i) ~~assistance~~Assistance with mobility and transferring in and out of bed, wheelchair, or motor vehicle, or all;

(ii) ~~assistance~~Assistance with routine bodily functions, such as:

(I) ~~bathing~~Bathing and personal hygiene;

(II) ~~dressing~~Dressing and grooming; and

(III) ~~eating,~~Eating, including meal preparation and cleanup;

(iii) ~~assistance~~Assistance with home services, such as shopping, laundry, cleaning, and seasonal chores;

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

(C) An APSA provides assistance with ADLs to a member with a stable, chronic condition, when such assistance requires devices and procedures related to altered body function if such activities, in the opinion of the attending physician or licensed nurse, may be performed if the member were physically capable, and the procedure may be safely performed in the home. Services provided by the APSA are maintenance services and are never used as therapeutic treatment. Members who develop medical complications requiring skilled nursing services while receiving APSA services are referred to his or her attending physician, who when appropriate, orders home health services. APSA includes assistance with health maintenance activities that may include:

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

(ii) ~~removing~~Removing external catheters, inspecting skin, and reapplication of same;

(iii) ~~administering~~Administering prescribed bowel program, including use of suppositories and sphincter stimulation, and enemas pre-packaged only without contraindicating rectal or intestinal conditions;

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

(v) ~~using~~Using a lift for transfers;

(vi) ~~manually~~Manually assisting with oral medications;

(vii) ~~providing~~Providing passive range of motion (non-resistive flexion of joint) therapy, delivered in

accordance with the person-centered service plan unless contraindicated by underlying joint pathology;

(viii) ~~applying~~Applying non-sterile dressings to superficial skin breaks or abrasions; and

(ix) ~~using~~Using universal precautions as defined by the Centers for Disease Control and Prevention.

(D) FMS are program administrative services provided to participating CD-PASS members/employers by AA. FMS are employer-related assistance that provides Internal Revenue Service (IRS) fiscal reporting agent and other financial management tasks and functions including, but not limited to:

(i) ~~processing~~Processing employer payroll, after the member/employer has verified and approved the employee timesheet, at a minimum of semi-monthly, and associated withholding for taxes, or for other payroll withholdings performed on behalf of the member as employer of the PSA or APSA;

(ii) ~~other~~Other employer related payment disbursements as agreed to with the member/employer and in accordance with the member/employer's individual budget allocation;

(iii) ~~responsibility~~Responsibility for obtaining criminal and abuse registry background checks on prospective hires for PSA or APSA on the member/employer's behalf;

(iv) ~~providing~~Providing orientation and training regarding employer responsibilities, as well as employer information and management guidelines, materials, tools, and staff consultant expertise to support and assist the member successfully perform employer-related functions; and

(v) ~~making~~Making Hepatitis B vaccine and vaccination series available to PSA and APSA employees in compliance with Occupational Safety and Health Administration (OSHA) standards.

(E) The PSA service is billed per ~~fifteen-minute (15-minute)~~fifteen (15) minute unit of service. The number of units of PSA a member may receive is limited to the number of units approved on the person-centered service plan.

(F) The APSA service is billed per ~~fifteen-minute (15-minute)~~fifteen (15) minute unit of service. The number of units of APSA a member may receive is limited to the number of units approved on the person-centered service plan.

(17) **Institutional transition services.**

(A) Institutional transition services are those services necessary to enable a member to leave the institution and

receive necessary support through ADvantage waiver services in his or her home and community.

(B) Transitional case management services are services per OAC 317:30-5-763(1) required by the member and included on the member's person-centered service plan that are necessary to ensure the member's health, welfare, and safety, or to enable the member to function with greater independence in the home, and without which, the member would continue to require institutionalization. ADvantage transitional case management services assist institutionalized members who are eligible to receive ADvantage services in gaining access to needed Waiver and other State plan services, as well as needed medical, social, educational, and other services to assist in the transition, regardless of the funding source for the services to which access is gained. Transitional case management services may be authorized for periodic monitoring of an ADvantage member's progress during an institutional stay and for assisting the member transition from institution to home by updating the person-centered service plan, including necessary institutional transition services to prepare services and supports to be in place or to start on the date the member is discharged from the institution. Transitional case management services may be authorized to assist individuals that have not previously received ADvantage services, but were referred by DHS AS to the case management provider for assistance in transitioning from the institution to the community with ADvantage services support.

