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Brad Henry, Governor
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Secretary of State
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Notices of Rulemaking Intent

Prior to adoption and gubernatorial/legislative review of a proposed PERMANENT rulemaking action, an agency must publish a Notice of Rulemaking Intent in the *Register*. In addition, an agency may publish a Notice of Rulemaking Intent in the *Register* prior to adoption of a proposed EMERGENCY or PREEMPTIVE rulemaking action.

A Notice of Rulemaking Intent announces a comment period, or a comment period and public hearing, and provides other information about the intended rulemaking action as required by law, including where copies of proposed rules may be obtained.

For additional information on Notices of Rulemaking Intent, see 75 O.S., Section 303.

TITLE 45. ALCOHOLIC BEVERAGE LAWS ENFORCEMENT COMMISSION CHAPTER 30. MANUFACTURERS, WHOLESALEERS, BREWERS, NONRESIDENT SELLERS AND CLASS B WHOLESALERS

[OAR Docket #05-1219]

RULEMAKING ACTION:

Notice of proposed **PERMANENT** rulemaking

PROPOSED RULES:

Subchapter 1. General Provisions

45:30-1-2. Definitions [AMENDED]

Subchapter 5. Brewers, Nonresident Sellers and Class B Wholesalers

45:30-5-7. Class B Wholesaler's price registration [AMENDED]

SUMMARY:

Proposed rule 45:30-5-07 was submitted to the ABLE Commission on August 10, 2005, through a written Petition for Rule Change or Amendment filed by John B. Jarboe, Attorney at Law, on behalf of certain petitioners. Proposed rule 45:30-1-2 was submitted to the ABLE Commission by its Staff to conform the existing rule 45:3-1-2 to the proposed rule 45:30-5-7 as to the definition of the phrase "Adjusted Price", in the event that proposed rule 45:30-5-7 is adopted by the ABLE Commission and in order to prevent any inconsistencies between these two rules. The intended purpose of the proposed rule changes is to permit the ABLE Commission to provide to Class B Wholesalers and their retail and on-premises customers more adequate and timely notice of prices posted by Class B Wholesalers prior to the effective date of those monthly price postings. The proposed rule 45:30-5-7 would alter the dates of which Class B Wholesalers submit their original and adjusted monthly price postings to the ABLE Commission.

Currently on or before the 15th day of each month, Class B Wholesalers register or file a listing of all beer or brewed products and the proposed price to market these products during the following month with the ABLE Commission. Further, currently, after filing the initial price posting, Class B Wholesalers are permitted to register with the ABLE Commission on or before the 25th day of each month an "Adjusted Price" no lower than the lowest price posted on the 15th day of the posting month by any Class B Wholesaler, the Class B Wholesaler(s) posting the lowest price cannot adjust to a lower or higher price than the originally posted on the 15th day of the month and a Class B Wholesaler may adjust

his prices for one or more items or he may remain at his initial 15th day of the posting month posting. Still further, currently, if no price adjustments are made, a Class B Wholesaler shall file a certificate to that effect with the ABLE Commission on or before the 25th day of the month.

Under the proposed rule 45:30-5-7, on or before the 10th day of each month, Class B Wholesalers register or file a listing of all beer or brewed products and the proposed price to market these products during the following month with the ABLE Commission. Further under proposed rule 45:30-5-7, after filing the initial price posting, Class B Wholesalers are permitted to register with the ABLE Commission on or before the 20th day of each month an "Adjusted Price," no lower than the lowest price posted on the 10th day of the posting month by any Class B Wholesaler, the Class B Wholesaler(s) posting the lowest price cannot adjust to a lower or higher price than he originally posted on the 10th day of the month and a Class B Wholesaler may adjust his prices for one or more items or he may remain at his initial 10th day of the posting month posting. Still further, under proposed rule 45:30-5-7, if no price adjustments are made, a Class B Wholesaler shall file a certificate to the effect with the ABLE Commission on or before the 20th day of the month.

The proposed rule 45:30-1-2 would alter the dates on which Class B Wholesalers submit their original and adjusted monthly price postings to the ABLE Commission to correspond with those of the proceeding proposed rule 45:30-5-7 contained in the definition of the phrase "Adjusted Price."

Currently the phrase "Adjusted Price" means percentage or individual item prices reported and registered by a Wholesaler on or before the 25th day of a posting month in response to a lower percentage reported and registered by a competitor Wholesaler on the 15th day of the month. Under the proposed rule 45:30-1-2, the phrase "Adjusted Price" means percentage or individual item prices reported and registered by a Wholesaler on or before the 20th day of a posting month in response to a lower percentage reported and registered by a competitor Wholesaler on the 10th day of the month.

AUTHORITY:

Alcoholic Beverage Laws Enforcement Commission, 37 O.S., Section 502 et seq.

COMMENT PERIOD:

Any interested party may present their views by submitting them in writing by 4:30 p.m., October 17, 2005, to the ABLE Commission, 4545 North Lincoln, Suite 270, Oklahoma City, Oklahoma 73105.

Notices of Rulemaking Intent

PUBLIC HEARING:

A public hearing regarding the proposed rule change will be held before the ABLE Commission at 10:00 a.m., on October 21, 2005, at 4545 North Lincoln, Suite 270, Oklahoma City, Oklahoma.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

The ABLE Commission requests that business entities affected by this proposed rule provide the Commission, within the comment period, in dollar amounts, if possible, the increase in the level of direct costs such as fees, and indirect costs such as reports, recordkeeping, equipment, construction, labor, professional services, revenue loss, or other costs expected to be incurred by a particular entity due to compliance with the proposed rules. Business entities may submit this information in writing to the Commission, at the above address, before the close of the comment period on October 17, 2005.

COPIES OF PROPOSED RULES:

A copy of the proposed rules may be obtained for review by the public from the ABLE Commission, 4545 North Lincoln, Suite 270, Oklahoma City, Oklahoma.

RULE IMPACT STATEMENT:

The ABLE Commission will prepare a rule impact statement which will be available on September 15, 2005, from the ABLE Commission, 4545 North Lincoln, Suite 270, Oklahoma City, Oklahoma.

CONTACT PERSON:

Bryan Neal, Assistant Attorney General and Legal Counsel
(405) 521-3484

[OAR Docket #05-1219; filed 8-26-05]

TITLE 235. OKLAHOMA FUNERAL BOARD CHAPTER 10. FUNERAL SERVICES LICENSING

[OAR Docket #05-1220]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

Subchapter 3. Qualifications and Requirements for Licensure

235:10-3-1. [AMENDED]

SUMMARY:

Effective 2005 all graduates from American Board of Funeral Service Education accredited programs must take the National Board Examination. The Funeral Board will no longer administer the State Board Examination.

AUTHORITY:

Funeral Services Licensing Act; 59 O.S. §396.2a

COMMENT PERIOD:

Persons wishing to present their views in writing may do so before 4:00 PM November 9, 2005 at the following address:

Funeral Board, 4545 N. Lincoln Blvd., Ste. 175, Oklahoma City, OK 73105.

PUBLIC HEARING:

A public hearing will be held at 10AM on Thursday November 10, 2005 at 4545 N. Lincoln, Room 284, Oklahoma City.

REQUEST FOR COMMENTS FROM BUSINESS ENTITIES:

Business entities affected by these proposed rules are requested to provide the agency with information, in dollar amounts if possible, about the increase in the level of direct costs, indirect costs, or other cost expected to be incurred by the business entity due to compliance with the proposed rules. Business entities may submit this information in writing by the conclusion of the comment period on November 9, 2005 at the following address: Funeral Board, 4545 N. Lincoln Blvd., Ste. 175, Oklahoma City, OK 73105.

COPIES OF PROPOSED RULES:

Copies of the proposed rules may be obtained by written request mailed to: Funeral Board, 4545 N. Lincoln Blvd., Ste. 175, Oklahoma City, OK 73105. The proposed rule is also available on the agency web site www.okfuneral.com under NEWS.

RULE IMPACT STATEMENT:

Pursuant to 75 O.S. §303(D), a rule impact statement has been prepared and is available by written request at the following address: Funeral Board, 4545 N. Lincoln Blvd., Ste. 175, Oklahoma City, OK 73105.

CONTACT PERSON:

Terry McEnany, Executive Director, (405) 522-1790

[OAR Docket #05-1220; filed 8-26-05]

TITLE 252. DEPARTMENT OF ENVIRONMENTAL QUALITY CHAPTER 100. AIR POLLUTION CONTROL

[OAR Docket #05-1218]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking.

PROPOSED RULES:

Subchapter 1. General Provisions

252:100-1-3. [AMENDED]

Subchapter 4. New Source Performance Standards

252:100-4-5. [AMENDED]

Subchapter 8. Permits for Part 70 Sources

Part 1. General Provisions

252:100-8-1.1. [AMENDED]

Part 5. Permits for Part 70 Sources

252:100-8-2. [AMENDED]

Part 7. Prevention of Significant Deterioration (PSD)

Requirements for Attainment Areas

252:100-8-30. [AMENDED]

252:100-8-31. [AMENDED]

- 252:100-8-32. [REVOKED]
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- 252:100-8-55. [NEW]
- 252:100-8-56. [NEW]
- 252:100-8-57. [NEW]
- Part 11. Visibility Protection Standards [NEW]
- 252:100-8-70. [NEW]
- 252:100-8-71. [NEW]
- 252:100-8-72. [NEW]
- 252:100-8-73. [NEW]
- 252:100-8-74. [NEW]
- 252:100-8-75. [NEW]
- 252:100-8-76. [NEW]
- Subchapter 37. Control of Emission of Volatile Organic Compounds (VOCs)
- Part 1. General Provisions
- 252:100-37-2. [AMENDED]
- Subchapter 39. Emission of Volatile Organic Compounds (VOCs) in Nonattainment Areas and Former Nonattainment Areas
- Part 1. General Provisions
- 252:100-39-2. [AMENDED]
- Subchapter 41. Control of Emission of Hazardous Air Pollutants and Toxic Air Contaminants
- Part 3. Hazardous Air Pollutants
- 252:100-41-15. [AMENDED]

SUMMARY:

The Department is proposing amendments to Subchapter 8, Permits for Part 70 Sources. The Department proposes to rename the Subchapter "Permits for Major Sources". The Department proposes to revise Parts 7 and 9 to incorporate the Environmental Protection Agency's revisions to the New Source Review (NSR) permitting program under the Federal Clean Air Act. These proposed amendments include

revisions to the method of determining if a modification to an NSR source is a major modification and includes Plantlike Applicability Limitations (PAL) Exclusions. The Department proposes to update and clarify Parts 7 and 9. This will include federal revisions not previously incorporated by the Department. The Department proposes to move a number of definitions from Section 8-1.1 of Subchapter 8 to Subchapter 1 since these terms are used in more than one Subchapter in Chapter 100. The Department proposes to move three (3) definitions from 8-31 to 8-1.1 because those terms are applicable to both NSR and Visibility Protection Standards requirements.

The Department proposes to revise the definition of "insignificant activities" in Section 8-2 of Subchapter 8 due to the recent revision to Subchapter 41 and the promulgation of new Subchapter 42 and to move paragraph (B) of the definition of "begin actual construction" from Section 8-1.1 to Section 8-2.

The Department is proposing a new Part 11 which incorporates the federal Best Available Retrofit Technology (BART) requirements into Chapter 100. The BART requirements are part of the Regional Haze State Implementation Plan (SIP).

The Department is proposing to amend Subchapters 1, 37 and 39 to accommodate the new definition for Volatile Organic Compound (VOC) contained in 40 CFR 51.100(s). Section 252:100-1-3, is also being amended to incorporate definitions associated with revisions to the NSR permitting program.

Section 252:100-4-5 is being amended to incorporate by reference 40 CFR Part 60 New Source Performance Standards (NSPS).

Section 252:100-41-15 is being amended to incorporate by reference 40 CFR Part 61 and Part 63 National Emission Standards for Hazardous Air Pollutants (NESHAP).

AUTHORITY:

Environmental Quality Board powers and duties, 27A O.S., §§ 2-2-101, 2-2-201; and Oklahoma Clean Air Act, §§ 2-5-101 *et seq.*

COMMENT PERIOD:

Written comments on the proposed rulemakings will be accepted prior to and at the hearing on October 19, 2005. For comments received at least 5 business days prior to the council meeting, staff will post written responses on our web page at least 1 day prior to the Council meeting and provide hard copy written responses to these comments to the council and the public at that council meeting. Oral comments may be made at the October 19, 2005 hearing and at the appropriate Environmental Quality Board meeting.

PUBLIC HEARINGS:

Before the Air Quality Council at 9:00 a.m. on Wednesday, October 19, 2005, at the Oklahoma Department of Environmental Quality, 707 North Robinson, Oklahoma City, Oklahoma. Before the Environmental Quality Board at 9:30 a.m. on November 15, 2005, at the Braman Town Complex, 302 Broadway, Braman, OK.

Notices of Rulemaking Intent

REQUEST FOR COMMENTS FROM BUSINESS ENTITIES:

The Department requests that business entities or any other members of the public affected by these rules provide the Department, within the comment period, in dollar amounts if possible, the increase in the level of direct costs such as fees, and the indirect costs such as reporting, record keeping, equipment, construction, labor, professional services, revenue loss, or other costs expected to be incurred by a particular entity due to compliance with the proposed rules.

COPIES OF PROPOSED RULES:

The proposed rules are available for review at the Air Quality Division of the Department and on the Department website (www.deq.state.ok.us), Air Quality Division, What's New, or copies may be obtained from the contact person by calling (405) 702-4100.

RULE IMPACT STATEMENT:

Copies of the rule impact statement may be obtained from the contact person.

CONTACT PERSON:

Please send written comments to Max Price (e-mail: Max.Price@deq.state.ok.us) for Subchapters 1, 4, 37, 39 and 41. For Subchapter 8, send written comments to Joyce Sheedy (e-mail: joyce.sheedy@deq.state.ok.us), Department of Environmental Quality, Air Quality Division, 707 N. Robinson, Oklahoma City, OK 73102. Mailing address is P.O. Box 1677, Oklahoma City, Oklahoma 73101-1677, Fax (405)702-4101.

PERSONS WITH DISABILITIES:

Should you desire to attend but have a disability and need an accommodation, please notify the Air Quality Division three (3) days in advance at (405)702-4100.

ADDITIONAL INFORMATION:

DEQ proposes to submit Subchapters 1, 4, 8, 37, 39 and 41 to the EPA for inclusion in the Oklahoma SIP. This hearing shall also serve as the public hearing to receive comments on the proposed revisions to the SIP under the requirements of 40 Code of Federal Regulations (CFR)§ 51.102 of the EPA regulations concerning the SIPs and 27A O.S. § 2-5-107(6)(c).

[OAR Docket #05-1218; filed 8-25-05]

TITLE 325. OKLAHOMA HORSE RACING COMMISSION CHAPTER 35. GENERAL CONDUCT

[OAR Docket #05-1210]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking.

PROPOSED RULE:

325:35-1-34. Election of horsemen's representative organizations and agreements [AMENDED]

SUMMARY:

The State-Tribal Gaming Act was passed November 2, 2004 in the General Election as State Question 712. Section 267 of the Act recognizes those horsemen's representative organizations that operated as such in CY 2001 as the horsemen's representative organizations for the breeds: the Thoroughbred Racing Association of Oklahoma for Thoroughbreds and the Oklahoma Quarter Horse Racing Association for Quarter Horses, Paints and Appaloosas.

The Commission is proposing the rule amendments to the current election language in order to be in compliance with Section 267 of the State-Tribal Gaming Act.

AUTHORITY:

75 O.S., §303; Title 3A O.S. §204(A); Oklahoma Horse Racing Commission.

COMMENT PERIOD:

Persons wishing to present their views in writing may do so before 4:30 p.m., Monday, October 17, 2005, at the following address: Oklahoma Horse Racing Commission, Shepherd Mall, 2401 N.W. 23, Suite 78, Oklahoma City, OK 73107

PUBLIC HEARING:

A public hearing will be held between the hours of 9:00 a.m. and 12:00 p.m. and 1:00 p.m. and 4:30 p.m. on Monday, October 17, 2005, at the following address: Oklahoma Horse Racing Commission, Shepherd Mall, 2401 N.W. 23, Suite 78, Oklahoma City, OK 73107. Anyone who wishes to present oral comment at the public hearing must sign a speaker's register.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

The Oklahoma Horse Racing Commission requests that business entities affected by this proposed rule provide the Commission, within the comment period, in dollar amounts, if possible, the increase in the level of direct costs, indirect costs, or other costs expected to be incurred by the business entity due to compliance with the proposed rule. Business entities may submit this information in writing to the Commission, at the above address, before the close of the comment period on October 17, 2005.

COPIES OF PROPOSED RULES:

A copy of the proposed rule amendment may be obtained from the Oklahoma Horse Racing Commission, Shepherd Mall, 2401 N.W. 23, Suite 78, Oklahoma City, OK 73107.

RULE IMPACT STATEMENT:

Pursuant to 75 O.S. §303(D), a rule impact statement will be prepared by September 1, 2005 and may be obtained from the Oklahoma Horse Racing Commission at the above address.

CONTACT PERSON:

Bonnie Morris, Assistant to the Administrator, (405) 943-6472.

[OAR Docket #05-1210; filed 8-19-05]

**TITLE 545. BOARD OF PODIATRIC
MEDICAL EXAMINERS
CHAPTER 15. EXAMINATION/LICENSURE**

[OAR Docket #05-1202]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

545:15-1-3. Requirements for application [AMENDED]

SUMMARY:

Title 59 O.S., §144 states in part that an applicant for examination/licensure shall not have been finally convicted of any crime involving moral turpitude or of any felony. The rule is being amended to allow the Board to require a criminal background check on all applicants.

AUTHORITY:

Title 59 O.S., Section 141, Board of Podiatric Medical Examiners

COMMENT PERIOD:

The comment period will run from September 15, 2005 to October 28, 2005. Written comments may be sent to the office of the Board, PO Box 18256, Oklahoma City, OK 73154-0256.

