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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 195. BOARD OF DENTISTRY CHAPTER 3. COMPLAINTS, INVESTIGATIONS AND HEARINGS**

*[OAR Docket #05-1344]*

### **RULEMAKING ACTION:**

Notice of proposed PERMANENT rulemaking.

### **PROPOSED RULES:**

195:3-1-1.1. thru 195:3-1-8. [AMENDED]

### **SUMMARY:**

New language amended to provide consistency with 2005 statutes.

### **AUTHORITY:**

Title 59 O.S., Supp. 1996, Section 328.15 (A), Board of Dentistry of Oklahoma.

### **COMMENT PERIOD:**

Office of the Board of Dentistry, 201 North East 38<sup>th</sup> Terrace, Suite 2, Oklahoma City, Oklahoma 73105. January 3 to February 2, 2006.

### **PUBLIC HEARING:**

A public hearing has been scheduled for Friday, February 3, 2006, at 9:00 a.m., at the office of the Board, 201 North East 38<sup>th</sup> Terrace, Suite 2, Oklahoma City, Oklahoma. The hearing will conclude at 2:00 p.m. The Board will adopt rules after the public hearing to ensure sufficient time is provided to each member to review all information from both the comment period and the hearing process on February 10, 2006.

### **REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:**

Business entities affected by these proposed rules are requested to provide the Board with information, in dollar amounts if possible, about 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 rules. These amendments should have no financial impact on businesses. Business entities may submit this information in writing from January 3, 2006 to February 2, 2006 to: Oklahoma Board of Dentistry 201 North East 38<sup>th</sup> Terrace, Suite 2, Oklahoma City, Oklahoma 73015, Attn.: Linda C. Campbell.

### **COPIES OF PROPOSED RULES:**

Copies of the proposed rules for review by the public may be obtained at the Board office address.

### **RULE IMPACT STATEMENT:**

Rule Impact Statement has been prepared and copies will be available for inspection at the office of the Board, 201 North East 38<sup>th</sup> Terrace, Suite 2, Oklahoma City, Oklahoma 73105.

### **CONTACT PERSON:**

Linda C. Campbell, Executive Director, (405) 524-9037/Fax (405) 524-2223.

*[OAR Docket #05-1344; filed 11-8-05]*

## **TITLE 195. BOARD OF DENTISTRY CHAPTER 10. EXAMINATIONS AND LICENSING OF DENTISTS, DENTAL HYGIENISTS, AND DENTAL SPECIALISTS**

*[OAR Docket #05-1345]*

### **RULEMAKING ACTION:**

Notice of proposed PERMANENT rulemaking.

### **PROPOSED RULES:**

Subchapter 9. Recognition of Specialties

195:10-9-2. [AMENDED]

Subchapter 11. Specialty Examinations

195:10-11-5. thru 195:10-11-10. [AMENDED]

### **SUMMARY:**

Define each specialty of dentistry consistent with national policy. The amended rule will facilitate protection of the public by ensuring minimum standards for all dental specialty applicants.

### **AUTHORITY:**

Title 59 O.S., Supp. 1996, Section 328.15 (A), Board of Dentistry of Oklahoma.

### **COMMENT PERIOD:**

Office of the Board of Dentistry, 201 North East 38<sup>th</sup> Terrace, Suite 2, Oklahoma City, Oklahoma 73105. January 3, thru February 2, 2006.

### **PUBLIC HEARING:**

A public hearing has been scheduled for Friday, February 3, 2006, at 9:00 a.m., at the office of the Board, 201 North East 38<sup>th</sup> Terrace, Suite 2, Oklahoma City, Oklahoma. The hearing will conclude at 12:00 noon. The Board will adopt rules after the public hearing to ensure sufficient time is provided to each member to review all information from both the comment period and the hearing process on February 10, 2006.

### **REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:**

Business entities affected by these proposed rules are requested to provide the Board with information, in dollar amounts if possible, about 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 rules. These amendments should have no financial impact

## Notices of Rulemaking Intent

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on businesses. Business entities may submit this information in writing from January 3, 2006 to February 2, 2006 to: Oklahoma Board of Dentistry 201 North East 38<sup>th</sup> Terrace, Suite 2, Oklahoma City, Oklahoma 73015, Attn.: Linda C. Campbell.

### COPIES OF PROPOSED RULES:

Copies of the proposed rules for review by the public may be obtained at the Board office address.

### RULE IMPACT STATEMENT:

Rule Impact Statements have been prepared and copies will be available for inspection at the office of the Board, 201 North East 38<sup>th</sup> Terrace, Suite 2, Oklahoma City, Oklahoma 73105.

### CONTACT PERSON:

Linda C. Campbell, Executive Director, (405) 524-9037/Fax (405) 524-2223.

*[OAR Docket #05-1345; filed 11-8-05]*

### TITLE 195. BOARD OF DENTISTRY CHAPTER 25. RULES FOR CONTINUING DENTAL EDUCATION

*[OAR Docket #05-1346]*

### RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking.

### PROPOSED RULES:

195:25-1-2. thru 195:25-1-8. [AMENDED]

195:25-1-9. [NEW]

### SUMMARY:

Establish a rule to ensure both dentists and dental hygienists complete required continuing education in a timely manner. Provides for hour for hour credit for self-study. Provides for flexible reporting on form lists. Establishes monetary fines of \$1,000.00 for dentists and \$500.00 for dental hygienists who fail to secure the required hours during the specified three-year reporting periods.

### AUTHORITY:

Title 59 O.S., Supp. 1996, Section 328.15 (A) & (B) Board of Dentistry of Oklahoma.

### COMMENT PERIOD:

Office of the Board of Dentistry, 201 North East 38<sup>th</sup> Terrace, Suite 2, Oklahoma City, Oklahoma 73105. January 3 thru February 2, 2006.

### PUBLIC HEARING:

A public hearing has been scheduled for Friday, February 3, 2006, at 9:00 a.m., at the office of the Board, 201 North East 38<sup>th</sup> Terrace, Suite 2, Oklahoma City, Oklahoma. The hearing will conclude at 12:00 noon. The Board will adopt rules after the public hearing to ensure sufficient time is provided to each member to review all information from both the comment period and the hearing process on February 10, 2006.

### REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

Business entities affected by these proposed rules are requested to provide the Board with information, in dollar amounts if possible, about 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 rules. These amendments should have no financial impact on businesses. Business entities may submit this information in writing from January 3, 2006 to February 2, 2006 to: Oklahoma Board of Dentistry 201 North East 38<sup>th</sup> Terrace, Suite 2, Oklahoma City, Oklahoma 73015, Attn.: Linda C. Campbell.

### COPIES OF PROPOSED RULES:

Copies of the proposed rules for review by the public may be obtained at the Board office address.

### RULE IMPACT STATEMENT:

Rule Impact Statements have been prepared and copies will be available for inspection at the office of the Board, 201 North East 38<sup>th</sup> Terrace, Suite 2, Oklahoma City, Oklahoma 73105.

### CONTACT PERSON:

Linda C. Campbell, Executive Director, (405) 524-9037/Fax (405) 524-2223.

*[OAR Docket #05-1346; filed 11-8-05]*

### TITLE 210. STATE DEPARTMENT OF EDUCATION CHAPTER 10. SCHOOL ADMINISTRATION AND INSTRUCTIONAL SERVICES

*[OAR Docket #05-1331]*

### RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

### PROPOSED RULES:

Subchapter 13. Student Assessment

210:10-13-18. [AMENDED]

### SUMMARY:

The proposed rule change would allow charter schools to appeal Adequate Yearly Progress decisions on their behalf based on statistical or other substantial reasons, directly to the State Department of Education.

### AUTHORITY:

70 O.S. § 3-104, State Board of Education

### COMMENT PERIOD:

All interested persons wishing to present their views orally or in writing may do so before 4:30 p.m., January 25, 2006, at the following address: Office of the State Board of Education, Room 1-18, Hodge Education Building, 2500 North Lincoln Boulevard, Oklahoma City, Oklahoma 73105-4599.

### PUBLIC HEARING:

A public hearing will be held at 9:00 a.m. on Thursday, January 26, 2006, at the Hodge Education Building, State Board Room, Room 1-20, 2500 North Lincoln Boulevard,

Suite 1-20, Oklahoma City, Oklahoma 73105-4599. Persons wishing to speak must sign in at the door of the State Board Room by 9:05 a.m.

**REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:**

N/A

**COPIES OF PROPOSED RULES:**

Copies are on file for public viewing in the office of the State Board of Education, Room 1-18, Hodge Education Building, 2500 North Lincoln Boulevard, Oklahoma City, Oklahoma.

**RULE IMPACT STATEMENT:**

A Rule Impact Statement has been prepared, according to 70 O.S. §303(D), and will be available at the Office of the State Board of Education, Room 1-18, Hodge Education Building, 2500 North Lincoln Boulevard, Oklahoma City, Oklahoma, on December 2, 2005.

**CONTACT PERSON:**

Connie Holland, 405-521-3308

*[OAR Docket #05-1331; filed 11-4-05]*

**TITLE 210. STATE DEPARTMENT OF EDUCATION  
CHAPTER 15. CURRICULUM AND INSTRUCTION**

*[OAR Docket #05-1329]*

**RULEMAKING ACTION:**

Notice of proposed PERMANENT rulemaking

**PROPOSED RULES:**

Subchapter 8. Six-Year Comprehensive Local Education Plan [NEW]

210:15-8-1. [NEW]

210:15-8-2. [NEW]

**SUMMARY:**

The proposed rule change establishes the submission date for the Comprehensive Local Education Plan to the State Board of Education for school districts with one or more school sites which are identified for school improvement, to report to the Board the following plans: the Comprehensive Local Education Plan as required in Section 3-104.2; the school improvement plan as required in Section 5-117.4; the professional development plan as required in Section 6-194; the capital improvement plan as required in Section 18-153; and the Reading Sufficiency plan as required in Section 1210.508C.

**AUTHORITY:**

70 O.S. § 3-104, State Board of Education

**COMMENT PERIOD:**

All interested persons wishing to present their views orally or in writing may do so before 4:30 p.m., January 25, 2006, at the following address: Office of the State Board of Education, Room 1-18, Hodge Education Building, 2500 North Lincoln Boulevard, Oklahoma City, Oklahoma 73105-4599.

**PUBLIC HEARING:**

A public hearing will be held at 9:00 a.m. on Thursday, January 26, 2006, at the Hodge Education Building, State Board Room, Room 1-20, 2500 North Lincoln Boulevard, Suite 1-20, Oklahoma City, Oklahoma 73105-4599. Persons wishing to speak must sign in at the door of the State Board Room by 9:05 a.m.

**REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:**

N/A

**COPIES OF PROPOSED RULES:**

Copies are on file for public viewing in the office of the State Board of Education, Room 1-18, Hodge Education Building, 2500 North Lincoln Boulevard, Oklahoma City, Oklahoma.

**RULE IMPACT STATEMENT:**

A Rule Impact Statement has been prepared, according to 70 O.S. §303(D), and will be available at the Office of the State Board of Education, Room 1-18, Hodge Education Building, 2500 North Lincoln Boulevard, Oklahoma City, Oklahoma, on December 2, 2005.

**CONTACT PERSON:**

Connie Holland, 405-521-3308

*[OAR Docket #05-1329; filed 11-4-05]*

**TITLE 210. STATE DEPARTMENT OF EDUCATION  
CHAPTER 15. CURRICULUM AND INSTRUCTION**

*[OAR Docket #05-1330]*

**RULEMAKING ACTION:**

Notice of proposed PERMANENT rulemaking

**PROPOSED RULES:**

Subchapter 27. Reading Sufficiency Act

210:15-27-1. [AMENDED]

**SUMMARY:**

The proposed rule change update student eligibility for participation in the Reading Sufficiency Act, allowable expenditures, dates for reporting from districts, requirements for evaluation of the program, the claims process, and requirements for content, teaching training, and student eligibility for the new summer academy reading programs. The rules outline components important to implementation of the program.

**AUTHORITY:**

70 O.S. § 3-104, State Board of Education

**COMMENT PERIOD:**

All interested persons wishing to present their views orally or in writing may do so before 4:30 p.m., January 25, 2006, at the following address: Office of the State Board of Education, Room 1-18, Hodge Education Building, 2500 North Lincoln Boulevard, Oklahoma City, Oklahoma 73105-4599.

## Notices of Rulemaking Intent

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### **PUBLIC HEARING:**

A public hearing will be held at 9:00 a.m. on Thursday, January 26, 2006, at the Hodge Education Building, State Board Room, Room 1-20, 2500 North Lincoln Boulevard, Suite 1-20, Oklahoma City, Oklahoma 73105-4599. Persons wishing to speak must sign in at the door of the State Board Room by 9:05 a.m.

### **REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:**

N/A

### **COPIES OF PROPOSED RULES:**

Copies are on file for public viewing in the office of the State Board of Education, Room 1-18, Hodge Education Building, 2500 North Lincoln Boulevard, Oklahoma City, Oklahoma.

### **RULE IMPACT STATEMENT:**

A Rule Impact Statement has been prepared, according to 70 O.S. §303(D), and will be available at the Office of the State Board of Education, Room 1-18, Hodge Education Building, 2500 North Lincoln Boulevard, Oklahoma City, Oklahoma, on December 2, 2005.

### **CONTACT PERSON:**

Connie Holland, 405-521-3308

*[OAR Docket #05-1330; filed 11-4-05]*

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### **TITLE 210. STATE DEPARTMENT OF EDUCATION CHAPTER 20. STAFF**

*[OAR Docket #05-1325]*

### **RULEMAKING ACTION:**

Notice of proposed PERMANENT rulemaking

### **PROPOSED RULES:**

Subchapter 9. Professional Standards: Teacher Education and Certification

Part 17. Full (Subject Matter) Competencies for Licensure and Certification

210:20-9-172. [AMENDED]

### **SUMMARY:**

The proposed rule change would update teacher competencies for licensure for physical education to include skills in technology which will bring the state competencies in line with the National Association of Sport and Physical Education, the learned society for physical education, a division of the American Alliance of Health, Physical Education, Recreation, and Dance.

### **AUTHORITY:**

70 O.S. § 3-104, State Board of Education

### **COMMENT PERIOD:**

All interested persons wishing to present their views orally or in writing may do so before 4:30 p.m., January 25, 2006, at the following address: Office of the State Board of Education, Room 1-18, Hodge Education Building, 2500 North Lincoln Boulevard, Oklahoma City, Oklahoma 73105-4599.

### **PUBLIC HEARING:**

A public hearing will be held at 9:00 a.m. on Thursday, January 26, 2006, at the Hodge Education Building, State Board Room, Room 1-20, 2500 North Lincoln Boulevard, Suite 1-20, Oklahoma City, Oklahoma 73105-4599. Persons wishing to speak must sign in at the door of the State Board Room by 9:05 a.m.

### **REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:**

N/A

### **COPIES OF PROPOSED RULES:**

Copies are on file for public viewing in the office of the State Board of Education, Room 1-18, Hodge Education Building, 2500 North Lincoln Boulevard, Oklahoma City, Oklahoma.

### **RULE IMPACT STATEMENT:**

A Rule Impact Statement has been prepared, according to 70 O.S. §303(D), and will be available at the Office of the State Board of Education, Room 1-18, Hodge Education Building, 2500 North Lincoln Boulevard, Oklahoma City, Oklahoma, on December 2, 2005.

### **CONTACT PERSON:**

Connie Holland, 405-521-3308

*[OAR Docket #05-1325; filed 11-4-05]*

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### **TITLE 210. STATE DEPARTMENT OF EDUCATION CHAPTER 20. STAFF**

*[OAR Docket #05-1326]*

### **RULEMAKING ACTION:**

Notice of proposed PERMANENT rulemaking

### **PROPOSED RULES:**

Subchapter 26. Academic Achievement Award Program  
[NEW]

210:20-26-1. [NEW]

210:20-26-2. [NEW]

210:20-26-3. [NEW]

### **SUMMARY:**

The proposed rule will provide monetary awards to certified, qualified employees at schools that attain the highest overall student achievement and the highest annual improvement in student achievement as measured by the Academic Performance Index (API) in each of five groups based on average daily membership.

### **AUTHORITY:**

70 O.S. § 3-104, State Board of Education

### **COMMENT PERIOD:**

All interested persons wishing to present their views orally or in writing may do so before 4:30 p.m., January 25, 2006, at the following address: Office of the State Board of Education, Room 1-18, Hodge Education Building, 2500 North Lincoln Boulevard, Oklahoma City, Oklahoma 73105-4599.

**PUBLIC HEARING:**

A public hearing will be held at 9:00 a.m. on Thursday, January 26, 2006, at the Hodge Education Building, State Board Room, Room 1-20, 2500 North Lincoln Boulevard, Suite 1-20, Oklahoma City, Oklahoma 73105-4599. Persons wishing to speak must sign in at the door of the State Board Room by 9:05 a.m.

**REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:**

N/A

**COPIES OF PROPOSED RULES:**

Copies are on file for public viewing in the office of the State Board of Education, Room 1-18, Hodge Education Building, 2500 North Lincoln Boulevard, Oklahoma City, Oklahoma.

**RULE IMPACT STATEMENT:**

A Rule Impact Statement has been prepared, according to 70 O.S. §303(D), and will be available at the Office of the State Board of Education, Room 1-18, Hodge Education Building, 2500 North Lincoln Boulevard, Oklahoma City, Oklahoma, on December 2, 2005.

**CONTACT PERSON:**

Connie Holland, 405-521-3308

*[OAR Docket #05-1326; filed 11-4-05]*

**TITLE 210. STATE DEPARTMENT OF EDUCATION  
CHAPTER 20. STAFF**

*[OAR Docket #05-1327]*

**RULEMAKING ACTION:**

Notice of proposed PERMANENT rulemaking

**PROPOSED RULES:**

Subchapter 9. Professional Standards: Teacher Education and Certification

Part 19. Competencies for Licensure and Certification of Administrative Personnel

210:20-9-182. [AMENDED]

210:20-9-189. [NEW]

**SUMMARY:**

The proposed rule change would bring our state competencies in alignment with national competencies for administrator certification. The changes would also add skills in developing professional learning communities and ethical decision making to administrator certification competencies.

**AUTHORITY:**

70 O.S. § 3-104, State Board of Education

**COMMENT PERIOD:**

All interested persons wishing to present their views orally or in writing may do so before 4:30 p.m., January 25, 2006, at the following address: Office of the State Board of Education, Room 1-18, Hodge Education Building, 2500 North Lincoln Boulevard, Oklahoma City, Oklahoma 73105-4599.

**PUBLIC HEARING:**

A public hearing will be held at 9:00 a.m. on Thursday, January 26, 2006, at the Hodge Education Building, State Board Room, Room 1-20, 2500 North Lincoln Boulevard, Suite 1-20, Oklahoma City, Oklahoma 73105-4599. Persons wishing to speak must sign in at the door of the State Board Room by 9:05 a.m.

**REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:**

N/A

**COPIES OF PROPOSED RULES:**

Copies are on file for public viewing in the office of the State Board of Education, Room 1-18, Hodge Education Building, 2500 North Lincoln Boulevard, Oklahoma City, Oklahoma.

**RULE IMPACT STATEMENT:**

A Rule Impact Statement has been prepared, according to 70 O.S. §303(D), and will be available at the Office of the State Board of Education, Room 1-18, Hodge Education Building, 2500 North Lincoln Boulevard, Oklahoma City, Oklahoma, on December 2, 2005.

**CONTACT PERSON:**

Connie Holland, 405-521-3308

*[OAR Docket #05-1327; filed 11-4-05]*

**TITLE 210. STATE DEPARTMENT OF EDUCATION  
CHAPTER 20. STAFF**

*[OAR Docket #05-1328]*

**RULEMAKING ACTION:**

Notice of proposed PERMANENT rulemaking

**PROPOSED RULES:**

Subchapter 17. Mentor Teacher

210:20-17-3. [AMENDED]

**SUMMARY:**

The proposed rule change is to delete rules not reflected in new law on the selection process for mentor teachers. 70 O.S. § 6-182 changed the selection process for mentor teachers effective July 1, 2005.

**AUTHORITY:**

70 O.S. § 3-104, State Board of Education

**COMMENT PERIOD:**

All interested persons wishing to present their views orally or in writing may do so before 4:30 p.m., January 25, 2006, at the following address: Office of the State Board of Education, Room 1-18, Hodge Education Building, 2500 North Lincoln Boulevard, Oklahoma City, Oklahoma 73105-4599.

**PUBLIC HEARING:**

A public hearing will be held at 9:00 a.m. on Thursday, January 26, 2006, at the Hodge Education Building, State Board Room, Room 1-20, 2500 North Lincoln Boulevard, Suite 1-20, Oklahoma City, Oklahoma 73105-4599. Persons

## Notices of Rulemaking Intent

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wishing to speak must sign in at the door of the State Board Room by 9:05 a.m.

### REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

N/A

### COPIES OF PROPOSED RULES:

Copies are on file for public viewing in the office of the State Board of Education, Room 1-18, Hodge Education Building, 2500 North Lincoln Boulevard, Oklahoma City, Oklahoma.

### RULE IMPACT STATEMENT:

A Rule Impact Statement has been prepared, according to 70 O.S. §303(D), and will be available at the Office of the State Board of Education, Room 1-18, Hodge Education Building, 2500 North Lincoln Boulevard, Oklahoma City, Oklahoma, on December 2, 2005.

### CONTACT PERSON:

Connie Holland, 405-521-3308

*[OAR Docket #05-1328; filed 11-4-05]*

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### TITLE 245. STATE BOARD OF REGISTRATION LICENSURE FOR PROFESSIONAL ENGINEERS AND LAND SURVEYORS CHAPTER 2. ADMINISTRATIVE OPERATIONS

*[OAR Docket #05-1332]*

### RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

### PROPOSED RULES:

- 245:2-1-1. [AMENDED]
- 245:2-1-4. [AMENDED]
- 245:2-1-5. [AMENDED]
- 245:2-1-6. [AMENDED]
- 245:2-1-7. [AMENDED]
- 245:2-1-9. [AMENDED]
- 245:2-1-10. [AMENDED]
- 245:2-1-11. [AMENDED]
- 245:2-1-18. [AMENDED]

### SUMMARY:

The proposed revisions to Chapter 2, Subchapter 1 are as follows:

(1) Per revisions to Title 59, 475.1 et seq. effective November 1, 2005, changed the word "registration" to "license" and all derivatives thereof.

(2) Revise rules to reflect all other language and provisions in Title 59, 475.1 et seq. effective November 1, 2005.

### AUTHORITY:

59 O.S. 475.1 et seq; 65 O.S., 1991 Sections 3-116 et seq; 75 O.S. Sections 301 et seq

### COMMENT PERIOD:

Persons wishing to present their views orally or in writing may do so before 4:30 p.m., January 11, 2006 at: Oklahoma

Engineering Center, 201 N.E. 27<sup>th</sup> St., Room 120, Oklahoma City, OK 73105, Attn: Kathy Hart.

### PUBLIC HEARING:

A Public Hearing will be held to provide an opportunity for persons to orally present their views. Each person will be allowed a maximum of 5 minutes to speak and must sign in at the door. The hearing will be held on January 13, 2006, at 9:00 a.m. at the Oklahoma Engineering Center, 201 N.E. 27<sup>th</sup> St., Oklahoma City, OK.

### REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

N/A

### COPIES OF PROPOSED RULES:

Copies of the rules may be obtained by contacting Kathy Hart at the Board office, 201 N.E. 27<sup>th</sup> St., Room 120, Oklahoma City, OK 73105. Persons requesting more than one copy of the proposed rules will be charged \$.25 per page. Copies of the rules may also be downloaded from our website at [www.pels.state.ok.us](http://www.pels.state.ok.us).

### RULE IMPACT STATEMENT:

Pursuant to 75 O.S., § 303(D), a rule impact statement will be issued and made available at the offices of the Board (address above).

### CONTACT PERSON:

Kathy Hart, Executive Director, (405) 521-2874 ext. 24

*[OAR Docket #05-1332; filed 11-4-05]*

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### TITLE 245. STATE BOARD OF REGISTRATION LICENSURE FOR PROFESSIONAL ENGINEERS AND LAND SURVEYORS CHAPTER 15. REGISTRATION LICENSING AND PRACTICE OF PROFESSIONAL ENGINEERS AND LAND SURVEYORS

*[OAR Docket #05-1333]*

### RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

### PROPOSED RULES:

- Subchapter 1. General Provisions [AMENDED]
- Subchapter 3. Application and Eligibility for ~~Registration~~ Licensing [AMENDED]
- Subchapter 5. Examinations [AMENDED]
- Subchapter 7. Registration [AMENDED]
- Subchapter 9. Rules of Professional Conduct [AMENDED]
- Subchapter 11. Continuing Education [AMENDED]
- Subchapter 13. Minimum Standards for Land Surveying [AMENDED]
- Subchapter 15. Ethical Marketing of Services [AMENDED]
- Subchapter 17. ~~Registrant's Licensee's Seal~~ [AMENDED]
- Subchapter 19. Organizational Practice [AMENDED]
- Subchapter 21. Corner Perpetuation and Filing Act Requirements [AMENDED]

Subchapter 23. Violations [AMENDED]  
Appendix A. Registrant's Seal [REVOKED]  
Appendix A. Licensee's Seal [NEW]

**SUMMARY:**

The proposed revisions to the subchapters are as follows:

**Subchapter 1:**

(a) Per revisions to Title 59, 475.1 et seq. effective November 1, 2005, changed the word "registration" to "license" and all derivatives thereof.

(b) Delete definitions that are duplicated in Title 59, 475.1 et seq.

(c) Move all definitions that were scattered throughout the chapter to the same section.

(d) Further define and clarify the intent of that portion of the definition of "Practice of land surveying" which was amended in the November 1, 2005, statutory revisions in Title 59, 475.1 et seq. dealing with the preparation of legal descriptions. The new definition is not to be interpreted that only land surveyors can write legal descriptions. The control portion of geographic information systems and land information systems is also defined.

**Subchapter 3:**

(a) Per revisions to Title 59, 475.1 et seq. effective November 1, 2005, changed the word "registration" to "license" and all derivatives thereof.

(b) Further clarify administrative procedures for active and inactive applications.

(c) Qualifications for engineer license - re-write section to be more readable and add a provision for one year of experience credit for the M.S. degree in engineering following a related science degree.

(d) Qualifications for land surveyor license - re-write section per revisions to Title 59, 475.1 et seq. effective November 1, 2005, to reflect the revised educational requirements.

**Subchapter 5:**

(a) Further clarify administrative procedures regarding examinations.

(b) Revoke OAC 245:15-5-6. Re-examination - provision is addressed in other parts of this chapter.

**Subchapter 7:**

(a) Per revisions to Title 59, 475.1 et seq. effective November 1, 2005, changed the word "registration" to "license" and all derivatives thereof.

(b) Further clarify administrative procedures regarding licensing.

**Subchapter 9:**

(a) Per revisions to Title 59, 475.1 et seq. effective November 1, 2005, changed the word "registration" to "license" and all derivatives thereof.

(b) Further clarify and define appropriate rules of professional conduct for professional engineers and land surveyors to protect the health, safety, and welfare of the public

**Subchapter 11:**

(a) Per revisions to Title 59, 475.1 et seq. effective November 1, 2005, changed the word "registration" to "license" and all derivatives thereof.

(b) Revise age at which a professional who is no longer practicing their profession may be exempt from continuing education requirements, from 70 to 62.

**Subchapter 13:**

(a) Per revisions to Title 59, 475.1 et seq. effective November 1, 2005, changed the word "registration" to "license" and all derivatives thereof.

(b) Move definitions to beginning of chapter.

(c) Revise and clarify error analysis and maximum allowable positional error in surveys.

(d) Add minimum standards for Property Descriptions

**Subchapter 15:**

(a) Per revisions to Title 59, 475.1 et seq. effective November 1, 2005, changed the word "registration" to "license" and all derivatives thereof.

(b) Further define qualifications based selection in the area of design/build.

**Subchapter 17:**

(a) Per revisions to Title 59, 475.1 et seq. effective November 1, 2005, changed the word "registration" to "license" and all derivatives thereof.

(b) Require licensees to register their full legal name with the Board, but allow them to practice in a registered name, which is also registered with the Board.

(c) Further clarify the responsible charge requirement for a licensee who becomes involved in a project when the original licensee is no longer available to complete the work.

(d) Further clarify the signing and sealing requirement for record drawings.

**Subchapter 19:**

(a) Per revisions to Title 59, 475.1 et seq. effective November 1, 2005, changed the word "registration" to "license" and all derivatives thereof.

(b) Further define the responsible charge requirement for licensees in responsible charge of the professional services for firms.

**Subchapter 21:**

(a) Per revisions to Title 59, 475.1 et seq. effective November 1, 2005, changed the word "registration" to "license" and all derivatives thereof.

(b) Update language reflected in the regulations regarding signing and sealing and further define information required on a corner record form.

**Subchapter 23:**

(a) Per revisions to Title 59, 475.1 et seq. effective November 1, 2005, changed the word "registration" to "license" and all derivatives thereof.

(b) Describe the violation of offering services without authorization.

(c) Further define the terms fraud and misrepresentation to differentiate between the two terms.

(f) Clarify the make-up and duties of the Investigation Committee and the investigation process.

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(g) Further define requirements for the exchange of information between the parties for hearings.

### Appendix A:

(a) Per revisions to Title 59, 475.1 et seq. effective November 1, 2005, changed the word "registration" to "license" and all derivatives thereof.

### AUTHORITY:

59 O.S. 475.1 et seq; 65 O.S., 1991 Sections 3-116 et seq; 75 O.S. Sections 301 et seq

### COMMENT PERIOD:

Persons wishing to present their views orally or in writing may do so before 4:30 p.m., January 11, 2006 at: Oklahoma Engineering Center, 201 N.E. 27<sup>th</sup> St., Room 120, Oklahoma City, OK 73105, Attn: Kathy Hart.

### PUBLIC HEARING:

A Public Hearing will be held to provide an opportunity for persons to orally present their views. Each person will be allowed a maximum of 5 minutes to speak and must sign in at the door. The hearing will be held on January 13, 2006, at 9:00 a.m. at the Oklahoma Engineering Center, 201 N.E. 27<sup>th</sup> St., Oklahoma City, OK.

### REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

N/A

### COPIES OF PROPOSED RULES:

Copies of the rules may be obtained by contacting Kathy Hart at the Board office, 201 N.E. 27<sup>th</sup> St., Room 120, Oklahoma City, OK 73105. Persons requesting more than one copy of the proposed rules will be charged \$.25 per page. Copies of the rules may also be downloaded from our website at [www.pels.state.ok.us](http://www.pels.state.ok.us).

### RULE IMPACT STATEMENT:

Pursuant to 75 O.S., § 303(D), a rule impact statement will be issued and made available at the offices of the Board (address above).

### CONTACT PERSON:

Kathy Hart, Executive Director, (405) 521-2874 ext. 24

*[OAR Docket #05-1333; filed 11-4-05]*

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### TITLE 252. DEPARTMENT OF ENVIRONMENTAL QUALITY CHAPTER 606. OKLAHOMA POLLUTANT DISCHARGE ELIMINATION SYSTEM (OPDES) STANDARDS

*[OAR Docket #05-1334]*

### RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

### PROPOSED RULES:

Subchapter 1. Introduction

252:606-1-4. [AMENDED]

Subchapter 9. Land Application of Biosolids

252:606-9-1. [AMENDED]

### SUMMARY:

The Department proposes to update its rules concerning the date of the incorporation by reference of certain federal regulations. The change updates the publication date of the federal rules to July 1, 2005. Additionally, the Department proposes to amend its rules to prohibit the land application of biosolids in the watershed of an outstanding resource water.

### AUTHORITY:

Environmental Quality Board powers and duties, 27A O.S. § 2-2-101; Water Quality Management Advisory Council powers and duties, 27A O.S. § 2-2-201; and Water Quality, 27A O.S. § 2-6-101 *et seq.*

### COMMENT PERIOD:

Written comments on the proposed rulemaking will be accepted prior to and at the Water Quality Management Advisory Council hearing on January 10, 2006. To be thoroughly considered by staff prior to the hearing, written comments should be submitted to the contact person by January 6, 2006. Oral comments may be made at the January 10, 2006 hearing and the February 24, 2006 Environmental Quality Board meeting.

### PUBLIC HEARINGS:

Before the Water Quality Management Advisory Council at 1:00 p.m. on Tuesday, January 10, 2006, at the offices of the Oklahoma Department of Environmental Quality, Room 101, 707 North Robinson, Oklahoma City, Oklahoma.

Before the Environmental Quality Board at 9:30 a.m. on February 24, 2006, at the offices of the Oklahoma Department of Environmental Quality, Room 101, 707 North Robinson, Oklahoma City, Oklahoma.

### REQUEST FOR COMMENTS FROM BUSINESS ENTITIES:

The DEQ requests that business entities or any other members of the public affected by these rules provide the DEQ, 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, 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.

### COPIES OF PROPOSED RULES:

The proposed rules are available for review at the Water Quality Division of DEQ and on the DEQ website ([www.deq.state.ok.us](http://www.deq.state.ok.us)), Water Quality Division, What's New, or copies may be obtained from the contact person by calling (405) 702-8100.

### RULE IMPACT STATEMENT:

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

### CONTACT PERSON:

Please send written comments to Donald D. Maisch (e-mail: [don.maisch@deq.state.ok.us](mailto:don.maisch@deq.state.ok.us)) at the Oklahoma Department of Environmental Quality, Water Quality Division, 707 N. Robinson, Oklahoma City, OK 73102. Mailing address is P.O. Box 1677, Oklahoma City, Oklahoma 73101-1677, phone (405) 702-7189, fax (405) 702-7199.

**PERSONS WITH DISABILITIES:**

Should you desire to attend but have a disability and need an accommodation, please notify the Water Quality Division three (3) days in advance at (405) 702-8100.

*[OAR Docket #05-1334; filed 11-4-05]*

**TITLE 252. DEPARTMENT OF ENVIRONMENTAL QUALITY  
CHAPTER 611. GENERAL WATER QUALITY**

*[OAR Docket #05-1335]*

**RULEMAKING ACTION:**

Notice of proposed PERMANENT rulemaking

**PROPOSED RULES:**

Subchapter 1. General Provisions  
252:611-1-3. [AMENDED]

**SUMMARY:**

The Department proposes to update its rules concerning the date of the incorporation by reference of certain federal regulations. The change updates the publication date of the federal rules to July 1, 2005.

**AUTHORITY:**

Environmental Quality Board powers and duties, 27A O.S. § 2-2-101; Water Quality Management Advisory Council powers and duties, 27A O.S. § 2-2-201; and Water Quality, 27A O.S. § 2-6-101 *et seq.*

**COMMENT PERIOD:**

Written comments on the proposed rulemaking will be accepted prior to and at the Water Quality Management Advisory Council hearing on January 10, 2006. To be thoroughly considered by staff prior to the hearing, written comments should be submitted to the contact person by January 6, 2006. Oral comments may be made at the January 10, 2006 hearing and the February 24, 2006 Environmental Quality Board meeting.

**PUBLIC HEARINGS:**

Before the Water Quality Management Advisory Council at 1:00 p.m. on Tuesday, January 10, 2006, at the offices of the Oklahoma Department of Environmental Quality, Room 101, 707 North Robinson, Oklahoma City, Oklahoma.

Before the Environmental Quality Board at 9:30 a.m. on February 24, 2006, at the offices of the Oklahoma Department of Environmental Quality, Room 101, 707 North Robinson, Oklahoma City, Oklahoma.

**REQUEST FOR COMMENTS FROM BUSINESS ENTITIES:**

The DEQ requests that business entities or any other members of the public affected by these rules provide the DEQ, 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, 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.

**COPIES OF PROPOSED RULES:**

The proposed rules are available for review at the Water Quality Division of DEQ and on the DEQ website ([www.deq.state.ok.us](http://www.deq.state.ok.us)), Water Quality Division, What's New, or copies may be obtained from the contact person by calling (405) 702-8100.

**RULE IMPACT STATEMENT:**

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

**CONTACT PERSON:**

Please send written comments to Donald D. Maisch (e-mail: [don.maisch@deq.state.ok.us](mailto:don.maisch@deq.state.ok.us)) at the Oklahoma Department of Environmental Quality, Water Quality Division, 707 N. Robinson, Oklahoma City, OK 73102. Mailing address is P.O. Box 1677, Oklahoma City, Oklahoma 73101-1677, phone (405) 702-7189, fax (405) 702-7199.

**PERSONS WITH DISABILITIES:**

Should you desire to attend but have a disability and need an accommodation, please notify the Water Quality Division three (3) days in advance at (405) 702-8100.

*[OAR Docket #05-1335; filed 11-4-05]*

**TITLE 252. DEPARTMENT OF ENVIRONMENTAL QUALITY  
CHAPTER 616. INDUSTRIAL WASTEWATER SYSTEMS**

*[OAR Docket #05-1336]*

**RULEMAKING ACTION:**

Notice of proposed PERMANENT rulemaking

**PROPOSED RULES:**

Subchapter 3. Permit Procedures  
252:616-3-1. [AMENDED]  
Subchapter 11. Land Application Standards  
252:616-11-1. [AMENDED]

**SUMMARY:**

The Department proposes to amend its rules concerning the conditions for sand mining operations to obtain a permit and amend its rules concerning the prohibition on the land application of industrial sludge. The amendment would change the prohibition on the land application of industrial sludge from a scenic river basin to the watershed of an outstanding resource water to be consistent with other rules of the Department.

