

**Oklahoma Health Care Authority**

It is very important that you provide your comments regarding the proposed rule change by the comment due date. Comments are directed to the [Oklahoma Health Care Authority \(OHCA\) Proposed Changes Blog](#).

**OHCA COMMENT DUE DATE:** February 17, 2017

The proposed policy is a Permanent Rule. The proposed policy was presented at the November 1, 2016 Tribal Consultation and is scheduled to be presented to the Medical Advisory Committee on March 9, 2017 and the OHCA Board of Directors on March 23, 2017.

**Reference: APA WF 16-25B**

**SUMMARY:**

**ADvantage Waiver** - The proposed revisions update rules for the ADvantage program and related services. The revisions add language to comply with Federal regulations specific to home and community based settings. Rules also clarify compensable services and contract requirements. In addition, rules outline audit procedures for specific providers.

**LEGAL AUTHORITY**

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR Part 430, 431 et. Al.

**RULE IMPACT STATEMENT:**

**STATE OF OKLAHOMA  
OKLAHOMA HEALTH CARE AUTHORITY**

TO: Tywanda Cox  
Health Policy

FROM: Carmen Johnson  
Health Policy

SUBJECT: Circulation Document  
APA WF # 16-25B

A. Brief description of the purpose of the rule:

The proposed revisions to Chapter 35 (Subchapters 15, 17, & 19) update rules for the Advantage program and related services. The revisions add language to comply with Federal regulations specific to home and community based settings. Rules also clarify compensable services and contract requirements. In addition, rules outline audit procedures for specific providers.

The proposed policy is amended to:

- clarify technical services provided by State Plan Personal Care services program;
- add previously removed language to add clarity and avoid confusion of the provider agencies referencing when personal care may not be approved;
- add language to clarify who is not qualified to provide services as an Individual Personal Care Assistant and exceptions that may be made for a legal guardian to provide services with prior approval from DHS Aging Services;
- update and clarify that mental impairment language includes an individual who is actively psychotic or believed to be in danger of imminent harm to self or others may not be approved to receive Personal Care Services;
- clarify timeframe in which nurses are to complete the Service Authorization Model (SAM) visit for determination for State Plan Personal Care program;
- add clarity of DHS forms to be used in the eligibility processes for personal care service authorization;
- clarify the SPPC grievance process and billing process for personal care services;
- add language for the personal care provider agency nurse in resuming the personal care services process, the nurse may give verbal verification to start services if it has been less than 90 days, however, when the nurse contacts the member and determines that there have been changes in health or service needs the nurse must make a home visit and submit a nursing re-assessment of need within ten business days of the resumed plan start date;
- add language to clarify if nurse determines that there have been no changes in health or service needs, nurse documents and forwards to DHS nurse to resume the plan start date;
- add language for those members that personal care services may be discontinued for;

- clarify the policy regarding payment for personal care services if the client lives in the PCA's home without DHS approval;
- update wording changes to be in continuity with policy due to changes in the IVRA system to EVV (Electronic Visit Verification), update wording to be in continuity with the target population language;
- clarify processes and who is required to document through the EVV system;
- clarify and update language to be in continuity with the ADvantage Waiver services target population of 65 years of age or older;
- remove services listed that are no longer provided by the ADvantage Waiver;
- add language that would identify what members would not be able to receive ADvantage Waiver services due to illegal drug activity in the home;
- update commonly used terms and remove duplicative language;
- add language to clarify the ADvantage program case manager's duties when performing a home visit;
- remove the SPEED process that is no longer part of the ADvantage waiver, was used to re-establish ADvantage eligibility to coincide with the date of discharge from the nursing facility;
- update language in policy to reflect the current practice and implementation of nursing home assessments; and
- update form numbers to be used by the DHS nurses and processes for Nursing Home Level of Care Assessments.

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:

The classes of persons affected by the proposed amendments are individuals receiving DHS Aging Services (AS), ADvantage Waiver services, who bear no costs associated with the implementation of the rule.

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

The classes of persons who benefit are individuals receiving

DHS AS ADvantage Waiver services.

- 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:

There is no economic impact on individuals who receive DHS AS ADvantage Waiver services.

- 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 probable cost to DHS includes the cost of printing and distributing the rules, estimated to be less than \$20.

- 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 amendments do not have an impact on any political subdivisions or require their cooperation in enforcing the rules.

- 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 proposed amendments do not have an adverse effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act.

- 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 proposed amendments do not increase compliance costs. There are no less costly or non-regulatory methods or less intrusive methods.

- 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 amendments clarify the grievance processes for personal care services, thereby increasing program effectiveness positively impacting the health, safety, and well-being of affected persons.

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

If the proposed amendments are not implemented, the rules will continue to not provide clarification of services provided by the ADvantage Waiver.

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

Prepared: December 5, 2016

Modified: January 24, 2017

#### **RULE TEXT**

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

#### **SUBCHAPTER 15. PERSONAL CARE SERVICES**

##### **317:35-15-2. Personal Carecare services**

(a) Personal ~~Carecare~~ is assistance to an individual in carrying out ~~activities of daily living~~ Activities of Daily Living (ADLs) or in carrying out ~~instrumental activities of daily living~~ Instrumental Activities of Daily Living (IADLs) directly related to the member's personal care needs to prevent or minimize physical health regression or deterioration. ~~The Personal Care~~ Personal care service requires a skilled nursing assessment of need, development of a care plan to meet

identified personal care needs, care plan oversight, and periodic re-assessment and updating, ~~if of the care plan, when necessary, of the care plan.~~ Personal Care services do not include technical services, such as—tracheal suctioning, tracheal care, gastrostomy-tube feeding or care, specialized feeding due to choking risk, application of compression stockings, bladder catheterization, colostomy irrigation, wound care, application of prescription lotions or topical ointments, range of motion exercises, or the operation of equipment of a technical nature, such as a patient lift— or oxygen equipment.

(b) Personal Care members may receive services in limited types of living arrangements. The specific living arrangements are set forth below.

(1) Personal Care members are not eligible to receive services while residing in an institutional setting including, but not limited to, licensed facilities, such as a hospital, nursing facility, licensed residential care facility or licensed assisted living facility, or in an unlicensed institutional living arrangement, such as a room and board home or facility. Personal care may not be approved when the client lives in the personal care assistant's home except with the approval of Oklahoma Department of Human Services (DHS) Aging Services.

(2) Additional living arrangements in which members may receive Personal Care services are the member's own home, apartment, or a family or friend's home or apartment. A home or apartment unit is defined as a self-contained living space having a lockable entrance to the unit including a bathroom and food storage/preparation amenities in addition to bedroom/living space.

(3) For Personal Care members who are full-time students, a dormitory room qualifies as an allowable living arrangement in which to receive Personal Care services for the period during which the member is a student.

(4) With prior approval of the ~~OKDHS~~ DHS area nurse, Personal Care services may be provided in an educational or employment setting to assist the member in ~~achieving~~ achieve vocational goals identified in the care plan.

(c) Personal Care services may be provided by an individual employed by the member referred to as an ~~Individual Personal Care Assistant~~ individual personal care assistant (IPCA) or by a ~~Personal Care Assistant~~ personal care assistant (PCA) employed by a home care agency ~~that is~~ certified to provide Personal Care services and contracted with the ~~OHCA~~ Oklahoma Health Care Authority (OHCA) to provide Personal Care services. ~~OKDHS~~ DHS must determine an IPCC to be qualified

to provide ~~Personal Care~~personal care services and not identified as formal/informal support for member before they can provide services. Persons eligible to serve as either IPCAs or PCAS must ~~meet the following criteria:~~

- (1) ~~are~~be at least 18 years of age;
  - (2) have no pending notation related to abuse, neglect, or exploitation as reported by the Oklahoma State Department of Health Nurse Aide Registry;
  - (3) ~~are not~~be included in the ~~OKDHS~~DHS Community Services Worker Registry;
  - (4) ~~have not been~~be convicted of a crime or have any criminal background history or registry listings that prohibit employment ~~as defined in~~per O.S. Title 63, Section 1-1950.1;
  - (5) demonstrate the ability to understand and carry out assigned tasks;
  - (6) ~~are not~~be a legally responsible family member, such as a spouse, legal guardian, or parent of a minor child of the member being served ~~(exceptions may be made for a legal guardian to provide services only with prior approval from the OKDHS Aging Services Division);~~, exceptions may be made for a legal guardian to provide services only with prior approval from DHS Aging Services;
  - (7) have a verifiable work history and/or personal references, verifiable identification; and
  - (8) meet any additional requirements ~~as~~ outlined in the contract and certification requirements with ~~the~~ OHCA.
- (d) Eligibility for Personal Care is contingent on an individual requiring one or more of the services offered at least monthly that include personal care, meal preparation, housekeeping, laundry, shopping or errands, or specified special tasks to meet ~~Activities of Daily Living~~ADL or ~~Instrumental Activities of Daily Living~~IADL assessed needs.

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

(a) **Eligibility.** The ~~OKDHS~~Oklahoma Department of Human Services (DHS) area nurse determines medical eligibility for ~~Personal Care~~personal care services based on the ~~UCAT~~Uniform Comprehensive Assessment Tool (UCAT) and the determination that the member has unmet care needs that require ~~Personal Care~~personal care services. ~~Personal Care~~care services are initiated to support the informal care ~~that is being~~ provided in the member's home. ~~Personal Care~~care services are not intended to take the place of regular care and general maintenance tasks or meal preparation shared or done for one another by natural supports, such as spouses or other adults who live in the same household. Additionally, ~~Personal Care~~personal care services are

not furnished when they principally benefit the family unit. To be eligible for ~~Personal Care~~personal care services, the individual must:

(1) have adequate informal supports ~~that~~consisting of adult supervision that is present or available to contribute to care, or decision-makingdecision-making ability as documented on the UCAT, to remain in his/herhis or her home without risk to his/herhis or her health, safety, and well-being~~;~~, the individual:

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

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

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

(3) have a physical impairment or combination of physical and mental impairments as documented on the UCAT. An individual who poses a threat to self or others as supported by professional documentation or other credible documentation may not be approved for ~~Personal Care services~~. An individual who is actively psychotic or believed to be in danger of potential harm to self or others may not be approved for personal care services;

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

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

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

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

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

and safety such as:

- (A) bathing<sub>τi</sub>
- (B) eating<sub>τi</sub>
- (C) dressing<sub>τi</sub>
- (D) grooming<sub>τi</sub>
- (E) transferring, ~~(includes activities such as getting in and out of a tub, bed to chair, etc.)~~, includes activities, such as getting in and out of a tub, or bed to chair;
- (F) mobility<sub>τi</sub>
- (G) toileting<sub>τi</sub>; and
- (H) bowel/bladder control.

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

(3) means the member's UCAT Consumer Support score is zero ~~which~~ that indicates<sub>τ</sub> in the UCAT assessor's clinical judgment, formal and informal sources are sufficient for present level of member need in most functional areas.

(4) means the member's UCAT Consumer Support score is five ~~which~~ that indicates<sub>τ</sub> in the UCAT assessor's clinical judgment, support from formal and informal sources are nearly sufficient for present level of member need in most functional areas. The member, family, or informal supports are meeting most needs typically expected of family or household members to share or do for one another, such as general household maintenance. There is little risk of institutional placement with loss of current supports.

(5) means the UCAT Consumer score is 15 ~~which~~ that indicates<sub>τ</sub> in the UCAT assessor's clinical judgment, formal and informal support is available, but overall, it is inadequate, changing, fragile, or otherwise problematic. The member requires additional assistance that usually includes personal care assistance with one or more ~~ADL tasks~~ ADLs not available through Medicare, the Veterans Administration, or other federal entitlement programs. Support provided by informal caregivers is of questionable reliability due to one or more of the following:

- (A) care or support is required continuously with no relief or backup available;
- (B) informal support lacks continuity due to conflicting responsibilities, such as work or child care;
- (C) care or support is provided by persons with advanced age or disability; or
- (D) institutional placement can reasonably be expected with any loss of existing support

(6) means the member's UCAT Consumer score is 25 ~~which~~ that indicates<sub>τ</sub> in the UCAT assessor's clinical judgment, formal

and informal supports are not sufficient as there is very little or no support available to meet a high degree of member need.