PUBLIC HEARING:

A public hearing will be held to provide an opportunity for persons to orally present their views on November 4, 2005 at 5:30 p.m. at the following location: Southern Hills Marriott, 1902 East 71st Street, Tulsa, Oklahoma. Written notice of intent to make oral comment must be received by this office no later than October 28, 2005.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

n/a

COPIES OF PROPOSED RULES:

Copies of the proposed rules may be obtained at the office of the Board, 5104 North Francis Avenue, Suite C, Oklahoma City, Oklahoma.

RULE IMPACT STATEMENT:

A rule impact statement will be prepared and available after September 15, 2005 at the office of the Board, 5104 North Francis Avenue, Suite C, Oklahoma City, Oklahoma.

CONTACT PERSON:

Jan Ewing, Assistant to the Director (405) 848-6841, ext. 104

[OAR Docket #05-1202; filed 8-15-05]

**TITLE 545. BOARD OF PODIATRIC
MEDICAL EXAMINERS
CHAPTER 20. MAINTAINING LICENSURE**

[OAR Docket #05-1203]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking.

PROPOSED RULES:

Subchapter 3. Continuing Education

545:20-3-3. Approved continuing education programs [AMENDED]

SUMMARY:

This rules outlines the programs that are approved for continuing education and the number of hours that may be obtained in each category.

AUTHORITY:

Title 59 O.S., Section 141, Board of Podiatric Medical Examiners

COMMENT PERIOD:

The comment period will run from September 15, 2005 to October 28, 2005. Written comments may be sent to the office of the Board, PO Box 18256, Oklahoma City, OK 73154-0256.

PUBLIC HEARING:

A public hearing will be held to provide an opportunity for persons to orally present their views on November 4, 2005 at 5:30 p.m. at the following location: Southern Hills Marriott, 1902 East 71st Street, Tulsa, Oklahoma. Written notice of intent to make oral comment must be received by this office no later than October 28, 2005.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

n/a

COPIES OF PROPOSED RULES:

Copies of the proposed rules may be obtained at the office of the Board, 5104 North Francis Avenue, Suite C, Oklahoma City, Oklahoma.

RULE IMPACT STATEMENT:

A rule impact statement will be prepared and available after September 15, 2005 at the office of the Board, 5104 North Francis Avenue, Suite C, Oklahoma City, Oklahoma.

CONTACT PERSON:

Jan Ewing, Assistant to the Director (405) 848-6841, ext. 104

[OAR Docket #05-1203; filed 8-15-05]

Submissions for Review

Within 10 calendar days after adoption by an agency of a proposed PERMANENT rulemaking action, the agency must submit the proposed rules to the Governor and the Legislature for review. In addition, the agency must publish in the *Register* a "statement" that the rules have been submitted for gubernatorial/legislative review.

For additional information on submissions for gubernatorial/legislative review, see 75 O.S., Section 303.1, 303.2, and 308.

**TITLE 325. OKLAHOMA HORSE RACING
COMMISSION
CHAPTER 25. ENTRIES AND
DECLARATIONS**

[OAR Docket #05-1208]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULE:

325:25-1-5. [AMENDED]

SUBMITTED TO GOVERNOR:

August 18, 2005

SUBMITTED TO HOUSE:

August 18, 2005

SUBMITTED TO SENATE:

August 18, 2005

[OAR Docket #05-1208; filed 8-19-05]

**TITLE 325. OKLAHOMA HORSE RACING
COMMISSION
CHAPTER 30. CLAIMING RACES**

[OAR Docket #05-1209]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

325:30-1-13. [AMENDED]

325:30-1-17. [AMENDED]

SUBMITTED TO GOVERNOR:

August 18, 2005

SUBMITTED TO HOUSE:

August 18, 2005

SUBMITTED TO SENATE:

August 18, 2005

[OAR Docket #05-1209; filed 8-19-05]

Gubernatorial Approvals

Upon notification of approval by the Governor of an agency's proposed PERMANENT rulemaking action, the agency must submit a notice of such gubernatorial approval for publication in the *Register*.

For additional information on gubernatorial approvals, see 75 O.S., Section 303.2.

**TITLE 252. DEPARTMENT OF ENVIRONMENTAL QUALITY
CHAPTER 100. AIR POLLUTION CONTROL**

[OAR Docket #05-1206]

RULEMAKING ACTION:

Gubernatorial approval

RULES:

Subchapter 41. Control of Emission of Hazardous Air Pollutants and Toxic Air Contaminants

Part 1. General Provisions [AMENDED]

252:100-41-1.1. [NEW]

Part 3. Hazardous Air Pollutants [AMENDED]

252:100-41-13. [NEW]

252:100-41-14. [NEW]

Subchapter 42. Control of Toxic Air Contaminants [NEW]

Part 1. General Provisions [NEW]

252:100-42-1. [NEW]

252:100-42-1.1. [NEW]

252:100-42-2. [NEW]

252:100-42-3. [NEW]

252:100-42-4. [NEW]

Part 3. Standards [NEW]

252:100-42-20. [NEW]

Part 5. TAC MAAC Exceedance [NEW]

252:100-42-30. [NEW]

252:100-42-31. [NEW]

252:100-42-32. [NEW]

Appendix O. Toxic Air Contaminants (TAC) Maximum Acceptable Ambient Concentrations (MAAC) [NEW]

GUBERNATORIAL APPROVAL:

August 11, 2005

[OAR Docket #05-1206; filed 8-18-05]

Emergency Adoptions

An agency may adopt new rules, or amendments to or revocations of existing rules, on an emergency basis if the agency determines that "an imminent peril exists to the preservation of the public health, safety, or welfare, or that a compelling public interest requires an emergency rule[s] [A]n agency may promulgate, at any time, any such [emergency] rule[s], provided the Governor first approves such rule[s]" [75 O.S., Section 253(A)].

An emergency action is effective immediately upon approval by the Governor or on a later date specified by the agency in the preamble of the emergency rule document. An emergency rule expires on July 15 after the next regular legislative session following promulgation, or on an earlier date specified by the agency, if not already superseded by a permanent rule or terminated through legislative action as described in 75 O.S., Section 253(H)(2).

Emergency rules are not published in the *Oklahoma Administrative Code*; however, a source note entry, which references the *Register* publication of the emergency action, is added to the *Code* upon promulgation of a superseding permanent rule or expiration/termination of the emergency action.

For additional information on the emergency rulemaking process, see 75 O.S., Section 253.

TITLE 35. OKLAHOMA DEPARTMENT OF AGRICULTURE, FOOD, AND FORESTRY CHAPTER 15. ANIMAL INDUSTRY

[OAR Docket #05-1201]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 11. Importation of Livestock, Poultry, and Pets
Part 7. Livestock
35:15-11-20. [AMENDED]

AUTHORITY:

State Board of Agriculture and the Oklahoma Agricultural Code; 2 O.S. 2001 §§ 2-4(2), 2-4(7), 2-4(29), 6-150, 6-151, and 6-153; Article 6, Section 31, Constitution of the State of Oklahoma

DATES:

Adoption:

June 23, 2005

Approved by Governor:

August 4, 2005

Effective:

Immediately upon Governor's approval

Expiration

Effective through July 14, 2006 unless superseded by another rule or disapproved by the Legislature

SUPERSEDED EMERGENCY ACTIONS:

N/A

INCORPORATIONS BY REFERENCE:

N/A

FINDING OF EMERGENCY:

This emergency rule will assist in the prevention of a diagnosis of vesicular stomatitis in Oklahoma's livestock population. Recent diagnoses in surrounding states indicate that this year the Oklahoma livestock industry could be at risk. Vesicular stomatitis is a contagious animal disease that is virtually indistinguishable from foot and mouth disease (FMD). If vesicular stomatitis is diagnosed within a state, significant movement restrictions immediately become effective. In Oklahoma, these restrictions would result in a severe economic injury to the state, because it greatly impacts the state's horse show events and other livestock events that contribute millions annually. Due to the potential for severe economic hardship to the state of Oklahoma, the agency finds a compelling public interest and immediate need for these emergency rules.

ANALYSIS:

At the request of the State Veterinarian, this rule requires all livestock entering Oklahoma, including those that leave the state temporarily and seek reentry, to be examined by a veterinarian in that state prior to reentry into Oklahoma and be accompanied by a certificate of veterinary inspection dated within five days of entry.

CONTACT PERSON:

Dr. Becky Brewer-Walker, (405) 522-6142

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE

CONSIDERED PROMULGATED AND EFFECTIVE UPON APPROVAL BY THE GOVERNOR AS SET FORTH IN 75 O.S., SECTION 253 (D):

SUBCHAPTER 11. IMPORTATION OF LIVESTOCK, POULTRY, AND PETS

PART 7. LIVESTOCK

35:15-11-20. Requirements regarding vesicular stomatitis

(a) Any livestock (equine, bovine, porcine, caprine, ovine, or cervidae) entering or reentering Oklahoma from a state where vesicular stomatitis has been diagnosed within the last thirty (30) days ~~must~~ shall be accompanied by a Certificate of Veterinary Inspection ~~with~~ dated within five (5) days of entry containing the following statement written on the certificate by the accredited veterinarian: "All animals identified on this health certificate have been examined and found to be free from signs of vesicular stomatitis and have not originated from a premise which is under quarantine for vesicular stomatitis."

(b) The Certificate of Veterinary Inspection shall be signed by an accredited veterinarian of the state where vesicular stomatitis has been diagnosed and shall be obtained prior to each entry or reentry into Oklahoma.

[OAR Docket #05-1201; filed 8-11-05]

TITLE 87. OKLAHOMA STATE EMPLOYEES BENEFITS COUNCIL CHAPTER 1. ADMINISTRATIVE OPERATIONS

[OAR Docket #05-1213]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 3. Organization and Administration
87:1-3-14. [AMENDED]

AUTHORITY:

Oklahoma State Employees Benefits Council; Employees Benefits Act, 74 O.S. §1361 et seq.

Emergency Adoptions

DATES:**Adoption:**

July 26, 2005

Approved by Governor:

August 1, 2005

Effective:

Immediately upon Governor's approval

Expiration:

Effective through July 14, 2006, unless superseded by another rule or disapproved by the Legislature.

SUPERSEDED EMERGENCY ACTIONS:

n/a

INCORPORATIONS BY REFERENCE:

n/a

FINDING OF EMERGENCY:

The State of Oklahoma Employees Benefits Council (EBC) has found that a compelling public interest requires the emergency rule changes identified herein. In order for EBC to provide an opportunity for authorized payroll deduction vendors affected by this legislation to have vendor material distributed to State employees during the enrollment period for Plan Year 2006, EBC must promulgate rules immediately. Waiting to promulgate rules to implement this legislation would delay the ability for an authorized payroll deduction vendors to take advantage of the opportunity until the Plan Year beginning January 1, 2007.

ANALYSIS:

Senate Bill 586, signed into law in June 2005, requires materials from vendors that have an authorized payroll deduction pursuant to Section 7.10 of Title 62 of the Oklahoma Statutes or Section 1701 of Title 74 of the Oklahoma Statutes to be placed in the annual benefit enrollment materials provided to state employees and their dependents. EBC is the agency responsible for developing benefit communication material for State employees. Benefit Coordinators are a vital part of the communication and distribution process. Therefore, the following rules have been adopted to implement the provisions of the Bill. The rules define a vendor as a product vendor which has been approved for an authorized payroll deduction on or before the last calendar day of July prior to each Plan Year. Such a vendor has the opportunity to provide a one page, front and back, eight and one-half inch by eleven inch document which, at a minimum, identifies the vendor, describes the product being offered, includes the vendor's contact information, and includes the premium or cost of the product. Vendors bear the responsibility of designing and printing the material in a quantity determined by EBC. A vendor must deliver its material to the Employees Benefits Council on or before the second Friday in August prior to the beginning of the benefits enrollment period. The Council will bear the expense of binding and distributing all timely and properly submitted vendor material. A comment period and hearing were held to solicit comment on the proposed rules. EBC received and discussed these comments. The rules were adopted by EBC on July 26, 2005.

CONTACT PERSON:

Russell D. Nash, (405) 232-1190 ext. 103

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED AND EFFECTIVE UPON APPROVAL BY THE GOVERNOR AS SET FORTH IN 75 O.S., SECTION 253(D):

SUBCHAPTER 3. ORGANIZATION AND ADMINISTRATION

87:1-3-14. Benefits Coordinators

(a) Each participating employer shall designate at least one person as a Benefits Coordinator to serve as a representative between the Council and the participating employer. Each participating employer shall communicate its Benefits Coordinator designation to the Council in writing.

(b) A Benefits Coordinator shall be responsible for assisting the Council in handling employee enrollment and changes in

the flexible benefits plans offered by the Council. A Benefits Coordinator shall be responsible for ensuring that each participant is notified of and has an opportunity to receive flexible benefit plan enrollment materials from the Council, materials from the vendors identified in Chapter 20 of this title, and other notifications from the Council.

(c) A Benefits Coordinator shall keep participant enrollment information confidential.

[OAR Docket #05-1213; filed 8-23-05]

TITLE 87. OKLAHOMA STATE EMPLOYEES BENEFITS COUNCIL CHAPTER 10. FLEXIBLE BENEFITS PLAN

[OAR Docket #05-1214]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 17. Benefit Plan Election

87:10-17-3. [AMENDED]

Subchapter 19. Benefit Allowance

87:10-19-1. [AMENDED]

Subchapter 25. Dependent Care Reimbursement Account Option

87:10-25-2. [AMENDED]

87:10-25-9. [AMENDED]

87:10-25-10. [AMENDED]

Subchapter 27. Health Care Reimbursement Account Option

87:10-27-2. [AMENDED]

87:10-27-4. [AMENDED]

87:10-27-9. [AMENDED]

87:10-27-10. [AMENDED]

Subchapter 35. Group Health Plan Disclosure of Protected Health Information to the Plan Administrator [NEW]

87:10-35-1. [NEW]

AUTHORITY:

Oklahoma State Employees Benefits Council; Employees Benefits Act, 74 O.S. §1361 et seq.

DATES:**Adoption:**

July 26, 2005

Approved by Governor:

August 1, 2005

Effective:

Immediately upon Governor's approval

Expiration:

Effective through July 14, 2006, unless superseded by another rule or disapproved by the Legislature.

SUPERSEDED EMERGENCY ACTIONS:

n/a

INCORPORATIONS BY REFERENCE:

n/a

FINDING OF EMERGENCY:

The State of Oklahoma Employees Benefits Council (EBC) has found that a compelling public interest requires the emergency rule changes identified herein. In order for EBC to provide an opportunity for persons affected by this legislation to make the choice to enroll in a TRICARE Supplemental Plan during the enrollment period for Plan Year 2006, EBC must promulgate rules immediately. Waiting to promulgate rules to implement this legislation would delay the ability for a state employee to take advantage of the opportunity until the Plan Year beginning January 1, 2007. The proposed rules will provide state employee veterans with greater flexibility to choose the benefits that best suit their needs.

EBC also believes a compelling public interest exists to adopt emergency rules that allow State employees to take advantage of a new IRS provision which allows Dependent Care and Health Care Reimbursement Account participants additional time after the plan year to incur expenses. In order for

State employees to benefit from these provisions, rules must be enacted prior to January 1, 2006.

Finally, a compelling public interest exists to adopt emergency rules which allow group health plans (HMOs, dental plans, vision plans, etc.) to disclose information to the State. In order to give group health plan the comfort of exchanging information about the State's wellness initiatives, the Council is recommending adopting the proposed language.

ANALYSIS:

House Bill 1362, signed into law on in June 2005, amends a section of the Oklahoma Statutes that governs the Flexible Benefits Plan administered by the State of Oklahoma Employees Benefits Council. The Bill provides State employees who have retired from the military an option to enroll in a TRICARE Supplemental Plan in lieu of purchasing a primary HMO or PPO medical plan. Accordingly, EBC has amended Chapter 10 of this title to implement the provisions of House Bill 1362 so that State employees who are also retired veterans can take advantage of these provisions effective January 1, 2006. The Internal Revenue Service has recently provided guidance to employers which allows participants in a Dependent Care and Health Care Reimbursement Account additional time after the plan year to incur expenses. In order for State employees to benefit from these provisions, rules must be enacted prior to January 1, 2006. Finally, EBC is offering a comprehensive wellness benefit to all state employees beginning in January 2006. In order to determine the effectiveness of the program, EBC and its health plan partners will exchange health information about the participants in the program. The proposed rule changes allow group health plans (HMOs, dental plans, vision plans, etc.) to disclose information to the State.

CONTACT PERSON:

Russell D. Nash, (405) 232-1190 ext. 103

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED AND EFFECTIVE UPON APPROVAL BY THE GOVERNOR AS SET FORTH IN 75 O.S., SECTION 253(D):

SUBCHAPTER 17. BENEFIT PLAN ELECTION

87:10-17-3. Employee election of benefit plans

(a) Choices of benefit plans shall be made by a new eligible employee within thirty (30) days after date of employment. This thirty (30) day period shall be known as the employee's enrollment period. Each new employee failing to make such a valid election will be deemed to have elected employee-only coverage under the basic State health plan, basic State dental plan, basic State life plan, and basic State disability plan.

(b) Choices of benefit plans shall be made on a Plan Year basis by the eligible employees during the enrollment period as set by the Plan Administrator. The Plan Administrator will establish eligibility requirements for all benefit plan options each year.

(c) Eligible employees are required to elect medical, dental, life and disability plans except as provided in the following paragraphs. Employees who fail to make a valid election during each designated enrollment period will be deemed to have elected the same plans elected during the most recent enrollment period during which a valid election was made. Where the plan(s) will no longer be available for the upcoming Plan Year, employees will be deemed to have elected HealthChoice High Option health plan and/or HealthChoice Dental.