**AUTHORITY:**

Environmental Quality Board powers and duties, 27A O.S. § 2-2-101; Water Quality Management Advisory Council powers and duties, 27A O.S. § 2-2-201; and Water Quality, 27A O.S. § 2-6-101 *et seq.*

**COMMENT PERIOD:**

Written comments on the proposed rulemaking will be accepted prior to and at the Water Quality Management

## Notices of Rulemaking Intent

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Advisory Council hearing on January 10, 2006. To be thoroughly considered by staff prior to the hearing, written comments should be submitted to the contact person by January 6, 2006. Oral comments may be made at the January 10, 2006 hearing and the February 24, 2006 Environmental Quality Board meeting.

### **PUBLIC HEARINGS:**

Before the Water Quality Management Advisory Council at 1:00 p.m. on Tuesday, January 10, 2006, at the offices of the Oklahoma Department of Environmental Quality, Room 101, 707 North Robinson, Oklahoma City, Oklahoma.

Before the Environmental Quality Board at 9:30 a.m. on February 24, 2006, at the offices of the Oklahoma Department of Environmental Quality, Room 101, 707 North Robinson, Oklahoma City, Oklahoma.

### **REQUEST FOR COMMENTS FROM BUSINESS ENTITIES:**

The DEQ requests that business entities or any other members of the public affected by these rules provide the DEQ, 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, 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.

### **COPIES OF PROPOSED RULES:**

The proposed rules are available for review at the Water Quality Division of DEQ and on the DEQ website ([www.deq.state.ok.us](http://www.deq.state.ok.us)), Water Quality Division, What's New, or copies may be obtained from the contact person by calling (405) 702-8100.

### **RULE IMPACT STATEMENT:**

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

### **CONTACT PERSON:**

Please send written comments to Donald D. Maisch (e-mail: [don.maisch@deq.state.ok.us](mailto:don.maisch@deq.state.ok.us)) at the Oklahoma Department of Environmental Quality, Water Quality Division, 707 N. Robinson, Oklahoma City, OK 73102. Mailing address is P.O. Box 1677, Oklahoma City, Oklahoma 73101-1677, phone (405) 702-7189, fax (405) 702-7199.

### **PERSONS WITH DISABILITIES:**

Should you desire to attend but have a disability and need an accommodation, please notify the Water Quality Division three (3) days in advance at (405) 702-8100.

*[OAR Docket #05-1336; filed 11-4-05]*

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## **TITLE 252. DEPARTMENT OF ENVIRONMENTAL QUALITY CHAPTER 631. PUBLIC WATER SUPPLY OPERATION**

*[OAR Docket #05-1337]*

### **RULEMAKING ACTION:**

Notice of proposed PERMANENT rulemaking

### **PROPOSED RULES:**

Subchapter 1. Introduction  
252:631-1-3. [AMENDED]

### **SUMMARY:**

The Department proposes to update its rules concerning the date of the incorporation by reference of certain federal regulations. The change updates the publication date of the federal rules to July 1, 2005.

### **AUTHORITY:**

Environmental Quality Board powers and duties, 27A O.S. § 2-2-101; Water Quality Management Advisory Council powers and duties, 27A O.S. § 2-2-201; and Water Quality, 27A O.S. § 2-6-101 *et seq.*

### **COMMENT PERIOD:**

Written comments on the proposed rulemaking will be accepted prior to and at the Water Quality Management Advisory Council hearing on January 10, 2006. To be thoroughly considered by staff prior to the hearing, written comments should be submitted to the contact person by January 6, 2006. Oral comments may be made at the January 10, 2006 hearing and the February 24, 2006 Environmental Quality Board meeting.

### **PUBLIC HEARINGS:**

Before the Water Quality Management Advisory Council at 1:00 p.m. on Tuesday, January 10, 2006, at the offices of the Oklahoma Department of Environmental Quality, Room 101, 707 North Robinson, Oklahoma City, Oklahoma.

Before the Environmental Quality Board at 9:30 a.m. on February 24, 2006, at the offices of the Oklahoma Department of Environmental Quality, Room 101, 707 North Robinson, Oklahoma City, Oklahoma.

### **REQUEST FOR COMMENTS FROM BUSINESS ENTITIES:**

The DEQ requests that business entities or any other members of the public affected by these rules provide the DEQ, 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, 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.

### **COPIES OF PROPOSED RULES:**

The proposed rules are available for review at the Water Quality Division of DEQ and on the DEQ website ([www.deq.state.ok.us](http://www.deq.state.ok.us)), Water Quality Division, What's New, or copies may be obtained from the contact person by calling (405) 702-8100.

**RULE IMPACT STATEMENT:**

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

**CONTACT PERSON:**

Please send written comments to Donald D. Maisch (e-mail: don.maisch@deq.state.ok.us) at the Oklahoma Department of Environmental Quality, Water Quality Division, 707 N. Robinson, Oklahoma City, OK 73102. Mailing address is P.O. Box 1677, Oklahoma City, Oklahoma 73101-1677, phone (405) 702-7189, fax (405) 702-7199.

**PERSONS WITH DISABILITIES:**

Should you desire to attend but have a disability and need an accommodation, please notify the Water Quality Division three (3) days in advance at (405) 702-8100.

*[OAR Docket #05-1337; filed 11-4-05]*

**TITLE 252. DEPARTMENT OF ENVIRONMENTAL QUALITY  
CHAPTER 690. WATER QUALITY STANDARDS IMPLEMENTATION**

*[OAR Docket #05-1338]*

**RULEMAKING ACTION:**

Notice of proposed PERMANENT rulemaking

**PROPOSED RULES:**

Subchapter 1. Introduction  
252:690-1-4. [AMENDED]

**SUMMARY:**

The Department proposes to update its rules concerning the date of the incorporation by reference of certain federal regulations. The change updates the publication date of the federal rules to July 1, 2005.

**AUTHORITY:**

Environmental Quality Board powers and duties, 27A O.S. § 2-2-101; Water Quality Management Advisory Council powers and duties, 27A O.S. § 2-2-201; and Water Quality, 27A O.S. § 2-6-101 *et seq.*

**COMMENT PERIOD:**

Written comments on the proposed rulemaking will be accepted prior to and at the Water Quality Management Advisory Council hearing on January 10, 2006. To be thoroughly considered by staff prior to the hearing, written comments should be submitted to the contact person by January 6, 2006. Oral comments may be made at the January 10, 2006 hearing and the February 24, 2006 Environmental Quality Board meeting.

**PUBLIC HEARINGS:**

Before the Water Quality Management Advisory Council at 1:00 p.m. on Tuesday, January 10, 2006, at the offices of the Oklahoma Department of Environmental Quality, Room 101, 707 North Robinson, Oklahoma City, Oklahoma.

Before the Environmental Quality Board at 9:30 a.m. on February 24, 2006, at the offices of the Oklahoma Department

of Environmental Quality, Room 101, 707 North Robinson, Oklahoma City, Oklahoma.

**REQUEST FOR COMMENTS FROM BUSINESS ENTITIES:**

The DEQ requests that business entities or any other members of the public affected by these rules provide the DEQ, 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, 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.

**COPIES OF PROPOSED RULES:**

The proposed rules are available for review at the Water Quality Division of DEQ and on the DEQ website (www.deq.state.ok.us), Water Quality Division, What's New, or copies may be obtained from the contact person by calling (405) 702-8100.

**RULE IMPACT STATEMENT:**

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

**CONTACT PERSON:**

Please send written comments to Donald D. Maisch (e-mail: don.maisch@deq.state.ok.us) at the Oklahoma Department of Environmental Quality, Water Quality Division, 707 N. Robinson, Oklahoma City, OK 73102. Mailing address is P.O. Box 1677, Oklahoma City, Oklahoma 73101-1677, phone (405) 702-7189, fax (405) 702-7199.

**PERSONS WITH DISABILITIES:**

Should you desire to attend but have a disability and need an accommodation, please notify the Water Quality Division three (3) days in advance at (405) 702-8100.

*[OAR Docket #05-1338; filed 11-4-05]*

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

*[OAR Docket #05-1340]*

**RULEMAKING ACTION:**

Notice of proposed PERMANENT rulemaking

**PROPOSED RULES:**

270:10-1-5. [AMENDED]  
270:10-1-8. [AMENDED]

**SUMMARY:**

The proposed rule changes in 270:10-1-5 would reflect some of the proposed changes to the National Fire Protection Association Standards medical requirements for candidates seeking entrance into the Oklahoma Firefighters Pension and Retirement System. The proposed rule changes in 270:10-1-8 would reflect grammatical corrections and other changes,

## Notices of Rulemaking Intent

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as identified, to the Oklahoma Firefighters Pension and Retirement System's standard operating procedure.

### **AUTHORITY:**

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

### **COMMENT PERIOD:**

Written or oral comments will be accepted from 08:00 a.m. to 04:30 p.m., from December 1, 2005 to January 3, 2006, at the office of the Oklahoma Firefighters Pension and Retirement System, which is located at 4545 N. Lincoln Blvd., Suite 265, Oklahoma City, Oklahoma 73105-3414.

### **PUBLIC HEARING:**

The Board of Trustees of the Oklahoma Firefighters Pension and Retirement System has not scheduled an official hearing. However, if comments arise, the public may demand a hearing at any time from 08:00 a.m. to 04:30 p.m., from December 1, 2005 to January 3, 2006, at the office of the Oklahoma Firefighters Pension and Retirement System, which is located at 4545 N. Lincoln, Suite 265, Oklahoma City, Oklahoma 73105-3414.

### **REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:**

N/A

### **COPIES OF PROPOSED RULES:**

Copies of the proposed rules are available at the office of the Oklahoma Firefighters Pension and Retirement System, which is located at 4545 N. Lincoln, Suite 265, Oklahoma City, Oklahoma 73105-3414.

### **RULE IMPACT STATEMENT:**

Pursuant to 75 O.S., Section 303 (D), a rule impact statement will be prepared and will be available at the office of the Oklahoma Firefighters Pension and Retirement System on or after December 14, 2005.

### **CONTACT PERSON:**

Herb Bradshaw, Deputy Director, Oklahoma Firefighters Pension and Retirement System, (405) 522-4600.

*[OAR Docket #05-1340; filed 11-7-05]*

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

*[OAR Docket #05-1350]*

### **RULEMAKING ACTION:**

Notice of proposed PERMANENT rulemaking

### **PROPOSED RULES:**

Subchapter 5. Individual Providers and Specialties  
Part 85. ADvantage Program Waiver Services  
317:30-5-761. through 317:30-5-764. [AMENDED]  
(Reference APA WF # 05-01B and 05-02B)

### **SUMMARY:**

Rules are revised to implement a Consumer-Directed Personal Assistance Services and Supports (CD-PASS) service

option in the ADvantage Waiver Program. With funding from a CMS Systems Change Grant, the Oklahoma Department of Human Services, the Long Term Care Authority of Tulsa along with Independent Living Centers and consumers of Personal Care services have been working on developing CD-PASS services for the past two years. The voluntary pilot project in the Tulsa area will offer some clients an option of directing their personal care services with assistance from an Employee Support Services Provider. Clients who elect to participate will be the provider's "employer of record" and will employ, train, discharge and schedule their personal care assistant, instead of utilizing a licensed home care agency. Support assistance provided to the client will include payroll functions (including appropriate withholding), technical assistance, and consultation. Expected outcomes are that client satisfaction with services increase, health and safety of clients is comparable if not better than that for clients served through traditional Personal Care and that cost between CD-PASS and traditional Personal Care is about the same. Revisions are needed to implement the Consumer-Directed Personal Assistance Services and Supports service option.

ADvantage Waiver Services rules are revised to establish Institution Transition Services as a separate billable service under Medicaid for individuals who qualify for ADvantage Program services. Revisions are needed to address transition services consistent with the Centers for Medicare and Medicaid directions as a result of approval of a consumer directed personal assistance service system waiver amendment, also known as CD pass. Institution Transition Services are those services that are necessary to enable an individual to leave an institution and receive necessary support in their own home. This service may include Case Management, Nursing Assessment and Evaluation for in-home service planning, Environmental Modifications and Medical Equipment and Supplies. The Centers for Medicare and Medicaid Services has directed the State to restructure the definitions of Institution Transition Services to make them distinct and separate from the homologous, non-ITS Case Management, Skilled Nursing, Environmental Modification and Equipment and Supply services.

### **AUTHORITY:**

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; House Bill 2300 of the 2nd Session of the 49th Legislature; Senate Bill 1109 of the 2nd Session of the 49th Legislature; 42 CFR 440.180

### **COMMENT PERIOD:**

Written and oral comments will be accepted December 1, 2005 through January 3, 2006, during regular business hours by contacting Joanne Terlizzi, Oklahoma Health Care Authority, 4545 N. Lincoln Blvd., Suite 124, Oklahoma City, Oklahoma, 73105, Telephone 405-522-7272.

### **PUBLIC HEARING:**

A public hearing will be held at 1:00 p.m. on Thursday, January 5, 2006, at the Oklahoma Health Care Authority, 4545 N. Lincoln Blvd., Suite 124, Oklahoma City, Oklahoma 73105.

**REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:**

Business entities affected by these proposed rules may provide the OHCA, 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, recordkeeping, equipment, construction, labor, professional services, revenue loss, or other costs expected to be incurred by the particular business entity due to compliance with the proposed rules. Business entities may submit this information in writing to Joanne Terlizzi, at the above address, before the close of the comment period on January 3, 2006.

**COPIES OF PROPOSED RULES:**

Copies of proposed rules may be obtained for review by contacting the above listed contact person.

**RULE IMPACT STATEMENT:**

Copies of the Rule Impact Statement may be obtained for review by contacting the above listed person.

**CONTACT PERSON:**

Joanne Terlizzi, Director, Policy Development, 405-522-7272.

*[OAR Docket #05-1350; filed 11-9-05]*

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

*[OAR Docket #05-1351]*

**RULEMAKING ACTION:**

Notice of proposed PERMANENT rulemaking

**PROPOSED RULES:**

Subchapter 5. Individual Providers and Specialties

Part 9. Long Term Care Facilities

317:30-5-133. [AMENDED]

(Reference APA WF # 05-03)

**SUMMARY:**

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 90<sup>th</sup> 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.

**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

**COMMENT PERIOD:**

Written and oral comments will be accepted December 1, 2005 through January 3, 2006, during regular business hours by contacting Joanne Terlizzi, Oklahoma Health Care Authority, 4545 N. Lincoln Blvd., Suite 124, Oklahoma City, Oklahoma, 73105, Telephone 405-522-7272.

**PUBLIC HEARING:**

A public hearing will be held at 1:00 p.m. on Thursday, January 5, 2006, at the Oklahoma Health Care Authority, 4545 N. Lincoln Blvd., Suite 124, Oklahoma City, Oklahoma 73105.

**REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:**

Business entities affected by these proposed rules may provide the OHCA, 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, recordkeeping, equipment, construction, labor, professional services, revenue loss, or other costs expected to be incurred by the particular business entity due to compliance with the proposed rules. Business entities may submit this information in writing to Joanne Terlizzi, at the above address, before the close of the comment period on January 3, 2006.

**COPIES OF PROPOSED RULES:**

Copies of proposed rules may be obtained for review by contacting the above listed contact person.

**RULE IMPACT STATEMENT:**

Copies of the Rule Impact Statement may be obtained for review by contacting the above listed person.

**CONTACT PERSON:**

Joanne Terlizzi, Director, Policy Development, 405-522-7272.

*[OAR Docket #05-1351; filed 11-9-05]*

## Notices of Rulemaking Intent

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

*[OAR Docket #05-1352]*

#### **RULEMAKING ACTION:**

Notice of proposed PERMANENT rulemaking

#### **PROPOSED 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)

#### **SUMMARY:**

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.

#### **AUTHORITY:**

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

#### **COMMENT PERIOD:**

Written and oral comments will be accepted December 1, 2005 through January 3, 2006, during regular business hours by contacting Joanne Terlizzi, Oklahoma Health Care Authority, 4545 N. Lincoln Blvd., Suite 124, Oklahoma City, Oklahoma, 73105, Telephone 405-522-7272.

#### **PUBLIC HEARING:**

A public hearing will be held at 1:00 p.m. on Thursday, January 5, 2006, at the Oklahoma Health Care Authority, 4545 N. Lincoln Blvd., Suite 124, Oklahoma City, Oklahoma 73105.

#### **REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:**

Business entities affected by these proposed rules may provide the OHCA, 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, recordkeeping, equipment, construction, labor, professional services, revenue loss, or other costs expected to be incurred by the particular business entity due to compliance with the proposed rules.

Business entities may submit this information in writing to Joanne Terlizzi, at the above address, before the close of the comment period on January 3, 2006.

#### **COPIES OF PROPOSED RULES:**

Copies of proposed rules may be obtained for review by contacting the above listed contact person.

#### **RULE IMPACT STATEMENT:**

Copies of the Rule Impact Statement may be obtained for review by contacting the above listed person.

#### **CONTACT PERSON:**

Joanne Terlizzi, Director, Policy Development, 405-522-7272.

*[OAR Docket #05-1352; filed 11-9-05]*

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

*[OAR Docket #05-1353]*

#### **RULEMAKING ACTION:**

Notice of proposed PERMANENT rulemaking

#### **PROPOSED RULES:**

Subchapter 5. Individual Providers and Specialties

Part 1. Physicians

317:30-5-14. [AMENDED]

(Reference APA WF # 05-05)

#### **SUMMARY:**

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.

#### **AUTHORITY:**

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

#### **COMMENT PERIOD:**

Written and oral comments will be accepted December 1, 2005 through January 3, 2006, during regular business hours by contacting Joanne Terlizzi, Oklahoma Health Care Authority, 4545 N. Lincoln Blvd., Suite 124, Oklahoma City, Oklahoma, 73105, Telephone 405-522-7272.

**PUBLIC HEARING:**

A public hearing will be held at 1:00 p.m. on Thursday, January 5, 2006, at the Oklahoma Health Care Authority, 4545 N. Lincoln Blvd., Suite 124, Oklahoma City, Oklahoma 73105.

**REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:**

Business entities affected by these proposed rules may provide the OHCA, 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, recordkeeping, equipment, construction, labor, professional services, revenue loss, or other costs expected to be incurred by the particular business entity due to compliance with the proposed rules. Business entities may submit this information in writing to Joanne Terlizzi, at the above address, before the close of the comment period on January 3, 2006.

**COPIES OF PROPOSED RULES:**

Copies of proposed rules may be obtained for review by contacting the above listed contact person.

**RULE IMPACT STATEMENT:**

Copies of the Rule Impact Statement may be obtained for review by contacting the above listed person.

**CONTACT PERSON:**

Joanne Terlizzi, Director, Policy Development, 405-522-7272.