(7) **"Community Services Worker" ~~services worker~~**

means any ~~person~~ non-licensed health professional employed by or under contract with a community services provider who provides, for compensation or as a volunteer, health-related services, training, or supportive assistance to frail elderly, disabled person(s), or person(s) with developmental disabilities, ~~and who is not a licensed health professional.~~

(8) **"Community Services Worker Registry"** means a registry established by the ~~OKDHS, DHS,~~ as required by Section 1025.1 et seq. of Title 56 of the Oklahoma Statutes, to list community services workers against whom a final investigative finding of abuse, neglect, or exploitation, ~~as defined in~~ Section 10-103 of Title 43A of the Oklahoma Statutes, involving a frail elderly, disabled person(s), or person(s) with developmental disabilities ~~has been~~ was made by ~~OKDHS~~ DHS or an administrative law judge, amended in 2002, to include the listing of SoonerCare ~~PCAs~~ personal care assistants (PCAs) providing personal care services.

(9) **"Instrumental activities of daily living (IADL)"**

means those activities that reflect the member's ability to perform household chores and tasks within the community essential for sustaining health and safety, such as:

- (A) shopping<sub>7i</sub>
- (B) cooking<sub>7i</sub>
- (C) cleaning<sub>7i</sub>
- (D) managing money<sub>7i</sub>
- (E) using a telephone<sub>7i</sub>
- (F) doing laundry<sub>7i</sub>
- (G) taking medication<sub>7i</sub> and
- (H) accessing transportation.

(10) **"IADLs score is at least six"** means the member needs some help with at least three IADLs or cannot do two IADLs at all.

(11) **"IADLs score of eight or greater"** means the member needs some help with at least four IADLs or the member cannot do two IADLs at all and needs some help with one or more other IADLs.

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

(13) **"MSQ moderate risk range"** means a total ~~weighted score~~ reweighted-score of seven to ~~eleven~~ which all that indicates an orientation-memory-concentration impairment or memory impairment.

(14) **"Nutrition moderate risk"** means the total weighted UCAT Nutrition score is eight or more ~~which~~ that indicates poor

appetite or weight loss combined with special diet requirements, medications, or difficulties in eating.

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

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

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

(2) Consumer Support is 15 or more; or Consumer Support score is five and the Social Resources score is eight or more.

(d) **Medical eligibility determination.** Medical eligibility for Personal Care ~~personal care~~ is determined by the ~~OKDHS~~ DHS. The medical decision for Personal Care ~~personal care~~ is made by the ~~OKDHS~~ DHS area nurse utilizing the UCAT.

(1) Categorical relationship must be established for determination of eligibility for Personal Care ~~personal care~~. ~~If~~ When categorical relationship to Aid to the Disabled ~~has~~ was not ~~already been~~ established, but there is an extremely emergent need for Personal Care ~~personal care~~, and current medical information is not available, the local office authorizes a medical examination. When authorization is necessary, the county director issues ~~the~~ Form 08MA016E, Authorization for Examination, OKDHS form 08MA016E, and ~~the~~ Form 08MA02E, Report of Physician's Examination, OKDHS form 08MA02E, to a licensed medical or osteopathic ~~physician~~ health care professional, refer to Oklahoma Administrative Code OAC 317:30-5-1. The ~~physician~~ licensed health care professional cannot be in a medical facility ~~intern,~~ internship, residency, or fellowship program or in the full time employment of the Veterans Administration, United States Public Health Service, or other agency. The ~~OKDHS~~ DHS county worker submits the information to the Level of Care Evaluation Unit (LOCEU) to request a determination of eligibility for categorical relationship. LOCEU renders a decision on the categorical relationship using the Social Security Administration (SSA) ~~same~~ definition ~~used by SSA.~~ A follow-up is required by the ~~OKDHS~~ DHS county worker with ~~the~~ Social Security Administration (SSA) ~~(SSA)~~ to be sure that SSA's ~~sensure the SSA~~ disability decision agrees with ~~this~~ also the LOCEU decision ~~of~~

~~LOCEU.~~

(2) Approved contract agencies or the AAADvantage Administration (AA) may complete the UCAT Part I for intake and screening and forward the form to the county office.

(3) Upon receipt of the referral, ~~OKDHS~~DHS county staff may initiate the UCAT, Part I.

(4) The ~~OKDHS~~DHS nurse is responsible for completing the UCAT assessment visit within ~~10-working~~10-business days of the ~~Personal Care~~personal care referral for the applicant who is SoonerCare eligible at the time of the request. The ~~OKDHS~~DHS nurse completes the assessment visit within ~~20-working~~20-business days of the referral for the applicant not determined SoonerCare eligible at the time of the request. ~~If~~When the UCAT Part I indicates the request is from an individual who resides at home and an immediate response is required to ensure the health and safety of the person, ~~(emergency situation)~~emergency situation, or to avoid institutional placement, the UCAT Part III assessment visit has ~~top priority for scheduling.~~top-scheduling priority.

(5) During the assessment visit, the ~~OKDHS~~DHS nurse completes the UCAT and reviews ~~with the member~~ rights to privacy, fair hearing, provider choice, and the pre-service acknowledgement agreement, with the member. The ~~OKDHS~~DHS nurse informs the applicant of medical eligibility criteria and provides information about ~~OKDHS~~DHS long-term care service options. The ~~OKDHS~~DHS nurse documents ~~on the UCAT III whether~~if the member wants to be considered for nursing facility level of care services or if the member is applying for a specific service program, on UCAT III. ~~If~~When, based ~~upon~~on the information obtained during the assessment, the ~~OKDHS~~DHS nurse determines if the member may be at risk for health and safety, an immediate referral is made to Adult Protective Services (APS), or Child Protective Services, as applicable. The referral is documented on the UCAT.

(A) ~~If~~When the applicant's needs cannot be met by ~~Personal Care~~personal care services alone, the ~~OKDHS~~DHS nurse informs the applicant of the other community long-term care service options. The ~~OKDHS~~DHS nurse assists the applicant in ~~accessing~~access service options selected by the applicant in addition to, or in place of, Personal Care services.

(B) ~~If~~When multiple household members are applying for SoonerCare Personal Care services, the UCAT assessment is done for all the household members at the same time.

(C) The ~~OKDHS~~DHS nurse informs the applicant of the qualified agencies in ~~their~~this or her local area ~~available~~that provide services and obtains the applicant's

primary and secondary choice of agencies. ~~If~~When the applicant or family declines to choose a primary personal care service agency, the ~~OKDHS~~DHS nurse selects an agency from a list of all available agencies, using a round-robin system. The ~~OKDHS~~DHS nurse documents the name of the selected personal care provider agency.

(6) The ~~OKDHS~~DHS nurse completes the UCAT within ~~three working~~three-business days of the assessment visit and sends it to the ~~OKDHS~~DHS area nurse for medical eligibility determination. Personal ~~Care~~care service eligibility is established ~~as on~~ the date ~~when~~ medical eligibility is approved and financial eligibility is established. This date serves as the certification date for services to be initiated.

(A) ~~If~~When the length of time from the ~~date~~ the initial assessment to the date of service eligibility determination exceeds ~~90 days~~, 90-calendar days, a new UCAT and assessment visit is required.

(B) The ~~OKDHS~~DHS area nurse assigns a medical certification period of not more than 36 months. The service plan period under the Service Authorization Model (SAM) is for a period of 12 months and is provided by the ~~OKDHS~~DHS nurse.

(7) The ~~OKDHS~~DHS area nurse notifies the ~~OKDHS~~DHS county worker via ELDERS of the ~~Personal Care~~personal care certification. The authorization line is open via automation from ELDERS ~~and five visits by a skilled nurse are automatically authorized.~~

(8) Upon establishment of ~~Personal Care~~personal care certification, the ~~OKDHS~~DHS nurse contacts the member's preferred provider agency, or when necessary, the secondary provider agency, or the provider agency selected by the round robin system. Within ~~one working~~one-business day of provider agency acceptance, the ~~OKDHS~~DHS nurse forwards the referral information to the provider agency for SAM plan development. ~~(see OAC 317:35-15-8(a)).~~ Refer to OAC 317:35-15-8 (a).

(9) Following the SAM packet development by the provider agency, and within ~~three working~~three-business days of receipt of the packet from the provider agency, the ~~OKDHS~~DHS nurse reviews the documentation to ensure agreement with the plan. Once agreement is established, the packet is authorized by the designee or submitted to the area nurse for review.

(10) Within ~~10 working~~10-business days of receipt of the SAM case from the ~~OKDHS~~DHS nurse, the ~~OKDHS~~DHS area nurse ~~either~~ authorizes or denies the SAM units. If the SAM case fails to meet standards for authorization, the case is returned to the ~~OKDHS~~DHS nurse ~~for revision~~ for further justification.

(11) Within ~~one working~~one-business day of knowledge of the authorization, the ~~OKDHS~~DHS nurse forwards the service plan authorization to the provider agency.

**317:35-15-8. Agency ~~Personal Care Service Authorization and Monitoring~~personal care service authorization and monitoring**

(a) Within ~~ten working~~10-business days of receipt of the referral for ~~Personal Care~~personal care services, the ~~Personal Care~~personal care provider agency nurse completes a ~~SAM~~Service Authorization Model (SAM) visit in the home to assess the member's ~~Personal Care~~personal care service needs, completes a SAM packet based on the member's needs and submits the packet to the ~~OKDHS~~DHS nurse. The member's SAM packet includes ~~+~~DHS Forms:

- (1) 02AG044E, Personal Care Progress Notes ~~(OKDHS form 02AG044E)~~;
- (2) 02AG030E, Personal Care Planning Schedule/Service Plan ~~{OKDHS form 02AG030E (AG 5)/02AG031E (AG 6)}~~; and
- (3) 02AG029E, Personal Care Plan ~~{OKDHS form 02AG029E (AG 4)}~~.

(b) ~~If~~When more than one person in the household ~~has been~~was referred to receive ~~Personal Care~~personal care or ADvantage services, all household members' SAM packets are discussed and developed with the eligible members so service delivery ~~can be~~is coordinated to achieve the most efficient use of resources. The number of units of ~~Personal Care~~personal care service authorized for each individual is distributed between all eligible family members to ~~assure~~ensure that the absence of one family member does not adversely affect the family member(s) remaining in the home. ~~If~~When one or more persons in the same household with a ~~Personal Care~~personal care member ~~have been~~were referred to or are receiving other formal services, such as ADvantage or Developmental Disability Services, then those services are coordinated as well.

(c) The ~~Personal Care~~personal care provider agency receives documentation from ~~OKDHS~~DHS as authorization to begin services. The agency delivers a copy of the care plan ~~{OKDHS form 02AG029E(AG 4)}~~Form 02AG029E and the Personal Care Planning Schedule/Service Plan to the member upon initiating services.

(d) Prior to placing a PCA~~personal care~~ assistant (PCA) in the member's home or other service-delivery setting, by the provider agency, an Oklahoma State Bureau of Investigation (OSBI) background check, an Oklahoma State Department of Health Registry check, and an ~~OKDHS~~DHS Community Services Worker Registry check must be completed ~~in accordance with~~per Sections 1-1944 through 1-1948 of Title 63 of the Oklahoma Statutes. Payment is made for PCAs who provide ~~Personal Care~~personal care

services ~~who also~~ and meet the criteria ~~as defined in OAC 317:35-15-2(c)(1)(1 through 8).~~ 317:35-15-2(c)(1) 1 through 8).

(e) The provider agency nurse monitors ~~their~~ the member's plan of care.

(1) The ~~Personal Care~~ personal care provider agency contacts the member within ~~five working~~ five-business days of receipt of the authorized document in order to ensure ~~that~~ services ~~have been~~ were implemented ~~and the needs of the member are being met.~~ according to the authorized plan of care.