(d) An eligible employee who has retired from a branch of the United States military and has been provided with health coverage through a federal plan can elect not to participate in

the Flexible Benefits Plan pursuant to the provisions of this section or elect to participate in the basic plan and purchase a TRICARE Supplement plan in lieu of any other medical plans offered for the Plan Year subject to the provision of this section.

(1) An eligible employee who has retired from a branch of the United States military and has been provided with health coverage through a federal plan can elect not to participate in the Flexible Benefits Plan or can elect to participate in the Flexible Benefits Plan and purchase a TRICARE Supplement plan in lieu of any other medical plans offered for the Plan Year only if the following conditions are met prior to the close of each annual enrollment period beginning with the enrollment period for Plan Year 2004:

(A) The employee must provide proof that he or she is retired from a branch of the United States military; and

(B) The employee must provide proof of health coverage through a federal plan; and

(C) The employee must make a proper election either not to participate in the Flexible Benefits Plan or to participate in the Flexible Benefits Plan and purchase a TRICARE Supplement plan in lieu of any other medical plans offered for the Plan Year.

(2) The Council has the authority to determine the type of information that satisfies the requirements of this subsection.

(3) An eligible employee making an election not to participate under paragraph (1) of this subsection must make such an election each Plan Year.

(A) An employee who is eligible to make an election not to participate under paragraph (1) of this subsection and has never previously made an election not to participate under paragraph (1) of this subsection, may, during the enrollment period, enroll in the Flexible Benefits Plan or may make an election not to participate under paragraph (1) of this subsection. If the employee who is eligible to, but has never previously made an election not to participate under paragraph (1) of this subsection, fails to enroll in the Flexible Benefits Plan and fails to make an election not to participate under paragraph (1) of this subsection, the employee will be deemed to have elected coverage that was in effect during the previous Plan Year. Where the plan(s) will no longer be available for the upcoming Plan Year, employees will be deemed to have elected HealthChoice High Option health plan and/or HealthChoice Dental.

(B) An employee who is eligible to make an election not to participate under paragraph (1) of this subsection and has previously made an election not to participate under paragraph (1) of this subsection, may, during the enrollment period, enroll in the Flexible Benefits Plan, or may make an election not to participate under paragraph (1) of this subsection. If an employee who has previously made an election not to participate under paragraph (1) of this subsection fails to enroll in the Flexible Benefits Plan and fails to

Emergency Adoptions

make an election not to participate under paragraph (1) of this subsection during the annual enrollment period, the employee will be deemed to have elected employee-only coverage under the HealthChoice High Option health plan, the HealthChoice dental plan, the basic State life plan, and the basic State disability plan.

(4) Except as provided by the applicable provisions of OAC 87:10-17-4, an eligible employee making an election not to participate under paragraph (1) of this subsection is prohibited from participating in any health plan, dental plan, life plan, supplemental life plan, dependent life plan, and disability plan at any time during the Plan Year for which he or she made the election. Upon re-entry into the state benefits package either through an acceptable midyear event or at the annual Option Period enrollment, benefit options which were declined through the opt-out election by retired military state employees will not automatically be reinstated. The retired military employee must reapply for and be approved through satisfactory evidence of coverage (EOI) before any amounts of Supplemental Life Insurance will again be issued. Only the Basic Life amount (20,000) will be automatically reinstated upon such re-entry. No Guaranteed Issue levels of Supplemental Life will be available. Furthermore, if no proof is submitted showing previous dental coverage, then the \$250 limit of benefits for HealthChoice Dental will be applied for the first year following reenrollment.

(5) Except as provided by the applicable provisions of OAC 87:10-17-4, an eligible employee making an election not to participate under paragraph (1) of this subsection is prohibited from electing coverage for his or her dependents under any health plan, dental plan, life plan, supplemental life plan, dependent life plan, and disability plan prior to or at any time during the Plan Year for which he or she made the election.

(6) An eligible employee making an election not to participate under paragraph (1) of this section may continue participation in any of the following:

- (A) Benefit plans available under the Flexible Benefit Plan other than a health plan, dental plan, life plan, supplemental life plan, dependent life plan, and a disability plan;
- (B) Health Care Reimbursement Account Option;
- (C) Dependent Care Reimbursement Account Option; and the
- (D) Insurance Premium Conversion Option.

(d) Each employee who meets the eligibility requirements but fails to make a proper election under the Flexible Benefits Plan shall be deemed a participant in the Flexible Benefits Plan.

(e) Coverage shall be effective for a new participant beginning on the first day of the month following the participant's first day in an active pay status.

(f) Eligible employees may elect to cover a dependent under the following insurance plans: health insurance, dental insurance, dependent life insurance, or vision insurance. When one eligible dependent is covered, all eligible dependents must be covered for all plans except the dependent life insurance

plan. An eligible employee cannot be enrolled as a principal insured and also as a dependent for any benefit options except dependent life.

(g) Primary participants electing coverage for eligible dependents cannot enroll the dependents in a benefit plan or a coverage that differs from the benefit plan or coverage chosen by the primary participant.

(h) An affirmative election of a vision plan is required for each Plan Year.

(i) In order for an eligible employees to choose health plan coverage under a Health Maintenance Organization (HMO) plan, the eligible employee must reside or be employed within the selected HMO's service area.

SUBCHAPTER 19. BENEFIT ALLOWANCE

87:10-19-1. Flexible benefit allowance

(a) Each participating employer shall credit to each of its participating employees the specified amount as determined by law, as a flexible benefits allowance. Each participant must use a portion or all of their flexible benefit allowance to purchase at least the basic plan.

(b) An eligible employee making an election not to participate under OAC 87:10-17-3(c)(1) will not be eligible for or credited with any amount of the employee or dependent flexible benefit allowance.

(c) An eligible employee making an election to participate under OAC 87:10-17-3(c)(2) will be eligible for the employee and dependent flexible benefit allowance set by 74 O.S. § 1370(D).

SUBCHAPTER 25. DEPENDENT CARE REIMBURSEMENT ACCOUNT OPTION

87:10-25-2. Definitions

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

"**Dependent**" means any individual who is:

(A) A dependent of the participant who is under the age of 13 and with respect to whom the participant is entitled to an exemption under Section 15(c) of the Internal Revenue Code or, is otherwise, a qualifying individual as provided in Section 21(d)(2) of the Internal Revenue Code, or

(B) A dependent or spouse of the participant who is physically or mentally incapable of caring for himself or herself.

"**Dependent care expenses**" means expenses incurred by a participant which are incurred for the care of a dependent of the participant or for related household services, and are eligible expenses as allowed under and defined in the prevailing Internal Revenue Code and rules promulgated thereunder and as allowed by the Plan Administrator.

SUBCHAPTER 27. HEALTH CARE REIMBURSEMENT ACCOUNT OPTION

"**Dependent care reimbursement account**" means the bookkeeping account maintained by the Plan Administrator used for crediting contributions and accounting for benefit payments.

"**Eligible period of coverage**" means that time period in which the participant contributes to the dependent care reimbursement account and that the participant is on an active pay status.

"Grace Period" means the period from the end of the Plan Year through March 15th of the subsequent Plan Year during which reimbursable expenses can be incurred and attributable to the previous Plan Year's account balance.

"Run Out Period" means the ninety (90) day period following a Plan Year in which claims can be made for reimbursable expenses incurred during the Plan Year.

87:10-25-9. Reimbursement or payment of dependent care expenses

(a) Subject to limitations contained in this section, the Plan Administrator shall reimburse the participant from the participant's dependent care reimbursement account for dependent care expenses incurred during the Plan Year for which the participant submits documentation in accordance with OAC 87:10-25-8. No reimbursement or payment of dependent care expenses incurred during a Plan Year shall exceed the balance available in the participant's dependent care reimbursement account.

(b) Participants shall be reimbursed for dependent expenses on a weekly or other reasonable basis during the Plan Year as determined by the Plan Administrator. Reimbursement can also be made for expenses incurred by any participant during the Grace Period. The final payment of benefits for any Plan Year may be made following the close of such Plan Year based on accepted claims filed with the Plan Administrator no later than ~~ninety days following the close of the Plan Year~~ the end of the Run Out Period.

(c) Upon demand a participant shall immediately refund any overpayment made by the Plan Administrator on behalf of the participant. Likewise, items charged to a debit card that are unacceptable to the Plan Administrator will require a participant to immediately refund such an overpayment to the Plan Administrator.

(d) If a participant ceases to be a participant or terminates employment, such participant shall be entitled to continue receiving benefits pursuant to the dependent care reimbursement account option to the extent of the amount remaining in the participant's dependent care reimbursement account for the expenses incurred during the eligible period of coverage in which termination of participation occurs.

87:10-25-10. Forfeiture of unused benefits

Amounts remaining in a participant's dependent care reimbursement account following final payment of all dependent care expenses incurred during the applicable Plan Year periods described in OAC 87:10-25-9(b) shall be forfeited to pay administrative expenses of the Flexible Benefits Plan.

87:10-27-2. Definitions

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

"**Dependent**" means an individual who qualifies as a dependent under Section 125 of the Internal Revenue Code, taking into account Section 105(b) of the Internal Revenue Code.

"**Health care reimbursement account**" means the bookkeeping account maintained by the Plan Administrator used for crediting contributions and accounting for benefit payments.

"**Medical care expenses**" means any expenses incurred by a participant or by a spouse or dependent of such participant for medical care as described in Section 213 of the Internal Revenue Code and subject to the limitations of section 125 and this Flexible Benefits Plan, but only to the extent that the participant or other person incurring the expense is not reimbursed for the expense through insurance or otherwise.

"Grace Period" means the period from the end of the Plan Year through March 15th of the subsequent Plan Year during which reimbursable expenses can be incurred and attributable to the previous Plan Year's account balance.

"Run Out Period" means the ninety (90) day period following a Plan Year in which claims can be made for reimbursable expenses incurred during the Plan Year.

87:10-27-4. Amount of benefits available

(a) Subject to the limitations imposed by federal law to avoid discrimination, the maximum benefit which a participant may receive in any Plan Year for medical care expenses under the health care reimbursement account option shall be subject to a monthly maximum of ~~\$300.00~~ \$350.00 or other amount as determined by the Plan Administrator.

(b) The minimum salary adjustment amount for participation in this option shall be \$10.00 per month.

87:10-27-9. Reimbursement of health care expenses

(a) Subject to limitations contained in this section, the Plan Administrator shall reimburse the participant from the participant's health care reimbursement account for health care expenses incurred during the eligible period of coverage, for which the participant submits documentation, in accordance with OAC 87:10-27-8. No reimbursement of health care expenses incurred during a Plan Year shall exceed the maximum amount defined in the salary adjustment agreement.

(b) Participants shall be reimbursed for medical care expenses on a weekly or other reasonable basis during the Plan Year in accordance with Flexible Benefits Plan Administration Rules. Reimbursement can also be made for expenses incurred by any participant during the Grace Period. The final payment of benefits for any Plan Year may be made following the close of such Plan Year based on accepted claims filed with the Plan Administrator no later than ~~ninety (90) days following the close of the Plan Year~~ the end of the Run Out Period.

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(c) Upon demand a participant shall immediately refund any overpayment made by the Plan Administrator on behalf of the participant. Likewise, items charged to a debit card that are unacceptable to the Plan Administrator will require a participant to immediately refund such an overpayment to the Plan Administrator.

(d) If a participant ceases to be a participant or terminates employment, the participant shall be entitled to continue receiving benefits pursuant to this health care option to the extent of the amount remaining in the participant's health care reimbursement account for expenses incurred during the eligible period of coverage of the current Plan Year.

(e) If a participant ceases to be a participant or terminates employment, claims incurred after the last day of the month of termination or the date participation ceased shall not be considered for reimbursement, unless the participant elects to continue participation in this option by elected coverage continuation as provided for in this section.

(f) Any participant may continue this option under the coverage continuation guidelines for COBRA, as provided under OAC 87:10-33-1 on a post tax basis.

87:10-27-10. Forfeiture of unused benefits

Following final payment of all health care expenses incurred during the applicable Plan Year periods described in OAC 87:10-27-9(b), amounts remaining in the health care reimbursement account shall be forfeited to pay administrative expenses of the Flexible Benefits Plan.

SUBCHAPTER 35. GROUP HEALTH PLAN DISCLOSURE OF PROTECTED HEALTH INFORMATION TO THE PLAN ADMINISTRATOR

87:10-35-1. General Provisions

A group health plan may disclose protected health information to the Plan Administrator in its capacity as plan sponsor. The Plan Administrator will use and disclose such information in a manner consistent with the HIPAA requirements of the Standards for Privacy of Individually Identifiable Health Information including the applicable requirements of 45 CFR §164.504(f).

[OAR Docket #05-1214; filed 8-23-05]

TITLE 87. OKLAHOMA STATE EMPLOYEES BENEFITS COUNCIL CHAPTER 20. AUTHORIZED PAYROLL DEDUCTION VENDOR MATERIALS

[OAR Docket #05-1215]

RULEMAKING ACTION:
EMERGENCY adoption

RULES:
87:20-1-1. [NEW]

87:20-1-2. [NEW]

87:20-1-3. [NEW]

AUTHORITY:

Oklahoma State Employees Benefits Council; Employees Benefits Act, 74 O.S. §1361 et seq.

DATES:

Adoption:

July 26, 2005

Approved by Governor:

August 1, 2005

Effective:

Immediately upon Governor's approval

Expiration:

Effective through July 14, 2006, unless superseded by another rule or disapproved by the Legislature.

SUPERSEDED EMERGENCY ACTIONS:

n/a

INCORPORATIONS BY REFERENCE:

n/a

FINDING OF EMERGENCY:

The State of Oklahoma Employees Benefits Council (EBC) has found that a compelling public interest requires the emergency rule changes identified herein. In order for EBC to provide an opportunity for authorized payroll deduction vendors affected by this legislation to have vendor material distributed to State employees during the enrollment period for Plan Year 2006, EBC must promulgate rules immediately. Waiting to promulgate rules to implement this legislation would delay the ability for an authorized payroll deduction vendor take advantage of the opportunity until the Plan Year beginning January 1, 2007.

ANALYSIS:

Senate Bill 586, signed into law in June 2005, requires materials from vendors that have an authorized payroll deduction pursuant to Section 7.10 of Title 62 of the Oklahoma Statutes or Section 1701 of Title 74 of the Oklahoma Statutes to be placed in the annual benefit enrollment materials provided to state employees and their dependents. EBC is the agency responsible for developing benefit communication material for State employees. Therefore, the following rules have been adopted to implement the provisions of the Bill. The rules define a vendor as a product vendor which has been approved for an authorized payroll deduction on or before the last calendar day of July prior to each Plan Year. Such a vendor has the opportunity to provide a one page, front and back, eight and one-half inch by eleven inch document which, at a minimum, identifies the vendor, describes the product being offered, includes the vendor's contact information, and includes the premium or cost of the product. Vendors bear the responsibility of designing and printing the material in a quantity determined by EBC. A vendor must deliver its material to the Employees Benefits Council on or before the second Friday in August prior to the beginning of the benefits enrollment period. The Council will bear the expense of binding and distributing all timely and properly submitted vendor material. A comment period and hearing were held to solicit comment on the proposed rules. EBC received and discussed these comments. The rules were adopted by EBC on July 26, 2005.

CONTACT PERSON:

Russell D. Nash, (405) 232-1190 ext. 103

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED AND EFFECTIVE UPON APPROVAL BY THE GOVERNOR AS SET FORTH IN 75 O.S., SECTION 253(D):

87:20-1-1. Purpose

The purpose of this Chapter is to describe the rules governing the process by which materials from vendors that have an authorized payroll deduction pursuant to Section 7.10 of Title 62 of the Oklahoma Statutes or Section 1701 of Title 74 of the Oklahoma Statutes shall be placed in the annual benefit enrollment materials provided to state employees and their dependents. The provisions of this Chapter do not apply to vendors

who do not have authorized payroll deduction pursuant to Section 7.10 of Title 62 of the Oklahoma Statutes or Section 1701 of Title 74 of the Oklahoma Statutes.

87:20-1-2. Definitions

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

"Council" means the State of Oklahoma Employees Benefits Council

"Plan Year" means the period of time, established by the Council, for which benefits are offered to State employees and their eligible dependents.

"Vendor" means a product vendor that has been approved for an authorized payroll deduction pursuant to Section 7.10 of Title 62 of the Oklahoma Statutes or Section 1701 of Title 74 of the Oklahoma Statutes on or before the last calendar day of July prior to each Plan Year.

"Vendor Material" means a one page, front and back, eight and one-half inch by eleven inch document which, at a minimum, identifies the vendor, describes the product being offered, includes the vendor's contact information, and includes the premium or cost of the product. Vendor material must be printed on white paper with a weight equal to 50# off-set or 20# bond copy paper.

87:20-1-3. General provisions

(a) A vendor must deliver its vendor material to the Employees Benefits Council no later than 4:45 p.m., Central Time, on the second Friday in August prior to the beginning of the benefits enrollment period announced by the Council.

(b) Vendor material must be designed, printed, and reproduced by the vendor at the vendor's expense.

(c) The Council will determine the number of copies of vendor material each vendor must supply. Such amount will be communicated to vendors each year.

(d) The Council will bind and distribute all timely and properly submitted vendor material at its own expense.

(e) The Council may create forms to standardize and simply the information required by this section. If a form(s) have been created, a vendor must complete the form(s) to provide proper delivery.