*[OAR Docket #05-1353; filed 11-9-05]*

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

*[OAR Docket #05-1354]*

**RULEMAKING ACTION:**

Notice of proposed PERMANENT rulemaking

**PROPOSED 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)

**SUMMARY:**

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.

**AUTHORITY:**

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

**COMMENT PERIOD:**

Written and oral comments will be accepted December 1, 2005 through January 3, 2006, during regular business hours by contacting Joanne Terlizzi, Oklahoma Health Care Authority, 4545 N. Lincoln Blvd., Suite 124, Oklahoma City, Oklahoma, 73105, Telephone 405-522-7272.

**PUBLIC HEARING:**

A public hearing will be held at 1:00 p.m. on Thursday, January 5, 2006, at the Oklahoma Health Care Authority, 4545 N. Lincoln Blvd., Suite 124, Oklahoma City, Oklahoma 73105.

**REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:**

Business entities affected by these proposed rules may provide the OHCA, 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, recordkeeping, equipment, construction, labor, professional services, revenue loss, or other costs expected to be incurred by the particular business entity due to compliance with the proposed rules. Business entities may submit this information in writing to Joanne Terlizzi, at the above address, before the close of the comment period on January 3, 2006.

**COPIES OF PROPOSED RULES:**

Copies of proposed rules may be obtained for review by contacting the above listed contact person.

**RULE IMPACT STATEMENT:**

Copies of the Rule Impact Statement may be obtained for review by contacting the above listed person.

**CONTACT PERSON:**

Joanne Terlizzi, Director, Policy Development, 405-522-7272.

*[OAR Docket #05-1354; filed 11-9-05]*

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

*[OAR Docket #05-1358]*

**RULEMAKING ACTION:**

Notice of proposed PERMANENT rulemaking

**PROPOSED RULES:**

Subchapter 3. General Provider Policies  
Part 5. Eligibility  
317:30-3-74. [REVOKED]  
(Reference APA WF # 05-09B)

## Notices of Rulemaking Intent

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### SUMMARY:

The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to allow the state to use federal Medicaid funds to offset expenditures for medical care provided to certain individuals who are inpatients in an institution for mental disease, in the custody of the Office of Juvenile Affairs, or inmates in a correctional facility.

### AUTHORITY:

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR 435.1008 and 435.1009; Section 1905(a)(27)(A) and (B) of the Social Security Act

### COMMENT PERIOD:

Written and oral comments will be accepted December 1, 2005 through January 3, 2006, during regular business hours by contacting Joanne Terlizzi, Oklahoma Health Care Authority, 4545 N. Lincoln Blvd., Suite 124, Oklahoma City, Oklahoma, 73105, Telephone 405-522-7272.

### PUBLIC HEARING:

A public hearing will be held at 1:00 p.m. on Thursday, January 5, 2006, at the Oklahoma Health Care Authority, 4545 N. Lincoln Blvd., Suite 124, Oklahoma City, Oklahoma 73105.

### REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

Business entities affected by these proposed rules may provide the OHCA, 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, recordkeeping, equipment, construction, labor, professional services, revenue loss, or other costs expected to be incurred by the particular business entity due to compliance with the proposed rules. Business entities may submit this information in writing to Joanne Terlizzi, at the above address, before the close of the comment period on January 3, 2006.

### COPIES OF PROPOSED RULES:

Copies of proposed rules may be obtained for review by contacting the above listed contact person.

### RULE IMPACT STATEMENT:

Copies of the Rule Impact Statement may be obtained for review by contacting the above listed person.

### CONTACT PERSON:

Joanne Terlizzi, Director, Policy Development, 405-522-7272.

*[OAR Docket #05-1358; filed 11-9-05]*

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

*[OAR Docket #05-1360]*

### RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

### PROPOSED RULES:

Subchapter 5. Individual Providers and Specialties

Part 9. Long Term Care Facilities

317:30-5-122. [AMENDED]

(Reference APA WF # 05-12)

### SUMMARY:

Long Term Care Facilities rules are revised to increase the Medicaid payment for Part A coinsurance for Medicare covered skilled nursing facility care for dually eligible individuals. Current rules provide for payment at 50% of the Part A coinsurance for Medicare covered skilled nursing facility care. Additional funds appropriated to the Oklahoma Health Care Authority by House Bill 1088 were mandated to increase certain provider reimbursement rates. The agency is proposing to increase the Medicare skilled nursing facility payment to 100% of the Part A coinsurance. Rule revisions are needed in order to comply with the provisions of House Bill 1088 to increase the Medicaid provider reimbursement rate for Medicare skilled nursing facility care.

### AUTHORITY:

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; House Bill 1088 of the 1<sup>st</sup> Session of the 50<sup>th</sup> Legislature

### COMMENT PERIOD:

Written and oral comments will be accepted December 1, 2005 through January 3, 2006, during regular business hours by contacting Joanne Terlizzi, Oklahoma Health Care Authority, 4545 N. Lincoln Blvd., Suite 124, Oklahoma City, Oklahoma, 73105, Telephone 405-522-7272.

### PUBLIC HEARING:

A public hearing will be held at 1:00 p.m. on Thursday, January 5, 2006, at the Oklahoma Health Care Authority, 4545 N. Lincoln Blvd., Suite 124, Oklahoma City, Oklahoma 73105.

### REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

Business entities affected by these proposed rules may provide the OHCA, 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, recordkeeping, equipment, construction, labor, professional services, revenue loss, or other costs expected to be incurred by the particular business entity due to compliance with the proposed rules. Business entities may submit this information in writing to Joanne Terlizzi, at the above address, before the close of the comment period on January 3, 2006.

**COPIES OF PROPOSED RULES:**

Copies of proposed rules may be obtained for review by contacting the above listed contact person.

**RULE IMPACT STATEMENT:**

Copies of the Rule Impact Statement may be obtained for review by contacting the above listed person.

**CONTACT PERSON:**

Joanne Terlizzi, Director, Policy Development, 405-522-7272.

*[OAR Docket #05-1360; filed 11-9-05]*

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

*[OAR Docket #05-1361]*

**RULEMAKING ACTION:**

Notice of proposed PERMANENT rulemaking

**PROPOSED RULES:**

Subchapter 5. Individual Providers and Specialties

Part 19. Nurse Midwives

317:30-5-225. [AMENDED]

Part 37. Advanced Practice Nurse

317:30-5-375. [AMENDED]

(Reference APA WF # 05-13)

**SUMMARY:**

Nurse Midwives and Advanced Practice Nurses rules are revised to clarify provider requirements for providers who practice in states other than Oklahoma. Current rules state that reimbursement may only be made to Advances Practice Nurses and Nurse Midwives who are registered with the Oklahoma Board of Nursing which prevents payments to qualified providers who serve Oklahoma's Medicaid eligible recipients in border states. Revisions will allow reimbursement to out of state providers who are appropriately licensed in the state in which they practice and who have a current contract with the agency.

**AUTHORITY:**

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

**COMMENT PERIOD:**

Written and oral comments will be accepted December 1, 2005 through January 3, 2006, during regular business hours by contacting Joanne Terlizzi, Oklahoma Health Care Authority, 4545 N. Lincoln Blvd., Suite 124, Oklahoma City, Oklahoma, 73105, Telephone 405-522-7272.

**PUBLIC HEARING:**

A public hearing will be held at 1:00 p.m. on Thursday, January 5, 2006, at the Oklahoma Health Care Authority, 4545 N. Lincoln Blvd., Suite 124, Oklahoma City, Oklahoma 73105.

**REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:**

Business entities affected by these proposed rules may provide the OHCA, 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, recordkeeping, equipment, construction, labor, professional services, revenue loss, or other costs expected to be incurred by the particular business entity due to compliance with the proposed rules. Business entities may submit this information in writing to Joanne Terlizzi, at the above address, before the close of the comment period on January 3, 2006.

**COPIES OF PROPOSED RULES:**

Copies of proposed rules may be obtained for review by contacting the above listed contact person.

**RULE IMPACT STATEMENT:**

Copies of the Rule Impact Statement may be obtained for review by contacting the above listed person.

**CONTACT PERSON:**

Joanne Terlizzi, Director, Policy Development, 405-522-7272.

*[OAR Docket #05-1361; filed 11-9-05]*

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

*[OAR Docket #05-1362]*

**RULEMAKING ACTION:**

Notice of proposed PERMANENT rulemaking

**PROPOSED RULES:**

Subchapter 5. Individual Providers and Specialties

Part 33. Transportation by Ambulance

317:30-5-335. through 317:30-5-336. [AMENDED]

317:30-5-342. [REVOKED]

317:30-5-343. [AMENDED]

(Reference APA WF # 05-14)

**SUMMARY:**

Ambulance rules are revised to add coverage by stretcher service, clarify coverage issues, and allow for the adoption of the payment methodology currently utilized by Medicare. The adoption of the Medicare payment methodology which wraps all services, except mileage, into the base rate will simplify billing and bring the Agency more in line with established practices. Clarification of coverage issues will enable ambulance entities to better understand the Agency's policies and is expected to result in less need for inquiries concerning coverage. These changes also clarify that the Agency's Non-Emergency Transportation Waiver, SoonerRide, is the first source of non-emergency transportation for medical services unless the patient's medical status requires transportation by ambulance or stretcher.

# Notices of Rulemaking Intent

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## **AUTHORITY:**

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR 440.170(a); House Bill 1088 of the 1<sup>st</sup> Session of the 50<sup>th</sup> Oklahoma Legislature

## **COMMENT PERIOD:**

Written and oral comments will be accepted December 1, 2005 through January 3, 2006, during regular business hours by contacting Joanne Terlizzi, Oklahoma Health Care Authority, 4545 N. Lincoln Blvd., Suite 124, Oklahoma City, Oklahoma, 73105, Telephone 405-522-7272.

## **PUBLIC HEARING:**

A public hearing will be held at 1:00 p.m. on Thursday, January 5, 2006, at the Oklahoma Health Care Authority, 4545 N. Lincoln Blvd., Suite 124, Oklahoma City, Oklahoma 73105.

## **REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:**

Business entities affected by these proposed rules may provide the OHCA, 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, recordkeeping, equipment, construction, labor, professional services, revenue loss, or other costs expected to be incurred by the particular business entity due to compliance with the proposed rules. Business entities may submit this information in writing to Joanne Terlizzi, at the above address, before the close of the comment period on January 3, 2006.

## **COPIES OF PROPOSED RULES:**

Copies of proposed rules may be obtained for review by contacting the above listed contact person.

## **RULE IMPACT STATEMENT:**

Copies of the Rule Impact Statement may be obtained for review by contacting the above listed person.

## **CONTACT PERSON:**

Joanne Terlizzi, Director, Policy Development, 405-522-7272.

*[OAR Docket #05-1362; filed 11-9-05]*

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

*[OAR Docket #05-1363]*

## **RULEMAKING ACTION:**

Notice of proposed PERMANENT rulemaking

## **PROPOSED RULES:**

Subchapter 3. General Provider Policies

Part 1. General Scope and Administration

317:30-3-5. [AMENDED]

Part 3. General Medical Program Information

317:30-3-59. [AMENDED]

Subchapter 5. Individual Providers and Specialties

Part 1. Physicians

317:30-5-2. [AMENDED]

317:30-5-9. [AMENDED]

Part 3. Hospitals

317:30-5-41. [AMENDED]

317:30-5-47. [AMENDED]

317:30-5-47.1 through 317:30-5-47.4. [NEW]

317:30-5-48. [REVOKED]

Part 8. Rehabilitation Hospitals [NEW]

317:30-5-110. through 317:30-5-114. [NEW]

**(Reference APA WF # 05-15)**

## **SUMMARY:**

Hospital rules are revised to modify the acute inpatient hospital services reimbursement from a level of care per diem system to a Diagnosis Related Group (DRG) reimbursement system. Under a DRG system, each case is categorized into a diagnosis related group (DRG). Each DRG has a payment weight assigned to it, based on the average resources used to treat Medicaid patients in a DRG. The DRG weight is multiplied by a peer grouped base rate to determine a hospital's level of payment. Payments to freestanding psychiatric facilities, freestanding rehabilitation hospitals, and children's long term care hospitals will continue to be paid under the per diem system. Payments for graduate medical education (GME) are excluded from this system. The current method of payment for GME will be adjusted to reflect the GME costs using Medicare cost reports, similar to the Medicare payment system. Proposed rule revisions for outpatient hospital reimbursement includes payment for emergency room visits, clinic fees, and observation, based on a hospital's trauma level of care classification as determined by the Oklahoma State Department of Health. Payments for hospitals classified as Level I and II Trauma Centers will receive one rate, Levels III and IV facilities will receive different rates.

## **AUTHORITY:**

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

## **COMMENT PERIOD:**

Written and oral comments will be accepted December 1, 2005 through January 3, 2006, during regular business hours by contacting Joanne Terlizzi, Oklahoma Health Care Authority, 4545 N. Lincoln Blvd., Suite 124, Oklahoma City, Oklahoma, 73105, Telephone 405-522-7272.

## **PUBLIC HEARING:**

A public hearing will be held at 1:00 p.m. on Thursday, January 5, 2006, at the Oklahoma Health Care Authority, 4545 N. Lincoln Blvd., Suite 124, Oklahoma City, Oklahoma 73105.

## **REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:**

Business entities affected by these proposed rules may provide the OHCA, 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, recordkeeping, equipment, construction, labor, professional services, revenue loss, or other costs expected to be incurred by the particular

business entity due to compliance with the proposed rules. Business entities may submit this information in writing to Joanne Terlizzi, at the above address, before the close of the comment period on January 3, 2006.

**COPIES OF PROPOSED RULES:**

Copies of proposed rules may be obtained for review by contacting the above listed contact person.

**RULE IMPACT STATEMENT:**

Copies of the Rule Impact Statement may be obtained for review by contacting the above listed person.

**CONTACT PERSON:**

Joanne Terlizzi, Director, Policy Development, 405-522-7272.

*[OAR Docket #05-1363; filed 11-9-05]*

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

*[OAR Docket #05-1349]*

**RULEMAKING ACTION:**

Notice of proposed PERMANENT rulemaking

**PROPOSED RULES:**

Subchapter 17. ADvantage Waiver Services

317:35-17-3. [AMENDED]

317:35-17-14. [AMENDED]

(Reference APA WF # 05-01A and 05-02A)

**SUMMARY:**

Rules are revised to implement a Consumer-Directed Personal Assistance Services and Supports (CD-PASS) service option in the ADvantage Waiver Program. With funding from a CMS Systems Change Grant, the Oklahoma Department of Human Services, the Long Term Care Authority of Tulsa along with Independent Living Centers and consumers of Personal Care services have been working on developing CD-PASS services for the past two years. The voluntary pilot project in the Tulsa area will offer some clients an option of directing their personal care services with assistance from an Employee Support Services Provider. Clients who elect to participate will be the provider's "employer of record" and will employ, train, discharge and schedule their personal care assistant, instead of utilizing a licensed home care agency. Support assistance provided to the client will include payroll functions (including appropriate withholding), technical assistance, and consultation. Expected outcomes are that client satisfaction with services increase, health and safety of clients is comparable if not better than that for clients served through traditional Personal Care and that cost between CD-PASS and traditional Personal Care is about the same. Revisions are needed to implement the Consumer-Directed Personal Assistance Services and Supports service option.

ADvantage Waiver Services rules are revised to establish Institution Transition Services as a separate billable service under Medicaid for individuals who qualify for ADvantage Program services. Revisions are needed to address transition services consistent with the Centers for Medicare and Medicaid directions as a result of approval of a consumer directed personal assistance service system waiver amendment, also known as CD pass. Institution Transition Services are those services that are necessary to enable an individual to leave an institution and receive necessary support in their own home. This service may include Case Management, Nursing Assessment and Evaluation for in-home service planning, Environmental Modifications and Medical Equipment and Supplies. The Centers for Medicare and Medicaid Services has directed the State to restructure the definitions of Institution Transition Services to make them distinct and separate from the homologous, non-ITS Case Management, Skilled Nursing, Environmental Modification and Equipment and Supply services.

**AUTHORITY:**

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; House Bill 2300 of the 2nd Session of the 49th Legislature; Senate Bill 1109 of the 2nd Session of the 49th Legislature; 42 CFR 440.180

**COMMENT PERIOD:**

Written and oral comments will be accepted December 1, 2005 through January 3, 2006, during regular business hours by contacting Joanne Terlizzi, Oklahoma Health Care Authority, 4545 N. Lincoln Blvd., Suite 124, Oklahoma City, Oklahoma, 73105, Telephone 405-522-7272.

**PUBLIC HEARING:**

A public hearing will be held at 1:00 p.m. on Thursday, January 5, 2006, at the Oklahoma Health Care Authority, 4545 N. Lincoln Blvd., Suite 124, Oklahoma City, Oklahoma 73105.

**REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:**

Business entities affected by these proposed rules may provide the OHCA, 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, recordkeeping, equipment, construction, labor, professional services, revenue loss, or other costs expected to be incurred by the particular business entity due to compliance with the proposed rules. Business entities may submit this information in writing to Joanne Terlizzi, at the above address, before the close of the comment period on January 3, 2006.

**COPIES OF PROPOSED RULES:**

Copies of proposed rules may be obtained for review by contacting the above listed contact person.

**RULE IMPACT STATEMENT:**

Copies of the Rule Impact Statement may be obtained for review by contacting the above listed person.

## Notices of Rulemaking Intent

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### CONTACT PERSON:

Joanne Terlizzi, Director, Policy Development,  
405-522-7272.

*[OAR Docket #05-1349; filed 11-9-05]*

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

*[OAR Docket #05-1355]*

### RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

### PROPOSED RULES:

Subchapter 5. Eligibility and Countable Income

Part 1. Determination of Qualifying Categorical  
Relationships

317:35-5-2. [AMENDED]

Subchapter 7. Medical Services

Part 3. Application Procedures

317:35-7-16. [AMENDED]

317:35-7-17. [REVOKED]

(Reference APA WF # 05-07)

### SUMMARY:

The Foster Care Independence Act of 1999, P.L. NO. 106-169 created a new optional Medicaid eligibility group for young individuals who leave state custody and foster care upon reaching age 18. Typically, young people aging out of the foster care system have significant health concerns but no insurance and limited access to health and mental health services. These young people often need health services more than other youth who have not been in foster care. Studies have shown that children in foster care suffer more frequent and more serious medical, developmental, and psychological problems than nearly any other group of children. Young people who have been in foster care may be at high risk for continuing health problems because of the circumstances that brought them into foster care, as well as the ongoing instability of their lives. Revisions are needed to the OHCA rules to allow these children access to medical care. OHCA rules are revised, consistent with the Foster Care Independence Act and the Centers for Medicare and Medicaid directions, to provide Medicaid coverage to these individuals who leave custody and foster care on their 18<sup>th</sup> birthday and transition into independent living, until they reach age 21.