(i) Institutional transition case management services are prior authorized and billed per ~~fifteen-minute (15-minute)~~fifteen (15) minute unit of service using the appropriate HCPC procedure code and modifier associated with the location of residence of the member served, per OAC 317:30-5-763(1)(C).

(ii) A unique modifier code is used to distinguish transitional case management services from regular case management services.

(C) Institutional transition services may be authorized and reimbursed, per the conditions in (i) through (iv).

(i) The service is necessary to enable the member to move from the institution to his or her home.

(ii) The member is eligible to receive ADvantage services outside of the institutional setting.

(iii) Institutional transition services are provided to the member within one-hundred and eighty (180) calendar-days of discharge from the institution.

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

(D) When the member receives institutional transition services but fails to enter the waiver, any institutional transition services provided are not reimbursable.

(18) **Assisted living services (ALS).**

(A) ALS are personal care and supportive services furnished to waiver members who reside in a homelike, non-institutional setting that includes twenty-four (24) hour on-site response capability to meet scheduled or unpredictable member needs and to provide supervision, safety, and security. Services also include social and recreational programming and medication assistance, to the extent permitted under State law. The ALS provider is responsible for coordinating services provided by third parties to ADvantage members in the assisted living center (ALC). Nursing services are incidental rather than integral to the provision of ALS. ADvantage reimbursement for ALS includes services of personal care, housekeeping, laundry, meal preparation, periodic nursing evaluations, nursing supervision during nursing intervention, intermittent or unscheduled nursing care, medication administration, assistance with cognitive orientation, assistance with transfer and ambulation, planned programs for socialization, activities, and exercise, and for arranging or coordinating transportation to and from medical appointments. Services, except for planned programs for socialization, activities, and exercise are to meet the member's specific needs as determined through the individualized assessment and documented on the member's person-centered service plan.

(B) The ADvantage ALS philosophy of service delivery promotes member choice, and to the greatest extent possible, member control. A member has control over his or her living space and his or her choice of personal amenities, furnishings, and activities in the residence. The ADvantage member must have the freedom to control his or her schedule and activities. The ALS provider's documented operating philosophy, including policies and procedures, must reflect and support the principles and values associated with the ADvantage assisted living philosophy and approach to service delivery emphasizing member dignity, privacy, individuality, and independence.

(C) ADvantage ALS required policies for admission and termination of services and definitions.

(i) ADvantage-certified assisted living centers (ALC) are required to accept all eligible ADvantage members who choose to receive services through the ALC, subject only to issues relating to, one (1) or more of the following:

(I) ~~rental~~Rental unit availability;

(II) ~~the~~The member's compatibility with other residents;

(III) ~~the~~The center's ability to accommodate residents who have behavior problems, wander, or have needs that exceed the services the center provides; or

(IV) ~~restrictions~~Restrictions initiated by statutory limitations.

(ii) The ALC may specify the number of units the provider is making available to service ADvantage members. At minimum, the ALC must designate ten (10) residential units for ADvantage members. Residential units designated for ADvantage may be used for other residents at the ALC when there are no pending ADvantage members for those units. Exceptions may be requested in writing subject to the approval of AA.

(iii) Mild or moderate, cognitive impairment of the applicant is not a justifiable reason to deny ALC admission. Centers are required to specify whether they are able to accommodate members who have behavior problems or wander. Denial of admission due to a determination of incompatibility must be approved by the case manager and the AA. Appropriateness of placement is not a unilateral determination by the ALC. The ADvantage case manager, the member, or member's designated representative, and the ALC in consultation determine the appropriateness of placement.