[OAR Docket #05-1215; filed 8-23-05]

**TITLE 252. DEPARTMENT OF ENVIRONMENTAL QUALITY
CHAPTER 100. AIR POLLUTION CONTROL**

[OAR Docket #05-1207]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 41. Control of Emission of Hazardous Air Pollutants and Toxic Air Contaminants

Part 1. General Provisions [AMENDED]

252:100-41-1.1. [NEW]

Part 3. Hazardous Air Pollutants [AMENDED]

252:100-41-13. [NEW]

252:100-41-14. [NEW]

Subchapter 42. Control of Toxic Air Contaminants [NEW]

Part 1. General Provisions [NEW]

252:100-42-1. [NEW]

252:100-42-1.1. [NEW]

252:100-42-2. [NEW]

252:100-42-3. [NEW]

252:100-42-4. [NEW]

Part 3. Standards. [NEW]

252:100-42-20. [NEW]

Part 5. TAC MAAC Exceedance [NEW]

252:100-42-30. [NEW]

252:100-42-31. [NEW]

252:100-42-32. [NEW]

Appendix O. Toxic Air Contaminants (TAC) Maximum Acceptable Ambient Concentrations (MAAC) [NEW]

AUTHORITY:

Environmental Quality Board; 27A O.S., §§ 2-2-101, 2-2-201 and 2-5-101, et seq.

DATES:

Comment period:

June 15, 2004 through July 21, 2004

September 15, 2004 through October 20, 2004

November 1, 2004 through December 9, 2004

December 1, 2004 through January 19, 2005

March 15, 2005 through April 20, 2005

June 21, 2005

Public hearing:

July 21, 2004; December 9, 2004; January 19, 2005; April 20, 2005; and June 21, 2005

Adoption:

June 21, 2005

Approved by Governor:

August 11, 2005

Effective:

Immediately upon Governor's signature

Expiration:

Effective through July 14, 2006, unless superseded by another rule or disapproved by the legislature

SUPERSEDED EMERGENCY ACTIONS:

None

INCORPORATIONS BY REFERENCE:

None

FINDING OF EMERGENCY:

The Environmental Quality Board finds that a compelling public interest necessitates the seeking of emergency certification of the rule being adopted today. The Department has identified that the emergency designation is necessary to allow affected facilities, as well as the Air Quality Division's permitting and compliance sections, to begin the transition from the toxics program as currently defined in Subchapter 41, to the program created by Subchapter 42. Under the replaced toxics program, the Department, in conjunction with affected facilities, is required to undertake a burdensome and often lengthy review of facility emissions to determine compliance with thousands of standards for Toxic Air Contaminants. Promulgating the new toxic program by emergency allows the Department to quickly refocus staff and resources towards the new program, eases the regulatory burden on affected facilities, and continues to protect human health from the effects of Toxic Air Contaminants.

ANALYSIS:

The Department is proposing to redefine the state air toxics program. Amendments are proposed to Subchapter 41, Control of Emission of Hazardous Air Pollutants and Toxic Air Contaminants, to partition existing Subchapter 41 into two subchapters. The proposed amendments will clarify and modify the state-only requirements for emissions from stationary sources and relocate these requirements into the new Subchapter 42. Subchapter 41 will contain the federal requirements for HAP and asbestos. The remaining Sections 15 and 16 of Subchapter 41, which incorporate by reference National Emission Standards for Hazardous Air Pollutants (NESHAP) in 40 CFR Parts 61 and 63 and specific asbestos requirements, would be retained in Subchapter 41. A statement has been added in 252:100-41-1.1 that will allow Subchapter 42 to supersede Subchapter 41, with the exception of Part 3. Also, two new

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sections would be added as 252:100-41-3 and -4 for conformity with existing rules.

The program proposed in new Subchapter 42, Control of Toxic Air Contaminants, intends to provide a more effective approach to the control of TAC while continuing to protect the public and environment from the potentially harmful effects of TAC. When ambient air monitoring indicates that a TAC Maximum Acceptable Concentration (MAAC) is exceeded in such a way as to endanger the public health, the proposed rule requires the Department to designate an Area of Concern (AOC) and to develop a strategy for bringing the ambient air concentration of the TAC in the AOC under the TAC MAAC.

Proposed Appendix O, Toxic Air Contaminants (TAC) Maximum Acceptable Ambient Concentrations (MAAC), includes substances that are considered toxic and harmful to human health, are emitted within the state of Oklahoma, and are able to be monitored at the proposed ambient standard levels with available technology. Appendix O was established using EPA's Residual Risk Report to Congress, which includes information on risk assessment and the risk management process. The EPA's IRIS database was used to gather human health effects information for each substance in Appendix O.

The proposed Subchapter 42 will lower DEQ permitting and enforcement costs because evaluation of TAC for permit application or compliance status of a stationary source will not occur until an AOC has been designated. However, DEQ may incur significant new costs to conduct monitoring and modeling of TAC when determining if a TAC standard has been exceeded. The proposed Subchapter 42 will generally lower compliance costs for owners and operators of major and minor sources because there are no additional compliance requirements for TAC unless an AOC has been designated.

CONTACT PERSON:

Lisa Donovan, Department of Environmental Quality, Air Quality Division, 707 North Robinson, P.O. Box 1677, Oklahoma City, Oklahoma 73101-1677, (405) 702-4100

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED PROMULGATED AND EFFECTIVE UPON APPROVAL BY THE GOVERNOR AS SET FORTH IN 75 O.S., SECTION 253(D):

SUBCHAPTER 41. CONTROL OF EMISSION OF HAZARDOUS AIR POLLUTANTS AND TOXIC AIR CONTAMINANTS

PART 1. GENERAL PROVISIONS

252:100-41-1.1. Supersession by Subchapter 42

(a) This Subchapter, with the exception of Part 3, shall remain effective so long as it is not superseded by Subchapter 42 of this Chapter.

(b) Part 3 of this Subchapter shall not be superseded by any other subchapter of this Chapter.

PART 3. HAZARDOUS AIR POLLUTANTS

252:100-41-13. Purpose

The purpose of this Part is to establish emission control technology, performance criteria and work practice standards for achieving emission standards from existing, new or modified sources that emit or have the potential to emit hazardous air pollutants in accordance with the authority delegated by the EPA under Section 111(b) of the federal Clean Air Act.

252:100-41-14. Reference to 40 CFR

(a) **Inclusions of CFR citations and definitions.** When a provision of Title 40 of the Code of Federal Regulations (40 CFR) is incorporated by reference, all citations contained therein are also incorporated by reference.

(b) **Inconsistencies or duplications.** In the event that there are inconsistencies or duplications in the requirements of those provisions incorporated by reference in OAC 252:100-41-15 and the regulations in this Chapter, the provisions incorporated by reference shall prevail, except where the regulations in the Chapter are more stringent.

(c) **Terminology related to 40 CFR.** For purposes of interfacing with 40 CFR, the following terms apply

(1) "Administrator" is synonymous with "Executive Director".

(2) "EPA" is synonymous with "Department of Environmental Quality (DEQ)".

SUBCHAPTER 42. CONTROL OF TOXIC AIR CONTAMINANTS

PART 1. GENERAL PROVISIONS

252:100-42-1. Purpose

The purpose of this Subchapter is to protect the public and the environment from the potentially harmful effects of toxic air contaminants (TAC) that are emitted into the ambient air.

252:100-42-1.1. Supersession of Subchapter 41

All parts of OAC 252:100-41, with the exception of Part 3, shall be superseded by this Subchapter.

252:100-42-2. Definitions

The following words and terms when used in this Subchapter shall have the following meanings unless the context clearly indicates otherwise.

"Area of concern" or "AOC" means a geographic area in Oklahoma designated as having exceeded a TAC maximum acceptable ambient concentration (MAAC).

"Emissions unit" means, for the purposes of this Subchapter, any part of a stationary source which emits a TAC.

"Malfunction" means any sudden, infrequent, and not reasonably preventable failure of air pollution control equipment, process equipment, or a process to operate in a normal or usual manner. Failures that are caused in part by poor maintenance or careless operation are not malfunctions.

"Maximum acceptable ambient concentration" or "MAAC" means the action levels and averaging times contained in Appendix O of this Chapter for TAC.

"Toxic air contaminant" or "TAC" means any substance listed in Appendix O of this Chapter.

252:100-42-3. Applicability

This Subchapter applies to stationary sources that emit any TAC.

252:100-42-4. Existing air pollution control requirements

Any work practice, material substitution, or control equipment required by the Department prior to June 11, 2004, to control a TAC, shall be retained, unless a modification is approved by the Director.

PART 3. STANDARDS

252:100-42-20. TAC MAAC

(a) **TAC MAAC.** The TAC MAAC list is located in Appendix O of this Chapter.

(b) **Protocol for creating and modifying the TAC MAAC list.**

(1) The Director may recommend substances to be added to the TAC MAAC list subject to the applicability of all of the following:

- (A) toxicity of the substance;
- (B) availability of methods for monitoring the ambient air concentration of the substance at the levels deemed to be acceptable for human health;
- (C) quantity of the substance emitted in Oklahoma; and
- (D) information indicating that anthropogenic emissions of the substance cause ambient air concentration levels to exceed those that have been determined to be acceptable based on health risks.

(2) The Director may recommend a substance be removed from the TAC MAAC list if the substance does not meet one of the criteria listed in subparagraphs 42-20(b)(1)(A) through (D).

(c) **Rulemaking requirements for TAC MAAC.** Adoption and modification of the TAC MAAC list will be in accordance with the rulemaking procedures of the Department.

PART 5. TAC MAAC EXCEEDANCE

252:100-42-30. Areas of concern

(a) **Designation.**

(1) **Proposed AOC.**

(A) The Director may propose designation of an Area of Concern (AOC) for a TAC when it is demonstrated by monitoring that the MAAC for that TAC is exceeded in such a way as to endanger the public health.

(B) Excess emissions caused by malfunction shall not form the basis for an AOC designation.

(2) **AOC boundaries.**

(A) The boundaries of the AOC will be determined by monitoring, modeling, or other means approved by the Director.

(B) The impact of TAC emissions from stationary, mobile, and biogenic sources shall be considered in determining the boundaries for an AOC.

(3) **Monitoring and modeling.**

(A) **AOC and boundaries.** Monitoring and modeling for the proposed AOC and its boundaries will be performed by the Department in accordance with the requirements of 42-30(a)(3)(D)(i) and (ii); however, the Department will accept monitoring and modeling from other sources if such monitoring and modeling meet the requirements of 42-30(a)(3)(D)(i) and (ii), respectively.

(B) **Decision to monitor.** The decision to monitor for TAC MAAC exceedance in an area will be based on but not limited to:

- (i) complaints received from the public;
- (ii) information collected during compliance evaluations;
- (iii) emission inventory data; or
- (iv) EPA reports.

(C) **Monitoring sites.** Monitors for TAC shall only be placed in areas where human health may be endangered by emissions of TAC.

(D) **Acceptable monitoring and modeling methods.**

(i) **Risk assessment and monitoring.**

(I) All risk assessment and monitoring methods used by the Department for purposes of this Subchapter shall be consistent with those in Volumes 1 and 2 of the United States Environmental Protection Agency Air Toxics Risk Assessment (ATRA) Reference Library, April 2004; documents referenced in ATRA; and State requirements in OAC 252:100-43.

(II) The Department will analyze the data collected from each monitoring location to determine the 95% upper confidence limit (95% UCL) for the mean ambient concentration for each TAC/monitor combination. The 95% UCL will be determined using at least 10 samples taken over a period of at least 30 days and will be the concentration used for comparison with the TAC MAAC action level for each monitoring location.

(ii) **Modeling.**

(I) All applications of air quality modeling shall be based on the applicable models, databases, and other requirements specified in appendix W of 40 CFR Part 51 Guideline on Air Quality Models and in OAC 252:100-8-35(e).

(II) Where an air quality model specified in appendix W of 40 CFR Part 51 Guideline on Air Quality Models is inappropriate, the model may be modified or another substituted. Such modification or substitution will be considered on a case-by-case basis. When modeling is performed by owners or operators of stationary sources, written approval of the Director must

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be obtained for any modification or substitution.

(4) **Final designation.** The Director shall not make a final designation of an AOC until at least 30 days following the public meeting held pursuant to subsection 42-30(c) below.

(b) **Public notification.** At least 30 days prior to the public meeting set forth in subsection 42-30(c) below, the Department shall publish notice of the boundaries and the availability of information associated with the proposed AOC.

(1) The notice shall be published on the Department website, in two newspapers circulated statewide, and in one newspaper local to the AOC.

(2) The notice shall identify locations where information may be reviewed.

(3) The notice shall include the date, time, and place for the public meeting on the proposed designation.

(4) The notice shall identify the process by which written comments regarding the proposed designation may be submitted to the Department.

(c) **Public meeting.** The Department shall schedule and hold a public meeting. Any local community meeting to be held on the proposed designation may be combined with the public meeting authorized by this Section.

252:100-42-31. AOC Compliance Strategies

(a) **Applicability.** Following final designation of an AOC by the Director, the Department shall determine AOC Compliance Strategies to bring the AOC into compliance with the TAC MAAC. AOC Compliance Strategies developed by the Department shall apply to any stationary source or emissions unit that:

(1) impacts an AOC;

(2) emits the TAC for which the AOC was designated; and

(3) is not subject to a final emission standard, work practice, or other requirement to control emissions of a TAC promulgated under Sections 112(d) or 129 of the Federal Clean Air Act, OAC 252:100-17, Parts 5, 7, and 9, or required by a Consent Order or Decree issued by the Department or another regulatory agency.

(b) **AOC Compliance Strategy development.**

(1) **General requirements.** After making a final designation of an AOC, the Department shall prepare a compliance strategy for the AOC. In developing an AOC Compliance Strategy the Department shall:

(A) take into consideration what portion of the pollutant load is attributable to stationary sources versus that attributable to mobile sources, non-road sources, and biogenic sources;

(B) determine de minimis emission levels if appropriate for a particular TAC and a particular AOC; and

(C) advise, consult and cooperate with other agencies of the State, towns, cities, and counties, industries, other states and the federal government, and with affected groups in bringing the AOC into compliance.

(2) **Additional rulemaking.** Any new requirements or standards developed for an AOC Compliance Strategy shall be developed in accordance with the rulemaking procedures of the Department.

(3) **Permit requirements.** In accordance with 27A O.S., Section 2-5-112, the Department may as part of an AOC Compliance Strategy:

(A) require owners or operators to obtain permits for facilities that emit the TAC, for which the AOC was designated, in a concentration that causes or contributes to an off-site violation of the TAC MAAC in an AOC designated for that TAC; or

(B) require owners or operators of such facilities to modify any existing permit to include the TAC MAAC and any control measures required by paragraph 42-31(b)(4).

(4) **Control measures.** The availability, feasibility, and cost of any control measures, work practice standards, control equipment requirements, material substitution requirements, or stack emissions standards shall be considered in developing the AOC Compliance Strategy.

(5) **On-site emissions.** Owners or operators of facilities located in an AOC shall not be required to demonstrate compliance with the TAC MAAC within the boundaries of their facilities.

(6) **Monitoring and modeling requirements.** As an AOC Compliance Strategy, the Department may require owners or operators of applicable stationary sources to perform ambient air monitoring and/or modeling for the TAC of concern. Such ambient air monitoring and modeling shall be performed using the references and requirements in 42-30(a)(3)(D)(i) and (ii).

(c) **Public notification.** Following final designation of an AOC, the Department shall publish a report outlining the compliance strategy developed to bring the AOC into compliance with the TAC MAAC.

252:100-42-32. Re-designation

(a) **Re-designation.** The Director shall re-designate an AOC as in compliance with the TAC MAAC when compliance is demonstrated through monitoring and/or modeling.

(b) **Public notice.** Following the re-designation of an AOC, the Department shall notify the public pursuant to paragraph 42-30(b)(1).

APPENDIX O. TOXIC AIR CONTAMINANTS (TAC) MAXIMUM ACCEPTABLE AMBIENT CONCENTRATIONS (MAAC) [NEW]

CAS	SUBSTANCE	MAAC ppb	MAAC µg/m ³	Time Period
Carcinogens				
75-07-0	Acetaldehyde	28	50	24-hr avg.
107-13-1	Acrylonitrile	0.5	1	24-hr avg.
Group	Arsenic compounds	NA	0.02	24-hr avg.
71-43-2	Benzene	10	30	24-hr avg.
Group	Beryllium compounds	NA	0.02	24-hr avg.
106-99-0	1,3-butadiene	1	3	24-hr avg.
Group	Cadmium compounds	NA	0.06	24-hr avg.
56-23-5	Carbon tetrachloride	1	7	24-hr avg.
67-66-3	Chloroform	0.8	4	24-hr avg.
Group	Hexavalent Chromium compounds	NA	0.008	24-hr avg.
107-06-2	Ethylene dichloride (1,2-dichloroethane)	1	4	24-hr avg.
50-00-0	Formaldehyde	7	8	24-hr avg.
75-09-2	Methylene chloride (dichloromethane)	58	200	24-hr avg.
Group	Nickel compounds	NA	0.15	24-hr avg.
79-34-5	1,1,2,2-tetrachloroethane	0.3	2	24-hr avg.
75-01-4	Vinyl chloride	9	23	24-hr avg.
Non-Carcinogens				
7664-41-7	Ammonia	2,500	1,742	24-hr avg.
100-41-4	Ethylbenzene	10,000	43,427	24-hr avg.
Group	Manganese compounds	NA	50	24-hr avg.
Group	Mercury compounds	NA	0.3	24-hr avg.
108-88-3	Toluene	10,000	37,668	24-hr avg.