### AUTHORITY:

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; The Foster Care Independence Act of 1999

### COMMENT PERIOD:

Written and oral comments will be accepted December 1, 2005 through January 3, 2006, during regular business hours by contacting Joanne Terlizzi, Oklahoma Health Care Authority,

4545 N. Lincoln Blvd., Suite 124, Oklahoma City, Oklahoma,  
73105, Telephone 405-522-7272.

### PUBLIC HEARING:

A public hearing will be held at 1:00 p.m. on Thursday, January 5, 2006, at the Oklahoma Health Care Authority, 4545 N. Lincoln Blvd., Suite 124, Oklahoma City, Oklahoma 73105.

### REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

Business entities affected by these proposed rules may provide the OHCA, 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, recordkeeping, equipment, construction, labor, professional services, revenue loss, or other costs expected to be incurred by the particular business entity due to compliance with the proposed rules. Business entities may submit this information in writing to Joanne Terlizzi, at the above address, before the close of the comment period on January 3, 2006.

### COPIES OF PROPOSED RULES:

Copies of proposed rules may be obtained for review by contacting the above listed contact person.

### RULE IMPACT STATEMENT:

Copies of the Rule Impact Statement may be obtained for review by contacting the above listed person.

### CONTACT PERSON:

Joanne Terlizzi, Director, Policy Development,  
405-522-7272.

*[OAR Docket #05-1355; filed 11-9-05]*

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

*[OAR Docket #05-1356]*

### RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

### PROPOSED RULES:

Subchapter 1. General Provisions

317:35-1-2. [AMENDED]

Subchapter 5. Eligibility and Countable Income

Part 1. Determination of Qualifying Categorical  
Relationships

317:35-5-7. [AMENDED]

Subchapter 6. SoonerCare Health Benefits for  
Categorically Needy Pregnant Women and Families  
with Children

Part 7. Certification, Redetermination and Notification

317:35-6-60. through 317:35-6-61. [AMENDED]

Subchapter 9. ICF/MR, HCBW/MR, and Individuals Age  
65 or Older in Mental Health Hospitals

Part 9. Certification, Redetermination and Notification

317:35-9-75. [AMENDED]

Subchapter 19. Nursing Facility Services

317:35-19-22. [AMENDED]  
(Reference APA WF # 05-08 and 05-18)

**SUMMARY:**

Eligibility rules are revised to remove deprivation as a condition of Medicaid eligibility for low income families. Under existing rules, in order to qualify for Medicaid, a child who is not disabled must be deprived of parental support due to death, continued absence, physical or mental incapacity, or unemployment. Therefore, low income families with both parents present in the home are generally not eligible for health benefits through the Medicaid program. Rule revisions are needed to eliminate the existing marriage penalty and extend health care coverage to low income children and their parents.

Eligibility rules are revised to increase the length of the Medicaid certification period for low income families with children from six to twelve months. If a redetermination of eligibility is not completed timely and entered into the OKDHS computer system during the early days of the last month of coverage, the Medicaid case is automatically closed. A patient in the midst of treatment may not be aware that eligibility has been terminated until immediate medical attention is needed. The process to recertify eligibility for health benefits generally takes up to 20 days. Also, by extending the certification to twelve months, the loss of coverage to children in families who experience financial fluctuations will be minimized. A longer eligibility period will also reduce the administrative work that focuses on checking and rechecking income levels of Medicaid families with state eligibility standards. Rule revisions are needed enhance the continuity of care for low income families with children.

**AUTHORITY:**

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR 435.916; Section 1902 (e)(12) of the Social Security Act

**COMMENT PERIOD:**

Written and oral comments will be accepted December 1, 2005 through January 3, 2006, during regular business hours by contacting Joanne Terlizzi, Oklahoma Health Care Authority, 4545 N. Lincoln Blvd., Suite 124, Oklahoma City, Oklahoma, 73105, Telephone 405-522-7272.

**PUBLIC HEARING:**

A public hearing will be held at 1:00 p.m. on Thursday, January 5, 2006, at the Oklahoma Health Care Authority, 4545 N. Lincoln Blvd., Suite 124, Oklahoma City, Oklahoma 73105.

**REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:**

Business entities affected by these proposed rules may provide the OHCA, 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, recordkeeping, equipment, construction, labor, professional services, revenue loss, or other costs expected to be incurred by the particular business entity due to compliance with the proposed rules.

Business entities may submit this information in writing to Joanne Terlizzi, at the above address, before the close of the comment period on January 3, 2006.

**COPIES OF PROPOSED RULES:**

Copies of proposed rules may be obtained for review by contacting the above listed contact person.

**RULE IMPACT STATEMENT:**

Copies of the Rule Impact Statement may be obtained for review by contacting the above listed person.

**CONTACT PERSON:**

Joanne Terlizzi, Director, Policy Development, 405-522-7272.

[OAR Docket #05-1356; filed 11-9-05]

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

[OAR Docket #05-1357]

**RULEMAKING ACTION:**

Notice of proposed PERMANENT rulemaking

**PROPOSED RULES:**

Subchapter 5. Eligibility and Countable Income  
Part 3. Non-Medical Eligibility Requirements  
317:35-5-26. [AMENDED]

(Reference APA WF # 05-09A)

**SUMMARY:**

The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to allow the state to use federal Medicaid funds to offset expenditures for medical care provided to certain individuals who are inpatients in an institution for mental disease, in the custody of the Office of Juvenile Affairs, or inmates in a correctional facility.

**AUTHORITY:**

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR 435.1008 and 435.1009; Section 1905(a)(27)(A) and (B) of the Social Security Act

**COMMENT PERIOD:**

Written and oral comments will be accepted December 1, 2005 through January 3, 2006, during regular business hours by contacting Joanne Terlizzi, Oklahoma Health Care Authority, 4545 N. Lincoln Blvd., Suite 124, Oklahoma City, Oklahoma, 73105, Telephone 405-522-7272.

**PUBLIC HEARING:**

A public hearing will be held at 1:00 p.m. on Thursday, January 5, 2006, at the Oklahoma Health Care Authority, 4545 N. Lincoln Blvd., Suite 124, Oklahoma City, Oklahoma 73105.

## Notices of Rulemaking Intent

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### REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

Business entities affected by these proposed rules may provide the OHCA, 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, recordkeeping, equipment, construction, labor, professional services, revenue loss, or other costs expected to be incurred by the particular business entity due to compliance with the proposed rules. Business entities may submit this information in writing to Joanne Terlizzi, at the above address, before the close of the comment period on January 3, 2006.

### COPIES OF PROPOSED RULES:

Copies of proposed rules may be obtained for review by contacting the above listed contact person.

### RULE IMPACT STATEMENT:

Copies of the Rule Impact Statement may be obtained for review by contacting the above listed person.

### CONTACT PERSON:

Joanne Terlizzi, Director, Policy Development, 405-522-7272.

*[OAR Docket #05-1357; filed 11-9-05]*

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### TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY CHAPTER 40. DEVELOPMENTAL DISABILITIES SERVICES

*[OAR Docket #05-1359]*

### RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

### PROPOSED RULES:

Subchapter 7. Waiver Employment Services

317:40-7-2. [AMENDED]

317:40-7-12. [AMENDED]

(Reference APA WF # 05-10)

### SUMMARY:

DDSD rules are revised to implement a rate increase appropriated by the Legislature for waiver employment services for persons with mental retardation. Rates will be increased for services to persons in individual placements who receive job coach services or community-based services. Also, the definition of an individual placement is established in the rules. Rule revisions are needed in order to implement the mandated rate increases and to insure an adequate pool of qualified providers are available to furnish services to individuals who qualify for DDSD waiver employment services.

### AUTHORITY:

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

### COMMENT PERIOD:

Written and oral comments will be accepted December 1, 2005 through January 3, 2006, during regular business hours by contacting Joanne Terlizzi, Oklahoma Health Care Authority, 4545 N. Lincoln Blvd., Suite 124, Oklahoma City, Oklahoma, 73105, Telephone 405-522-7272.

### PUBLIC HEARING:

A public hearing will be held at 1:00 p.m. on Thursday, January 5, 2006, at the Oklahoma Health Care Authority, 4545 N. Lincoln Blvd., Suite 124, Oklahoma City, Oklahoma 73105.

### REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

Business entities affected by these proposed rules may provide the OHCA, 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, recordkeeping, equipment, construction, labor, professional services, revenue loss, or other costs expected to be incurred by the particular business entity due to compliance with the proposed rules. Business entities may submit this information in writing to Joanne Terlizzi, at the above address, before the close of the comment period on January 3, 2006.

### COPIES OF PROPOSED RULES:

Copies of proposed rules may be obtained for review by contacting the above listed contact person.

### RULE IMPACT STATEMENT:

Copies of the Rule Impact Statement may be obtained for review by contacting the above listed person.

### CONTACT PERSON:

Joanne Terlizzi, Director, Policy Development, 405-522-7272.

*[OAR Docket #05-1359; filed 11-9-05]*

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### TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY CHAPTER 40. DEVELOPMENTAL DISABILITIES SERVICES

*[OAR Docket #05-1365]*

### RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

### PROPOSED RULES:

Subchapter 1. General Provisions

317:40-1-2. [NEW]

Subchapter 5. Client Services

Part 9. Service Provisions

317:40-5-102. [AMENDED]

317:40-5-104 [NEW]

317:40-5-110. [AMENDED]

Part 11. Community Residential Supports

317:40-5-150. [AMENDED]

317:40-5-152. [AMENDED]

(Reference APA WF # 05-19)

**SUMMARY:**

Developmental Disabilities Services rules are revised to establish guidelines to: (1) address situations in which Waiver-funded residential supports can be provided; and (2) govern the provision of specialized medical supplies. Nutrition Service rules are revised to provide for persons who refuse nutrition services and specify requirements for nutrition services for persons not receiving residential supports. Rules regarding the Authorization for Habilitation Training Specialist Services are revised to specify requirements for authorization of Habilitation Training Specialist services. Daily Living Supports rules are revised to clarify requirements for providers of Daily Living Supports services and criteria for a person receiving those services to receive additional staff supports. Rules for group home services for persons with mental retardation are revised to cite new rules governing alternative group homes established to implement Senate Bill 1583 and to remove the prohibition on serving persons with pending criminal charges in alternative group homes.

**AUTHORITY:**

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Section 1020 of Title 56 of the Oklahoma Statutes; Section 1430.1 et seq of Title 10 of the Oklahoma Statutes; Section 1175.6b of Title 22 of the Oklahoma Statutes

**COMMENT PERIOD:**

Written and oral comments will be accepted December 1, 2005 through January 3, 2006, during regular business hours by contacting Joanne Terlizzi, Oklahoma Health Care Authority, 4545 N. Lincoln Blvd., Suite 124, Oklahoma City, Oklahoma, 73105, Telephone 405-522-7272.

**PUBLIC HEARING:**

A public hearing will be held at 1:00 p.m. on Thursday, January 5, 2006, at the Oklahoma Health Care Authority, 4545 N. Lincoln Blvd., Suite 124, Oklahoma City, Oklahoma 73105.

**REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:**

Business entities affected by these proposed rules may provide the OHCA, 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, recordkeeping, equipment, construction, labor, professional services, revenue loss, or other costs expected to be incurred by the particular business entity due to compliance with the proposed rules. Business entities may submit this information in writing to Joanne Terlizzi, at the above address, before the close of the comment period on January 3, 2006.

**COPIES OF PROPOSED RULES:**

Copies of proposed rules may be obtained for review by contacting the above listed contact person.

**RULE IMPACT STATEMENT:**

Copies of the Rule Impact Statement may be obtained for review by contacting the above listed person.

**CONTACT PERSON:**

Joanne Terlizzi, Director, Policy Development, 405-522-7272.

[OAR Docket #05-1365; filed 11-9-05]

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY  
CHAPTER 45. OKLAHOMA EMPLOYER AND EMPLOYEE PARTNERSHIP FOR INSURANCE COVERAGE**

[OAR Docket #05-1364]

**RULEMAKING ACTION:**

Notice of proposed PERMANENT rulemaking

**PROPOSED RULES:**

Subchapter 1. General Provisions [NEW]

317:45-1-1. through 317:45-1-3. [NEW]

Subchapter 3. Carriers [NEW]

317:45-3-1. through 317:45-3-2. [NEW]

Subchapter 5. Qualified Health Plans [NEW]

317:45-5-1. through 317:45-5-2. [NEW]

Subchapter 7. Employer Eligibility [NEW]

317:45-7-1. through 317:45-7-8. [NEW]

Subchapter 9. Employee Eligibility [NEW]

317:45-9-1. through 317:45-9-8. [NEW]

(Reference APA WF # 05-16)

**SUMMARY:**

Agency rules are being issued to establish criteria that implements the Oklahoma Employer and Employee Partnership for Insurance Coverage Program (O-EPIC). The program establishes access to affordable health coverage for approximately 25,000 low-income working adults and their spouses. The Program is funded through a portion of monthly proceeds from the Tobacco Tax that are collected and dispersed through the Health Employee and Economy Improvement Act (HEEIA) Revolving Fund. Revisions will allow the state to provide health insurance premium assistance to small Oklahoma's business employers with 25 employees or less and their employees whose family income is at or below 185% of the Federal Poverty Level. The employer will be responsible for contributing a minimum of 25% of the eligible employee's monthly health plan premium.

**AUTHORITY:**

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; House Bill 2660 of the 2<sup>nd</sup> Session of the 49<sup>th</sup> Oklahoma Legislature

**COMMENT PERIOD:**

Written and oral comments will be accepted December 1, 2005 through January 3, 2006, during regular business hours by contacting Joanne Terlizzi, Oklahoma Health Care Authority, 4545 N. Lincoln Blvd., Suite 124, Oklahoma City, Oklahoma, 73105, Telephone 405-522-7272.

## Notices of Rulemaking Intent

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### **PUBLIC HEARING:**

A public hearing will be held at 1:00 p.m. on Thursday, January 5, 2006, at the Oklahoma Health Care Authority, 4545 N. Lincoln Blvd., Suite 124, Oklahoma City, Oklahoma 73105.

### **REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:**

Business entities affected by these proposed rules may provide the OHCA, 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, recordkeeping, equipment, construction, labor, professional services, revenue loss, or other costs expected to be incurred by the particular business entity due to compliance with the proposed rules. Business entities may submit this information in writing to Joanne Terlizzi, at the above address, before the close of the comment period on January 3, 2006.

### **COPIES OF PROPOSED RULES:**

Copies of proposed rules may be obtained for review by contacting the above listed contact person.

### **RULE IMPACT STATEMENT:**

Copies of the Rule Impact Statement may be obtained for review by contacting the above listed person.

### **CONTACT PERSON:**

Joanne Terlizzi, Director, Policy Development, 405-522-7272.

*[OAR Docket #05-1364; filed 11-9-05]*

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## **TITLE 325. OKLAHOMA HORSE RACING COMMISSION CHAPTER 20. RACING OFFICIALS AND RACING PERSONNEL**

*[OAR Docket #05-1304]*

### **RULEMAKING ACTION:**

Notice of proposed PERMANENT rulemaking.

### **PROPOSED RULE:**

325:20-1-6. Racing officials appointed by the Commission [AMENDED]

### **SUMMARY:**

The Commission was advised of a new model rule on stewards' accreditation adopted by the two regulatory associations, the North American Pari-Mutuel Regulators Association and the Association of Racing Commissioners International. After discussion at several meetings, the Commission accepted the model rule and added a grandfather clause.

### **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, January 9, 2006, 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, January 9, 2006, 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 January 9, 2006.

### **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 December 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 #05-1304; filed 11-1-05]*

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## **TITLE 325. OKLAHOMA HORSE RACING COMMISSION CHAPTER 80. GAMING LICENSING REQUIREMENTS**

*[OAR Docket #05-1305]*

### **RULEMAKING ACTION:**

Notice of proposed PERMANENT rulemaking.

### **PROPOSED RULES:**

Subchapter 1. General Provisions [NEW]

325:80-1-1. Purpose [NEW]

325:80-1-2. Definitions [NEW]

325:80-1-3. Applicability of rules - exceptions [NEW]

Subchapter 3. Gaming License Classifications [NEW]

325:80-3-1. Types of gaming licenses [NEW]

Subchapter 5. Gaming Licenses and Applications [NEW]

325:80-5-1. General provisions [NEW]

325:80-5-2. Time for filing an application for racetrack gaming operator license [NEW]

325:80-5-3. Application amendment and withdrawal [NEW]

- 325:80-5-4. Payment of non-refundable fees and costs required [NEW]
- 325:80-5-5. Conditions of a racetrack gaming operator license [NEW]
- 325:80-5-6. General grounds for refusal to issue license or denial of gaming license applications [NEW]
- Subchapter 7. Requirements for Racetrack Gaming Operator License and Recipient Racetrack Gaming License [NEW]
- 325:80-7-1. Prerequisite for eligibility for initial license and renewals [NEW]
- 325:80-7-2. General form and requirements for racetrack gaming operator license application [NEW]
- 325:80-7-3. Operations plan requirement [NEW]
- 325:80-7-4. Security plan requirement [NEW]
- 325:80-7-5. Requirements for a recipient racetrack gaming license [NEW]
- Subchapter 9. Requirements for Manufacturer, Distributor, or Manufacturer/Distributor, and Their Employee License Applicants [NEW]
- 325:80-9-1. Application for manufacturer, distributor, or manufacturer/distributor license [NEW]
- 325:80-9-2. Manufacturer's, distributor's, or manufacturer/distributor's employee license [NEW]
- Subchapter 11. Requirements for Vendor License [NEW]
- 325:80-11-1. Approved vendor list [NEW]
- 325:80-11-2. Vendor license [NEW]
- 325:80-11-3. Vendor employee license [NEW]
- 325:80-11-4. Vendor disclosure requirement [NEW]
- Subchapter 13. Requirements for Key Executive or Gaming Employee License and Amendments to Any Employee License [NEW]
- 325:80-13-1. Application required [NEW]
- 325:80-13-2. When key executive applications are due [NEW]
- 325:80-13-3. Employer-specific nature of all employee licenses [NEW]
- 325:80-13-4. New employee licenses [NEW]
- 325:80-13-5. License required prior to employment [NEW]
- 325:80-13-6. Employee licenses - refusal to issue or denial and license termination upon loss of employment [NEW]
- 325:80-13-7. Additional grounds for denial of key executive license application [NEW]
- 325:80-13-8. Initial start-up application procedure and limited pre-licensed employment for key executives and gaming employees [NEW]
- Subchapter 15. Requirements for Independent Testing Laboratory License [NEW]
- 325:80-15-1. Application required [NEW]
- Subchapter 17. Fees and Assessments [NEW]
- 325:80-17-1. Payment of fees and assessments [NEW]
- Subchapter 19. Consideration of License Application and Licensee Disciplinary Actions [NEW]
- 325:80-19-1. Procedures for consideration of applications for racetrack gaming operator and independent testing laboratory licenses [NEW]

- 325:80-19-2. Procedures for consideration of applications for manufacturer, distributor, manufacturer/distributor and key executive licenses [NEW]
- 325:80-19-3. Procedures for consideration of applications for vendor, vendor employee and gaming employee licenses [NEW]
- 325:80-19-4. Disciplinary actions against racetrack gaming operator licensees and independent testing laboratories [NEW]
- 325:80-19-5. Disciplinary actions against all other occupation gaming licensees [NEW]

**SUMMARY:**

The Commission's *Rules for Racetrack Gaming* were adopted under emergency rulemaking procedures on March 17, 2005 and Governor Henry approved the rules on April 6, 2005. The Commission is now starting the permanent rulemaking process for the *Rules for Racetrack Gaming*.