(2) The provider agency nurse makes a SAM home visit at least every six months to assess the member's satisfaction with ~~their~~ this or her care and to evaluate the SAM packet for adequacy of goals and authorized units. Whenever a home visit is made, the provider agency nurse documents ~~their~~ findings in the Personal Care Progress Notes. The provider agency forwards a copy of the Progress Notes to the ~~OKDHS~~ DHS nurse for review within ~~5-business~~ five-business days of the visit. The monitoring visit may be conducted by a Licensed Practical Nurse (LPN) only when the PCA is not performing hands-on personal care. A Registered Nurse (RN) must also co-sign the progress notes.

(3) Requests by the provider agency nurse to change the number of units authorized in the SAM packet are submitted to ~~OKDHS~~ (DHS) and are approved or denied by the ~~OKDHS~~ (DHS) area nurse, or designee, prior to ~~implementation of the changed number of units.~~ unit implementation.

(4) Annually, or more frequently ~~if~~ when the member's needs change, the provider agency nurse re-assesses the member's ~~need~~ need's and develops a new SAM packet to meet the member's needs. The provider agency nurse conducts a home visit and completes and submits the annual reassessment documents to the ~~OKDHS~~ DHS nurse no sooner than ~~60-days~~ 60-calendar days before the existing service plan end-date, ~~but sufficiently in advance of the end date.~~ and no later than 14-calendar days prior to service.

(5) ~~If~~ When the member is unstaffed, the provider agency communicates with the member and makes efforts to re-staff. It is recommended the provider agency contacts unstaffed members weekly by ~~telephone~~ phone to actively monitor the health and safety of the member and documents ongoing efforts to provide staff. ~~If~~ When the member is unstaffed for ~~30 calendar~~ 30-calendar days, the provider agency notifies the ~~OKDHS~~ DHS nurse on an ~~OKDHS form~~ Form 02AG032E, Provider Communication Form. The ~~OKDHS~~ DHS nurse contacts the member and ~~if~~ when the member chooses, initiates a transfer of the member to another provider agency that can provide staff.

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

The ~~AA~~Advantage Administration (AA) certifies qualified ~~Personal Care~~personal care provider agencies and facilitates the execution of the agencies' ~~SoonerCare~~ contracts on behalf of the ~~OHCA~~Oklahoma Health Care Authority (OHCA). The ~~OHCA~~ will ~~check~~checks the list of providers that ~~have been~~ barred from Medicare/~~SoonerCare~~ participation to ensure that the ~~Personal Care~~personal care services agency is not listed.

(1) **Payment for Personal Care.** ~~Personal Care~~personal care services is made for care provided in the member's "own home" or in other ~~limited types~~limited types of living arrangements in accordance with ~~per~~ OAC 317:35-15-2(b)(1 through 4).

(A) **Use of provider agency.** To provide ~~Personal Care~~personal care services, an agency must be licensed by the Oklahoma State Department of Health, meet certification standards identified by ~~OKDHS~~the Oklahoma Department of Human Services (DHS), and possess a current ~~SoonerCare~~ contract.

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

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

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

(iii) Service time for personal care services is documented through the use of the Electronic Visit Verification System (EVV), previously known as Interactive Voice Response Authentication (IVRA) system, when services are provided in the home.

(2) **Issue resolution.**

(A) The provider agency provides a written copy of their grievance process to each member at the commencement of services. The written grievance process includes the name and phone number of a provider agency contact person who is responsible for responding to such complaints and grievances. ~~If~~When the member is dissatisfied with the Personal Care provider agency or the assigned PCA and has exhausted attempts to work with the Personal Care provider agency's grievance process without resolution, the member ~~may contact the~~is referred to the ~~OKDHS nurse~~DHS State Plan Care Unit to attempt to resolve the issue(s). ~~The OKDHS nurse is to contact the State Plan Care unit for issues that cannot be resolved between the OKDHS nurse and the Personal Care Provider agency.~~ The member has the right to appeal to the OHCA ~~in accordance~~per with OAC 317:2-1-2.

(B) ~~When a problem with performance of the PCA performance issue is identified, the provider agency staff will conduct~~conducts a counseling conference with the member and/or the PCA as appropriate. ~~The Provider agency staff will counsel~~counsels the PCA regarding problems with his/her performance.

(3) **Persons ineligible to serve as PCAs.** Payment from SoonerCare funds for ~~Personal Care~~personal care services may not be made to an individual who is a legally responsible family member of the member, such as a spouse, legal guardian, or parent of minor child, to whom he/she is providing personal care services. (exceptions may be made for legal guardians with prior approval from the Department of Human Services/Aging Services (DHS/AS)).

**317:35-15-10. Redetermination of medical eligibility for ~~Personal Care~~personal care services**

(a) **Medical eligibility redetermination.** ~~The OKDHS~~Oklahoma Department of Human Services (DHS) area nurse must complete a redetermination of medical eligibility before the end of the long-term care medical certification period.

(b) **Recertification.** ~~The OKDHS~~DHS nurse re-assesses the ~~Personal Care~~personal care services member for medical re-certification based on the member's needs and level of caregiver support required, using the UCATUniform Comprehensive Assessment Tool (UCAT) at least every 36 months. During this re-certification assessment, the ~~OKDHS~~DHS nurse informs the member of the state's other SoonerCare long-term care options. The ~~OKDHS~~DHS nurse submits the re-assessment to the ~~OKDHS~~DHS area nurse for recertification. Documentation is sent to the ~~OKDHS~~DHS area

nurse no later than the ~~tenth~~10th-calendar day of the month in which the certification expires. When the ~~OKDHS~~DHS area nurse determines medical eligibility for ~~Personal Care~~personal care services, a recertification review date is entered on the system.

(c) **Change in amount of units or tasks.** When the ~~Personal Care~~personal care provider agency determines a need for a change in the amount of units or tasks within the ~~Personal Care~~personal care service, a new ~~SAM~~Service Authorization Model (SAM) packet is completed and submitted to ~~OKDHS~~DHS within ~~five calendar~~five-calendar business days of identifying the assessed need. The change is approved or denied by the ~~OKDHS~~DHS area nurse, or designee, prior to implementation.

(d) **Voluntary closure of Personal Care services.** ~~If~~When a member decides ~~Personal Care~~personal care services are no longer needed to meet ~~his/her~~his or her needs, a medical decision is not needed. The member and the ~~OKDHS~~DHS nurse or ~~OKDHS~~DHS county Social Services Specialist completes and signs ~~OKDHS form~~DHS Form 02AG038E, Adv-2, State Plan Personal Care/Advantage Program Voluntary Withdrawal Request. The ~~OKDHS~~DHS nurse submits closure notification to the provider agency.

(e) **Resuming Personal Care services.** ~~If~~When a member approved for Personal Care services ~~has been~~is without Personal Care services for less than ~~90 days~~90 calendar-days but ~~still~~ has a current medical and ~~SoonerCare~~financial eligibility approval, Personal Care services may be resumed using the member's previously approved SAM packet. The ~~Personal Care~~personal care provider agency nurse contacts the member to determine when changes in health or service needs occurred. When changes are identified, the provider agency nurse makes a home visit and submits a Personal Care services skilled nursing re-assessment of need within ~~ten working days~~10-business days of the resumed plan start date, using the State Plan Personal Care Progress Notes, ~~OKDHS form~~DHS Form 02AG044E. ~~If~~When the member's needs dictate, the Personal Care provider agency may submit a request for a change in authorized Personal Care services units with a SAM packet to ~~OKDHS~~DHS. When no changes occur, the agency nurse documents the contact on State Plan Personal Provider Communication Form 02AG032E and forwards it to the DHS nurse within 10-business days of the resumed plan start date.

(f) **Financial ineligibility.** When the ~~OKDHS~~DHS determines a Personal Care services member does not meet ~~the~~ SoonerCare financial eligibility criteria, the ~~OKDHS~~DHS office notifies the ~~OKDHS~~DHS area nurse to initiate the closure process due to financial ineligibility. Individuals determined financially ineligible for Personal Care services are notified by ~~OKDHS~~DHS in writing of the determination and of their right to appeal the decision. The ~~OKDHS~~DHS nurse submits closure notification to the provider agency.

(g) **Closure due to medical ineligibility.** Individuals determined

medically ineligible for Personal Care services are notified by ~~OKDHS~~DHS in writing of the determination and of their right to appeal the decision. The ~~OKDHS~~DHS nurse submits closure notification to the provider agency.

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

(1) Personal Care services may be discontinued ~~if~~when:

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

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

(C) the member or the other household members use:

(i) angry, insulting, threatening, intimidating, degrading, or sexually inappropriate language; or

(ii) innuendos or behavior towards service provider, whether in the home or through other contact or communications; or

(iii) as supported by professional documentation or other credible documentation.

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

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

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

~~(F)~~(G) the individual's living environment poses a physical threat to self or others as supported by professional documentation where applicable, and measures to correct hazardous conditions or assist the person to move are unsuccessful or are not feasible; or

~~(G)~~(H) the member refuses to select and/or accept the services of a provider agency or PCA for ~~90 consecutive~~90-consecutive days as supported by professional documentation.

(2) For persons receiving ~~Personal Care~~personal care services, the ~~Personal Care~~personal care provider agency submits documentation with the recommendation to discontinue services to ~~OKDHS-DHS~~. The ~~OKDHS~~DHS nurse reviews the documentation and submits it to the ~~OKDHS Area Nurse~~DHS area

nurse for determination. The ~~OKDHS~~DHS nurse notifies the ~~Personal Care~~personal care provider agency or PCA, and the local ~~OKDHS~~DHS county worker of the decision to terminate services. The member is sent an official closure notice informing ~~them~~him or her of ~~their~~ appropriate member rights to appeal the decision to discontinue services.

**317:35-15-13.1. Individual ~~Personal Care~~personal care service management**

(a) An ~~IPCA~~Individual Personal Care Assistant (IPCA) may be utilized to provide ~~Personal Care~~personal care services when it is documented to be in the best interest of the member to have an IPCA or when there are no qualified ~~Personal Care~~personal care provider agencies available in the member's local area. ~~OHCA will check~~Oklahoma Health Care Authority (OHCA) checks the list of providers ~~that have been~~barred from Medicare/Medicaid participation to ensure ~~that~~ the IPCA is not listed.

(b) After ~~Personal Care~~personal care services eligibility is established and prior to implementation of ~~Personal Care~~personal care services using an IPCA, the ~~OKDHS~~DHS nurse reviews the care plan with the member and IPCA and notifies the member and IPCA to begin ~~Personal Care~~personal care services delivery. The ~~OKDHS~~DHS nurse maintains the original care plan and forwards a copy of the care plan to the selected IPCA and member within ~~one~~workingone-business day of receipt of approval.

(c) The ~~OKDHS~~DHS nurse contacts the member within ~~five~~workingfive-business days to ensure services are in place and meeting the member's needs and also monitors the care plan for members with an IPCA. For any member receiving ~~Personal Care~~personal care services utilizing an IPCA, the ~~OKDHS~~DHS nurse makes a home visit at least every six months beginning within ~~90~~days of90-calendar days from the date of ~~Personal Care~~personal care service initiation. ~~OKDHS~~DHS assesses the member's satisfaction with ~~their~~his or her ~~Personal Care~~personal care services and evaluates the care plan for adequacy of goals and units allocated. Requests for changes in the units authorized in the care plan must be approved by the ~~OKDHS~~DHS area nurse, or designee, prior to implementation of the changed number of units.

**317:35-15-13.2. ~~IPCA~~Individual personal care assistants (IPCA) provider contractor; billing, training, and problem resolution**

While ~~OHCA~~the Oklahoma Health Care Authority (OHCA) is the contractor authorized under federal law, the ~~OKDHS~~Oklahoma Department of Human Services (DHS) nurse initiates initial contracts with qualified individuals for provision of ~~Personal Care~~personal care services as ~~defined in OAC~~per Oklahoma

Administrative Code (OAC) 317:35-15-2. The contract renewal for the IPCA is the responsibility of the OHCA.