[OAR Docket #05-1207; filed 8-18-05]

Emergency Adoptions

TITLE 270. OKLAHOMA FIREFIGHTERS PENSION AND RETIRMENT SYSTEM CHAPTER 10. FIREFIGHTERS PENSION AND RETIREMENT PLAN

[OAR Docket #05-1205]

RULEMAKING ACTION:
EMERGENCY ADOPTION

RULES:
270:10-1-5. [AMENDED]

AUTHORITY:
Board of Trustees of the Oklahoma Firefighters Pension and Retirement System; O.S. Title 11, Section 49-100.7 (B)

DATES:
Comment period:
n/a

Public hearing:
n/a

Adoption:
June 17, 2005

Approved by Governor:
August 4, 2005

Effective:
Immediately upon Governor's approval

Expiration:
Effective through July 14, 2006, unless superseded by another rule or disapproved by the Legislature

SUPERSEDED EMERGENCY ACTIONS:
n/a

INCORPORATIONS BY REFERENCE:
n/a

FINDING OF EMERGENCY:
The Board of Trustees promulgated permanent rules pursuant to Chapter 10, 270:10-1-5, which became effective on 05-28-96, and were further amended on 07-11-97 and 06-26-04. The rules adopted were extracted from standards developed by the National Fire Protection Association dealing with medical requirements for entry level candidates. The rules as amended on 06-24-04, provided that a history of laminectomy or discectomy would be a Category "A" medical condition, which would be an automatic per say disqualification of a candidate to enter the pension system as a paid firefighter. After a challenge by a prospective candidate, through the administrative appeals process, who was denied entrance into the pension system, further research revealed that the intent of the National Fire Protection Association's standard was that a history of a laminectomy or discectomy should be a Category "B" medical condition, which would hinge acceptance or denial of entrance into the pension system on whether or not a candidate could safely perform the essential job functions with the noted medical condition. The proposed amendment to the current rule, consistent with state national standards and the Board's new interpretation of those standards, will promote the ability of municipalities to attract and place qualified individuals into unfilled firefighter positions, especially in rural Oklahoma where the need is greatest. Therefore, the Board of Trustees has determined that a compelling public interest exists, which requires the amendment of the rule.

ANALYSIS:
The proposed emergency rule amendment clarifies the intent of the National Fire Protection Association standard by moving a history of a laminectomy or discectomy from a Category "A" medical condition, which is an automatic per say disqualification to a Category "B" medical condition, which would hinge acceptance or denial of entrance into the pension system on whether or not a candidate could safely perform essential job functions with the noted medical condition.

CONTACT PERSON:
Herb Bradshaw, Deputy Director, Oklahoma Firefighters Pension and Retirement System, 4545 N. Lincoln, Suite 265, Oklahoma City, Oklahoma, 73105-3414

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED AND EFFECTIVE

UPON APPROVAL BY THE GOVERNOR AS SET FORTH IN 75 O.S., SECTION 253(D):

270:10-1-5. Medical conditions affecting ability to safely perform essential job functions

(a) Medical conditions that can affect a candidate's ability to safely perform essential job functions shall be designated either Category A or Category B.

(b) Candidates with Category A medical conditions shall not be certified as meeting the medical requirements for entrance into the System.

(c) Candidates with Category B medical conditions shall be certified as meeting the medical requirements for entrance into the System only if they can perform the essential job functions without posing a significant safety and health risk to themselves, members, or civilians.

(1) Head.

(A) Category A medical conditions shall include the following:

(i) Defect of skull preventing helmet use or leaving underlying brain unprotected from trauma.

(ii) Any skull or facial deformity that would not allow for a successful respiratory facepiece fit test.

(iii) Any head condition that results in a person not being able to safely perform essential job functions.

(B) Category B medical conditions shall include the following:

(i) Deformities of the skull such as depressions or exostoses.

(ii) Deformities of the skull associated with evidence of disease of the brain, spinal cord, or peripheral nerves.

(iii) Loss or congenital absence of the bony substance of the skull.

(2) Neck.

(A) Category A medical conditions shall include the following:

(i) Any neck condition that results in a person not being able to safely perform essential job functions.

(ii) Reserved.

(B) Category B medical conditions shall include the following:

(i) Thoracic outlet syndrome.

(ii) Congenital cysts, chronic draining fistulas, or similar lesions.

(iii) Contraction of neck muscles.

(3) Eyes and Vision.

(A) Category A medical conditions shall include the following:

(i) Far visual acuity. Far visual acuity less than 20/40 binocular, corrected with contact lenses or spectacles. Far visual acuity less than 20/100 binocular for wearers of hard contacts or spectacles, uncorrected.

- (ii) Color perception. Monochromatic vision resulting in inability to use imaging devices.
 - (iii) Monocular vision.
 - (iv) Any eye condition that results in a person not being able to safely perform essential job functions.
- (B) Category B medical conditions shall include the following:
- (i) Diseases of the eye such as retinal detachment, progressive retinopathy, or optic neuritis.
 - (ii) Ophthalmological procedures such as radial keratotomy, Lasik procedure, or repair of retinal detachment.
 - (iii) Peripheral vision in the horizontal meridian of less than 110 degrees in the better eye or any condition that significantly affects peripheral vision in *both* eyes.
- (4) Ears and hearing.
- (A) Category A medical conditions shall include the following:
- (i) Chronic vertigo or impaired balance as demonstrated by the inability to tandem gait walk.
 - (ii) On audiometric testing, average hearing loss in the unaided better ear greater than 40 decibels (db) at 500 Hz, and 2000 Hz when audiometric device is calibrated to ANSI Z24.5.
 - (iii) Any ear condition (or hearing impairment) that results in a person not being able to safely perform essential job functions.
- (B) Category B medical conditions shall include the following:
- (i) Unequal hearing loss.
 - (ii) Average uncorrected hearing deficit at the test frequencies 500 Hz, 1000 Hz, 2000 Hz, and 3000 Hz greater than 40 dB in *either* ear.
 - (iii) Atresia, stenosis, or tumor of the auditory canal.
 - (iv) External otitis.
 - (v) Agenesis or traumatic deformity of the auricle.
 - (vi) Mastoiditis or surgical deformity of the mastoid.
 - (vii) Mènière's syndrome, labyrinthitis, or tinnitus.
 - (viii) Otitis media.
- (5) Dental.
- (A) Category A medical conditions shall include the following:
- (i) Any dental condition that results in a person not being able to safely perform the duties of a firefighter.
 - (ii) Reserved.
- (B) Category B medical conditions shall include the following:
- (i) Diseases of the jaws or associated tissues.
 - (ii) Orthodontic appliances.
 - (iii) Oral tissues, extensive loss.
 - (iv) Relationship between the mandible and maxilla that interferes with satisfactory postorthodontic replacement or ability to use protective equipment.
- (6) Nose, oropharynx, trachea, esophagus, and larynx.
- (A) Category A medical conditions shall include the following:
- (i) Tracheostomy.
 - (ii) Aphonia.
 - (iii) Any nasal, oropharyngeal, tracheal, esophageal, or laryngeal condition that results in not being able to perform essential job functions.
- (B) Category B medical conditions shall include the following:
- (i) Congenital or acquired deformity.
 - (ii) Allergic rhinitis.
 - (iii) Epistaxis, recurrent.
 - (iv) Sinusitis, recurrent.
 - (v) Dysphonia.
 - (vi) Anosmia.
 - (vii) Tracheal stenosis.
 - (viii) Naso-pharyngeal polyposis.
- (7) Lungs and chest wall.
- (A) Category A medical conditions shall include the following:
- (i) Active hemoptysis.
 - (ii) Empyema.
 - (iii) Pulmonary hypertension.
 - (iv) Active tuberculosis.
 - (v) Obstructive lung diseases (e.g., emphysema, chronic bronchitis, asthma, etc.) with an FEV₁/FVC <0.75, with both FEV₁ and FVC below normal (<0.80%) as defined by the American Thoracic Society.
 - (vi) Hypoxemia - Oxygen saturation <90% at rest or exercise desaturation to <90% (exercise testing indicated when resting oxygen is <94% but >90%). Evaluate VO₂ max as described by American College of Sports Medicine (ACSM).
 - (vii) Asthma - Reactive airways disease requiring bronchodilator or corticosteroid therapy in the previous 2 years. A candidate who has required these medications but who does not believe he/she has asthma shall demonstrate a normal response to cold air or methacholine (PC20 greater than 16mg/ml). To be safely administered, this test shall be performed by a qualified specialist and to be valid the candidate shall be off all anti-inflammatory medications for at least 4 weeks and off bronchodilators the day of testing. A negative challenge test [as described by American Thoracic Society (ATS)], along with no recent episode of bronchospasm off medication shall be considered evidence that the candidate does not have clinically significant airways hyperactivity or asthma.

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- (viii) Any pulmonary condition that results in a person not being able to safely perform essential job functions
- (B) Category B medical conditions shall include the following:
 - (i) Pulmonary resectional surgery, chest wall surgery, and pneumothorax.
 - (ii) Pleural effusion.
 - (iii) Fibrothorax, chest wall deformity, and diaphragm abnormalities.
 - (iv) Interstitial lung diseases.
 - (v) Pulmonary vascular diseases or history of pulmonary embolism.
 - (vi) Bronchiectasis.
 - (vii) Infectious diseases of the lung or pleural space.
 - (viii) Cystic fibrosis
 - (ix) Central or obstructive apnea.
 - (x) Any other pulmonary condition that results in a person not being able to safely perform as a member.
- (8) Heart
 - (A) Category A medical conditions shall include the following:
 - (i) Coronary artery disease, including history of myocardial infarction, angina pectoris, coronary artery bypass surgery, coronary angioplasty, and similar procedures.
 - (ii) Cardiomyopathy or congestive heart failure, including signs or symptoms of compromised left or right ventricular function, including dyspnea, S3 gallop, peripheral edema, enlarged ventricle, abnormal ejection fraction, and/or inability to increase cardiac output with exercise.
 - (iii) Acute pericarditis, endocarditis, or myocarditis.
 - (iv) Syncope, recurrent.
 - (v) A medical condition requiring an automatic implantable cardiac defibrillator or history of ventricular tachycardia or ventricular fibrillation due to ischemic or valvular heart disease, or cardiomyopathy.
 - (vi) Third-degree atrioventricular block.
 - (vii) Cardiac pacemaker.
 - (viii) Idiopathic hypertrophic subaortic stenosis.
 - (ix) Any cardiac condition that results in a person not being able to safely perform essential job functions.
 - (B) Category B medical conditions shall include the following:
 - (i) Valvular lesions of the heart, including prosthetic valves.
 - (ii) Recurrent supraventricular or atrial tachycardia, flutter, or fibrillation.
 - (iii) Left bundle branch block.
 - (iv) Second-degree atrioventricular block in the absence of structural heart disease.
 - (v) Sinus pause >3 seconds.
 - (vi) Ventricular arrhythmia (history or presence of multi-focal PVCs or nonsustained ventricular tachycardia on resting EKG with or without symptoms; history or presence of sustained ventricular tachycardia with or without symptoms).
 - (vii) Cardiac hypertrophy or hypertrophic cardiomyopathy.
 - (viii) History of congenital abnormality.
 - (ix) Chronic pericarditis, endocarditis, or myocarditis.
- (9) Vascular system.
 - (A) Category A medical conditions shall include the following:
 - (i) Hypertension with evidence of end organ damage or not controlled by approved medications.
 - (ii) Thoracic or abdominal aortic aneurysm.
 - (iii) Carotid artery stenosis or obstruction resulting in ≥ 50 percent reduction in blood flow.
 - (iv) Peripheral vascular disease resulting in symptomatic claudication.
 - (v) Any other vascular condition that results in a person not being able to safely perform essential job functions.
 - (B) Category B medical conditions shall include the following:
 - (i) Vasospastic phenomena such as Raynaud's phenomenon.
 - (ii) Thrombophlebitis and varicosities.
 - (iii) Chronic lymphedema due to lymphadenopathy or venous valvular incompetency.
 - (iv) Congenital or acquired lesions of the aorta or major vessels.
 - (v) Circulatory instability as indicated by orthostatic hypotension, persistent tachycardia, and peripheral vasomotor disturbances.
 - (vi) History of surgical repair of aneurysm of the heart or major vessel.
- (10) Abdominal organs and gastrointestinal system.
 - (A) Category A medical conditions shall include the following:
 - (i) Presence of uncorrected inguinal/femoral hernia regardless of symptoms.
 - (ii) Any gastrointestinal condition that results in a person not being able to safely perform essential job functions.
 - (B) Category B medical conditions shall include the following:
 - (i) Cholecystitis.
 - (ii) Gastritis.
 - (iii) GI bleeding.
 - (iv) Acute hepatitis.
 - (v) Hernia including the following:
 - (I) Uncorrected umbilical, ventral, or incisional hernia if significant risk exists for infection or strangulation.

- (II) Significant symptomatic hiatal hernia if associated with asthma, recurrent pneumonia, chronic pain, or chronic ulcers.
 - (III) Surgically corrected hernia >3months after surgical correction.
 - (vi) Inflammatory bowel disease or irritable bowel syndrome.
 - (vi) Intestinal obstruction.
 - (viii) Pancreatitis.
 - (ix) Diverticulitis.
 - (x) History of gastrointestinal surgery.
 - (xi) Peptic or duodenal ulcer or Zollinger-Ellison syndrome.
 - (xii) Asplenia.
 - (xiii) Cirrhosis, hepatic or biliary.
 - (xiv) Chronic active hepatitis.
- (11) Reproductive system.
- (A) Category A medical conditions shall include the following:
 - (i) Any genital condition that results in a person not being able to safely perform essential job functions.
 - (ii) Reserved.
 - (B) Category B medical conditions shall include the following:
 - (i) Pregnancy, for its duration.
 - (ii) Dysmenorrhea.
 - (iii) Endometriosis, ovarian cysts, or other gynecologic conditions.
 - (iv) Testicular or epididymal mass.
- (12) Urinary system.
- (A) Category A medical conditions shall include the following:
 - (i) Renal failure or insufficiency requiring continuous ambulatory peritoneal dialysis (CAPD) or hemodialysis.
 - (ii) Any urinary condition that results in a person not being able to safely perform essential job functions.
 - (B) Category B medical conditions shall include the following:
 - (i) Diseases of the kidney.
 - (ii) Diseases of the ureter, bladder, or prostate.
- (13) Spine and Axial Skeleton.
- (A) Category A medical conditions shall include the following:
 - (i) Scoliosis of thoracic or lumbar spine with angle ≥ 40 degrees.
 - (ii) ~~History of multiple spinal surgeries or spinal surgery involving fusion of more than 2 vertebrae, discectomy or laminectomy, or rods that are still in place.~~ History of spinal surgery involving fusion of two or more vertebrae or rods that are still in place.
 - (iii) Any spinal or skeletal condition producing sensory or motor deficit(s) or pain due to radiculopathy or nerve root compression.
 - (iv) Any spinal or skeletal condition causing pain that frequently or recurrently requires narcotic analgesic medication.
 - (v) Cervical vertebral fractures with multiple vertebral body compression greater than 25 percent; evidence of posterior element involvement, nerve root damage, disc involvement, dislocation (partial, moderate, severe), abnormal exam, ligament instability, symptomatic, and/or less than 6 months post injury or 1 year since surgery.
 - (vi) Thoracic vertebral fractures with vertebral body compression greater than 50 percent; evidence of posterior element involvement, nerve root damage, disc involvement, dislocation (severe-with or without surgery), abnormal exam, ligament instability, symptomatic, and/or less than 6 months post injury or 1 year since surgery.
 - (vii) Lumbosacral vertebral fractures with vertebral body compression greater than 50 percent; evidence of posterior element involvement, nerve root damage, disc involvement, dislocation (severe- with or without surgery), abnormal exam, ligament instability, symptomatic, and/or less than 6 months post injury or 1 year since surgery.
 - (viii) Any spinal or skeletal condition that results in a person not being able to safely perform essential job functions.
- (B) Category B medical conditions shall include the following:
 - (i) Congenital or developmental malformations of the back, particularly those that can cause instability, neurological deficits, pain, or limits flexibility.
 - (ii) Scoliosis with angle < 40 degrees.
 - (iii) Arthritis of the cervical, thoracic, or lumbosacral spine.
 - (iv) Facet atrophism, high lumbosacral angle, hyperlordosis, Schmorl's nodes, Scheuermann's disease, spina bifida occulta, spondylolisthesis, spondylolysis, Or transitional vertebrae.
 - (v) History of infections or infarcts in the spinal cord, epidural space, vertebrae, or axial skeletal joints.
 - (vi) History of laminectomy or discectomy or vertebral fractures.
 - (vii) Any spinal or skeletal condition that results in a person not being able to safely perform essential job functions.
- (14) Extremities.
- (A) Category A medical conditions shall include the following:
 - (i) Bone hardware such as metal plates or rods supporting the bone during healing.
 - (ii) History of total joint replacement.
 - (iii) Amputation or congenital absence of upper extremity limb (hand or higher).
 - (iv) Amputation of either thumb proximal to the mid-proximal phalanx.