**AUTHORITY:**

75 O.S., § 303; Title 3A O.S. § 204(A), § 262(F); Oklahoma Horse Racing Commission.

**COMMENT PERIOD:**

Persons wishing to present their views in writing may do so before 4:30 p.m., Monday, January 9, 2006, 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, January 9, 2006, 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 January 9, 2006.

**COPIES OF PROPOSED RULES:**

A copy of the proposed rule amendments 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 December 1, 2005 and may be obtained from the Oklahoma Horse Racing Commission at the above address.

## Notices of Rulemaking Intent

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### CONTACT PERSON:

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

*[OAR Docket #05-1305; filed 11-1-05]*

### **TITLE 325. OKLAHOMA HORSE RACING COMMISSION CHAPTER 85. GAMING MACHINE OR DEVICE SPECIFICATIONS AND USE AND OPERATION REQUIREMENTS**

*[OAR Docket #05-1306]*

### RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking.

### PROPOSED RULES:

Subchapter 1. General Provisions [NEW]

325:85-1-1. Purpose [NEW]

325:85-1-2. Definitions [NEW]

Subchapter 3. Authorized Games [NEW]

325:85-3-1. Types of authorized games [NEW]

Subchapter 5. Electronic Amusement Games Specifications [NEW]

325:85-5-1. Required specifications [NEW]

Subchapter 7. Electronic Bonanza-Style Bingo Games Specifications [NEW]

325:85-7-1. Required specifications [NEW]

Subchapter 9. Electronic Instant Bingo Games Specifications [NEW]

325:85-9-1. Required specifications [NEW]

Subchapter 11. Required Certification and Approval of All Types of Authorized Games, Gaming Machines or Devices and Components Thereof [NEW]

325:85-11-1. Machine and component certification and commission approval required [NEW]

325:85-11-2. All five types of authorized games subject to commission rules [NEW]

325:85-11-3. List of commission-approved independent testing laboratories [NEW]

325:85-11-4. Certification by independent testing laboratory and commission approval required [NEW]

325:85-11-5. Submission of game and gaming machine or device prototype for testing by independent testing laboratory required [NEW]

325:85-11-6. Submitting games and components to the independent testing laboratory [NEW]

325:85-11-7. RNG submissions [NEW]

325:85-11-8. Previous submission [NEW]

325:85-11-9. Submitting modifications to a previously certified item [NEW]

325:85-11-10. Joint venture submissions [NEW]

325:85-11-11. Procedures for commission approval of electronic gaming machine or device and components thereof [NEW]

325:85-11-12. Procedures for appeal of decision disapproving electronic game, gaming machine or device or components thereof [NEW]

Subchapter 13. Cashless Transactions [NEW]

325:85-13-1. General cashless transaction requirements [NEW]

325:85-13-2. Error conditions [NEW]

325:85-13-3. Transfer of transactions [NEW]

325:85-13-4. Security requirements [NEW]

325:85-13-5. Prevention of unauthorized transactions [NEW]

325:85-13-6. Diagnostic tests on a cashless player terminal [NEW]

325:85-13-7. Transaction auditing [NEW]

325:85-13-8. Financial and player reports [NEW]

325:85-13-9. Account balance [NEW]

Subchapter 15. Player Terminal General Specifications and Use and Operation Requirements [NEW]

325:85-15-1. General player terminal specifications [NEW]

325:85-15-2. Applicability of player terminal use and operation requirements [NEW]

325:85-15-3. General player terminal requirements [NEW]

325:85-15-4. Terminal security [NEW]

325:85-15-5. Player safety [NEW]

325:85-15-6. Microprocessor controlled [NEW]

325:85-15-7. Cabinet wiring [NEW]

325:85-15-8. Player terminal identification [NEW]

325:85-15-9. Tower light [NEW]

325:85-15-10. Power surges [NEW]

325:85-15-11. Coin diverter [NEW]

325:85-15-12. Drop box [NEW]

325:85-15-13. External doors/compartments [NEW]

325:85-15-14. Logic compartment [NEW]

325:85-15-15. Coin and currency compartments [NEW]

325:85-15-16. Function of a random access memory (RAM) clear [NEW]

325:85-15-17. Configuration setting [NEW]

325:85-15-18. Critical memory defined [NEW]

325:85-15-19. Critical memory integrity [NEW]

325:85-15-20. Program storage devices [NEW]

325:85-15-21. Write once (non-writable) program storage [NEW]

325:85-15-22. Writable program storage [NEW]

325:85-15-23. Integrity of the control program [NEW]

325:85-15-24. Multi-station games [NEW]

325:85-15-25. Circuit board identification [NEW]

325:85-15-26. Mechanical devices used for displaying game outcomes [NEW]

325:85-15-27. Video monitors/touchscreens [NEW]

325:85-15-28. Coin or token acceptors [NEW]

325:85-15-29. Bill acceptors [NEW]

325:85-15-30. Communications [NEW]

325:85-15-31. Factory set bill acceptors [NEW]

325:85-15-32. Tokenization [NEW]

- 325:85-15-33. Accountability of bills/tickets or other items accepted [NEW]
- 325:85-15-34. Bill acceptor recall [NEW]
- 325:85-15-35. Bill acceptor error conditions [NEW]
- 325:85-15-36. Bill acceptor stacker requirements [NEW]
- 325:85-15-37. Credit redemption [NEW]
- 325:85-15-38. Cancel credit [NEW]
- 325:85-15-39. Hoppers and hopper error conditions [NEW]
- 325:85-15-40. Payment by ticket printers [NEW]
- 325:85-15-41. Access to player terminal meters [NEW]
- 325:85-15-42. Credit meter [NEW]
- 325:85-15-43. Electronic accounting and occurrence meters [NEW]
- 325:85-15-44. Multi-game game specific meters [NEW]
- 325:85-15-45. Double-up or gamble meters [NEW]
- 325:85-15-46. Cashless transaction log [NEW]
- 325:85-15-47. Error conditions [NEW]
- 325:85-15-48. Game interruption and resumption [NEW]
- 325:85-15-49. Door open events [NEW]
- Subchapter 17. Use Requirements for All Authorized Games [NEW]
- 325:85-17-1. Game cycle [NEW]
- 325:85-17-2. RNG requirements [NEW]
- 325:85-17-3. Required notice of average theoretical percentage payout [NEW]
- 325:85-17-4. Multiple percentages [NEW]
- 325:85-17-5. Merchandise prizes in lieu of cash awards [NEW]
- 325:85-17-6. Bonus games [NEW]
- 325:85-17-7. Multi-line games [NEW]
- 325:85-17-8. Multiple games offered for play at one player terminal [NEW]
- 325:85-17-9. Taxation reporting limits [NEW]
- 325:85-17-10. Test/diagnostic mode (demo mode) [NEW]
- 325:85-17-11. Number of last plays required [NEW]
- 325:85-17-12. Software verification [NEW]
- Subchapter 19. Progressive Use and Operation Requirements [NEW]
- 325:85-19-1. Progressive prize management [NEW]
- 325:85-19-2. Progressive meter/display [NEW]
- 325:85-19-3. Progressive controllers [NEW]
- 325:85-19-4. Linked player terminal odds [NEW]
- Subchapter 21. Accounting System Requirements [NEW]
- 325:85-21-1. Subchapter purpose [NEW]
- 325:85-21-2. Electronic accounting systems [NEW]
- 325:85-21-3. On-line system [NEW]
- 325:85-21-4. Interface elements [NEW]
- 325:85-21-5. System server(s) [NEW]
- 325:85-21-6. Jackpot/fill functionality [NEW]
- 325:85-21-7. Required MCS functionality [NEW]
- 325:85-21-8. MCS stored accounting meters [NEW]
- 325:85-21-9. MCS required reports [NEW]
- 325:85-21-10. Security access control [NEW]
- 325:85-21-11. Data alteration [NEW]
- 325:85-21-12. System back-up [NEW]
- 325:85-21-13. Recovery requirements [NEW]
- 325:85-21-14. Verification of player terminal software via the system [NEW]
- 325:85-21-15. Download requirements [NEW]
- 325:85-21-16. Remote, on-site access requirements [NEW]
- 325:85-21-17. Ticket validation system - additional requirements [NEW]
- 325:85-21-18. Ticket information [NEW]
- 325:85-21-19. Ticket types [NEW]
- 325:85-21-20. Ticket issuance [NEW]
- 325:85-21-21. Ticket redemption [NEW]
- 325:85-21-22. Invalid ticket notification [NEW]
- 325:85-21-23. Offline ticket redemption [NEW]
- 325:85-21-24. Required reports [NEW]
- 325:85-21-25. Security of ticket Information [NEW]
- Subchapter 23. Redemption Terminal (Kiosk) Standards and Use Requirements [NEW]
- 325:85-23-1. General standards [NEW]
- 325:85-23-2. Error conditions [NEW]
- 325:85-23-3. Maximum redeemable value [NEW]
- 325:85-23-4. Metering [NEW]
- 325:85-23-5. Clearing meters [NEW]
- 325:85-23-6. Required logs [NEW]
- 325:85-23-7. Ticket acceptance [NEW]
- Subchapter 25. Transportation, Receipt, Installation and Disposal of Gaming Machines or Devices [NEW]
- 325:85-25-1. Restriction on sales, display, distribution, transportation and operation of gaming machines or devices [NEW]
- 325:85-25-2. Transportation of gaming devices into the state [NEW]
- 325:85-25-3. Receipt of gaming machines or devices in the state [NEW]
- 325:85-25-4. Transportation of gaming machines or devices between commission-licensed gaming facilities in the state [NEW]
- 325:85-25-5. Approval to distribute gaming machines or devices outside of the state [NEW]
- 325:85-25-6. On-site testing, installation and placement of gaming machines or devices - including each player terminal and each game [NEW]
- 325:85-25-7. Disposal of gaming machines or devices [NEW]
- Subchapter 27. Requirements for Audits Performed by Gaming Agents [NEW]
- 325:85-27-1. Daily and spot audits [NEW]

**SUMMARY:**

The Commission's *Rules for Racetrack Gaming* were adopted under emergency rulemaking procedures on March 17, 2005 and Governor Henry approved the rules on April 6, 2005. The Commission is now starting the permanent rulemaking process for the *Rules for Racetrack Gaming*.

**AUTHORITY:**

75 O.S., § 303; Title 3A O.S. § 204(A), § 262(F); Oklahoma Horse Racing Commission.

## Notices of Rulemaking Intent

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### COMMENT PERIOD:

Persons wishing to present their views in writing may do so before 4:30 p.m., Monday, January 9, 2006, 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, January 9, 2006, 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 January 9, 2006.

### COPIES OF PROPOSED RULES:

A copy of the proposed rule amendments 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 December 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 #05-1306; filed 11-1-05]

## TITLE 325. OKLAHOMA HORSE RACING COMMISSION CHAPTER 90. GAMING OPERATIONS

[OAR Docket #05-1307]

### RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking.

### PROPOSED RULES:

- Subchapter 1. General Provisions [NEW]
  - 325:90-1-1. Purpose [NEW]
  - 325:90-1-2. Definitions [NEW]
- Subchapter 3. Security and Surveillance Minimum Requirements [NEW]
  - 325:90-3-1. Surveillance systems [NEW]
  - 325:90-3-2. Security and surveillance logs [NEW]

325:90-3-3. Storage and retrieval of surveillance recordings [NEW]

325:90-3-4. Maintenance and testing [NEW]

325:90-3-5. Surveillance system compliance [NEW]

Subchapter 5. Unresolved Patron Disputes [NEW]

325:90-5-1. Unresolved patron disputes [NEW]

325:90-5-2. Compulsive gambling assistance plan [NEW]

325:90-5-3. Minimum standards for compulsive gambling assistance plan [NEW]

325:90-5-4. Employee training regarding compulsive gambling assistance plan [NEW]

325:90-5-5. Annual report regarding compulsive gambling activities [NEW]

Subchapter 7. Smoking Regulations [NEW]

325:90-7-1. Requirements for smoking in gaming facility [NEW]

### SUMMARY:

The Commission's *Rules for Racetrack Gaming* were adopted under emergency rulemaking procedures on March 17, 2005 and Governor Henry approved the rules on April 6, 2005. The Commission is now starting the permanent rulemaking process for the *Rules for Racetrack Gaming*.

### AUTHORITY:

75 O.S., § 303; Title 3A O.S. § 204(A), § 262(F); Oklahoma Horse Racing Commission.

### COMMENT PERIOD:

Persons wishing to present their views in writing may do so before 4:30 p.m., Monday, January 9, 2006, 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, January 9, 2006, 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 January 9, 2006.

### COPIES OF PROPOSED RULES:

A copy of the proposed rule amendments 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 December 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 #05-1307; filed 11-1-05]*

**TITLE 380. DEPARTMENT OF LABOR  
CHAPTER 25. BOILER AND PRESSURE  
VESSEL RULES**

*[OAR Docket #05-1366]*

**RULEMAKING ACTION:**

Notice of proposed PERMANENT rulemaking.

**PROPOSED RULES:**

Subchapter 7. General Requirements  
380:25-7-18. Air and ventilation requirements -  
combustion air supply and ventilation of boiler room  
[AMENDED]

**SUMMARY:**

The proposed amendment to OAC 380:25-7-18 will bring the boiler and pressure vessel rule for proper air and ventilation requirements of gas-fired boilers and pressure vessels installed prior to 1995 into alignment with nationally-recognized fire safety standards by mandating compliance with the National Fire Protection Association's National Fuel Gas Code, NFPA 54 - the standard already adopted by the Office of the Oklahoma State Fire Marshal. In order to prevent possible flame roll-out and the excess levels of carbon monoxide that can result from an inadequate supply of combustion air, the amendment specifies that boilers and pressure vessels must meet NFPA 54 requirements and replaces the inadequate formula and chart contained in the current text of the rule.

**AUTHORITY:**

Commissioner of Labor; 40 O.S. 141.1 et seq.

**COMMENT PERIOD:**

Written and oral comments on the proposed rules will be accepted until the conclusion of the public hearing January 6, 2006. Comments may be submitted in person between 8 a.m. and 5 p.m., Monday through Friday, except official state holidays, at the below address. Comments sent by mail must be received by the Oklahoma Department of Labor no later than January 6, 2006, and should be addressed as follows:

Oklahoma Department of Labor  
Comments: Chapter 25 Rules  
Attention: E.J. Stefanik  
4001 N. Lincoln Blvd.  
Oklahoma City, OK 73105

**PUBLIC HEARING:**

A public hearing is scheduled for 10 a.m. January 6, 2006. Interested persons may present oral argument, data, and

views at the public hearing. Time will be allocated evenly to each person who requests to be heard. The public hearing will conclude at such time as those attending have had full opportunity to present their views but in no event later than 11 a.m. January 6, 2006. The hearing will be held in the 3<sup>rd</sup> floor conference room at the Oklahoma Department of Labor, 4001 North Lincoln Blvd., Oklahoma City, Oklahoma.

**REQUESTS 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 costs, including costs such as reporting, recordkeeping, equipment, construction, labor, professional services, revenue loss, or other costs expected to be incurred by the business entity due to compliance with the proposed rules. Information mailed by business entities must be received by the Oklahoma Department of Labor by January 6, 2006, and should be addressed as follows:

Oklahoma Department of Labor  
Business Comments: Chapter 25 Rules  
Attention: E.J. Stefanik  
4001 N. Lincoln Blvd.  
Oklahoma City, OK 73105

**COPIES OF PROPOSED RULES:**

All requests for copies must be in writing and include the complete address of the person requesting the copies. Copies may be picked up in person between 8 a.m. and 5 p.m., Monday through Friday, except official state holidays, at the below address. Copies of the proposed rules may be obtained upon written request addressed to:

Oklahoma Department of Labor  
Copy of Proposed Rules: Chapter 25 Rules  
Attention: E.J. Stefanik  
4001 N. Lincoln Blvd.  
Oklahoma City, OK 73105

**RULE IMPACT STATEMENT:**

A Rule Impact Statement will be available by December 16, 2006. All requests for the Rule Impact Statement must be in writing and include the complete address of the person requesting it. The Rule Impact Statement may be picked up in person between 8 a.m. and 5 p.m., Monday through Friday, except official state holidays, at the above address. The Rule Impact Statement may be obtained upon written request addressed to:

Oklahoma Department of Labor  
Rule Impact Statement: Chapter 25 Rules  
Attention: E.J. Stefanik  
4001 N. Lincoln Blvd.  
Oklahoma City, OK 73105

**CONTACT PERSON:**

E.J. Stefanik, Rules Liaison, (405) 528-1500, Extension 231

**ADDITIONAL INFORMATION:**

Comments, requests for copies of proposed rules, and requests for the Rule Impact Statement, if any, must be made separately. Each item sent by mail must have sufficient postage

## Notices of Rulemaking Intent

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attached. Insufficient postage will result in the return of the item unopened. Requests for documents to be returned by mail must include a self-addressed envelope.

*[OAR Docket #05-1366; filed 11-9-05]*

### **TITLE 485. OKLAHOMA BOARD OF NURSING CHAPTER 10. LICENSURE OF PRACTICAL AND REGISTERED NURSES**

*[OAR Docket #05-1309]*

#### **RULEMAKING ACTION:**

Notice of proposed PERMANENT rulemaking

#### **PROPOSED RULES:**

Subchapter 7. Requirements for Registration and Licensure as a Registered Nurse

485:10-7-2. [AMENDED]

Subchapter 9. Requirements for Registration and Licensure as a Licensed Practical Nurse

485:10-9-1. [AMENDED]

485:10-9-2. [AMENDED]

Subchapter 10. Advanced Unlicensed Assistive Personnel

485:10-10-8.1. [NEW]

Subchapter 15. Requirements for Practice as an Advanced Practice Nurse

485:10-15-4. [AMENDED]

485:10-15-4.1. [AMENDED]

485:10-15-6. [AMENDED]

485:10-15-7. [AMENDED]

Subchapter 16. Requirements for Prescriptive Authority for Advanced Practice Nurses

485:10-16-1. [AMENDED]

485:10-16-2. [AMENDED]

485:10-16-3. [AMENDED]

485:10-16-4. [AMENDED]

485:10-16-5. [AMENDED]

485:10-16-6. [AMENDED]

485:10-16-7. [AMENDED]

485:10-16-8. [AMENDED]

Subchapter 18. Prescriptive Authority for C.R.N.A.