(1) ~~Payment for IPCA.~~ IPCA payment. Payment for ~~Personal Care~~ personal care services is made for care provided in the member's "own home" or in other limited types of living arrangements ~~in accordance with~~ per OAC 317:35-15-2(b) ~~(1 through 4).~~ (1) through (4). Personal care may not be approved when the client lives in the Personal Care Assistant's (PCA's) home except with the approval of DHS Aging Services.

(A) **Reimbursement.** Personal ~~Care~~ care payment for a member is made according to the number of units of service identified in the service plan.

(i) The unit amounts paid to individual contractors is according to the established rates. A service plan ~~will be~~ is developed for each eligible individual in the home and units of service assigned to meet the needs of each member. The service plans ~~will~~ combine units in the most efficient manner to meet the needs of all eligible persons in the household.

(ii) From the total amounts billed by the IPCA in (i) of this subparagraph, the OHCA ~~(acting as agent for the member employer),~~ acting as agent for the member-employer withholds the appropriate percentage of FICA tax and sends it to the Internal Revenue Service as the individual contractor's contribution toward Social Security coverage. To ~~assure that~~ ensure the individual contractor's ~~social security~~ Social Security account may be properly credited, it is vital that the individual contractor's ~~social security~~ Social Security number be entered correctly on each claim.

(iii) The contractor payment fee covers all ~~Personal Care~~ personal care services included on the service and care plans developed by the ~~OKDHS~~ DHS nurse. Payment is made for direct services and care of the eligible member(s) only. The area nurse, or designee, authorizes the number of units of service the member receives.

(iv) A member may select more than one IPCA. This may be necessary as indicated by the service and care plans.

(v) The IPCA may provide ~~SoonerCare~~ Personal Care personal care services for several households during one week, ~~as long as the daily number of paid service units does not exceed eight hours, 32 units per day.~~ as long as the daily number of paid service units does not exceed eight hours, 32 units per day. The total number of hours per week cannot exceed ~~40.~~ 40, 160 units.

(B) **Release of wage and/or employment information for IPCAs.** Any inquiry received by the local office

requesting wage and/or employment information for an IPCA will be forwarded to the OHCA, Claims Resolution.

(2) ~~Member~~IPCA member selection of IPCA.

Members and/or family members recruit, interview, conduct reference checks, and select the individual ~~to be considered as an~~for IPCA ~~consideration~~. Prior to placing a ~~Personal Care~~personal care service provider in the member's home, an OSBI background check, ~~and a~~DHS Community Services Worker registryRegistry check must be completed ~~in accordance with~~per Section 1-1944 through 1-1948 of Title 63 of the Oklahoma Statutes. The ~~OKDHS~~DHS nurse must also check the Certified Nurse Aide Registry. The ~~OKDHS~~DHS nurse must affirm that the applicant's name is not contained on any of the registries. The ~~OKDHS~~DHS nurse ~~will notify~~thenotifies OHCA ~~if~~when the applicant is on the ~~registry~~Registry.

(A) ~~Persons eligible to serve as individual Personal Care Assistants.~~IPCAs. Payment is made for ~~Personal Care Services~~personal care services to IPCAs who provide ~~Personal Care~~personal care services who ~~also~~ meet the criteria ~~as defined in~~per OAC 317:35-15-2(c)(~~1 through 8~~)(1) through (8).

(B) ~~Persons ineligible to serve as IPCAs.~~ Payment from SoonerCare funds for ~~Personal Care~~personal care services may not be made to an individual who is a legally responsible family member (~~spouse, legal guardian, or parent of a minor child~~)spouse, legal guardian, or parent of a minor child of the member being served (~~exceptions to legal guardian are made only with prior approval from Aging Services Division~~), exceptions to legal guardian are made only with prior approval from Aging Services Division.

(i) Payment cannot be made to ~~an OKDHS~~a DHS or an OHCA employee. Payment cannot be made to an immediate family member of ~~an OKDHS~~a DHS employee who works in the same county without ~~OKDHS/Aging Services Division~~DHS Aging Services approval. When a family member relationship exists between ~~an OKDHS~~a DHS nurse and an IPCA in the same county, the ~~OKDHS~~DHS nurse cannot manage services for a member whose IPCA is a family member of the ~~OKDHS~~DHS nurse.

(ii) If it is determined that ~~an OKDHS~~a DHS or OHCA employee is interfering in the process of providing ~~Personal Care~~ services for personal or family benefit, he/she will be or she is subject to disciplinary action.

(3) ~~Orientation of the IPCA.~~IPCA orientation. When a member selects an IPCA, the ~~OKDHS~~DHS nurse contacts the individual

to report to the county office to complete the Oklahoma State Department of Health form 805, Uniform Employment Application for Nurse Aide Staff, and the ~~OKDHS form~~ DHS Form 06PE039E, Employment Application Supplement, and for a determination of qualifications and orientation. For ~~Personal Care~~ personal care members, this process is the responsibility of the ~~OKDHS~~ DHS nurse. The IPCA can begin work when:

(A) ~~he/she has been~~ he or she was interviewed by the member,

(B) ~~he/she has been~~ he or she was oriented by the OKDHS nurse,

(C) ~~he/she has~~ he or she executed a contract (OHCA-0026) with the OHCA,

(D) the effective service date ~~has been~~ was established,

(E) all registries ~~have been~~ were checked and the IPCA's name is not listed,

(F) the Oklahoma State Department of Health Nurse Aide Registry ~~has been~~ was checked and no notations were found, and

(G) the OSBI background check ~~has been~~ was completed.

(4) **Training of IPCAs.** It is the responsibility of the ~~OKDHS~~ DHS nurse to make sure ~~that~~ the IPCA has the training needed to carry out the plan of care prior to service initiation for each member.

(5) **Problem resolution related to the performance of the IPCA.** When it comes to the attention of the ~~OKDHS~~ DHS nurse ~~or OKDHS Social Services Specialist~~ that there is a problem related to the performance of the IPCA, a counseling conference is held between the member, OKDHS nurse, and worker. The ~~OKDHS~~ DHS nurse ~~will counsel~~ counsels the IPCA regarding problems with ~~his/her~~ his or her performance. Counseling is considered when staff believes ~~that~~ counseling will result in improved performance.

(6) **Termination of the IPCA Provider Agreement.**

(A) A recommendation for the termination of an IPCA's contract is submitted to ~~the~~ OHCA and ~~the~~ IPCA services ~~of the IPCA~~ are suspended immediately when:

(i) an IPCA's performance is such that ~~his/her~~ his or her continued participation in the program could pose a threat to the health and safety of the member or others; or

(ii) the IPCA failed to comply with the expectations outlined in the PCA Provider Agreement and counseling is not appropriate or ~~has~~ was not ~~been~~ effective; or

(iii) an IPCA's name appears on the ~~OKDHS Community Services Worker Registry,~~ DHS Community Services Worker Registry, any of the registries listed in Section 1-

1947 of Title 63 of the Oklahoma Statutes, even though ~~his/her~~his or her name may not have appeared on the Registry at the time of application or hiring.

(B) The ~~OKDHS~~DHS nurse makes the recommendation for the termination of the IPCA to ~~the OKDHS State Office~~DHS Aging Services Division who ~~then~~ notifies the OHCA Legal Division of the recommendation. When the problem is related to allegations of abuse, neglect, or exploitation, ~~OKDHS~~DHS Adult Protective Services, State Attorney General's Medicaid Unit, ~~the~~ OHCA, and the Oklahoma State Department of Health are notified by the ~~OKDHS~~DHS nurse.

(C) When the problem is related to allegations of abuse, neglect, or exploitation, ~~the~~ ~~OKDHS~~DHS nurse follows the process as outlined in OAC 340:100-3-39.

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

Billing procedures for ~~Personal Care Services~~personal care services are contained in the ~~OKMMIS~~Oklahoma Medicaid Management Information Systems (OKMMIS) Billing and Procedure Manual. Questions regarding billing procedures that cannot be resolved through a study of the manual are referred to the ~~OHCA~~Oklahoma Health Care Authority (OHCA). Contractors for Personal Care bill on ~~CMS-1500~~CMS-1500 claim form. ~~The~~ OHCA provides instructions to an ~~IPCA~~Individual personal care assistant (IPCA) contracted provider for completion of the claim at the time of the contractor orientation. The contracted provider submits a claim for each member. The contracted provider prepares claims for services provided and submits the claims to the fiscal agent ~~who~~ is responsible for ~~assuring that the~~ensuring claims have ~~been~~were properly completed. All ~~Personal Care~~personal care contractors must have a unique provider number. New contracted providers ~~will be~~are mailed the provider number after they ~~have been~~are placed on the claims processing contractor's provider file. ~~Service time of~~All services provided in the service recipients home, member's home including Personal Care and Nursing is ~~must be~~must be documented ~~solely through the Interactive Voice Response Authentication (IVRA)~~Electronic Visit Verification (EVV) system after access to the system is made available by OKDHS. Additionally, work completed in the provider's office is documented in the EVV system. The ~~IVRA~~EVV system provides alternate backup solutions ~~should~~if the automated system ~~be~~is unavailable. ~~In~~however, in the event of an ~~IVRA~~EVV system failure, the provider ~~will document~~documents time in accordance with ~~their~~provider agency internal policy and procedures backup plan. This documentation is sufficient to account for both in-home and in-office services. The provider agency's backup procedures are

only permitted when the ~~IVRA~~EVV system is unavailable.

## SUBCHAPTER 17. ADVANTAGE WAIVER SERVICES

### 317:35-17-1. Overview of long-term medical care services; relationship to ~~QMBP~~, Qualified Medicare Beneficiary Plus (QMBP), ~~SLMB~~, Specified Low-Income Medicare Beneficiary (SLMB), and other Medicaid services eligibility

- (a) Long-term medical care for the categorically needy includes:
- (1) care in a nursing facility. ~~(refer to OAC 317:35-19);~~ Refer to Oklahoma Administrative Code (OAC) 317:35-19;
  - (2) care in a public or private intermediate care facility for the intellectually disabled. ~~(refer to OAC 317:35-9);~~ Refer to OAC 317:35-9;
  - (3) care of persons age 65 years ~~or~~ and older in mental health hospitals. ~~(refer to OAC 317:35-9);~~ Refer to OAC 317:35-9;
  - (4) Home and Community Based Services Waivers for persons with intellectual disabilities. ~~(refer to OAC 317:35-9);~~ Refer to OAC 317:35-9;
  - (5) Personal Care services. ~~(refer to OAC 317:35-15);~~ and Refer to OAC 317:35-15; and
  - (6) the Home and Community Based Services Waiver (ADvantage Waiver) for frail ~~elderly~~, elderly (65 years of age or older), and a targeted group of adults with physical disabilities age 21 to 64 years of age and ~~over~~older who do not have an intellectual disability or a cognitive impairment ~~(ADvantage Waiver)~~. related to a developmental disability.
- (b) ~~Any time~~ When an individual is certified as eligible for SoonerCare coverage of long-term care, ~~the individual~~ he or she is also eligible for other SoonerCare services. ADvantage Waiver members do not have a copayment for ADvantage services except for prescription drugs. For members residing in an ADvantage Assisted Living Center, any income beyond ~~150%~~ 150 percent of the federal benefit rate is available to defray the cost of the ~~Assisted Living~~ assisted living services received. The member is responsible for payment to the ~~Assisted Living Services Center~~ assisted living services center provider for days of service from the first day of each ~~full month~~ full-month in which services ~~have been~~ were received until the vendor pay obligation is met. ~~Any time~~ When an individual is aged, blind, or disabled and is determined eligible for long-term care, a separate eligibility determination must be made for ~~Qualified Medicare Beneficiary Plus (QMBP)~~ QMBP or ~~Specified Low-Income Medicare Beneficiary (SLMB)~~ SLMB benefits. An ADvantage program member may reside in a licensed assisted living ~~facility~~ services center only ~~if~~ when the assisted living ~~center~~ services is a certified ADvantage ~~Assisted Living Services~~ assisted living

services center provider from whom the member is receiving ADvantage Assisted Livingassisted living services.