(iv) The ALC is responsible for meeting the member's needs for privacy, dignity, respect, and freedom from coercion and restraint. The ALC must optimize the member's initiative, autonomy and independence in making life choices. The ALC must facilitate member choices regarding services and supports, and who provides them. Inability to meet those needs is not recognized as a reason for determining an ADvantage member's placement is inappropriate. The ALC agrees to provide or arrange and coordinate all of the services listed in the Oklahoma State Department of Health (OSDH) regulations, per OAC 310:663-3-3, except for specialized services.

(v) In addition, the ADvantage participating ALC agrees to provide or coordinate the services listed in (I) through (III).

(I) Provide an emergency call system for each participating ADvantage member.

(II) Provide ~~up to~~ three (3) meals per day plus snacks sufficient to meet nutritional requirements, including modified special diets, appropriate to the member's needs and choices; and provide members with twenty-four (24) hour access to food by giving members control in the selection of the foods they eat, by allowing the member to store personal food in his or her room, by allowing the member to prepare and eat food in his or her room, and allowing him or her to decide when to eat.

(III) Arrange or coordinate transportation to and from medical appointments. The ALC must assist the member with accessing transportation for integration into the community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, and control his or her personal resources and receive services in the community to the same degree of access as residents not receiving ADvantage services.

(vi) The provider may offer any specialized service or rental unit for members with Alzheimer's disease and related dementias, physical disabilities, or other special needs the facility intends to market. Heightened scrutiny, through additional monitoring of the ALC by AA, is utilized for those ALC's that also provide inpatient treatment; settings on the grounds of or adjacent to a public institution and/or other settings that tend to isolate individuals from the community. The ALC must include evidence that the ALC portion of the facility has clear administrative, financial, programmatic and environmental distinctions from the institution.

(vii) When the provider arranges and coordinates services for members, the provider is obligated to ensure the provision of those services.

(viii) Per OAC 310:663-1-2, "personal care" is defined as "assistance with meals, dressing, movement, bathing or other personal needs or maintenance, or general supervision of the physical and mental well-being of a person, and includes assistance with toileting." For ADvantage ALS, assistance with "other personal needs" in this definition includes assistance with grooming and transferring. The term "assistance" is clarified to mean hands-on help, in addition to supervision.

(ix) The specific ALS assistance provided along with amount and duration of each type of assistance is based upon the member's assessed need for service assistance and is specified in the ALC's service plan that is incorporated as supplemental detail into the ADvantage comprehensive person-centered service plan. The ADvantage case manager in cooperation with ALC professional staff, develops the person-centered service plan to meet member needs. As member needs change, the person-centered service plan is amended consistent with the assessed, documented need for change in services.

(x) Placement, or continued placement of an ADvantage member in an ALC, is inappropriate when any one (1) or more of the conditions exist.

(I) The member's needs exceed the level of services the center provides. Documentation must support ALC efforts to provide or arrange for the required services to accommodate participant needs.

(II) The member exhibits behavior or actions that repeatedly and substantially interferes with the rights or well-being of other residents and the ALC documented efforts to resolve behavior problems including medical, behavioral, and increased staffing interventions. Documentation must support the ALC attempted interventions to resolve behavior problems.

(III) The member has a complex, unstable, or unpredictable medical condition and treatment cannot be developed and implemented appropriately in the assisted living environment. Documentation must support the ALC attempts to obtain appropriate member care.

(IV) The member fails to pay room and board charges and/or DHS determined vendor payment obligation.

(xi) Termination of residence when inappropriately placed. Once a determination is made that a member is inappropriately placed, the ALC must inform the member, the member's representative, when applicable, the AA and the member's ADvantage case manager. The ALC must develop a discharge plan in consultation with the member, the member's representative, the ADvantage case manager, and the AA. The ALC and case manager must ensure the discharge plan includes strategies for providing increased services, when appropriate, to minimize risk and meet the higher care needs of members transitioning out of the ALC, when the reason for discharge is inability to meet member needs. When voluntary termination of residency is

not arranged, the ALC must provide written notice to the member and to the member's representative, with a copy to the member's ADvantage case manager and the AA. The written notice provides intent to terminate the residency agreement and move the member to an appropriate care provider. The thirty (30) calendar-day requirement must not apply when emergency termination of the residency agreement is mandated by the member's immediate health needs or when the termination of the residency agreement is necessary for the physical safety of the member or other ALC residents. The written involuntary termination of residency notice for reasons of inappropriate placement must include:

(I) a full explanation of the reasons for the termination of residency;

(II) the notice date;

(III) the date notice was given to the member and the member's representative, the ADvantage case manager, and the AA;

(IV) the date the member must leave ALC; and

(V) notification of appeal rights and the process for submitting appeal of termination of Medicaid ALS to OHCA.