485:10-18-2. [AMENDED]

#### **SUMMARY:**

The proposed revisions to 485:10-7-2 and 485:10-9-2 identify practice requirements for licensure by endorsement and clarify requirements for foreign-educated applicants and for issuance of a temporary license. The proposed revisions to 485:10-9-1 ensure that Air Force medics applying for practical nurse licensure meet educational requirements. The proposed addition of rules under 485:10-10-8.1 address requirements for reinstatement of Advanced Unlicensed Assistant certification. 485:10-15-4 clarifies national certification requirements for advanced practice nurses applying for initial and continuing recognition. 485:10-15-4.1 clarifies requirements for advanced practice nurses to receive

temporary recognition. In 485:10-15-6 and 485:10-15-7, education and national certification for Advanced Registered Nurse Practitioners (ARNP) and Clinical Nurse Specialists are addressed. In addition, a category for the Acute Care Pediatric ARNP is added. The proposed revisions to 485:10-16-1 clarify categories of education for advanced practice nurses applying for and holding prescriptive authority. In 485:10-16-3, information regarding initial educational requirements for prescriptive authority is clarified. There are minor clarifications made to 485:10-16-2, 485:10-16-4 and 485:10-16-6. Content from 485:10-16-8 has been moved to 485:10-16-5 to improve the flow of content and make it easier to find information. In addition, a statement regarding the need for a supervising physician is added to emphasize statutory requirements. Finally, requirements for initial application for authority to order, select, obtain and administer drugs by Certified Registered Nurse Anesthetists are clarified in 485:10-18-2.

#### **AUTHORITY:**

Oklahoma Board of Nursing 59 O.S. §567.2A.3, 567.3a.5, 567.3a.6., 567.3a.7, 567.3a.8, 567.3a.9, 567.3a.10, 567.3a.11, 567.3a.12, 567.3a.13, 567.4.F, 567.4a.1, 567.4a.2, 567.4a.3, 567.4a.4, 567.4a.6., 567.4a.7, 567.4a.8, 567.5, 567.6, 567.15.

#### **COMMENT PERIOD:**

Persons wishing to submit written comments must do so by January 20, 2006 at 4:30 p.m. to the Oklahoma Board of Nursing, 2915 N. Classen, Suite 524, Oklahoma City, Oklahoma 73106 Attn: Gayle McNish, R.N., Ed.D.

#### **PUBLIC HEARING:**

A public hearing will be held to provide an opportunity for persons to orally present their views on Tuesday, January 24, 2006 at 5:30 p.m. at the Holiday Inn Conference Center, 2101 S. Meridian, Oklahoma City. Anyone who wishes to speak must sign in at the door by 5:00 p.m., January 24, 2006.

#### **REQUESTS 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 costs expected to be incurred by the business entity due to compliance with the proposed rules. Business entities may submit this information in writing by January 20, 2006 at 4:30 p.m. to the Oklahoma Board of Nursing, 2915 N. Classen, Suite 524, Oklahoma City, OK 73106, Attn: Gayle McNish, R.N., Ed.D.

#### **COPIES OF PROPOSED RULES:**

Copies of the proposed rules may be obtained by contacting Gayle McNish, R.N., Ed.D., at the Oklahoma Board of Nursing, 2915 N. Classen, Suite 524, Oklahoma City, Oklahoma 73106, (405) 962-1800.

#### **RULE IMPACT STATEMENT:**

Pursuant to 75 O.S. Section 303(D), a rule impact statement will be prepared and available on and after publication of this Notice of Rulemaking Intent on December 1, 2005. The rule impact statement may be obtained by contacting Gayle McNish, R.N., Ed.D., at the Oklahoma Board of Nursing, 2915

N. Classen, Suite 524, Oklahoma City, Oklahoma 73106, (405) 962-1800.

**CONTACT PERSON:**

Gayle McNish, R.N., Ed.D., (405) 962-1800

*[OAR Docket #05-1309; filed 11-2-05]*

**TITLE 600. REAL ESTATE APPRAISER BOARD  
CHAPTER 10. LICENSURE AND CERTIFICATION REQUIREMENTS**

*[OAR Docket #05-1341]*

**RULEMAKING ACTION:**

Notice of proposed PERMANENT rulemaking

**PROPOSED RULES:**

- 600:10-1-5. Qualifying education prerequisites [AMENDED]
- 600:10-1-6. Experience prerequisite [AMENDED]
- 600:10-1-7. Continuing education [AMENDED]
- 600:10-1-8. Course approval requirements [AMENDED]
- 600:10-1-16. Supervision of trainee appraisers [AMENDED]

**SUMMARY:**

The proposed amendment to rule 600:10-1-5 removes language no longer necessary and brings the rule into compliance with Policy Statement 10 of the Appraisal Subcommittee of the Federal Financial Institutions Examination Council regarding affidavits. The proposed amendment to rule 600:10-1-6 further defines the procedures for experience review. The proposed amendments to rule 600:10-1-7 remove unnecessary language regarding Trainee Appraisers and specifies required compliance with the Appraiser Qualification Criteria promulgated by the Appraiser Qualification Board regarding the USPAP Update course. The proposed amendments to rule 600:10-1-8 provide for limiting periods of approval for courses and instructors and provide a means of supervision of course providers. The proposed amendments to rule 600:10-1-16 provide for a means of approving trainee supervisors for supervision of more than three Trainee Appraisers in accordance with the Criteria.

**AUTHORITY:**

Real Estate Appraiser Board, 59 O.S. § 858-706(A).

**COMMENT PERIOD:**

Persons may submit written or oral comments to Rod Stirman at the offices of the Real Estate Appraiser Board, Oklahoma Insurance Department, 2401 NW 23rd Street, Suite 28, Oklahoma City, Oklahoma 73107 during the period December 1, 2005 to 1:00 p.m., January 4, 2006.

**PUBLIC HEARING:**

A public hearing will be held at 9:30 a.m. on January 6, 2006, in the offices of the Insurance Commissioner of Oklahoma, the Honorable Kim Holland, at 2401 NW 23rd Street, Suite 28, Oklahoma City, Oklahoma 73107.

**REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:**

Business entities affected by these proposed rules are requested to provide the Board with information, in dollar amounts if possible, about any increases in the level of direct costs expected to be incurred by the business entity due to compliance with the proposed rules. Business entities may submit this information in writing to Rod Stirman at the above address during the period during the period December 1, 2005 to 1:00 p.m., January 4, 2006.

**COPIES OF PROPOSED RULES:**

Copies of proposed rules are available at the Offices of the Real Estate Appraiser Board, Oklahoma Insurance Department, at 2401 NW 23rd Street, Suite 28, Oklahoma City, Oklahoma 73107. Copies of proposed rules may also be obtained by written request to the attention of Rod Stirman, Real Estate Appraiser Board, PO Box 53408, Oklahoma City, OK 73152.

**RULE IMPACT STATEMENT:**

Copies of the Rule Impact Statement may be obtained at the Offices of the Real Estate Appraiser Board, Oklahoma Insurance Department, at 2401 NW 23rd Street, Suite 28, Oklahoma City, Oklahoma 73107.

**CONTACT PERSON:**

Rod Stirman, Director, (405) 521-6636.

*[OAR Docket #05-1341; filed 11-7-05]*

**TITLE 600. REAL ESTATE APPRAISER BOARD  
CHAPTER 15. DISCIPLINARY PROCEDURES**

*[OAR Docket #05-1342]*

**RULEMAKING ACTION:**

Notice of proposed PERMANENT rulemaking

**PROPOSED RULES:**

- 600:15-1-6. Notice of disciplinary proceedings [AMENDED]

**SUMMARY:**

The proposed amendment to rule 600:15-1-6 provides a method of resolving motions, objections and other matters encountered with respect to hearings.

**AUTHORITY:**

Real Estate Appraiser Board, 59 O.S. § 858-706(A).

**COMMENT PERIOD:**

Persons may submit written or oral comments to Rod Stirman at the offices of the Real Estate Appraiser Board, Oklahoma Insurance Department, 2401 NW 23rd Street, Suite 28, Oklahoma City, Oklahoma 73107 during the period December 1, 2005 to 1:00 p.m., January 4, 2006.

**PUBLIC HEARING:**

A public hearing will be held at 9:30 a.m. on January 6, 2006, in the offices of the Insurance Commissioner of

## Notices of Rulemaking Intent

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Oklahoma, the Honorable Kim Holland, at 2401 NW 23<sup>rd</sup> Street, Suite 28, Oklahoma City, Oklahoma 73107.

### **REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:**

Business entities affected by these proposed rules are requested to provide the Board with information, in dollar amounts if possible, about any increases in the level of direct costs expected to be incurred by the business entity due to compliance with the proposed rules. Business entities may submit this information in writing to Rod Stirman at the above address during the period December 1, 2005 to 1:00 p.m., January 4, 2006.

### **COPIES OF PROPOSED RULES:**

Copies of proposed rules are available at the Offices of the Real Estate Appraiser Board, Oklahoma Insurance Department, at 2401 NW 23<sup>rd</sup> Street, Suite 28, Oklahoma City, Oklahoma 73107. Copies of proposed rules may also be obtained by written request to the attention of Rod Stirman, Real Estate Appraiser Board, PO Box 53408, Oklahoma City, OK 73152.

### **RULE IMPACT STATEMENT:**

Copies of the Rule Impact Statement may be obtained at the Offices of the Real Estate Appraiser Board, Oklahoma Insurance Department, at 2401 NW 23<sup>rd</sup> Street, Suite 28, Oklahoma City, Oklahoma 73107.

### **CONTACT PERSON:**

Rod Stirman, Director, (405) 521-6636.

*[OAR Docket #05-1342; filed 11-7-05]*

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## **TITLE 600. REAL ESTATE APPRAISER BOARD CHAPTER 20. COMMITTEES**

*[OAR Docket #05-1343]*

### **RULEMAKING ACTION:**

Notice of proposed PERMANENT rulemaking

### **PROPOSED RULES:**

600:20-1-3. Appointment and Removal of Committee Members [AMENDED]

### **SUMMARY:**

The proposed amendment to 600:20-1-3 enables the Board to organize committees as required by prevailing circumstances.

### **AUTHORITY:**

Real Estate Appraiser Board, 59 O.S. § 858-706(A).

### **COMMENT PERIOD:**

Persons may submit written or oral comments to Rod Stirman at the offices of the Real Estate Appraiser Board, Oklahoma Insurance Department, 2401 NW 23<sup>rd</sup> Street, Suite 28, Oklahoma City, Oklahoma 73107 during the period December 1, 2005 to 1:00 p.m., January 4, 2006.

### **PUBLIC HEARING:**

A public hearing will be held at 9:30 a.m. on January 6, 2006, in the offices of the Insurance Commissioner of Oklahoma, the Honorable Kim Holland, at 2401 NW 23<sup>rd</sup> Street, Suite 28, Oklahoma City, Oklahoma 73107.

### **REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:**

Business entities affected by these proposed rules are requested to provide the Board with information, in dollar amounts if possible, about any increases in the level of direct costs expected to be incurred by the business entity due to compliance with the proposed rules. Business entities may submit this information in writing to Rod Stirman at the above address during the period during the period December 1, 2005 to 1:00 p.m., January 4, 2006.

### **COPIES OF PROPOSED RULES:**

Copies of proposed rules are available at the Offices of the Real Estate Appraiser Board, Oklahoma Insurance Department, at 2401 NW 23<sup>rd</sup> Street, Suite 28, Oklahoma City, Oklahoma 73107. Copies of proposed rules may also be obtained by written request to the attention of Rod Stirman, Real Estate Appraiser Board, PO Box 53408, Oklahoma City, OK 73152.

### **RULE IMPACT STATEMENT:**

Copies of the Rule Impact Statement may be obtained at the Offices of the Real Estate Appraiser Board, Oklahoma Insurance Department, at 2401 NW 23<sup>rd</sup> Street, Suite 28, Oklahoma City, Oklahoma 73107.

### **CONTACT PERSON:**

Rod Stirman, Director, (405) 521-6636.

*[OAR Docket #05-1343; filed 11-7-05]*

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## **TITLE 800. DEPARTMENT OF WILDLIFE CONSERVATION CHAPTER 1. OPERATIONS AND PROCEDURES**

*[OAR Docket #05-1319]*

### **RULEMAKING ACTION:**

Notice of proposed PERMANENT rulemaking

### **PROPOSED RULES:**

Chapter 1. Operations and Procedures [AMENDED]

### **SUMMARY:**

The proposed rule amendments will adjust hunter education class hours in accordance with House Concurrent Resolution 1010 (adopted 2005) and establish additional certification procedures.

### **AUTHORITY:**

Title 29 O.S., Sections 3-103 and 4-112A; Article XXVI, Sections 1 and 3 of the Constitution of Oklahoma; Department of Wildlife Conservation Commission.

**COMMENT PERIOD:**

Persons wishing to present their views in writing may do so on or before 4:30 p.m., January 13, 2006, at the following address: Oklahoma Department of Wildlife Conservation, Room 221, 1801 North Lincoln Boulevard, Oklahoma City, Oklahoma 73105.

**PUBLIC HEARINGS:**

**Date: January 9, 2006**

**Time: 7:00 p.m**

Ada - Pontotoc County Technology Center - 601 W. 33rd  
Caddo - Durant Fish Hatchery -2021 Caddo Hwy  
Lawton - Lawton Public Library - 410 SW 4<sup>th</sup> Street  
Okmulgee - East Central Electric Cooperative - 2001 South Wood Drive  
Tahlequah - Indian Capital Vo-Tech - Herb Roselle Seminar Center - 240 Vo-Tech Rd.

**Date: January 10, 2006**

**Time: 7:00 p.m.**

Altus - Altus Public Library - 421 N. Hudson  
Idabel - Kiamichi Technical Center - Intersection of Hwy 70 and 259 North of Idabel  
Oklahoma City - Oklahoma Department of Wildlife Conservation - 1801 N. Lincoln Blvd.  
Tulsa - Tulsa Technology Center Riverside Campus - Aud. Rm A150 - 801 E. 91<sup>st</sup> St  
Woodward - Northwest Electric - 2925 Williams Ave.

**REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:**

n/a

**COPIES OF PROPOSED RULES:**

Copies of the proposed rules will be available to the public at 1801 N. Lincoln Boulevard, Oklahoma City, Oklahoma 73105, Room 221.

**RULE IMPACT STATEMENT:**

Pursuant to 75 O.S., 303(D), a rule impact statement is being prepared and will be available for review after December 9, 2005 at the above address for the Oklahoma Department of Wildlife Conservation.

**CONTACT PERSON:**

Nels Rodefeld, Assistant Chief of Information and Education Division, 405/521-3855 or Rhonda Hurst, APA Liaison, 405/522-6279.

*[OAR Docket #05-1319; filed 11-2-05]*

**TITLE 800. DEPARTMENT OF WILDLIFE CONSERVATION  
CHAPTER 10. SPORT FISHING RULES**

*[OAR Docket #05-1320]*

**RULEMAKING ACTION:**

Notice of proposed PERMANENT rulemaking

**PROPOSED RULES:**

Chapter 10. Sport Fishing Rules [AMENDED]

**SUMMARY:**

The proposed rule amendments will adjust bag limits and size limits on various fish species and lakes. Proposals include a rule to include Sooner Lake with a limit of twenty (20) striped bass hybrids and/or white bass, or twenty (20) in combination, of which only five (5) may be twenty (20) inches or longer; a rule to include Lake Murray with a minimum size limit of 14 inches on walleye, and a rule to change the current size limit on walleye and saugeye at Foss Lake from 16 inches to 14 inches.

**AUTHORITY:**

Title 29 O.S., Sections 3-103, 4-110, 4-120, 6-302, 6-303; Article XXVI, Sections 1 and 3 of the Constitution of Oklahoma; Department of Wildlife Conservation Commission.

**COMMENT PERIOD:**

Persons wishing to present their views in writing may do so on or before 4:30 p.m., January 13, 2006, at the following address: Oklahoma Department of Wildlife Conservation, Room 221, 1801 North Lincoln Boulevard, Oklahoma City, Oklahoma 73105.

**PUBLIC HEARINGS:**

**Date: January 9, 2006**

**Time: 7:00 p.m.**

Ada - Pontotoc County Technology Center - 601 W. 33rd  
Caddo - Durant Fish Hatchery -2021 Caddo Hwy  
Lawton - Lawton Public Library - 410 SW 4<sup>th</sup> Street  
Okmulgee - East Central Electric Cooperative - 2001 South Wood Drive  
Tahlequah - Indian Capital Vo-Tech - Herb Roselle Seminar Center - 240 Vo-Tech Rd.

**Date: January 10, 2006**

**Time: 7:00 p.m.**

Altus - Altus Public Library - 421 N. Hudson  
Idabel - Kiamichi Technical Center - Intersection of Hwy 70 and 259 North of Idabel  
Oklahoma City - Oklahoma Department of Wildlife Conservation - 1801 N. Lincoln Blvd.  
Tulsa - Tulsa Technology Center Riverside Campus - Aud. Rm A150 - 801 E. 91<sup>st</sup> St  
Woodward - Northwest Electric - 2925 Williams Ave.

**REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:**

n/a

**COPIES OF PROPOSED RULES:**

Copies of the proposed rules will be available to the public at 1801 N. Lincoln Boulevard, Oklahoma City, Oklahoma 73105, Room 221.

**RULE IMPACT STATEMENT:**

Pursuant to 75 O.S., 303(D), a rule impact statement is being prepared and will be available for review after December 9, 2005 at the above address for the Oklahoma Department of Wildlife Conservation.

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### CONTACT PERSON:

Kim Erickson, Chief of Fisheries Division, 405/521-3721 or Rhonda Hurst, APA Liaison, 405/522-6279.

*[OAR Docket #05-1320; filed 11-2-05]*

### TITLE 800. DEPARTMENT OF WILDLIFE CONSERVATION CHAPTER 15. COMMERCIAL HARVEST RULES, AQUATIC SPECIES

*[OAR Docket #05-1321]*

### RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

### PROPOSED RULES:

Chapter 15. Commercial Harvest Rules, Aquatic Species  
[AMENDED]

### SUMMARY:

The proposed rule will remove duplicate language that is already stated in Title 29; 4-103 and correct misspelled words.

### AUTHORITY:

Title 29 O.S., Sections 3-103, 4-103,4-104, 4-105, 6-201, 6-202, 7-102.1; Article XXVI, Sections 1 and 3 of the Constitution of Oklahoma; Department of Wildlife Conservation Commission.