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- (v) Amputation or congenital absence of lower extremity limb (foot or above).
 - (vi) Chronic nonhealing or recent bone grafts.
 - (vii) History of more than one dislocation of the shoulder without surgical repair or with history of recurrent shoulder disorders within the last 5 years with pain or loss of motion, and with or without radiographic deviations from normal.
 - (viii) Any extremity condition that results in a person not being able to safely perform essential job functions.
- (B) Category B medical conditions shall include the following:
- (i) History of shoulder dislocation with surgical repair.
 - (ii) Significant limitation of function of shoulder, elbow, wrist, hand, or finger, due to weakness, reduced range of motion, atrophy, unequal length, absence, or partial amputation.
 - (iii) Significant lack of full motion of hip, knee, ankle, foot, or toes due to weakness, reduced range of motion, atrophy, unequal length, absence, or partial amputation.
 - (iv) History of meniscectomy or ligamentous repair of knee.
 - (v) History of intra-articular, malunited, or nonunion of upper or lower extremity fracture.
 - (vi) History of osteomyelitis, septic, or rheumatoid arthritis.
- (15) Neurological disorders.
- (A) Category A medical conditions shall include the following:
- (i) Ataxias of heredo-degenerative type.
 - (ii) Cerebral arteriosclerosis as evidenced by a history of transient ischemic attack, reversible ischemic neurological deficit, or ischemic stroke.
 - (iii) Hemiparesis or paralysis of a limb.
 - (iv) Multiple sclerosis with activity or evidence of progression within previous 3 years.
 - (v) Myasthenia gravis with activity or evidence of progression within previous 3 years.
 - (vi) Progressive muscular dystrophy or atrophy.
 - (vii) Uncorrected cerebral aneurysm.
 - (viii) All epileptic conditions to include simple partial, complex partial, generalized, and psychomotor seizure disorders other than those with complete control during previous 5 years. A candidate shall also have normal neurological examination without structural abnormality on brain imaging, normal awake and asleep EEG with photic stimulation and hyperventilation, as well as definitive statement from qualified neurological specialist. A candidate with epilepsy shall not be cleared for fire-fighting duty until he or she has completed 5 years without a seizure on a stable medical regimen or 1 year without a seizure after discontinuing all anti-epileptic drugs.
 - (ix) Dementia (Alzheimer's and other neuro-degenerative diseases) with symptomatic loss of function or cognitive impairment (e.g., ≤ 28 on Mini-Mental Status Exam).
 - (x) Any neurological condition that results in a person not being able to safely perform essential job functions.
- (B) Category B medical conditions shall include the following:
- (i) Congenital malformations.
 - (ii) Migraine.
 - (iii) Clinical disorders with paresis, dyscoordination, deformity, abnormal motor activity, abnormality of sensation, or complaint of pain.
 - (iv) History of subarachnoid or intraparenchymal hemorrhage.
 - (v) Abnormalities from recent head injury such as severe cerebral contusion or concussion.
- (16) Skin.
- (A) Category A medical conditions shall include the following:
- (i) Metastatic or locally extensive basal or squamous cell carcinoma or melanoma.
 - (ii) Any dermatologic condition that would not allow for a successful respiratory facepiece fit test.
 - (iii) Any dermatologic condition that results in the person not being able to safely perform essential job functions.
- (B) Category B medical conditions shall include the following:
- (i) Skin conditions of a chronic or recurrent nature (eczema, cystic acne, psoriasis) that cause skin openings or inflammation or irritation of the skin surface.
 - (ii) Surgery or skin grafting.
 - (iii) Mycosis fungoides.
 - (iv) Cutaneous lupus erythematosus.
 - (v) Raynaud's phenomenon.
 - (vi) Scleroderma (skin).
 - (vii) Vasculitic skin lesions.
 - (viii) Atopic dermatitis/eczema.
 - (ix) Contact or seborrheic dermatitis.
 - (x) Stasis dermatitis.
 - (xi) Albinism, Darier's Disease, Ichthyosis, Marfan's Syndrome, Neurofibromatosis, and other genetic conditions.
 - (xii) Folliculitis, Pseudo-folliculitis, Miliaria, Keloid folliculitis.
 - (xiii) Hidradenitis suppurativa, Furuncles, Carbuncles, or Grade IV acne (cystic).
 - (xiv) Mechano-Bullous Disorders (Epidermolysis Bullosa, Hailey Pemphigus, Porphyria, Pemphigoid).
 - (xv) Urticaria or Angioedema.
- (17) Blood and blood-forming organs.
- (A) Category A medical conditions shall include the following:

- (i) Hemorrhagic states requiring replacement therapy.
 - (ii) Sickle cell disease (homozygous)
 - (iii) Clotting disorders.
 - (iv) Any hematological condition that results in a person not being able to safely perform essential job functions.
- (B) Category B medical conditions shall include the following:
- (i) Anemia.
 - (ii) Leukopenia.
 - (iii) Polycythemia vera.
 - (iv) Splenomegaly.
 - (v) Any other hematological condition that results in a person not being able to safely perform essential job functions.
- (18) Endocrine and metabolic disorders.
- (A) Category A medical conditions shall include the following:
- (i) Diabetes mellitus, which is treated with insulin.
 - (ii) Diabetes not treated by insulin, which is not controlled as evidenced by Hemoglobin A1C (Hb A1C) measurement.
 - (iii) Any endocrine or metabolic condition that results in a person not being able to safely perform essential job functions.
- (B) Category B medical conditions shall include the following:
- (i) Diseases of the adrenal gland, pituitary gland, parathyroid gland, or thyroid gland of clinical significance.
 - (ii) Nutritional deficiency diseases or other metabolic disorder.
 - (iii) Diabetes mellitus that is well controlled on diet, exercise, and/or oral hypoglycemic agents.
- (19) Systemic diseases and miscellaneous conditions.
- (A) Category A medical conditions shall include the following:
- (i) Any systemic condition that results in a person not being able to safely perform essential job functions.
 - (ii) Reserved.
- (B) Category B medical conditions shall include the following:
- (i) Connective tissue disease, such as dermatomyositis, systemic lupus erythematosus, scleroderma, and rheumatoid arthritis.
 - (ii) History of thermal, chemical, or electrical burn injury with residual functional deficit.
 - (iii) Documented evidence of a predisposition to heat stress with recurrent episodes or resulting injury.
- (20) Tumors and malignant diseases.
- (A) Category A medical conditions shall include the following:
- (i) Malignant disease that is newly diagnosed, untreated, or currently being treated.
 - (ii) Any tumor or similar condition that results in a person not being able to safely perform essential job functions.
- (B) Category B medical conditions shall include the following:
- (i) Benign tumors.
 - (ii) History of CNS tumor or malignancy.
 - (iii) History of head and neck malignancy.
 - (iv) History of lung cancer.
 - (v) History of GI or GU malignancy.
 - (vi) History of bone or soft tissue tumors or malignancies.
 - (vii) History of hematological malignancy.
- (21) Psychiatric conditions.
- (A) Category A medical conditions shall include the following:
- (i) Any psychiatric condition that results in a person not being able to safely perform essential job functions.
 - (ii) Reserved.
- (B) Category B medical conditions shall include the following:
- (i) A history of psychiatric condition or substance abuse problem.
 - (ii) Requirement for medications that increase an individual's risk of heat stress, or other interference with the ability to safely perform essential job functions.
- (22) Chemicals, drugs, and medications.
- (A) Category A medical conditions shall include the following:
- (i) Narcotics, including methadone.
 - (ii) Sedative-hypnotics.
 - (iii) Drugs that prolong Prothrombin Time, Partial Thromboplastin Time, or INR.
 - (iv) Beta-adrenergic blocking agents.
 - (v) Respiratory medications: Inhaled bronchodilators, inhaled corticosteroids, systemic corticosteroids, theophylline, and leukotriene-receptor blockers/antagonists.
 - (vi) Any chemical drug, or medication that results in a person not being able to safely perform essential job functions.
 - (vii) Evidence of illegal drug use detected through testing, conducted in accordance with Substance Abuse and Mental Health Service Administration (SAMHSA), shall be a Category A medical condition.
 - (viii) Evidence of clinical intoxication or a measured blood alcohol level that exceeds the legal definition of intoxication according to the AHJ at the time of medical evaluation shall be a Category A medical condition.
- (B) Category B medical conditions shall include the use of the following:
- (i) Cardiovascular agents.
 - (ii) Stimulants.
 - (iii) Psychoactive agents.

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- (iv) Corticosteroids.
- (v) Antihistamines.
- (vi) Muscle relaxants.

[OAR Docket #05-1205; filed 8-18-05]

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

[OAR Docket #05-1217]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 5. Individual Providers and Specialties

Part 1. Physicians

317:30-5-14. [AMENDED]

(Reference APA WF #05-05)

AUTHORITY:

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes

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SUPERSEDED EMERGENCY ACTIONS:

N/A

INCORPORATIONS BY REFERENCE:

N/A

FINDING OF EMERGENCY:

The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to bring the agency's regulations in line with current practice patterns in the medical community regarding reimbursement for allergy injections.

ANALYSIS:

Physicians rules are revised to allow payment for allergy injections administered under the supervision of the contracted provider. This change has been requested by OHCA audit staff who determined that administration of these injections by nursing staff employed by the provider is a common occurrence. This change will provide the contracted provider more flexibility and reduce professional time involved in providing this service, thus resulting in reduced costs to the provider. The change reduces the regulatory restrictions on contracted provider and should help to increase access to care for Medicaid eligible individuals since it brings Medicaid expectations into line with current practices. Rules are in need of revision to allow for payment of allergy injections administered by the employees of the contracted provider.

CONTACT PERSON:

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED UPON APPROVAL BY THE GOVERNOR AS SET FORTH IN 75 O.S., SECTION 253(D), AND EFFECTIVE UPON APPROVAL BY GOVERNOR OR AUGUST 1, 2005, WHICHEVER IS LATER:

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 1. PHYSICIANS

317:30-5-14. Injections

(a) Coverage for injections is limited to those categories of drugs included in the vendor drug program for Medicaid. OHCA administers and maintains an open formulary subject to the provisions of Title 42, United States Code (U.S.C.), Section 1396r-8. The Authority covers any drug for its approved purpose that has been approved by the Food and Drug Administration (FDA). Administration of injections is paid in addition to the medication.

(1) **Immunizations for children.** An administration fee will be paid for vaccines administered by providers participating in the Vaccines for Children Program. When the vaccine is not included in the program, the administration fee is included in the vaccine payment. Payment will not be made for vaccines covered by the Vaccines for Children Program.

(2) **Immunizations for adults.** Coverage for adults is limited to:

- (A) influenza immunizations,
- (B) Pneumococcal Immunizations, and
- (C) Gamma Globulin and Hepatitis A Vaccine when documentation shows the individual has been exposed to Hepatitis.

(b) The following drugs, classes of drugs or their medical uses are excluded from coverage:

- (1) Agents used for the treatment of anorexia, weight gain, or obesity;
- (2) Agents used to promote fertility;
- (3) Agents used to promote hair growth;
- (4) Agents used for cosmetic purposes;
- (5) Agents used for the symptomatic relief of coughs and colds. Cough and cold drugs are not covered;
- (6) Agents that are experimental or whose side effects make usage controversial; and
- (7) Vitamins and Minerals with the following exception:

- (A) Vitamin B-12 is covered only when there is a documented occurrence of malabsorption disease;
- (B) Vitamin K injections are compensable; and
- (C) Iron injections when medically necessary and documented by objective evidence of failure to respond to oral iron.

(c) Use the appropriate HCPC code when available. When drugs are billed under miscellaneous codes, a paper claim must be filed. The claims must contain the drug name, strength, dosage amount, and National Drug Code (NDC).

(d) Payment is made for allergy injections for adults and children. ~~When the physician personally supervises preparation of the allergy antigen, payment is based on the number of treatments per vial. The appropriate CPT code is used times the number of treatments in a vial.~~ When the physician contracted provider actually administers or supervises

the administration of the injection, the administration fee is compensable. No payment is made for administration when the allergy antigen is self-administered by the patient. When the allergy antigen is purchased by the physician, payment is made by invoice attached to the claim. ~~If the physician also administers the allergy antigen, payment is made for each administration.~~

(e) Rabies vaccine, Imovax, Human Diploid and Hyperab, Rabies Immune Globulin are covered under the vendor drug program and may be covered as one of the covered prescriptions per month. Payment can be made separately to the physician for administration. If the vaccine is purchased by the physician, payment is made by invoice attached to the claim.

(f) Trigger point injections (TPI's) are covered using appropriate CPT codes. Modifiers are not allowed for this code. Payment is made for up to three injections (3 units) per day at the full allowable. Payment is limited to 12 units per month. The medical records must clearly state the reasons why any TPI services were medically necessary. All trigger point records must contain proper documents and be available for review. Any services beyond 12 units per month or 36 units per 12 months will require mandatory review for medical necessity. Medical records must be automatically submitted with any claims for services beyond 36 units.

(g) If a physician bills separately for surgical injections and identifies the drugs used in a joint injection, payment will be made for the cost of the drug in addition to the surgical injection. The same guidelines apply to aspirations.

(h) When IV administration in a Nursing Facility is filed by a physician, payment may be made for medication. Administration should be done by nursing home personnel.

(i) Intravenous fluids used in the administration of IV drugs are covered. Payment for the set is included in the office visit reimbursement.

[OAR Docket #05-1217; filed 8-25-05]

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

[OAR Docket #05-1211]

RULEMAKING ACTION:
EMERGENCY adoption

RULES:
Subchapter 5. Individual Providers and Specialties
Part 3. Hospitals
317:30-5-42. [AMENDED]
Part 58. Non-Hospital Based Hospice [NEW]
317:30-5-530. through 317:30-5-532. [NEW]
(Reference APA WF # 05-04)

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The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes

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N/A

INCORPORATIONS BY REFERENCE:

N/A

FINDING OF EMERGENCY:

The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of revisions that will allow terminally ill patients the option of receiving Medicaid compensable home based hospice services in lieu of standard Medicaid services that have the objective of treating or curing the client's illness.

ANALYSIS:

Provider rules are revised to allow for the payment of hospice services for children who have been certified by their physician as having a terminal illness and a life expectancy of less than six months. OHCA staff have been receiving requests for hospice services for children and current rules allow only for coverage of hospice services provided through the ADvantage Waiver for individuals age 21 and over. Children's hospice care requires preauthorization and is available for two 90-day periods and an unlimited number of 60-day periods during the remainder of the patient's lifetime. After the patient and/or family has chosen to receive hospice care, the hospice medical team is responsible for the patient's medical care for the terminal illness in the home environment. Agency rules are in need of revision in order to provide Medicaid compensable home based hospice services to eligible individuals under the age of 21.

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED UPON APPROVAL BY THE GOVERNOR AS SET FORTH IN 75 O.S., SECTION 253(D), AND EFFECTIVE UPON APPROVAL BY GOVERNOR OR AUGUST 1, 2005, WHICHEVER IS LATER:

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 3. HOSPITALS

317:30-5-42. Coverage for children

Payment is made to hospitals for medical and surgical services for persons under the age of 21 within the scope of the Authority's Medical Programs, provided the services are reasonable for the diagnosis and treatment of illness or injury, or to improve the functioning of a malformed body member. Medical and surgical services are comparable to those listed for adults except as follows.

(1) Inpatient general acute care services limitations.

All medically necessary inpatient hospital services, other than psychiatric services, for all persons under the age of 21 will not be limited.

(2) Utilization control requirements for psychiatric beds.

Medicaid utilization control requirements applicable to inpatient psychiatric services for persons under 21 years of age in psychiatric facilities apply to acute care

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hospitals. Acute care hospitals are required to maintain the same level of documentation on individuals receiving psychiatric services as the free-standing psychiatric facilities (refer to OAC 317:30-5-95.2).

(3) **Outpatient hospital services.** Payment is made for outpatient hospital services, including lab and x-rays.

(4) **Outpatient physical therapy.** Payment is made for preauthorized outpatient physical therapy. Payment is limited to four visits per month.

(5) **Hospice Services.** Hospice is palliative and/or comfort care provided to the client and his/her family when a physician certifies that the client has a terminal illness and has six months or less to live and orders hospice care. A hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional and spiritual stresses which are experienced during the final stages of illness and during dying and bereavement. The hospice services must be related to the palliation and management of the client's illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills. Payment is made for home based hospice services for terminally ill individuals with a life expectancy of six months or less when the patient and/or family has elected hospice benefits in lieu of standard Medicaid services that have the objective to treat or cure the client's illness. Once the client has elected hospice care, the hospice medical team assumes responsibility for the client's medical care for the terminal illness in the home environment. Hospice care includes nursing care, physician services, medical equipment and supplies, drugs for symptom control and pain relief, home health aide and personal care, physical, occupational and/or speech therapy, medical social services, dietary counseling and grief and bereavement counseling to the client and/or family. Services must be prior authorized. Hospice care is available for two 90-day periods and an unlimited number of 60-day periods during the remainder of the patient's lifetime. However, the patient and/or the family may voluntarily terminate hospice services. To be covered, hospice services must be reasonable and necessary for the palliation or management of a terminal illness or related conditions. A certification that the individual is terminally ill must be completed by the patient's attending physician or the Medical Director of an Interdisciplinary Group. Nurse practitioners serving as the attending physician may not certify or re-certify the terminal illness. A plan of care must be established before services are provided. The plan of care should be submitted with the prior authorization request.

(5) **Exclusions.** The following are excluded from coverage:

- (A) Inpatient diagnostic studies that could be performed on an outpatient basis.
- (B) Services or any expense incurred for cosmetic surgery unless the physician certifies the procedure emotionally necessary.
- (C) Sterilization of persons who are under 21 years of age.

(D) Reversal of sterilization procedures for the purposes of conception.

(E) Hysterectomy, unless therapeutic and unless a copy of an acknowledgment form, signed by the patient or an acknowledgment by the physician that the patient has already been rendered sterile is attached to the claim.

(F) Medical services considered to be experimental.

PART 58. NON-HOSPITAL BASED HOSPICE

317:30-5-530. Eligible providers

Non-Hospital Affiliated Hospice entities must be appropriately licensed and have a contract with the Oklahoma Health Care Authority to provide Hospice services.

317:30-5-531. Coverage for adults

There is no coverage for hospice services provided Medicaid eligible adults except for the hospice provision provided through the ADvantage Waiver.

317:30-5-532. Coverage for children

Hospice is palliative and/or comfort care provided to the client and his/her family when a physician certifies that the client has a terminal illness and has six months or less to live and orders hospice care. A hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional and spiritual stresses which are experienced during the final stages of illness and during dying and bereavement. The hospice services must be related to the palliation and management of the client's illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills. Payment is made for home based hospice services for terminally ill individuals with a life expectancy of six months or less when the patient and/or family has elected hospice benefits in lieu of standard Medicaid services that has the objective to treat or cure the client's illness. Once the client has elected hospice care, the hospice medical team assumes responsibility for the client's medical care for the terminal illness in the home environment. Hospice care includes nursing care, physician services, medical equipment and supplies, drugs for symptom control and pain relief, home health aide and personal care, physical, occupational and/or speech therapy, medical social services, dietary counseling and grief and bereavement counseling to the client and/or family. Services must be prior authorized. Hospice care is available for two 90-day periods and an unlimited number of 60-day periods during the remainder of the patient's lifetime. However, the patient and/or the family may voluntarily terminate hospice services. To be covered, hospice services must be reasonable and necessary for the palliation or management of a terminal illness or related conditions. A certification that the individual is terminally ill must be completed by the patient's attending physician or the Medical Director of an Interdisciplinary Group. Nurse practitioners serving as the attending physician

may not certify or re-certify the terminal illness. A plan of care must be established before services are provided. The plan of care should be submitted with the prior authorization request.