(D) ADvantage ALS provider standards in addition to licensure standards.

(i) **Physical environment.**

(I) The ALC must provide lockable doors on the entry door of each rental unit and an attached, lockable compartment within each member unit for valuables. Members must have exclusive rights to his or her unit with lockable doors at the entrance of the individual or shared rental unit. Keys to rooms may be held by only appropriate ALC staff as designated by the member's choice. Rental units may be shared only when a request to do so is initiated by the member. Members must be given the right to choose his or her roommate.

(II) The member has a legally enforceable agreement, lease, with the ALC. The member must have the same responsibilities and protections from eviction as all tenants under the landlord tenant law of the state, county, city, or other designated entity.

(III) The ALC must provide each rental unit with a means for each member to control the temperature in the residential unit through the use of a damper, register, thermostat, or other reasonable means under the control of the member and that preserves privacy,

independence, and safety, provided that the OSDH may approve an alternate means based on documentation that the design of the temperature control is appropriate to the special needs of each member who has an alternate temperature control.
(IV) For ALCs built prior to January 1, 2008, each ALC individual residential unit must have a minimum total living space, including closets and storage areas, of two-hundred and fifty (250) square feet~~;~~. ~~for ALCs built after December 31, 2007,~~Beginning January 1, 2008, each ALC individual residential unit must have a minimum total living space, including closets and storage areas, of three-hundred and sixty (360) square feet.
(V) The ALC must provide a private bathroom for each living unit that must be equipped with one lavatory, one toilet, and one bathtub or shower stall.
(VI) The ALC must provide at a minimum; a kitchenette, defined as a space containing a refrigerator, adequate storage space for utensils, and a cooking appliance, a microwave is acceptable.
(VII) The member is responsible for furnishing the rental unit. When a member is unable to supply basic furnishings defined as a bed, dresser, nightstand, chairs, table, trash can, and lamp, or if member supplied furnishings pose a health or safety risk, the member's ADvantage case manager in coordination with the ALC, must assist the member in obtaining basic furnishings for the rental unit. The member must have the freedom to furnish and decorate the rental unit within the scope of the lease or residency agreement.
(VIII) The ALC must meet the requirements of all applicable federal and state laws and regulations including, but not limited to, state and local sanitary codes, state building and fire safety codes, and laws and regulations governing use and access by persons with disabilities.
(IX) The ALC must ensure the design of common areas accommodates the special needs of the resident population and that the rental unit accommodates the special needs of the member in compliance with the Americans with Disabilities Act accessibility guidelines per 28 Code of Federal Regulations, Part 36, Appendix A, at no additional cost to the member.
(X) The ALC must provide adequate and appropriate social and recreational space for residents and the

common space must be proportionate to the number of residents and appropriate for the resident population.

(XI) The ALC must provide appropriately monitored outdoor space for resident use.

(XII) The ALC must provide the member with the right to have visitors of his or her choosing at any time. Overnight visitation is allowed as permissible by the Landlord/Tenant Agreement.

(XIII) The ALC must be physically accessible to members.

(ii) **Sanitation.**

(I) The ALC must maintain the facility, including its individual rental units in a clean, safe, and sanitary manner and be insect and rodent free, odorless, and in good repair at all times.

(II) The ALC must maintain buildings and grounds in a good state of repair, in a safe and sanitary condition, and in compliance with the requirements of applicable regulations, bylaws, and codes.

(III) The ALC stores clean laundry in a manner that prevents contamination and changes linens at time intervals necessary to avoid health issues.