### **317:35-17-3. ADvantage program services**

(a) The ADvantage program is a Medicaid Home and Community Based Waiver used to finance non-institutional, long-term care services for elderly and a targeted group of physically disabled adults when there is a reasonable expectation that within a ~~30 day~~30-calendar day period, the person's health, due to disease process or disability, would, without appropriate services, deteriorate and require nursing facility care to arrest the deterioration. Individuals may not be enrolled in ADvantage for the sole purpose of enabling them to obtain Medicaid eligibility. Eligibility for ADvantage is contingent on an individual requiring one or more of the services offered in the ~~waiver~~Waiver at least monthly in order to avoid institutionalization.

(b) The number of individuals who may receive ADvantage services is limited.

(1) To receive ADvantage services, individuals must meet one of the following categories~~+~~. He or she must:

(A) ~~be age 65 years or~~of age and older; or

(B) ~~be age 21 to 64 or~~years of age older ~~if when~~ physically disabled and not developmentally disabled or ~~if age~~when 21 to 64 ~~or~~years of age older and not physically disabled, the person has a clinically documented, progressive degenerative disease process that responds to treatment and previously ~~has~~ required hospital or nursing facility (NF) level of care services for treatment related to the condition; and requires ADvantage services to maintain the treatment regimen to prevent health deterioration~~;~~ or

(C) ~~if when~~ developmentally disabled, and ~~between the ages of 21 and 65,~~21 to 64 years of age; and does not have an intellectual disability or a cognitive impairment related to the developmental disability.

(2) In addition, the individual must meet ~~the following~~ criteria~~+~~ in (A) through (C). He or she must:

(A) require nursing facility level of care ~~[see OAC 317:35-17-2];~~ Refer to Oklahoma Administrative Code (OAC) 317:35-17-2;

(B) meet service eligibility criteria ~~[see OAC 317:35-17-3(f)];~~ and. Refer to OAC 317:35-17-3(f); and

(C) meet program eligibility criteria. ~~[see 317:35-17-3(g)].~~ Refer to OAC 317:35-17-3(g).

(c) ADvantage members are eligible for limited types of living arrangements. The specific living arrangements are set forth below.

(1) ADvantage program members are not eligible to receive services while residing in an institutional setting, including, but not limited to, licensed facilities, such as a hospital, a nursing facility, a licensed residential care facility, or a licensed assisted living facility, ~~(unless the facility is an ADvantage Assisted Living Center)~~ unless the facility is an ADvantage Assisted Living Center or in an unlicensed institutional living arrangement, such as a room and board home/facility.

~~(2) ADvantage program members may receive services in a contracted ADvantage Assisted Living Center; an ADvantage Assisted Living Center is the only housing with nursing-supervised personal care services option in which a person may appropriately receive ADvantage services.~~

~~(3)~~(2) Additional living arrangements in which members may receive ADvantage services are the member's own home, apartment or ~~independent living apartment~~ independent-living apartment, or a family or friend's home or apartment. A home/apartment unit is defined as a self-contained living space having a lockable entrance to the unit and including a bathroom and food storage/preparation amenities in addition to bedroom/living space.

~~(4)~~(3) ADvantage program members may receive services in a shelter or similar ~~temporary housing arrangement~~ temporary-housing arrangement that may or may not meet the definition of home/apartment, in emergency situations, for a period not to exceed ~~sixty (60)~~ 60-calendar days during which location and transition to permanent housing is ~~being~~ sought.

~~(5)~~(4) For ADvantage members who are full-time students, a dormitory room qualifies as an allowable living arrangement in which to receive ADvantage services for the period during which the member is a student.

~~(6)~~(5) Members may receive ADvantage respite services in a nursing facility for a continuous period not to exceed ~~thirty (30) days~~ 30-calendar days.

(d) Home and Community Based Waiver Services are outside of the scope of Medicaid State Plan services. The Medicaid ~~waiver~~ Waiver allows the OHCA to offer certain Home and Community Based Services to an annually capped number of persons who are categorically needy, ~~(refer to OKDHS form 08AX001E (Appendix C-1), Schedule VIII. B. 1.)~~ refer to DHS Form Appendix C-1, Schedule VIII. B. 1., and without such services would be institutionalized. The estimated cost of providing an individual's care outside the nursing facility cannot exceed the annual cost of caring for that individual in a nursing facility. When determining the ADvantage service plan cost cap for an

individual, the comparable SoonerCare cost to serve that individual in a ~~nursing facility~~<sup>NF</sup> is estimated.

(e) Services provided through the ADvantage ~~waiver~~<sup>Waiver</sup> are:

- (1) case management;
- (2) respite;
- (3) adult day health care;
- (4) environmental modifications;
- (5) specialized medical equipment and supplies;
- (6) ~~physical therapy/occupational therapy/speech therapy~~<sup>physical, occupational, or speech therapy</sup> or consultation;
- (7) advanced supportive/restorative assistance;
- (8) nursing;
- (9) skilled nursing;
- (10) ~~home-delivered~~<sup>home-delivered</sup> meals;
- (11) hospice care;
- (12) medically necessary prescription drugs within the limits of the ~~waiver~~<sup>Waiver</sup>;
- (13) personal care, ~~(state plan)~~<sup>State Plan</sup> or ADvantage personal care;
- (14) Personal Emergency Response System (PERS);
- (15) Consumer-Directed Personal Assistance Services and Supports (CD-PASS);
- (16) Institution Transition Services;
- (17) assisted living; and
- (18) SoonerCare medical services for individuals ~~age 21 years~~<sup>of age</sup> and over within the scope of the State Plan.

(f) The ~~OKDHS~~<sup>DHS</sup> area nurse or nurse designee makes a determination of service eligibility prior to evaluating the ~~UCAT~~<sup>Uniform Comprehensive Assessment Tool (UCAT)</sup> assessment for nursing facility level of care. The following criteria are used to make the service eligibility determination:

- (1) an open ADvantage Program ~~waiver~~<sup>Waiver</sup> slot, as authorized by the ~~waiver~~<sup>Waiver</sup> document approved by the Centers for Medicare and Medicaid Services (CMS), is available to ~~assure~~<sup>ensure</sup> federal participation in payment for services to the individual. ~~If the OKDHS/ASD~~<sup>When the Department of Human Services/Aging Services (DHS/AS)</sup> determines all ADvantage ~~waiver~~<sup>Waiver</sup> slots are filled, the individual cannot be certified ~~on the OKDHS computer system~~<sup>by DHS</sup> as eligible for ADvantage services, ~~and~~ the individual's name is placed on a waiting list for entry ~~as~~<sup>when</sup> an open slot becomes available;<sup>i</sup>
- (2) the individual is in the ADvantage targeted service group. ~~The target group is an individual who is frail and 65 years of age or older or age 21 or older with a physical disability and who does not have intellectual disability or a~~

~~cognitive impairment.~~ The target group are individuals, who:

(A) are frail and 65 years of age and older; or

(B) have a physical disability, are between 21 and 64 years of age, and do not have an intellectual disability or a cognitive impairment; or

(C) have developmental disability, are 21 and 64 years of age, and does not have an intellectual disability or cognitive impairment related to the developmental disability;

(3) ~~the individual is not eligible if he/she~~ because he or she poses a physical threat to ~~self~~himself or herself or others as supported by professional documentation-;

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

(5) ~~the individual is not eligible if his/her~~ when his or her living environment poses a physical threat to ~~self~~himself or herself or others as supported by professional documentation where applicable, and measures to correct hazardous conditions or assist the person to ~~individuals~~ move are unsuccessful or not feasible.

(g) ~~The State, as part of the waiver~~ Waiver program approval authorization, assures CMS ~~sures Centers for Medicare and Medicaid Services (CMS) that each member's health, safety, or welfare can be maintained in their~~ his or her home. If ~~When a member's identified needs cannot be met through provision of ADvantage program or Medicaid State Plan services and other formal or informal services are not in place or immediately available to meet those needs, the individual's health, safety, or welfare in their home cannot be assured.~~ ensured. ~~The AA~~ ADvantage Administration (AA) determines ADvantage program eligibility through the service plan approval process. An individual is deemed ineligible for the ADvantage program based on the following criteria:

(1) ~~the individual's needs, as identified by UCAT and other professional assessments cannot be met through ADvantage program services, Medicaid State Plan services, and other formal or informal services-;~~ The State, as part of the waiver program approval authorization, assures CMS that each waiver individual's health, safety, or welfare can be maintained in their home. If a member's identified needs cannot be met through provision of ADvantage program or Medicaid State Plan services and other formal or informal services are not in place or immediately available to meet those needs, the individual's health, safety or welfare in their home cannot be assured.

~~(2) the individual one or more members of the individual's household, and/or the conditions of the living environment itself, pose a physical threat to self or others as supported by professional documentation and measures to correct conditions are unsuccessful, or are not feasible.;~~

(3) the individual or other household members use threatening, intimidating, degrading, or sexually inappropriate language/innuendo or behavior towards service providers, either in the home or through other contact or communications, and significant efforts ~~have been~~were attempted to correct such behavior, as supported by professional documentation, or other credible documentation.

(4) the individual or the individual's authorized agent is uncooperative or refuses to participate in service development or service delivery and these actions result in unacceptable increases of risk to the individual's health, safety, or welfare in ~~their~~his or her home, as determined by the individual, the interdisciplinary team, or the AA.;

(5) the individual's living environment poses a physical threat to self or others as supported by professional documentation, ~~where applicable~~ and measures to correct hazardous conditions or assist the person to move are unsuccessful or are not feasible.;

(6) the individual provides false or materially inaccurate information ~~that is necessary to determine program eligibility,~~ or withholds information ~~that is necessary to determine program eligibility.;~~

(7) the individual does not require at least one ADvantage service monthly.;

(8) the individual, his or her family member(s), associate(s), or any other person(s) or circumstances as relates to care and coordination in the individual's living environment produces evidence of illegal drug activity or substances used illegally as intoxicants.

(A) This includes:

(i) use, possession, or distribution of illegal drugs;

(ii) abusive use of other drugs, such as medication prescribed by a doctor; or

(iii) use of substances, such as inhalants including, but not limited to:

(I) typewriter correction fluid;

(II) air conditioning coolant;

(III) gasoline;

(IV) propane;

(V) felt tip markers;

(VI) spray paint;

(VII) air freshener;

- (VIII) butane;
- (IX) cooking spray;
- (X) paint; and
- (XI) glue;

(iv) observed intoxication, consumption or sensory indicators, such as smell of the use of an drug or intoxicant by the individual, family members, associates, or any other person(s) present at the time care is provided may be construed as evidence indicative of illegal drug activity or intoxication. This includes drug use or intoxicated activity that is menacing to the member or staff providing services;

(v) the observance of drug paraphernalia or any instrument used in the manufacturing, production, distribution, sale, or consumption of drugs or substances including, but not limited to:

(I) smoking pipes used to consume substances other than tobacco;

(II) roach clips containing marijuana cigarettes;

(III) needles and other implements used for injecting drugs into the body;

(IV) plastic bags or other containers used to package drugs;

(V) miniature spoons used to prepare drugs; or

(VI) kits used in the production of synthetic controlled substances including

descriptive materials that accompany the item, describing or depicting its use;

(vi) instructions, oral or written, concerning the item or device including, but not limited to, the manner in which the object is labeled and displayed for sale;

(vii) the typical use of such items in the community; and/or

(viii) testimony of an expert witness regarding use of the item

(h) The case manager provides the AA with professional documentation or other credible documentation to support the recommendation for redetermination of program eligibility. The service providers continue providing services according to the person-centered service plan as provider safety permits until the individual is removed from the ADvantage program. As a part of the procedures requesting redetermination of program eligibility, ~~the OKDHS/ASD will provide~~ DHS AS provides technical assistance to the ~~Provider~~ provider for transitioning the individual to other services-, and

(i) ~~Individuals~~ individuals determined ineligible for ADvantage program services are notified in writing by ~~OKDHS~~ DHS AS of the

determination and of ~~their~~the right to appeal the decision.