[OAR Docket #05-1211; filed 8-22-05]

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

[OAR Docket #05-1212]

RULEMAKING ACTION: EMERGENCY adoption

RULES:

Subchapter 5. Individual Providers and Specialties
Part 9. Long Term Care Facilities
317:30-5-133. [AMENDED]
(Reference APA WF # 05-03)

AUTHORITY:

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 63 O.S. 2001, Section 1-1925.2

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INCORPORATIONS BY REFERENCE:

N/A

FINDING OF EMERGENCY:

The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions in order to comply with Senate Bill 1622 of the 2nd Session of the 49th Legislature.

ANALYSIS:

Long Term Care Facilities reimbursement rules are revised to reflect a new methodology for establishing reimbursement rates. Senate Bill 1622 created the Oklahoma Nursing Facility Funding Advisory Committee and established as their purpose the development and recommendation of a new methodology for calculating state Medicaid program reimbursement. The reimbursement will be facility specific, based on Direct Care Staffing Costs and will not reduce rates currently in effect. The new method is to only apply to new funds that become available. The new methodology will establish rates for each home which consist of a Base Rate and two add-ons, one for Direct Care and one for Other Costs. The base rate for the regular nursing facilities will be the rate in effect on June 30, 2005, with any changes that are specifically funded through new appropriations (such as an appropriation for minimum wage changes, etc.). The Direct Care component will be facility specific and will be determined by a facility's specific expense for Direct Care in relation to all other facilities' Direct Care expense, limited to the 90th percentile and paid from a pool of 70% of available funds. The Other Component will be a statewide adjustment (same for all facilities) and be paid from a pool of 30% of available funds. Annually, the pool of available funds will be re-established adding any new monies or changes in federal matching and re-allocated with new rate add-ons being established based on new cost report date. Rules revisions are needed in order to comply with Senate Bill 1622.

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED UPON APPROVAL BY THE GOVERNOR AS SET FORTH IN 75 O.S., SECTION 253(D), AND EFFECTIVE UPON APPROVAL BY GOVERNOR OR JULY 1, 2005, WHICHEVER IS LATER:

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 9. LONG TERM CARE FACILITIES

317:30-5-133. Payment methodologies

(a) Private Nursing Facilities.

(1) Facilities. Private Nursing Facilities include:

- (A) Nursing Facilities serving adults (NF),
(B) Nursing Facilities serving Aids Patients (NF-Aids),
(C) Nursing Facilities serving Ventilator Patients (NF-Vents),
(D) Intermediate Care Facilities for the Mentally Retarded (ICF/MR),
(E) Intermediate Care Facilities with 16 beds or less serving Severely or Profoundly Retarded Patients (Acute ICF/MR), and
(F) Payment will be made for non-routine nursing facility services identified in an individual treatment plan prepared by the State MR Authority. Services are limited to individuals approved for NF and specialized services as the result of a PASRR/MR Level II screen. The per diem add-on is calculated as the difference in the statewide standard private MR base rate and the statewide NF facility base rate.

(2) Reimbursement calculations. Rates for Private Nursing Facilities will be reviewed periodically and adjusted as necessary through a public process. The rates are based on a statewide rate for each type of facility which consists of the sum of one or more of four components.

(A) Base Year Rate component. The Base Year Rate component will consist of the Primary Operating Cost, the Administrative Services Allowance and the Capital Allowance. Each of these components is set through a review of statewide base year cost report data, as reported on the annual cost reports, and adjusted for a statewide average per diem audit amount. The Capital Allowance component is also adjusted to reflect an expected occupancy level of 93 percent in order to exclude payment for unfilled beds through the Medicaid program.

(B) Discretionary Inflation Rate component. A Discretionary Inflation Rate component may be added to the Base Year Rate component dependent upon the factors listed in (i)-(vii) of this paragraph. These factors may be reviewed individually or in the aggregate. Nothing in this paragraph shall mandate

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the State give majority consideration to any one factor or all factors. The factors include:

- (i) access to Medicaid Services;
- (ii) Medicaid utilization;
- (iii) Cost Report analyses;
- (iv) National and State-specific trends and costs including trends and salary levels and changes in minimum wage levels;
- (v) analyses of economic impact of changes in law or regulation;
- (vi) budget appropriations to OHCA; and
- (vii) Industry efforts to:
 - (I) reduce or contain employee benefits expenditures.
 - (II) consolidate or centralize personnel or departmental functions to reduce costs.
 - (III) review departmental staffing levels and to use lesser-skilled employees or reduce numbers of full-time equivalent employees where possible to do so without adversely affecting the quality of patient care.
 - (IV) standardize drugs and medical supplies in order to reduce costs that are unnecessary.
 - (V) expedite billings.
 - (VI) use volunteer service and fund raising.
 - (VII) control utility costs.
 - (VIII) reduce the incidence of employee injuries.
 - (IX) reduce employee turnover and to involve employees in cost containment efforts.
 - (X) review contractual arrangements to determine if more cost-effective ways of providing services and supplies can be achieved.
 - (XI) incorporate efficiency incentives into the compensation systems of employees.
 - (XII) use management information systems to plan and achieve efficiencies in operations (including but not limited to flexible budgeting, cost accounting, case-mix, group purchasing, etc.).

(C) **Wage Enhancement Payment component.** The Wage Enhancement payment is subject to Title 63 of Oklahoma Statute, Section 5022 and is described at OAC 317:30-5-131.1. The Wage Enhancement payment is added as per the methodology listed at OAC 317:30-5-131.1.

(D) **Periodic Incentive Payment component.** A Periodic Incentive payment may be made to certain facilities whose score on a predetermined array of factors meets levels that exceeds the standard or norm. Among factors under consideration are the Customer Satisfaction Surveys, the OSDH survey and Certification data, the Wage Enhancement audit data, the Recipient Trust Fund audit data, data from the State Ombudsman and Pharmacy Utilization (DUR program) data. This payment is made based upon the availability of additional funds and the reliability of the data collected.

(E) **Nursing Facilities serving ventilator-dependent patients.** A prospective statewide enhanced rate is paid to nursing facilities who do not have a waiver under Section 1919(b)(4)(C)(ii) of the Social Security Act on behalf of ventilator-dependent patients.

(i) Reimbursement is limited to the same rate paid for care of NF patients plus an enhancement for patients who are ventilator dependent. The enhanced rate is an amount reflecting the additional costs of meeting the specialized care needs of ventilator-dependent patients. In addition to increased skilled staffing costs, the following are used in calculating the enhanced rate:

- (I) additional nursing hours;
- (II) medical equipment and supplies;
- (III) nutritional therapy; and
- (IV) respiratory therapy.

(ii) Reimbursement for the enhanced rate requires prior authorization. In order for Medicaid eligible patients to be considered for prior authorization, the facility submits the treatment plan and most recent doctor's orders and/or hospital discharge summary for each ventilator-dependent patient to OHCA.

(iii) The enhanced rate will be reviewed periodically and adjusted as necessary through a public process.

(F) **Nursing Facilities Serving Adults.** Base Rate when used in this subpart is defined as the rate in effect on June 30, 2005, adjusted for any changes as described in (B) through (E) for which the legislature has specified appropriated funds. Direct Care Costs are defined as those costs for salaries, benefits and training for registered nurses, licensed practical nurses, nurse aides and certified medication aides. Other Costs are defined as the total allowable routine and ancillary costs of nursing facility care less the Direct Care Costs. As of July 1, 2005, Nursing Facilities Serving Adults will be reimbursed as follows:

(i) The rate for each facility will be the sum of the Base Rate plus the add-ons for Direct Care and Other Costs as described below.

(ii) Annually, any funds over and above those to cover the Base Rate described above will be used to create two pools of funds used to adjust the rates as follows:

(I) The first pool will be 30% of the total available funds and will be used to adjust the rates equally (a statewide adjustment) for Other Costs.

(II) The second pool will be 70% of the total available funds and will be used to adjust rates on a facility-specific basis for Direct Care Costs. The add-on for each facility will be determined by multiplying each facility's reported direct care cost per day (with a maximum limit set at the 90th percentile) by the percent increase

in the total direct care expenditures due to the addition of the direct care pool funds.

(iii) The available funds for establishing these pools and the subsequent add-ons for Direct Care and Other Costs will be re-determined and re-calculated annually and adjusted for changes in available funds and federal matching percentages.

(b) **Public Nursing Facilities.** Reimbursement for public Intermediate Care Facilities for the Mentally Retarded (ICF/MR) shall be based on each facility's reasonable cost and shall be paid on an interim basis with an annual retroactive adjustment. Reasonable costs shall be based on Medicare principles of cost reimbursement. Rates for Public facilities will be reviewed periodically and adjusted as necessary through a public process.

[OAR Docket #05-1212; filed 8-22-05]

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

[OAR Docket #05-1216]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 5. Individual Providers and Specialties
Part 62. Private Duty Nursing [NEW]
317:30-5-555. through 317:30-5-560.2. [NEW]
(Reference APA WF # 05-06)

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The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes

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N/A

INCORPORATIONS BY REFERENCE:

N/A

FINDING OF EMERGENCY:

The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to define the scope and duration of private duty nursing services for children as the lack of sufficient guidelines has left the agency unable to effectively monitor these services.

ANALYSIS:

Provider rules are revised to establish rules for private duty nursing care provided Medicaid eligible children. Currently, these services are covered under the EPSDT program but the agency's SURS and Care Management units have identified numerous problems with the management and audit of these services. Frequently, providers are not notifying the agency of changes to the patient's plan of care. Revisions are intended to clarify the conditions under which private duty nursing can be approved. Revisions are anticipated to result in better quality care for these medically fragile children by requiring the direct involvement of an OHCA Exceptional Needs Coordinator in the treatment process. Private duty nursing providers will benefit since the rules will make

the prior authorization process more efficient. The revisions will also enable SURS to effectively resolve overpayments identified by the audit process. Rule revisions are needed to establish specific provider rules for private duty nursing care for children.

CONTACT PERSON:

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED UPON APPROVAL BY THE GOVERNOR AS SET FORTH IN 75 O.S., SECTION 253(D), AND EFFECTIVE UPON APPROVAL BY GOVERNOR OR AUGUST 1, 2005, WHICHEVER IS LATER:

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 62. PRIVATE DUTY NURSING

317:30-5-555. Eligible providers

(a) An organization who desires to be paid by Oklahoma Medicaid for private duty nursing must meet the following requirements prior to providing services to eligible Medicaid beneficiaries:

- (1) an executed contract with OHCA, and
- (2) the organization must meet the requirements of OAC 317:30-5-545 or it must be licensed by the State Health Department as a Home Care Agency.

(b) The provider of services within the organization must be a licensed practical nurse or a registered nurse.

317:30-5-556. Definitions

The definition of private duty nursing is medically necessary care provided on a regular basis by a Licensed Practical Nurse or Registered Nurse in the patient's residence.

317:30-5-557. Coverage by category

(a) Adults. Oklahoma Medicaid does not cover adults (persons age 21 or over) for private duty nursing with the exception of subsection (c).

(b) Children. Oklahoma Medicaid does cover children (Persons under the age of 21) if:

- (1) the child is eligible for Medicaid and
- (2) the Oklahoma Health Care Authority, in its discretion, deems the services medically necessary. Medical necessity is determined in accordance with OAC 317:30-5-560.1.

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

317:30-5-558. Private duty coverage limitations

(a) The following regulations apply to all private duty nursing services and provide coverage limitations:

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(1) All services must be prior authorized to receive payment from the Medicaid agency. Prior authorization means authorization in advance of services provided in accordance with OAC 317:30-5-560.1;

(2) A treatment plan must be completed prior to the prior authorization and must be updated throughout the course of nursing treatment;

(3) A personal visit by an Oklahoma Health Care Authority Care Management Nurse is required prior to the authorization for services;

(4) Care in excess of the designated hours per day granted in the prior authorization are not compensable. The banking, saving or accumulation of unused prior authorized hours to be used later are not compensable.

(5) The agency requesting prior authorization must have adequate staff and resources to meet the Plan of Care requirements. Failure to provide care in the manner described on the Plan of Care will result in termination of the prior authorization and selection of another provider.

(6) Private duty nursing services does not include office time or administrative time in providing the service. The time billed is for direct nursing services only.

(7) Staff must be engaged in purposeful activity that directly benefit the person receiving services. Staff must be physically able and mentally alert to carry out the duties of the job. At no time will the Authority compensate an organization for nursing staff time when sleeping.

(8) OHCA will not compensate service if all health and safety issues cannot be met in the home setting.

(9) A provider may not misrepresent facts in a treatment plan or omit facts from a treatment plan.

(10) It is outside the scope of coverage to deliver care in a manner outside the treatment plan or to deliver units over the authorized units of care.

(11) Private duty nursing will not be authorized in excess of 16 hours per day except immediately following a hospital stay or the temporary incapacitation of the primary caregiver. Under these two exceptions, care in excess of 16 hours may be authorized for a period up to 30 days. As expressed in this subsection, incapacity means an involuntary ability to provide care.

(12) Family and/or caregivers and/or guardians are required to provide some of the nursing care without compensation.

(b) A violation of any private duty nursing coverage limitations will result in an overpayment. Continued violations may result in contract termination.

317:30-5-559. How services are authorized

An eligible provider may have private duty nursing services authorized by following all the following steps:

(1) create a treatment plan for the patient as expressed in OAC 317:30-5-560;

(2) request a home visit by an OHCA Care Management Nurse; and

(3) have an OHCA Care Management Nurse determine medical necessity of the service by scoring the client's

needs on the Private Duty Nursing Acuity Grid (Form OHCA-26).

317:30-5-560. Treatment Plan

(a) An eligible organization must create a treatment plan for the patient as part of the process to have private duty nursing services authorized. The treatment plan must be signed by the patient's attending physician.

(b) The treatment plan must include all of the following medical and social data so that OHCA Care Managers can appropriately determine medical necessity by the use of the Private Duty Nursing Acuity Grid:

(1) diagnosis

(2) prognosis

(3) anticipated length of treatment

(4) number of hours of private duty nursing requested per day

(5) assessment needs and frequency (e.g., vital signs, glucose checks, neuro checks, respiratory)

(6) medication method of administration and frequency

(7) age appropriate feeding requirements (diet, method and frequency)

(8) respiratory needs

(9) mobility requirements including need for turning and positioning, and the potential for skin breakdown

(10) developmental deficits

(11) casting, orthotics, therapies

(12) age appropriate elimination needs

(13) seizure activity and precautions

(14) age appropriate sleep patterns

(15) disorientation and/or combative issues

(16) age appropriate wound care and/or personal care

(17) communication issues

(18) social support needs

(19) name, skill level, and availability of all caregivers

(20) other pertinent nursing needs such as dialysis, isolation

317:30-5-560.1. Prior authorization requirements

(a) Authorizations are provided for a maximum period of six months.

(b) Authorizations may only be received by creating a treatment plan for the patient, requesting a visit by an OHCA Care Management Nurse, and having the Care Management Nurse determine medical necessity by scoring the client's needs on the Private Duty Nursing Acuity Grid. The number of hours requested on the treatment plan may be modified based on the assessment of OHCA staff during a visit by a Care Management Nurse. If the patient's condition necessitates a change in the treatment plan, the provider must request a new prior authorization.

(c) Changes in the treatment plan may necessitate another visit by the Care Management staff.

317:30-5-560.2. Record documentation

Copies of the treatment plan signed by the attending physician. Copies of the attending physician's orders and, at a minimum, the last 30 days of medical records for the actual care provided must be maintained in the home. Medical records must include the beginning and ending time of the care and must be signed by the person providing care. The nurse's credentials must also be included. All provisions of the treatment plan, such as vital signs, medication administration, glucose/neuro checks, vital signs, respiratory assessments, and all applicable treatments must be documented in the record. All records must meet the requirements set forth in OAC 317:30-3-15.

[OAR Docket #05-1216; filed 8-25-05]

**TITLE 340. DEPARTMENT OF HUMAN SERVICES
CHAPTER 40. CHILD CARE SERVICES**

[OAR Docket #05-1204]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 5. Plan of Service
340:40-5-1. [AMENDED]
(Reference APA WF 05-04)

AUTHORITY:

Commission for Human Services, Article XXV, Sections 2, 3, and 4 of the Oklahoma Constitution; Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Public Law (P.L.) 104-193; the Balanced Budget Act of 1997, P.L. 105-33; and 45 Code of Federal Regulations (CFR) Parts 98 and 99.

DATES:

Adoption:

July 26, 2005

Approved by Governor:

August 4, 2005

Effective:

Immediately upon Governor's approval or September 1, 2005, whichever is later.

Expiration:

Effective through July 14, 2006, unless superseded by another rule or disapproved by the Legislature.

SUPERSEDED EMERGENCY ACTIONS:

n/a

INCORPORATIONS BY REFERENCE:

n/a

FINDING OF EMERGENCY:

Emergency rulemaking approval is requested as OKDHS finds compelling public interest exists in limiting the number of clients who remain eligible for child care benefits at the higher income eligibility level to those who were grandfathered in at this higher income eligibility level on September 1, 2004.

ANALYSIS:

Two income levels for determining child care eligibility were established effective September 1, 2004. The income eligibility level for clients approved for child care after September 1, 2004 is lower than for clients who have been continuously eligible for child care since August 31, 2004. The purpose of the proposed rule is to move language regarding the two eligibility levels to the Oklahoma Department of Human Services (OKDHS) Appendix C-4, Child Care Eligibility/Rates Schedule and to limit the number of clients who are still eligible for the higher income eligibility level.