(IV) The ALC must provide housekeeping in member rental units to maintain a safe, clean, and sanitary environment.

(V) The ALC must have policies and procedures for members' pets.

(iii) **Health and Safety.**

(I) The ALC must provide building security that protects members from intruders with security measures appropriate to building design, environmental risk factors, and the resident population.

(II) The ALC must respond immediately and appropriately to missing members, accidents, medical emergencies, or deaths.

(III) The ALC must have a plan in place to prevent, contain, and report any diseases considered to be infectious or are listed as diseases that must be reported to the OSDH.

(IV) The ALC must adopt policies for the prevention of abuse, neglect, and exploitation that include screening, training, prevention, investigation, protection during investigation, and reporting.

(V) The ALC must provide services and facilities that accommodate the needs of members to safely evacuate in the event of fires or other emergencies.

(VI) The ALC must ensure staff is trained to respond appropriately to emergencies.

(VII) The ALC must ensure that fire safety requirements are met.

(VIII) The ALC must offer meals that provide balanced and adequate nutrition for members.

(IX) The ALC must adopt safe practices for the preparation and delivery of meals.

(X) The ALC must provide a twenty-four (24) hour response to personal emergencies appropriate to the needs of the resident population.

(XI) The ALC must provide safe transportation to and from ALC sponsored social or recreational outings.

(iv) **Staff to resident ratios.**

(I) The ALC must ensure a sufficient number of trained staff are on duty, awake, and present at all times, twenty-four (24) hours a day, and seven (7) days a week, to meet the needs of residents and to carry out all of the processes listed in the ALC's written emergency and disaster preparedness plan for fires and other disasters.

(II) The ALC must ensure staffing is sufficient to meet ADvantage Program members' needs in accordance with each member's ADvantage person-centered service plan.

(III) The ALC must have plans in place to address situations where there is a disruption to the ALC's regular work force.

(v) **Staff training and qualifications.**

(I) The ALC must ensure staff has qualifications consistent with their job responsibilities.

(II) All staff assisting in, or responsible for, food service must have attended a food service training program offered or approved by OSDH.

(III) The ALC must provide staff orientation and ongoing training to develop and maintain staff knowledge and skills. All direct care and activity staff receive at least eight (8) hours of orientation and initial training within the first month of employment and at least four (4) hours annually thereafter. Staff providing direct care on a dementia unit must receive four (4) additional hours of dementia specific training. Annual first aid and cardiopulmonary resuscitation (CPR) certification do not count toward the four (4) hours of annual training.

(vi) **Staff supervision.**

(I) The ALC must ensure delegation of tasks to non-licensed staff is consistent and in compliance with all applicable state regulations including, but not limited to, the Oklahoma Nurse Practice Act and OSDH Nurse Aide Certification rules.

(II) The ALC must ensure that, where the monitoring of food intake or therapeutic diets is provided at the prescribed services level, a registered dietitian monitors member health and nutritional status.

(vii) **Resident rights.**

(I) The ALC must provide to each member and each member's representative, at the time of admission, a copy of the resident statutory rights listed in Section 1-1918 of Title 63 of the Oklahoma Statutes (O.S.) amended to include additional rights and the clarification of rights as listed in the ADvantage Member Assurances. A copy of resident rights must be posted in an easily accessible, conspicuous place in the facility. The facility must ensure that staff is familiar with and observes, the resident rights.

(II) The ALC must conspicuously post for display in an area accessible to residents, employees, and visitors, the ALC's complaint procedures and the name, address, and phone number of a person authorized to receive complaints. A copy of the complaint procedure must also be given to each member, the member's representative, or the legal guardian. The ALC must ensure all employees comply with the ALC's complaint procedure.

(III) The ALC must provide to each member and member's representative, at the time of admission, information about Medicaid grievance and appeal rights, including a description of the process for submitting a grievance or appeal of any decision that decreases Medicaid services to the member.

(viii) **Incident reporting.**

(I) The ALC must maintain a record of incidents that occur and report incidents to the member's ADvantage case manager and to the AA, utilizing the AA Critical Incident Reporting form. Incident reports are also made to Adult Protective Services (APS) and to the OSDH, as appropriate, per ALC licensure rules, utilizing the specific reporting forms required.