**317:35-17-5. ADvantage program medical eligibility determination**

The Oklahoma Department of Human Services(DHS) area nurse, or nurse designee, makes the medical eligibility determination utilizing professional judgment, the Uniform Comprehensive Assessment Tool (UCAT)Parts I and III, and other medical information.

(1) When ADvantage care services are requested or the UCAT I is received in the county office, the:

(A) DHS nurse is responsible for completing the UCAT III; and

(B) social service specialist is responsible for contacting the applicant within three business days to initiate the financial eligibility application process.

(2) Categorical relationship must be established for determination of eligibility for ADvantage services. ~~If~~When a categorical relationship to disability was not established, the local social service specialist submits the same information per Oklahoma Administrative Code (OAC) 317:35-5-4(2) to the Level of Care Evaluation Unit (LOCEU) to request a determination of eligibility for categorical relationship. LOCEU renders a decision on the categorical relationship to the person with the disability using the Social Security Administration (SSA) definition. A follow-up is required by the DHS social service specialist with SSA to ensure the disability decision agrees with the LOCEU decision.

(3) Community agencies complete the UCAT I, and forward the form to the county office. When the UCAT I indicates the applicant does not qualify for Medicaid long-term care services, the applicant is referred to appropriate community resources. Members may ~~also~~ call the care line at ~~800-435-4711~~1-800-435-4711.

(4) The DHS nurse ~~visits~~completes the UCAT III assesement visit with the member within ~~10-business~~10-business days of receipt of the referral for ADvantage services for an applicant who is Medicaid eligible at the time of the request. The DHS nurse completes the UCAT III assessment visit within ~~20-business~~20-business days of the date the Medicaid application is completed for new applicants.

(5) During the UCAT III assessment visit, the DHS nurse informs the applicant of medical eligibility criteria and provides information about the different long-term care service options. When there are multiple household members applying for the ADvantage program, the UCAT assessment is done for them during the same visit. The DHS nurse documents whether the member chooses nursing facility program services

or ADvantage program services and makes a level of care and service program recommendation.

(6) The DHS nurse informs the member and family of agencies certified to deliver ADvantage case management and in-home care services in the local area to obtain the applicant's primary and secondary informed choices, ensuring adherence to conflict free case management requirements.

(A) 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.

(B) ~~If~~When the member and/or family declines to make a provider choice, the DHS nurse documents the decision on Form 02CB001, Member Consents and Rights.

(C) The AA uses a rotating system to select an agency for the member from a list of all local, certified case management and in-home care agencies, ensuring adherence to conflict free case management requirements.

(7) The DHS nurse documents the names of the chosen agencies and the agreement of the member, by dated signature, to receive services provided by the agencies.

(8) When the member's needs require an immediate interdisciplinary team (IDT) meeting with home health agency nurse participation to develop a ~~care plan and~~person-centered service plan, the DHS nurse documents the need for priority processing.

(9) The DHS nurse scores the ~~UCAT, Part III.~~UCAT III. The DHS nurse forwards the ~~UCAT, Parts I and III,~~UCAT III and documentation of financial eligibility, documentation of the member's case management and in-home care agency choices to the area nurse, or nurse designee, for medical eligibility determination.

(10) ~~If~~When based upon the information obtained during the assessment, the DHS nurse determines the member may be at risk for health and safety, DHS Adult Protective Services staff is notified immediately and the referral is documented on the UCAT.

(11) Within ~~10-business~~10-business days of receipt of a complete ADvantage application, the area nurse or nurse designee, determines medical eligibility using nursing facility level of care criteria and service eligibility criteria per OAC 317:35-17-2 and 317:35-17-3 and enters the medical decision on the system.

(12) Upon notification of financial eligibility from the social service specialist, medical eligibility, and approval for ADvantage entry from the area nurse or nurse designee, the AA communicates with the case management provider to begin care and service plan development. The AA communicates to the case management provider, the member's name, address, case number, Social Security number, the number of units of case management and, ~~when applicable,~~ the number of units of home healthcare agency nurse evaluation authorized for service plan development. When the member requires an immediate home visit to develop a ~~service plan~~person-centered within 24 hours, the AA contacts the case management provider directly to confirm availability and ~~sends~~sends electronically ~~sends~~ the new case packet information to the case management provider ~~via email~~.

(13) When the services must be in place to ensure the health and safety of the member upon discharge to the home from the nursing facility or hospital, a case manager from an ADvantage case management provider selected by the member and referred by the AA follows the ADvantage institution transition, case management procedures for care, and service plan development and implementation.

(14) A new medical level of care determination is required when a member requests any changes in service program, from:

- (A) State Plan Personal Care to ADvantage services;
- (B) ADvantage to State Plan Personal Care services;
- (C) nursing facility to ADvantage services; or
- (D) ADvantage to nursing facility services.

(15) A new medical level of care determination is not required when a member requests re-activation of ADvantage services after a short-term stay of ~~90 calendar days~~90-calendar days or less in a nursing facility when the member ~~has~~ had previous ADvantage services and the ADvantage certification period has not expired.

(16) When a UCAT assessment was completed more than ~~90 ealendar days~~90-calendar days prior to submission to the area nurse or nurse designee for a medical decision, a new assessment is required.

### **317:35-17-14. Case management services**

(a) Case management services involve ongoing assessment, service planning and implementation, service monitoring and evaluation, member advocacy, and discharge planning.

(1) Within ~~one working~~one-business day of receipt of an ADvantage referral from the ADvantage Administration (AA), the case management supervisor assigns a case manager to the member. The case manager makes a home visit to review the

~~ADvantage program (its purpose, philosophy, and the roles and responsibilities of the member, service provider, case manager, and OKDHS in the program), review, update and complete the UCAT assessment, discuss service needs and ADvantage service providers;~~ its purpose, philosophy, and the roles and responsibilities of the member, service provider, case manager, and the Oklahoma Department of Human Services (DHS). The case manager will review; update and complete the Uniform Comprehensive Assessment Tool (UCAT); and discuss service needs and ADvantage service providers. The Case Manager notifies ~~in writing~~ in writing the member's UCAT identified primary physician in writing that the member ~~has been~~ was determined eligible to receive ADvantage services. The notification is ~~via~~ a preprint form that contains the member's signed permission to release this health information and requests physician's office verification of primary and secondary diagnoses and diagnoses code obtained from the UCAT.

(2) Within ~~14 calendar~~ 14-calendar days of the receipt of an ADvantage referral, the case manager completes and submits to the AA an ~~individualized care~~ person-centered service plan and service plan for the member, signed by the member and the case management supervisor. The case manager completes and submits to the AA the annual reassessment person-centered service plan documents no sooner than ~~60 days~~ 60-calendar days before the existing service plan end date but sufficiently in advance of the end date to be received by the AA at least ~~30 calendar~~ 30-calendar days before the end date of the existing person-centered service plan. The case manager submits revisions for denied services to be resubmitted to the AA for approval within 5-business days. Within ~~14 calendar~~ 14-calendar days of receipt of a Service Plan Review Request (SPR) for short-term authorizations from the AA, the ~~Case Manager~~ case manager provides corrected ~~care plan and~~ person-centered service plan documentation. Within ~~five calendar~~ five-business days of assessed need, the case manager completes and submits a service plan addendum to the AA to amend current services on the ~~care plan and~~ person-centered service plan. The ~~care plan~~ person-centered and service plan ~~are~~ is based on the member's service needs identified by the UCAT, ~~Part III,~~ UCAT III, and includes only those ADvantage services required to sustain and/or promote the health and safety of the member. The case manager uses an interdisciplinary team (IDT) planning approach for ~~care plan and~~ person-centered service plan development. Except for extraordinary circumstances, the IDT meetings are ~~to be~~ held in the member's home. Variances from this policy must be

presented to, and approved by, the AA in advance of the meeting. ~~If~~When in-home care is the primary service, the IDT includes, at a minimum, the member, a nurse from the ADvantage in-home care provider chosen by the member, and the case manager. Otherwise, the member and case manager constitute a minimum IDT.

(3) The case manager identifies long-term goals, challenges to meeting goals, and service goals including plan objectives, actions steps and expected outcomes. The ADvantage case manager documents on the ~~care plan~~person-centered service plan, the presence of two or more ADvantage members residing in the same household and/or when the member and personal care provider reside together. The case manager documents on the ~~IVRA~~Electronic Visit Verification (EVV) system in the member record any instance in which a member's health or safety would be ~~"at risk"~~ if at risk when even one personal care visit is missed. The case manager identifies services, service provider, funding source, units and frequency of service and service cost, cost by funding source and total cost for ADvantage services. The member signs and indicates review/agreement with the ~~care plan~~ and person-centered service plan by indicating acceptance or non-acceptance of the plans. The member, the member's legal guardian, or legally authorized representative ~~shall sign~~ signs the person-centered service plan in the presence of the case manager. The signatures of two witnesses are required when the member signs with a mark. ~~If~~When the member refuses to cooperate in development of the person-centered service plan, ~~or, if~~ for when the member refuses to sign the person-centered service plan, the case management agency refers the case to the AA for resolution. In addition, based on the UCAT and/or case progress notes that document chronic uncooperative or disruptive behaviors, the ~~OKDHS~~DHS nurse or AA may identify members that require AA intervention through referral to the AA's Escalated Issues unit.

(A) For members that are uncooperative or disruptive, the case manager develops ~~an~~person-centered service individualized plan to overcome challenges to receiving services focusing on behaviors, both favorable and those that jeopardize the member's well-being and includes a design approach of incremental plans and an addenda that ~~allow~~allows the member to achieve stepwise successes in ~~the~~behavior modification ~~of their behavior~~.

(B) The AA may implement a person-centered service plan without the member's signature when, ~~for these members,~~ the presence of a document that ~~"requires"~~ requires their signature may itself trigger a ~~"conflict"~~ conflict. In

these circumstances, mental health/behavioral issues may prevent the member from controlling ~~their~~his or her behavior to act in ~~their~~his or her own interest. Since ~~the~~The person by virtue of level of care and the IDT assessment, needs ADvantage services to ~~assure their~~ensure his or her health and safety, the AA may authorize the person-centered service plan ~~if~~when the case manager demonstrates effort to work with and obtain the member's agreement. Should negotiations not result in agreement with the ~~care plan and~~person-centered service plan, the member may withdraw ~~their~~his or her request for services or request a fair hearing.

(4) CD-PASS Planning and Supports Coordination. Consumer-Directed Personal Assistance Services and Supports (CD-PASS) planning and supports coordination.

(A) The ADvantage ~~Case Management~~case management provider assigns ~~to~~ the CD-PASS member a Case Manager~~case manager~~ that ~~has~~ successfully completed training on CD-PASS, Independent Living Philosophy, Person-Centered Planning and the individual budgeting process and process guidelines. Case Managers ~~that have completed this~~managers, who complete specialized CD-PASS training are referred to as Consumer-Directed Agent/Case Managers (CDA/CM) with respect to ~~their~~his or her CD-PASS service planning and support role in working with CD-PASS members. The CDA/CM educates the member about ~~their~~his or her rights and responsibilities as well as ~~about~~ community resources, service choices, and options available to the member to meet CD-PASS service goals and objectives.

(B) The member may designate a family member or friend as an ~~"authorized representative"~~authorized representative to assist in the service planning process and in executing member employer responsibilities. ~~If~~When the member chooses to designate an ~~"authorized representative"~~authorized representative, the designation and agreement identifying the "willing adult"~~willing adult~~ to assume this role and responsibility is documented with dated signatures of the member, the designee, and the member's ~~Case Manager~~case manager, or ~~the~~ AA staff.