When rule revisions became effective September 1, 2004, the intention at that time was to maintain the two income eligibility levels until August 31, 2005. Based on current budget estimates, it is possible to continue this higher income eligibility level only for those clients whose family share co-payment

appears in the shaded area of the chart as of August 31, 2005. Budget estimates do not make it fiscally possible to open up the higher income eligibility to others.

CONTACT PERSON:

Dena Thayer at (405)521-4326

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED UPON APPROVAL BY THE GOVERNOR AS SET FORTH IN 75 O.S., SECTION 253(D) AND EFFECTIVE UPON APPROVAL BY THE GOVERNOR OR SEPTEMBER 1, 2005, WHICHEVER IS LATER:

SUBCHAPTER 5. PLAN OF SERVICE

340:40-5-1. Plan of service

(a) **Plan of service.** Providing child care is part of an overall plan of service designed to help the parent(s) or caretaker(s) with whom the child(ren) lives to achieve his or her maximum potential for self-support. Quality child care services assure the parent(s) or caretaker(s) that each child has adequate care ~~which that~~ affords developmental and learning experiences while the parent(s) or caretaker(s) is engaged in self-support activities.

(b) **Plan components.** The plan of service consists of many components that all link to form a goal-directed plan of care. ~~These components include and includes:~~

- (1) the name, age, and grade level of the child(ren) for whom child care is needed;
- (2) ~~need for the reason~~ child care is needed, per OAC 340:40-7-7 and 340:40-7-8;
- (3) the days and hours for which care is approved, including travel time;
- (4) whether care is approved on a weekly, full-time, blended, or part-time care basis;
- (5) exploring whether there is an appropriate, feasible alternative to Oklahoma Department of Human Services (OKDHS) subsidized child care;
- (6) ~~that the a~~ plan to increase the client's income ~~is in place;~~
- (7) a back up plan for care when the child(ren) cannot go to the authorized child care provider;
- (8) the name, address, and telephone number of a person to call in case of an emergency;
- (9) a plan to help the client choose a child care provider;
- (10) a discussion about the family share co-payment, if one is required;
- (11) a discussion of any other social service needs of the family; and
- (12) a discussion of the client's responsibilities and rights when using subsidized child care.

(c) **Alternative to subsidized child care.** The worker explores with the client whether there is an appropriate, feasible alternative to OKDHS subsidized child care. The client has a choice whether to use this alternative unless the alternative is a spouse or the natural or adoptive parent of the child(ren) who

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lives in the home and who does not meet a need factor. Possible alternatives include:

- (1) care by a dependable relative who is able and willing to assume responsibility for care and supervision of the child(ren) for part of the day;
 - (2) care in a free or low cost facility, such as a preschool, pre-kindergarten, kindergarten, Head Start, Early Head Start, or tribal child care program;
 - (3) dependent care expenses ~~paid directly by a Temporary Assistance for Needy Families (TANF) client which that~~ are considered as earned income exemptions, per OAC 340:10-3-33(3); and
 - (4) for a school age child(ren), the ~~possible~~ rearrangement of the parent's or caretaker's employment or training schedule to coincide with the hours the child(ren) is in school.
- (d) **Plan to increase income.** At each application or review, the client and ~~the~~ worker discuss ways the client can increase income to the household. ~~The client and worker identify together~~ the goals child care helps the family achieve. Together they estimate when the family can assume progressively greater responsibility for the cost of child care. The worker makes referrals to other agencies as appropriate and per OAC 340:40-7-9.
- (e) **Back up plan.** The worker discusses with the client the back up plan for child care he or she has in place if the child(ren) cannot go to the usual provider ~~for some reason such as~~ because of illness, school holidays, or ~~another other~~ unforeseen emergency. The back up plan includes the name and address of a person the client feels he or she can rely on when the normal plan of care cannot be used.
- (f) **Emergency contact.** Form FSS-1, Comprehensive Application and Review, or Form K-2, Application for Child Care Services, includes the name, phone number, and address of a person to contact in case of emergency when the primary parent or caretaker cannot be reached.
- (g) **Choice of provider.** The worker documents the choice of provider on Form FSS-1 or Form K-2. He or she calls the chosen provider to ensure acceptance of the child(ren) does not cause the provider to exceed his or her licensed capacity after describing the days and hours care is needed. If the client does not choose a provider at the time of the request, the worker provides the client with information to help in making the choice. The client can may choose a family child care home regardless of star level. The client ~~cannot may not~~ choose a child care:
- (1) facility that does not have a valid contract with OKDHS;
 - (2) facility in which the client or his or her spouse, including the child's parent or stepparent, has an ownership interest;
 - (3) home in which the child resides;
 - (4) home in which the client also works during the hours his or her child(ren) is in care;
 - (5) center in which the client works and has job responsibilities which include care of the child(ren) for whom child care is requested;
 - (6) provider who is related to the client and only accepts a relative's child(ren);

- (7) provider who does not allow parental access during the hours the provider is caring for children;
 - (8) provider who is receiving state or federal funds, such as Head Start, Early Head Start, or public schools, unless:
 - (A) all parents are charged a fee for the hours subsidy payment is requested; and
 - (B) the program ~~is offering offers~~ extended day services. Programs operating only during typical school or Head Start hours are not eligible;
 - (9) provider caring for a school age child during the regular school day when such student could be attending a public or private school during those hours; or
 - (10) center which is a one star facility unless there are no one ~~star~~ plus, two, or three star centers in the community or one of the special exception criteria are met. Special exception criteria are:
 - (A) the child(ren) was already approved for care at this one star center prior to January 1, 2003. The child(ren) can remain at this facility unless the child(ren) stops attending there for more than 30 days. The child(ren) ~~can also may~~ be approved at this same facility again if the only reason the child(ren) did not attend for more than 30 days was because of a school break or due to circumstances beyond the control of the family such as illness of the child;
 - (B) care is requested for a child living in the same home as a child already approved for care as described in (10)(A) of this subsection for the same one star child care provider; or
 - (C) the parent or guardian demonstrates ~~that~~ there is no other child care option that meets the family's needs.
- (h) **Income determination.** ~~The worker uses policy in Based on OAC 340:40-7 to determine, the worker determines who must be is~~ considered part of the household for income determination, what income is countable, and what income is excluded. After determining the amount of countable household income, the worker uses OKDHS Appendix C-4, Child Care Eligibility/Rates Schedule, to determine whether the household meets income guidelines. ~~Clients who are approved for child care prior to September 1, 2004 meet income eligibility guidelines if their income, family size, and number of children in care meet the guidelines stated on the Schedule of Co-payments chart on OKDHS Appendix C 4, as amended from time to time, as approved by the Commission for Human Services, with or without a transition plan as determined by the Commission. If the Commission approves a transition plan to migrate to a new eligibility schedule pursuant to a new Schedule of Co-payments chart on OKDHS Appendix C 4, previously eligible clients continue to be eligible using the previously approved Schedule of Co-payments chart as long as they do not lose eligibility for more than one month. If these clients stop receiving child care assistance or lose eligibility for more than one month, the worker determines their eligibility using the new eligibility Schedule of Co-payments chart. Clients approved for child care on or after September 1, 2004 meet income eligibility guidelines if their income,~~

family size, and number of children in care meet the eligibility standards stated in the Schedule of Co-payments chart which is effective on September 1, 2004, or such other later date as their eligibility is determined which matches the Schedule of Co-payments then in effect. The OKDHS Appendix C-4 is amended from time to time and the Commission for Human Services must approve any changes. If the income of the family exceeds the eligibility standard of on the chart or are off is above the income level on the chart, they are the family is not eligible for a child care services benefit.

(i) **Family share co-payment.** The worker uses OKDHS Appendix C-4 to determine income eligibility and the family share co-payment for each family. The family share co-payment is applied before OKDHS pays a child care subsidy. The amounts the family and OKDHS pay toward the cost of care varies depending on the plan of service, family size, income, and the number of children receiving child care services.

(j) **Social services requests.** When a client requests help in meeting the social services needs listed on Form FSS-1 or Form K-2, the worker provides all available information to aid a client in meeting these needs.

(k) **Client rights and responsibilities.** The worker advises the client of rights and responsibilities listed in (1) through (7).

(1) The client has the right to an explanation by the worker of the "Client Child Care Responsibilities and Service Plan Agreement" listed on Form FSS-1 or Form K-2 before signing the form.

(2) ~~The worker must advise the client that a~~ A child care request is not approved back to the date of request unless the interview is conducted and verification is provided on that same date.

(3) The client has the right to ask for a fair hearing if ~~he or she~~ the client disagrees with an action taken on his or her case, per OAC 340:2-5.

(4) ~~The client is advised by the worker that the~~ The provider may charge the client extra for special fees, such as enrollment or transportation fees, ~~as long as~~ provided these fees are posted and also charged to the general public.

(5) The provider may also charge the client for any days OKDHS refuses to pay for care because when:

(A) the client did not swipe attendance for the correct days and times his or her child(ren) attended child care;

(B) swipes were denied and the client did not get them corrected within ten days; or

(C) the provider loses the absent day payment for a child(ren) approved for a weekly authorization because the client did not swipe correct attendance for every day the child(ren) attended that month.

(56) ~~The worker advises the client that the provider is~~ may not allowed to charge him or her the client for:

(A) days and hours covered in the child care plan when all attendance was correctly swiped even if the hours are more than customary for a full-time day; and

(B) days the child(ren) is not in attendance.

(67) ~~The client is advised he or she~~ is required to cooperate with the OKDHS Office of Inspector General in any audit or investigation of possible overpayments by the client or by ~~his or her~~ the client's chosen provider.

[OAR Docket #05-1204; filed 8-15-05]

**TITLE 725. OKLAHOMA TOURISM AND RECREATION DEPARTMENT
CHAPTER 20. MARKETING SERVICES OPERATION**

[OAR Docket #05-1200]

RULEMAKING ACTION:
EMERGENCY adoption

RULES:
Subchapter 7. Reimbursement of Matching Funds to Multicounty Organizations
725:20-7-10. [NEW]

AUTHORITY:
Oklahoma Tourism and Recreation Commission to make rules pursuant to Sections 1830 and 1847.1 of Title 74 of the Oklahoma Statutes.

DATES:

Adoption:
June 16, 2005

Approved by Governor:
July 26, 2005

Effective:
Immediately upon Governor's approval

Expiration:
Effective through July 14, 2006, unless superseded by another rule or disapproved by the Legislature.

SUPERSEDED EMERGENCY ACTIONS:
NA

INCORPORATIONS BY REFERENCE:
NA

FINDING OF EMERGENCY:
The compelling extraordinary circumstance necessitating the approval of the rules submitted herewith relates to the passage of legislation during the 2005 Legislative Session authorizing the allocation of Tourism Promotion Tax funds (Enrolled HB 1122). The legislation stipulates that "not more than Four Hundred Thousand Dollars (\$400,000.00) shall be made available to the multicounty organizations, as defined by paragraph 1 of subsection A of Section 1830 of Title 74 of the Oklahoma Statutes, as a grant partnership program allowed under subsection B of Section 1834 of Title 74 of the Oklahoma Statutes." In order to implement the provisions of the non-codified statute for the current fiscal year, and to execute an effective 2006 spring and summer marketing campaign, an emergency rule is necessary.

ANALYSIS:
These rules provide the basis for administering allocation of Tourism Promotion Tax funds to qualified multicounty organizations. Sections 1830 and 1830.1 of Title 74 of the Oklahoma Statutes authorize and direct the Oklahoma Tourism and Recreation Commission to develop rules to administer the allocation and expenditure of matching funds of multicounty organizations. The proposed rule serves to articulate the program requirements and qualifications, eligibility, and procedures for submission of claims for review to qualify for approval of payment of tourism tax funds. The rule provides the administrative mechanisms whereby payment of tourism tax funds to multicounty organizations must operate.

CONTACT PERSON:
Keith Farris, Travel and Tourism Division (405) 230-8405

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED AND EFFECTIVE UPON APPROVAL BY THE GOVERNOR AS SET FORTH IN 75 O.S., SECTION 253 (D):

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SUBCHAPTER 7. REIMBURSEMENT OF MATCHING FUNDS TO MULTICOUNTY ORGANIZATIONS

725:20-7-10. Special allocation

(a) The purpose is to specify how multicounty organizations apply for and use tourism tax funds provided for by the Legislature for fiscal year 2006.

(b) For the purposes of allocating tourism tax funds, the following definitions shall apply:

(1) "Tourism tax funds", as defined in the Oklahoma Tourism Promotion Act as created by Sections 50010 through 50015 of Title 68 of the Oklahoma Statutes, refers to those funds specifically authorized by the Legislature for the multicounty organizations for purposes specified by law.

(2) "Multicounty organizations" refers to the regional non-profit associations defined by Section 1830 of Title 74 of the Oklahoma Statutes.

(c) Multicounty organizations may apply for grants from tourism tax funds to use for designing and placing media advertising that will complement the Oklahoma Tourism and Recreation Department's ("Department") 2006 spring campaign. Applications will be accepted only for projects that are allowed by the Tourism Promotion Act as provided for in Section 50011 of Title 68 of the Oklahoma Statutes.

(d) The maximum amount approved for an individual multicounty organization's project will be ten percent (10%) of the total tourism tax funds made available by the Oklahoma Tourism and Recreation Commission ("Commission"). Two or more organizations may cooperate to implement a project. If multicounty organizations apply jointly, the total for each joint application shall not exceed fifteen percent (15%) of the total allocation. An organization may submit an application for, or be a participant in, only one project. Amounts approved for projects will be contingent upon the number of projects approved by the Commission.

(e) Applications are to be submitted to the Department not later than November 15, 2005. Notice shall be provided by email to each multicounty organization not less than thirty (30) days before applications are due to the Department.

(f) Promotion projects shall specify geographic and demographic target markets; media and method of promotion to be used; and, costs for production and placement. Theme, images and messages of the advertising shall be consistent with the state's official tourism promotion theme. The state's official tourism logo or slogan shall be prominently displayed. In addition to the multicounty organization being identified as a

source for more information about their region's tourism attractions and facilities, the advertising and promotion shall identify the Department as a source for more information about tourism attractions and facilities throughout the state; provided, however, radio advertising shall not be required to meet the provisions of this sentence. Content and design of all advertising shall be approved by the Department's Executive Director, or designee, before being contracted for with media.

(g) Description of a project shall include measures to evaluate effectiveness. To determine cost effectiveness of advertising, cost per thousand (CPT) shall be used as a measure for print advertising and total rating points (TRP) shall be used to measure television and radio advertising. The number of inquiries from each target market attributable to each advertising medium shall be compiled. Evaluation of the effectiveness of advertising festivals, sites and events concerning ethnic history and ethnic history particular to the state shall be determined by verification of the number of people in attendance and the home counties and states of a random sampling of attendees. Each multicounty organization's evaluation of its advertising and promotion shall be reported to the Department within thirty (30) days of the conclusion of the advertising or the ethnic history festival or event. The Department will prepare a report of the evaluations for the Commission.

(h) Applications received by the Department will be presented to the Tourism Promotion Advisory Committee at its January 2006 regularly scheduled meeting. Applications, with a "yes" or "no" recommendation from the Tourism Promotion Advisory Committee, will be presented for Commission consideration and approval at its February 2006 regularly scheduled meeting. The Commission may approve, deny or recommend changes to any application. The decision of the Commission is final.

(i) At least five percent (5%) of the cost of a multicounty organization's project must be funded by the organization with funds other than those received from the State. Not more than ninety-five percent (95%) of the total cost of a project will be funded with tourism tax funds. To receive the funds approved, a multicounty organization shall submit an itemized invoice on its letterhead, signed by the multicounty organization's president, and include copies of original invoices for design and insertion or space reservation agreements. Proof of performance and proof of payment shall be provided to the Department within thirty (30) days of the conclusion of the advertising.

[OAR Docket #05-1200; filed 8-11-05]

Executive Orders

As required by 75 O.S., Sections 255 and 256, Executive Orders issued by the Governor of Oklahoma are published in both the *Oklahoma Register* and the *Oklahoma Administrative Code*. Executive Orders are codified in Title 1 of the *Oklahoma Administrative Code*.

Pursuant to 75 O.S., Section 256(B)(3), "Executive Orders of previous gubernatorial administrations shall terminate ninety (90) calendar days following the inauguration of the next Governor unless otherwise terminated or continued during that time by Executive Order."

TITLE 1. EXECUTIVE ORDERS

1:2005-18.

EXECUTIVE ORDER 2005-18

I, Mary Fallin, Governor of the State of Oklahoma, pursuant to the authority vested in me by Sections 1 and 2 of Article VI of the Oklahoma Constitution and 63 O.S. §§ 683.1 et seq., hereby declare that because there exists a state of emergency in the States of Florida, Louisiana, Mississippi and Alabama due to Hurricane Katrina, it is necessary to expedite restoration of services and relief in those States. In order to accommodate this need and to provide assistance to the citizens of Florida, Louisiana, Mississippi and Alabama in this extraordinary situation, I hereby order that:

1. The requirements for special permits for use of overweight/oversized vehicles are temporarily suspended as they apply to vehicles used in these restoration efforts.

2. The requirements for licensing/operating authority/registration as required by the Oklahoma Corporation Commission are temporarily suspended as they apply to vehicles used for restoration efforts.

3. This temporary order shall terminate as provided in 63 O.S. § 683.3(3).

This Executive Order shall be forwarded to the Oklahoma Corporation Commission and the Commissioner of Public Safety, who shall cause the provisions of this order to be implemented by all appropriate agencies of state government.

IN WITNESS WHEREOF, I have hereunto set my hand and caused the Great Seal of the State of Oklahoma to be affixed at Oklahoma City, this 30 day of August, 2005.

BY THE GOVERNOR OF THE
STATE OF OKLAHOMA

Mary Fallin

ATTEST:
Tod Wall
Acting Assistant Secretary of State

[OAR Docket #05-1224; filed 9-1-05]