(II) Incidents requiring report by licensed ALC are those defined by OSDH, per OAC 310:663-19-1 and listed on the AA Critical Incident Reporting form.

(III) Reports of incidents must be made to the member's ADvantage case manager and to the AA via electronic submission within one (1) business day of the reportable incident's discovery utilizing the AA Critical Incident Reporting form. When required, a follow-up report of the incident must be submitted via electronic submission to the member's ADvantage case manager and to the AA. The follow-up report must be submitted within ~~five-business (5-business)~~five (5) business days of the incident. The final report must be filed with the member's ADvantage case manager and the AA when the investigation is complete, not to exceed ~~ten-business (10-business)~~ten (10) business days after the incident.

(IV) Each ALC having reasonable cause to believe that a member is suffering from abuse, neglect, exploitation, or misappropriation of member property must make a report to APS as soon as the person is aware of the situation per ~~O.S. 43A § 10-104.A.~~43A O.S. § 10-104.A. Reports are also made to OSDH, as appropriate, per ALC licensure rules.

(V) The preliminary incident report must at the minimum, include who, what, when, where, and the measures taken to protect the member and resident(s) during the investigation. The follow-up report must at the minimum, include preliminary information, the extent of the injury or damage, when any, and preliminary investigation findings. The final report at a minimum includes preliminary and follow-up information, a summary of investigative actions representing a thorough investigation, investigative findings and conclusions based on findings, and corrective measures to prevent future occurrences. When it is necessary to omit items, the final report must include why such items were omitted and when they will be provided.

(ix) Provision of or arrangement for necessary health services. The ALC must:

(I) ~~arrange~~Arrange or coordinate transportation for members to and from medical appointments; and

(II) ~~provide~~Provide or coordinate with the member and the member's ADvantage case manager for delivery of necessary health services. The ADvantage case manager is responsible for monitoring all health-related services required by the member as identified through assessment and documented on the person-centered

service plan, are provided in an appropriate and timely manner. The member has the freedom to choose any available provider qualified by licensure or certification to provide necessary health services in the ALC.

(E) ALS are billed per diem of service for days covered by the ADvantage member's person-centered service plan and during which the ALS provider is responsible for providing ALS for the member. The per diem rate for ADvantage assisted living services for a member is one (1) of three (3) per diem rate levels based on a member's need for type of, intensity of, and frequency of service to address member ADLs, instrumental activities of the daily living(IADLs), and health care needs. The rate level is based on the Uniform Comprehensive Assessment Tool (UCAT) assessment by the member's ADvantage case manager employed by a case management agency independent of the ALS provider. The determination of the appropriate per diem rate is made by the AA clinical review staff.

(F) The ALC must notify AA ~~ninety-calendar (90-calendar)~~ninety (90) calendar days before terminating or not renewing the ALC's ADvantage contract.

(i) The ALC must give notice in writing to the member, the member's representative(s), the AA, and the member's ADvantage case manager ninety-calendar (90-calendar) days before:

(I) ~~voluntary~~Voluntary cessation of the ALC's ADvantage contract; or

(II) ~~closure~~Closure of all or part of the ALC.

(ii) The notice of closure must include:

(I) ~~the~~The proposed ADvantage contract termination date;

(II) ~~the~~The termination reason;

(III) ~~an~~An offer to assist the member to secure an alternative placement; and

(IV) ~~available~~Available housing alternatives.

(iii) The facility must comply with all applicable laws and regulations until the closing date, including those related to resident transfer or discharge.

(iv) Following the last move ~~to~~of the last ADvantage member, the ALC must provide in writing to the AA:

(I) ~~the~~The effective date of closure based on the discharge date of the last resident;

(II) ~~a~~A list of members transferred or discharged and where they relocated~~,~~; and

(III) ~~the~~The plan for storage of resident records per OAC 310:663-19-3(g), relating to preservation of resident records and the name, address, and phone numbers of the person responsible for the records.