(i) A person having guardianship or power of attorney or other court sanctioned authorization to make decisions on behalf of the member has legal standing to be the member's designated ~~"authorized representative"~~authorized representative.

(ii) An individual hired to provide ~~Consumer-Directed Personal Assistance Services and Supports (CD-PASS)~~CD-PASS services to a member may not be designated the

~~"authorized representative"~~authorized representative  
for the member.

(iii) The case manager reviews the designation of ~~Authorized Representative,~~authorized representative, ~~Power of Attorney,~~power of attorney, and ~~Legal Guardian~~legal guardian status on an annual basis and includes ~~this is included~~ in the reassessment packet to AA.

(C) The CDA/CM provides support to the member in the Person-Centered CD-PASS Planning process. Principles of Person-Centered Planning are ~~as follows:~~listed in (i) through (v) of the subparagraph.

(i) The person is the center of all planning activities.

(ii) The member and ~~their~~his or her representative, or support team, are given the requisite information to assume a controlling role in the development, implementation, and management of the member's services.

(iii) The individual and those who know and care about him or her are the fundamental sources of information and decision-making.

(iv) The individual directs and manages a planning process that identifies his or her strengths, capacities, preferences, desires, goals, and support needs.

(v) Person-Centered Planning results in personally-defined outcomes.

(D) The CDA/CM encourages and supports the member, or as applicable ~~their~~his or her designated ~~"authorized representative"~~authorized representative, to lead, to the extent feasible, the CD-PASS service planning process for Personal Services Assistance. The CDA/CM helps the member define support needs, service goals, and service preferences including access to and use of generic community resources. Consistent with member-direction and preferences, the CDA/CM provides information and helps the member locate and access community resources. Operating within the constraints of the Individual Budget Allocation (IBA) units, the CDA/CM assists the member ~~in translating~~translate the assessment of member needs and preferences into an individually tailored, ~~personalized~~person-centered service plan.

(E) To the extent the member prefers, the CDA/CM develops assistance to meet member needs using a combination of traditional Personal Care and CD-PASS PSA services. However, the CD-PASS IBA and the PSA unit authorization

~~will be~~ reduced proportional to agency Personal Care service utilization.

(F) The member determines with the PSA to be hired, a start date for PSA services. The member coordinates with the CDA/CM to finalize the person-centered service plan. The start date must be after:

(i) authorization of services;

~~(ii) after~~ completion and approval of the background checks; and

~~(ii) after~~ completion of the member employee packets.

(G) Based on outcomes of the planning process, the CDA/CM prepares an ADvantage person-centered service plan or plan amendment to authorize CD-PASS Personal Service Assistance units consistent with this individual plan and notifies existing duplicative Personal Care service providers of the end date for those services.

(H) ~~If~~When the plan requires an ~~APSA~~Advanced Personal Service Assistant (APSA) to provide assistance with ~~Health Maintenance~~health maintenance activities, the CDA/CM works with the member and, as appropriate, arranges for training by a skilled nurse for the member or member's family and the APSA to ensure that the APSA performs the specific ~~Health Maintenance~~health maintenance tasks safely and competently;

(i) ~~If~~when the member's APSA ~~has been~~was providing Advanced Supportive Restorative Assistance to the member for the same tasks in the period immediately prior to being hired as the ~~PSA, APSA,~~ additional documentation of competence is not required; and

(ii) ~~If~~when the member and APSA attest that the APSA ~~has been~~was performing the specific ~~Health Maintenance~~health maintenance tasks to the member's satisfaction on an informal basis as a friend or family member for a minimum of two months in the period immediately prior to being hired as the PSA, and no evidence contra-indicates the attestation of safe and competent performance by the APSA, additional documentation is not required.

(I) The CDA/CM monitors the member's ~~well-being~~well-being and the quality of supports and services and assists the member in revising the PSA services plan as needed. ~~If~~When the member's need for services changes due to a change in health/disability status and/or a change in the level of support available from other sources to meet needs, the CDA/CM, based upon an updated assessment, amends the person-centered service plan to modify CD-PASS service units appropriate to meet additional member's need and

forwards the plan amendment to the AA for authorization and update of the member's IBA.

(J) In the event of a disagreement between the member and CD-PASS provider the following process is followed:

(i) either party may contact via a toll free number the Member/Provider Relations Resource Center to obtain assistance with issue resolution;

(ii) ~~if~~when the issue cannot be resolved with assistance from the Member/Provider Relations Resource Center or from CD-PASS Program Management, the CD-PASS Program Management ~~will submit~~submits the dispute to the ADvantage Escalated Issues Unit for resolution. The Escalated Issues Unit ~~will work~~works with the member and provider to reach a ~~mutually agreed~~mutually-agreed upon resolution;

(iii) ~~if~~when the dispute cannot be resolved by the ADvantage Escalated Issues Unit it ~~will be~~is heard by the Ethics of Care Committee. The Ethics of Care Committee ~~will make~~makes a final determination with regard to settlement of the dispute;

(iv) at any step of this dispute resolution process the member may request a fair hearing, to appeal the dispute resolution decision.

(K) The CDA/CM and the member prepare an emergency ~~backup/emergency~~backup response capability for CD-PASS ~~PSAPSA/APSA~~PSAPSA/APSA services in the event a ~~PSAPSA/APSA~~PSAPSA/APSA services provider ~~of services~~ essential to the individual's health and welfare fails to deliver services. As part of the backup planning process, the CDA/CM and member define what failure of service or neglect of service tasks ~~would constitute~~constitutes a risk to health and welfare to trigger implementation of the emergency backup. ~~Any of the following~~(i) or (ii) may be used ~~in planning for the backup.~~

(i) Identification of a qualified substitute provider of ~~PSAPSA/APSA~~PSAPSA/APSA services and preparation for their quick response to provide backup emergency services, ~~when called upon in emergency circumstances, (including execution of all qualifying background checks, training and employment processes);~~including execution of all qualifying background checks, training, and employment processes; and/or,

(ii) Identification of one or more qualified substitute ADvantage agency service providers, ~~(Adult Day Care, Personal Care or Nursing Facility Respite provider)~~adult day health, personal care, or nursing facility (NF) respite provider, and preparation for

~~their~~ quick response to provide backup emergency services when called upon in emergency circumstances.

(L) ~~If the emergency backup fails, the CDA/CM is to request the AA to~~To obtain authorizations for providers other than PSA and APSA identified as emergency backups, requests the AA authorize and facilitate member access to Adult Day Care, adult day health, Agency Personal Care, agency personal care, or Nursing Facility Respite services.

(5) The case manager submits the ~~care plan and~~person-centered service plan to the case management supervisor for review. The case management supervisor documents the review/approval of the plans within ~~two working~~two-business days of receipt from the case manager or returns the plans to the case manager with notations of errors, problems, and concerns to be addressed. The case manager re-submits the corrected ~~care plan and~~person-centered service plan to the case management supervisor within ~~two working~~two-business days. The case management supervisor returns the approved ~~care plan and~~person-centered service plan to the case manager. Within ~~one working~~one-business day of receiving supervisory approval, the case manager forwards, ~~via postal~~by United States mail, a legible copy of the ~~care plan and~~person-centered service plan to the AA. Case managers are responsible for retaining all original documents for the member's file at the agency. Only priority service needs and supporting documentation may be faxed to the AA with the word, "PRIORITY"—~~being~~ clearly indicated and the justification attached. "Priority" service needs are defined as services needing immediate authorization to protect the health and welfare of the member and/or avoid premature admission to the ~~nursing facility.~~NF. Corrections to service conditions set by the AA are not considered ~~to be~~ a priority unless the health and welfare of the member would otherwise be immediately jeopardized and/or the member would otherwise require premature admission to a ~~nursing facility.~~NF.

(6) Within ~~one working~~one-business day of notification of care plan and person-centered service plan authorization, the case manager communicates with the service plan providers and ~~with the member~~ to facilitate service plan implementation. Within ~~five working~~five-business days of notification of an initial person-centered service plan or a new reassessment service plan authorization, the case manager visits the member, gives the member a copy of the person-centered service plan or computer-generated copy of the person-centered service plan, and evaluates the ~~progress of the service plan implementation.~~service plan implementation

progress. The case manager evaluates service plan implementation on the following minimum schedule:

(A) within ~~30-calendar~~30-calendar days of the authorized effective date of the person-centered service plan or service plan addendum amendment; and

(B) monthly after the initial ~~30-day~~30-calendar follow-up evaluation date.

(b) **Authorization of service plans and amendments to service plans.** The ~~Advantage Administration~~ ~~(AA)~~AA authorizes the individual person-centered service plan and all service plan amendments for each Advantage member. When the AA verifies member Advantage eligibility, service plan cost effectiveness, ~~that for~~ service providers that are Advantage authorized and SoonerCare contracted, and that the delivery of Advantage services are consistent with the member's level of care need, the service plan is authorized.

(1) Except as provided by the process ~~described in~~ per OAC 317:30-5-761(6), family members may not receive payment for providing Advantage waiver services. A family member is defined as an individual who is legally responsible for the member ~~(spouse or parent of a minor child).~~, such as the spouse or parent of a minor child.

(2) The ~~OKDHS/ASDDHS AS~~ may under criteria described in, per OAC 317:35-15-13 authorize personal care service provision by an Individual PCA ~~(an individual contracted directly with OHCA).~~an individual contracts directly with OHCA. Legally responsible family members are not eligible to serve as Individual PCA's. PCAs.

(3) ~~If~~When the service plan authorization or amendment request packet received from case management is complete and the service plan is within ~~cost-effectiveness~~cost-effectiveness guidelines, the AA authorizes or denies authorization within ~~five-working~~five-business days of receipt of the request. ~~If~~When the service plan is not within cost-effectiveness guidelines, the plan is referred for administrative review to develop an alternative cost-effective plan or assist the member ~~to~~ access services in an alternate setting or program. ~~If~~When the request packet is not complete, the AA notifies the case manager immediately and puts a ~~"hold"~~hold on authorization until the required additional documents are received from case management.

(4) The AA authorizes the service plan by entering the authorization date and assigning a control number that internally identifies the ~~OKDHS~~DHS staff completing the authorization. Notice of authorization and a computer-generated copy of the authorized plan or a computer-generated copy of the authorized plan are provided to case management.

AA authorization determinations are provided to case management within ~~one working~~one-business day of the authorization date. A person-centered service plan may be authorized and implemented with specific services temporarily denied. The AA communicates to case management the conditions for approval of temporarily denied services. The case manager submits revisions for denied services to AA for approval within ~~5 working~~5-business days.

(5) For audit purposes ~~(including Program Integrity reviews)~~, including Program Integrity reviews, the computer-generated copy of the authorized service plan is documentation of service authorization for ADVantage waiver and State Plan Personal Care services. ~~State or Federal~~ or State quality review and audit officials may obtain a copy of specific person-centered service plans with original signatures by submitting a request to the member's case manager.

(c) **Change in service plan.** The process for initiating a change in the person-centered service plan is described in this subsection.

(1) The service provider initiates the process for an increase or decrease in service to the member's person-centered service plan. The requested changes and justification ~~for them~~ are documented by the service provider and, if when initiated by a direct care provider, are submitted to the member's case manager. ~~If~~When in agreement, the case manager requests the service changes on a ~~care plan~~ and service plan amendment submitted to the AA within ~~five calendar~~five-business days of assessed need. The AA authorizes or denies the ~~care plan and~~person-centered service plan changes per Oklahoma Administrative Code (OAC) 317:35-17-14.

(2) The member initiates the process for replacing Personal Care services with Consumer-Directed Personal Services and Supports (CD-PASS) in geographic areas ~~in which~~where CD-PASS services are available. The member may contact the AA or ~~by~~ eallingcall the toll-free number ~~established~~ to process requests for CD-PASS services.

(3) A significant change in the member's physical condition or caregiver support, one that requires additional goals, deletion of goals or goal changes, or requires a four-hour or more adjustment in services per week, requires an updated UCAT reassessment by the case manager. The case manager develops an amended or new person-centered service plan ~~and care plan~~, as appropriate, and submits the new amended person-centered service plan ~~plans~~ for authorization.

(4) One or more of the following changes or service requests require an Interdisciplinary Team review and service plan

goals amendment:

(A) the presence of two or more ADvantage members residing in the same household~~;~~ ~~or~~

(B) the member and personal care provider residing together~~;~~ ~~or~~

(C) a request for a family member to be a paid ADvantage service provider~~;~~ or;

(D) a request for an ~~Individual~~individual PCA service provider.

(5) Based on the reassessment and consultation with the AA as needed, the member may, as appropriate, be authorized for a new person-centered service plan or be eligible for a different service program. ~~If~~When the member is significantly improved from the previous assessment and does not require ADvantage services, the case manager obtains the member's dated signature indicating voluntary withdrawal for ADvantage program services. ~~If~~When unable to obtain the member's consent for voluntary closure, the case manager requests ~~assistance from the AA.~~(AA) assistance. The AA requests that the ~~OKDHS~~DHS area nurse initiate a reconsideration of level of care.

(6) Providers of Home and Community Based Services (HCBS) for the member, or those who have an interest in or are employed by a provider of HCBS for the member, must not provide case management or develop the person-centered service plan, except when the State demonstrates~~that~~ the only willing and qualified entity to provide case management ~~and/or~~and develop person-centered service plans in a geographic area also provides HCBS.

### **317:35-17-18. ADvantage services during hospitalization or NF placement**

When the member's ~~OKDHS~~DHS social worker, ADvantage case manager, or the AA is informed ~~(by the member, family or service provider)~~by the member, family, or service provider of a member's hospitalization or placement in a nursing facility~~;~~ (NF), that party determines the date of the member's institutionalization and communicates the date, name of the institution, reason for placement, and expected duration for placement~~;~~ to the other ADvantage Program Administrative partners. ~~If~~When a member requires hospital or ~~nursing facility~~NF services, the case manager assists the member ~~in accessing~~access institutional care, periodically monitors the member's progress during the institutional stay and, as appropriate, updates the person-centered service plan and prepares services to start on the date the member is discharged from the institution and returns home. All case management

units for ~~"institution—transition"~~institution transition services to plan for and coordinate service delivery and to assist the member to safely return home, even ~~if~~when provided while the person is in an institution, ~~are—to-be~~ considered delivered on and billed for the date the member returns home from institutional care.

(1) **Hospital discharge.** When the member returns home from a hospital or when notified of the member's anticipated discharge date, the case manager notifies relevant providers and the ~~AA~~ADvantage Administration (AA), and coordinates the resumption of services.

(2) **~~NF~~Nursing Facility placement of less than ~~30—days~~30-calendar days.** When the member returns home from a NF stay of ~~30—days~~30-calendar or less or when notified of the member's anticipated discharge date, the case manager notifies relevant providers, the member's ~~OKDHS~~DHS worker and the AA of the discharge and coordinates the resumption of ADvantage services in the home.

(3) **~~NF~~Nursing Facility placement ~~greater~~longer than ~~30 days~~30-calendar days.** When the member is scheduled to be discharged and return home from a NF stay that is ~~greater~~longer than ~~30—days~~30-calendar the member's ~~OKDHS~~DHS worker, ADvantage case manager, or the AA ~~(whoever first receives notification of the discharge)~~, whoever first receives notification of the discharge, notifies other ADvantage Program Administrative partners to expedite the restart of ADvantage services for the member. ~~In these circumstances, the SPEED process may be used to re-establish ADvantage eligibility to coincide with the date of discharge from the NF.~~ The member's case manager provides ~~"institution transition"~~institution transition case management services to assist the member to re-establish him or herself safely in the home.

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

(a) Billing procedures for long-term care medical services are contained in the Oklahoma Medicaid Management Information Systems (OKMMIS) Billing and Procedure Manual. Questions regarding billing procedures ~~which~~that cannot be resolved through a study of the manual ~~should be~~referred to the Oklahoma Health Care Authority (OHCA).

(b) The Oklahoma Department of Human Services (DHS) Aging Services ~~(DHS/AS)~~(AS) approved ADvantage service plan is the basis for the Medicaid Management Information Systems (MMIS) service prior authorization, specifying:

- (1) service;
- (2) service provider;

(3) units authorized; and

(4) begin and end dates of service authorization.

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

(d) ~~Service time of Personal Care, Case Management, Case Management for transitioning, Nursing, Advanced Supportive/Restorative Assistance, In-Home Respite, CD-PASS Personal Services Assistance, and Advanced Personal Services Assistance~~personal care, case management, case management for transitioning, nursing, advanced supportive/restorative assistance, in-home respite, consumer-directed personal assistance services and supports (CD-PASS), personal services assistance, and advanced personal services assistance is documented solely through the Electronic Visit Verification System (EVV) also known as Interactive Voice Response Authentication (IVRA) system, when provided in the home. Providers are required to use the IVRAEVV system ~~after access to the system is made available by OKDHS~~. The IVRAEVV system provides alternate backup solutions ~~should~~when the automated system ~~be~~is unavailable. In the event of ~~IVRA backup~~EVV system failure, the provider documents time in accordance with ~~their agency backup plan; however, backup procedures are only permitted when the IVRA system is unavailable~~internal policy and procedures. This documentation suffices to account for in-home and office services delivered. Provider agency backup procedures are only permitted when the EVV system is unavailable.

(e) The provider must document the amount of time spent for each service, per ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-5-763. For service codes that specify a time segment in their description, such as 15 minutes, each timed segment equals one unit. Only time spent fulfilling the service for which the provider is authorized, per OAC 317:30-5-763, ~~shall be~~is authorized for ~~timed based~~time-based services. Providers ~~shall do~~do not bill for a unit of time when not more than one-half of a timed unit is performed. For example, ~~if~~when a unit is defined as 15 minutes, providers ~~should do~~do not bill for services performed for less than ~~eight~~eight minutes. The rounding rules utilized by the IVRAEVV and web-based billing system to calculate the billable ~~amount~~unit-amount of a ~~unit~~are ~~are~~are, services provided for duration of:

(1) ~~services provided for a duration of less than 8 minutes~~8-

minutes cannot be rounded up and do not constitute a billable 15-minute unit; and  
(2) ~~services provided for a duration of 8 to 158 to 15 minutes are rounded up and do constitute a billable 15-minute unit.~~

## SUBCHAPTER 19. NURSING FACILITY SERVICES

### 317:35-19-2. Nursing Facility (NF) program medical eligibility determination

The ~~OKDHS~~ DHS area nurse, or nurse designee ~~(OHCA, LOCEU makes some determinations when PASRR is involved)~~, determines medical eligibility for nursing facility (NF) services based on the ~~Long Term Care (LTC)~~ long term care (LTC) nurse's UCAT, Part III Uniform Comprehensive Assessment Tool (UCAT III) assessment of the client's needed level of care, the outcome of the Level II Preadmission Screening and Resident Review (PASRR), if/when completed, and his or her professional judgment. The Oklahoma Healthcare Authority Level of Care Evaluation Unit makes some determinations when the (PASRR) is involved. Refer to OAC Oklahoma Administrative Code (OAC) 317:35-19-7.1(3) for nursing facility level of care medical eligibility requirements.

(1) When NF care services are requested prior to admission, the same rules related to medical eligibility determination identified in OAC 317:35-17-5 for Advantage services are followed.

(2) ~~The LTC nurse submits the UCAT, Part III, the Long Term Care Preadmission Screen form (PASRR), and the NF request for assessment to the area nurse, or nurse designee, for medical eligibility determination. The LTC nurse reviews the PASRR Level I in the Oklahoma Health Care Authority system; completes the UCAT III; and enters the date OHCA received the PASRR Level I (LTC-300R) from the NF and admission date to the NF; financial eligibility effective date and notes any Level II PASRR results if available in the UCAT III. This information is submitted to the DHS Area Nurse for medical eligibility determination.~~

(3) PASRR requirements are identified in OAC 317:35-19-8 and 317:35-19-9.

(4) When it is not possible for the UCAT assessment to be completed prior to admission, the NF is responsible for notifying the ~~OKDHS~~ DHS of the admission. ~~Notification will be by mailing or by faxing the OKDHS form ABCDM-83 (Notification Regarding Patient In A Nursing Facility, Intermediate Care Facility for the Mentally Retarded or Hospice), OKDHS form ABCDM-96 (Management of Recipient's Funds), and OKDHS form ABCDM-83-A, Request for Title XIX~~

Nursing Assessment, to the local OKDHS county office. Notification is mailed or faxed on DHS Form 08MA083E, Notification regarding Patient In A Nursing Facility, Intermediate Care Facility for the Mentally Retarded or Hospice, and Management Recipient Funds to the local DHS county office. Upon receipt, the OKDHS DHS county office processes the ABCDM-83, Forms 08MA084E and 08MA084E ABCDM-96, and the ABCDM-83 Forms 08MA083E and 08MA084E and completes and forwards the OKDHS form ABCDM-37D Form 08MA038E (Notice Regarding Financial Eligibility), Notice Regarding Financial Eligibility to the NF. Identified sections of the UCAT reflecting the domains for meeting medical criteria are completed for applicants residing in the NF at the time of assessment. The area nurse, or nurse designee, determines confirms the date of medical eligibility and records it ~~on~~ in the system based on the date of financial eligibility. The facility is responsible for performing the PASRR Level I screen and consulting with OHCA staff of the OHCA as to whether to determine when a need exists for a Level II screen. The LTC nurse will conduct conducts the assessment visit within 15 working 15-business days of request for assessment if PASRR clearance when the individual's needs are included in an active ABCDM DHS coded case. If When the individual's needs are not included in an active ABCDM case, the assessment is conducted within 20 working 20-business days of the date of the signed application. The LTC nurse forwards the completed preadmission screen, the ABCDM 83 A, and the UCAT, Part III to the area nurse or nurse designee. PASRR clearance.

(5) The area nurse, or nurse designee, will evaluate evaluates the PASRR Level I screen and the UCAT, Part III and consult with staff of the OHCA as to whether a need exists for a Level II screen as necessary. in consultation with the DHS nurse when the completed LTC-300R and/or facility documentation shows a need exists for a possible Level II screen. The area nurse or nurse designee consults with OHCA staff as necessary.

(6) The area nurse, or nurse designee, will evaluate evaluates the UCAT, Parts I and III, the Long-Term Care Preadmission Screen form and the physician's diagnosis to determine whether if the applicant meets the medical eligibility criteria for NF level of care. Individuals may be medically certified medically-certified for NF level of care for various lengths of time depending upon on the client's needs of the client. The area nurse, or nurse designee, enters the medical eligibility decision, and, when required, the medical certification review date on the system into Aging Services

Division Electronic Data Entry and Retrieval System (ELDERS)  
within ~~ten working~~10-business days. A medical eligibility redetermination is not required when a client is discharged from the NF for a period not to exceed ~~90~~90-calendar days and the original certification is current.

(7) ~~If~~When the LTC nurse recommends NF level of care and the client is determined by the area nurse, or nurse designee, not to be medically eligible for NF level of care, the LTC nurse can submit additional information to the area nurse, or nurse designee. When necessary, a visit by the LTC nurse to obtain additional information ~~can be~~is initiated at the recommendation of the area nurse, or nurse designee.

(8) Categorical relationship must be established for determination of eligibility for NF services. ~~If~~When categorical relationship to disability has not ~~already~~ been established, the worker submits the same information ~~described in~~per OAC 317:35-5-4(2) to the LOCEU to request a determination of eligibility for categorical relationship. LOCEU renders a decision on categorical relationship to the disabled applicant using the ~~same~~Social Security Administration (SSA) definition ~~used by SSA~~. A follow-up with the SSA by the ~~OKDHS~~DHS worker is required to ~~be sure~~that ensure the SSA disability decision agrees with the LOCEU decision ~~of LOCEU~~.