### COMMENT PERIOD:

Persons wishing to present their views in writing may do so on or before 4:30 p.m., January 13, 2006, at the following address: Oklahoma Department of Wildlife Conservation, Room 221, 1801 North Lincoln Boulevard, Oklahoma City, Oklahoma 73105.

### PUBLIC HEARINGS:

**Date: January 9, 2006**

**Time: 7:00 p.m.**

Ada - Pontotoc County Technology Center - 601 W. 33rd  
Caddo - Durant Fish Hatchery -2021 Caddo Hwy  
Lawton - Lawton Public Library - 410 SW 4<sup>th</sup> Street  
Okmulgee - East Central Electric Cooperative - 2001 South Wood Drive  
Tahlequah - Indian Capital Vo-Tech - Herb Roselle Seminar Center - 240 Vo-Tech Rd.

**Date: January 10, 2006**

**Time: 7:00 p.m.**

Altus - Altus Public Library - 421 N. Hudson  
Idabel - Kiamichi Technical Center - Intersection of Hwy 70 and 259 North of Idabel  
Oklahoma City - Oklahoma Department of Wildlife Conservation - 1801 N. Lincoln Blvd.  
Tulsa - Tulsa Technology Center Riverside Campus - Aud. Rm A150 - 801 E. 91<sup>st</sup> St  
Woodward - Northwest Electric - 2925 Williams Ave.

### REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

n/a

### COPIES OF PROPOSED RULES:

Copies of the proposed rules will be available to the public at 1801 N. Lincoln Boulevard, Oklahoma City, Oklahoma 73105, Room 221.

### RULE IMPACT STATEMENT:

Pursuant to 75 O.S., 303(D), a rule impact statement is being prepared and will be available for review after December 9, 2005 at the above address for the Oklahoma Department of Wildlife Conservation.

### CONTACT PERSON:

Kim Erickson, Chief of Fisheries Division, 405/521-3721 or Rhonda Hurst, APA Liaison, 405/522-6279.

*[OAR Docket #05-1321; filed 11-2-05]*

### TITLE 800. DEPARTMENT OF WILDLIFE CONSERVATION CHAPTER 20. RESTRICTIONS ON AQUATIC SPECIES INTRODUCTIONS

*[OAR Docket #05-1322]*

### RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

### PROPOSED RULES:

Chapter 20. Restrictions on aquatic Species Introductions  
[AMENDED]

### SUMMARY:

The proposed rule will add Salvinia species to the "Prohibited Species List" and move alligatorweed from the "Species to Watch List" to the "Prohibited Species List" and add congeneric species.

### AUTHORITY:

Title 29 O.S., Sections 3-103 and 6-601; Article XXVI, Sections 1 and 3 of the Constitution of Oklahoma; Department of Wildlife Conservation Commission.

### COMMENT PERIOD:

Persons wishing to present their views in writing may do so on or before 4:30 p.m., January 13, 2006, at the following address: Oklahoma Department of Wildlife Conservation, Room 221, 1801 North Lincoln Boulevard, Oklahoma City, Oklahoma 73105.

### PUBLIC HEARINGS:

**Date: January 9, 2006**

**Time: 7:00 p.m.**

Ada - Pontotoc County Technology Center - 601 W. 33rd  
Caddo - Durant Fish Hatchery -2021 Caddo Hwy  
Lawton - Lawton Public Library - 410 SW 4<sup>th</sup> Street  
Okmulgee - East Central Electric Cooperative - 2001 South Wood Drive  
Tahlequah - Indian Capital Vo-Tech - Herb Roselle Seminar Center - 240 Vo-Tech Rd.

**Date: January 10, 2006**

**Time: 7:00 p.m.**

Altus - Altus Public Library - 421 N. Hudson  
Idabel - Kiamichi Technical Center - Intersection of Hwy 70 and 259 North of Idabel

Oklahoma City - Oklahoma Department of Wildlife Conservation - 1801 N. Lincoln Blvd.

Tulsa - Tulsa Technology Center Riverside Campus - Aud. Rm A150 - 801 E. 91<sup>st</sup> St

Woodward - Northwest Electric - 2925 Williams Ave.

**REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:**

n/a

**COPIES OF PROPOSED RULES:**

Copies of the proposed rules will be available to the public at 1801 N. Lincoln Boulevard, Oklahoma City, Oklahoma 73105, Room 221.

**RULE IMPACT STATEMENT:**

Pursuant to 75 O.S., 303(D), a rule impact statement is being prepared and will be available for review after December 9, 2005 at the above address for the Oklahoma Department of Wildlife Conservation.

**CONTACT PERSON:**

Kim Erickson, Chief of Fisheries Division, 405/521-3721 or Rhonda Hurst, APA Liaison, 405/522-6279.

*[OAR Docket #05-1322; filed 11-2-05]*

**TITLE 800. DEPARTMENT OF WILDLIFE CONSERVATION  
CHAPTER 25. WILDLIFE RULES**

*[OAR Docket #05-1323]*

**RULEMAKING ACTION:**

Notice of proposed PERMANENT rulemaking

**PROPOSED RULES:**

Chapter 25. Wildlife Rules [AMENDED]

**SUMMARY:**

The proposed rules will clarify what regulations/rules the Department will be enforcing on Corps of Engineers nonlicensed property; include elk and antelope in the big game general provisions; change spring turkey rules to allow more than one tom turkey to be taken in one day; allow the use of recorded turkey calls while hunting turkey; add a new youth only spring turkey season; reduce the number of antlered deer that a hunter may harvest annually; increase the number of deer that can be harvested by archers and make January archery season either sex; lengthen the muzzleloader season by adding an additional seven days; allow limited harvest of red fox; allow an increase in the harvest limit of raccoons; various wildlife management area season adjustments; remove the once in a lifetime restriction from landowner antelope permits; adjust

general antelope regulations; make minimum age restriction for McAAP the same as department areas; add exemptions to Commercial Hunt Areas; adjust application process for Import/Export permits and update various housekeeping measures.

**AUTHORITY:**

Title 29 O.S., Sections 3-103 and 5-401; Article XXVI, Sections 1 and 3 of the Constitution of Oklahoma; Department of Wildlife Conservation Commission.

**COMMENT PERIOD:**

Persons wishing to present their views in writing may do so on or before 4:30 p.m., January 13, 2006, at the following address: Oklahoma Department of Wildlife Conservation, Room 221, 1801 North Lincoln Boulevard, Oklahoma City, Oklahoma 73105.

**PUBLIC HEARINGS:**

**Date: January 9, 2006**

**Time: 7:00 p.m.**

Ada - Pontotoc County Technology Center - 601 W. 33rd  
Caddo - Durant Fish Hatchery -2021 Caddo Hwy  
Lawton - Lawton Public Library - 410 SW 4<sup>th</sup> Street  
Okmulgee - East Central Electric Cooperative - 2001 South Wood Drive  
Tahlequah - Indian Capital Vo-Tech - Herb Roselle Seminar Center - 240 Vo-Tech Rd.

**Date: January 10, 2006**

**Time: 7:00 p.m.**

Altus - Altus Public Library - 421 N. Hudson  
Idabel - Kiamichi Technical Center - Intersection of Hwy 70 and 259 North of Idabel

Oklahoma City - Oklahoma Department of Wildlife Conservation - 1801 N. Lincoln Blvd.

Tulsa - Tulsa Technology Center Riverside Campus - Aud. Rm A150 - 801 E. 91<sup>st</sup> St

Woodward - Northwest Electric - 2925 Williams Ave.

**REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:**

n/a

**COPIES OF PROPOSED RULES:**

Copies of the proposed rules will be available to the public at 1801 N. Lincoln Boulevard, Oklahoma City, Oklahoma 73105, Room 221.

**RULE IMPACT STATEMENT:**

Pursuant to 75 O.S., 303(D), a rule impact statement is being prepared and will be available for review after December 9, 2005 at the above address for the Oklahoma Department of Wildlife Conservation.

**CONTACT PERSON:**

Bill Dinkines, Assistant Chief of Wildlife Division, 405/521-2739 or Rhonda Hurst, APA Liaison, 405/522-6279.

*[OAR Docket #05-1323; filed 11-2-05]*

## Notices of Rulemaking Intent

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### **TITLE 800. DEPARTMENT OF WILDLIFE CONSERVATION CHAPTER 30. DEPARTMENT OF WILDLIFE LANDS MANAGEMENT**

*[OAR Docket #05-1324]*

#### **RULEMAKING ACTION:**

Notice of proposed PERMANENT rulemaking

#### **PROPOSED RULES:**

Chapter 30. Department of Wildlife Lands Management  
[AMENDED]

#### **SUMMARY:**

These rules will change the rules for ATV use on the Ouachita and Rita Blanca WMA's to be the same as the US Forest Service rules and will update policy and charges for oil and gas activity/exploration on department lands.

#### **AUTHORITY:**

Title 29 O.S., Sections 3-103, 3-304 and 5-401; Article XXVI, Sections 1 and 3 of the Constitution of Oklahoma; Department of Wildlife Conservation Commission.

#### **COMMENT PERIOD:**

Persons wishing to present their views in writing may do so on or before 4:30 p.m., January 13, 2006, at the following address: Oklahoma Department of Wildlife Conservation, Room 221, 1801 North Lincoln Boulevard, Oklahoma City, Oklahoma 73105.

#### **PUBLIC HEARINGS:**

**Date: January 9, 2006**

**Time: 7:00 p.m.**

Ada - Pontotoc County Technology Center - 601 W. 33rd

Caddo - Durant Fish Hatchery -2021 Caddo Hwy

Lawton - Lawton Public Library - 410 SW 4<sup>th</sup> Street

Okmulgee - East Central Electric Cooperative - 2001 South Wood Drive

Tahlequah - Indian Capital Vo-Tech - Herb Roselle Seminar Center - 240 Vo-Tech Rd.

**Date: January 10, 2006**

**Time: 7:00 p.m.**

Altus - Altus Public Library - 421 N. Hudson

Idabel - Kiamichi Technical Center - Intersection of Hwy 70 and 259 North of Idabel

Oklahoma City - Oklahoma Department of Wildlife Conservation - 1801 N. Lincoln Blvd.

Tulsa - Tulsa Technology Center Riverside Campus - Aud. Rm A150 - 801 E. 91<sup>st</sup> St

Woodward - Northwest Electric - 2925 Williams Ave.

#### **REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:**

n/a

#### **COPIES OF PROPOSED RULES:**

Copies of the proposed rules will be available to the public at 1801 N. Lincoln Boulevard, Oklahoma City, Oklahoma 73105, Room 221.

#### **RULE IMPACT STATEMENT:**

Pursuant to 75 O.S., 303(D), a rule impact statement is being prepared and will be available for review after December 9, 2005 at the above address for the Oklahoma Department of Wildlife Conservation.

#### **CONTACT PERSON:**

Bill Dinkines, Assistant Chief of Wildlife Division, 405/521-2739 or Rhonda Hurst, APA Liaison, 405/522-6279.

*[OAR Docket #05-1324; filed 11-2-05]*

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# 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.*

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

*[OAR Docket #05-1347]*

**RULEMAKING ACTION:**

Gubernatorial approval of permanent rule

**RULE:**

325:25-1-5. [AMENDED]

**GUBERNATORIAL APPROVAL:**

November 3, 2005

*[OAR Docket #05-1347; filed 11-8-05]*

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

*[OAR Docket #05-1348]*

**RULEMAKING ACTION:**

Gubernatorial approval of permanent rules

**RULE:**

325:30-1-13. [AMENDED]

325:30-1-17. [AMENDED]

**GUBERNATORIAL APPROVAL:**

November 3, 2005

*[OAR Docket #05-1348; filed 11-8-05]*

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

*[OAR Docket #05-1310]*

### RULEMAKING ACTION:

EMERGENCY adoption

### RULES:

Subchapter 3. General Provider Policies

Part 1. General Scope and Administration

317:30-3-5. [AMENDED]

Part 3. General Medical Program Information

317:30-3-59. [AMENDED]

Subchapter 5. Individual Providers and Specialties

Part 1. Physicians

317:30-5-2. [AMENDED]

317:30-5-9. [AMENDED]

Part 3. Hospitals

317:30-5-41. [AMENDED]

317:30-5-47. [AMENDED]

317:30-5-47.2. through 317:30-5-47.5. [NEW]

317:30-5-48. [REVOKED]

Part 8. Rehabilitation Hospitals [NEW]

317:30-5-110. through 317:30-5-114. [NEW]

(Reference APA WF # 05-15)

### AUTHORITY:

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

### DATES:

#### Adoption:

August 24, 2005

#### Approved by Governor:

October 3, 2005

#### Effective:

Immediately upon Governor's approval or October 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:

The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to comply with House Bill 1088 of the 1<sup>st</sup> Session of the 50<sup>th</sup> Legislature, which provided funding to increase provider reimbursement rates.

### ANALYSIS:

Hospital rules are revised to modify the acute inpatient hospital services reimbursement from a level of care per diem system to a Diagnosis Related Group (DRG) reimbursement system. Under a DRG system, each case is

categorized into a diagnosis related group (DRG). Each DRG has a payment weight assigned to it, based on the average resources used to treat Medicaid patients in a DRG. The DRG weight is multiplied by a peer grouped base rate to determine a hospital's level of payment. Payments to freestanding psychiatric facilities, freestanding rehabilitation hospitals, and children's long term care hospitals will continue to be paid under the per diem system. Payments for graduate medical education (GME) are excluded from this system. The current method of payment for GME will be adjusted to reflect the GME costs using Medicare cost reports, similar to the Medicare payment system. Proposed rule revisions for outpatient hospital reimbursement includes payment for emergency room visits, clinic fees, and observation, based on a hospital's trauma level of care classification as determined by the Oklahoma State Department of Health. Payments for hospitals classified as Level I and II Trauma Centers will receive one rate, Levels III and IV facilities will receive different rates.

### CONTACT PERSON:

Joanne Terlizzi at (405)522-7272

**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 OCTOBER 1, 2005, WHICHEVER IS LATER:**

## SUBCHAPTER 3. GENERAL PROVIDER POLICIES

### PART 1. GENERAL SCOPE AND ADMINISTRATION

#### 317:30-3-5. Assignment and Cost Sharing

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

(1) **"Fee-for-service contract"** means the provider agreement specified in OAC 317:30-3-2. This contract is the contract between the Oklahoma Health Care Authority and medical providers which provides for a fee with a specified service involved.

(2) **"Within the scope of services"** means the set of covered services defined at OAC 317:25-7 and the provisions of the Primary Care Case Manager contracts in the SoonerCare Program.

## Emergency Adoptions

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- (3) **"Outside of the scope of the services"** means all medical benefits outside the set of services defined at OAC 317:25-7 and the provisions of the Primary Care Case Manager contracts in the SoonerCare Program.
- (b) **Assignment in fee-for-service.** The Authority's Medicaid State Plan provides that participation in the medical program is limited to providers who accept, as payment in full, the amounts paid by OHCA plus any deductible, coinsurance, or copayment required by the State Plan to be paid by the recipient and make no additional charges to the patient or others.
- (1) OHCA presumes acceptance of assignment upon receipt of an assigned claim. This assignment, once made, cannot be rescinded, in whole or in part by one party, without the consent of the other party.
- (2) Once an assigned claim has been filed, the patient must not be billed and the patient is not responsible for any balance except the amount indicated by OHCA. The only amount a patient may be responsible for is the personal participation as agreed to at the time of determination of eligibility, or the patient may be responsible for services not covered under the medical programs. The amount of personal participation will be shown on the OHCA notification of eligibility. In any event, the patient should not be billed for charges on an assigned claim until the claim has been adjudicated or other notice of action received by the provider. Any questions regarding amounts paid should be directed to OHCA, Customer Services.
- (3) When potential assignment violations are detected, the Authority will contact the provider to assure that all provisions of the assignment agreement are understood. When there are repeated or uncorrected violations of the assignment agreement, the Authority is required to suspend further payment to the provider.
- (c) **Assignment in SoonerCare.** Any provider who holds a fee for service contract and also executes a contract with a provider in the Primary Care Case Management program shall adhere to the rules of this subsection regarding assignment.
- (1) If the service provided to the recipient is within the scope of the services outlined in the SoonerCare Contract, the recipient shall not be billed for the service. In this case, the provider shall pursue collection from the Primary Care Physician in the case of the SoonerCare Program.
- (2) If the service provided to the recipient is outside of the scope of the services outlined in the SoonerCare Contract, then the provider may bill or seek collection from the recipient.
- (3) In the event there is a disagreement whether the services are in or out of the scope of the contracts referenced in (1) and (2) of this subsection, the Oklahoma Health Care Authority shall be the final authority for this decision. The provider seeking payment under the SoonerCare Program may appeal to OHCA under the provisions of OAC 317:2-1-2.1.
- (4) Violation of this provision shall be grounds for a contract termination in the fee-for-service and SoonerCare programs.
- (d) **Cost Sharing-Copayment.** Section 1902(a)(14) of the Social Security Act permits states to require certain recipients to share some of the costs of Medicaid by imposing upon them such payments as enrollment fees, premiums, deductibles, coinsurance, copayments, or similar cost sharing charges. OHCA requires a copayment of some Medicaid recipients for certain medical services provided through the fee for service program. A copayment is a charge which must be paid by the recipient to the service provider when the service is covered by Medicaid. Section 1916(e) of the Act requires that a provider participating in the Medicaid program may not deny care or services to an eligible individual based on such individual's inability to pay the copayment. A person's assertion of their inability to pay the copayment establishes this inability. This rule does not change the fact that a recipient is liable for these charges and it does not preclude the provider from attempting to collect the copayment.
- (1) Copayment is not required of the following recipients:
- (A) Individuals under age 21. Each recipient's date of birth is available on the REVS system or through a commercial swipe card system.
- (B) Recipients in nursing facilities and intermediate care facilities for the mentally retarded.
- (C) Pregnant women.
- (D) Home and Community Based Waiver service recipients except for prescription drugs.
- (2) Copayment is not required for the following services:
- (A) Family planning services. Includes all contraceptives and services rendered.
- (B) Emergency services provided in a hospital, clinic, office, or other facility.
- (3) Copayments required include:
- (A) \$3.00 per day for inpatient hospital services. Copayments for inpatient care paid under the Diagnosis Related Groups (DRG) methodology are calculated on the actual length of stay and are capped at \$90. Copayments for claims paid under Level of Care methodology are calculated at \$3.00 per day.
- (B) \$3.00 per day for outpatient hospital services.
- (C) \$3.00 per day for ambulatory surgery services including free-standing ambulatory surgery centers.
- (D) \$1.00 for each service rendered by the following providers:
- (i) Physicians,
- (ii) Optometrists,
- (iii) Home Health Agencies,
- (iv) Rural Health Clinics,
- (v) Certified Registered Nurse Anesthetists, and
- (vi) Federally Qualified Health Centers.
- (E) Prescription drugs.
- (i) \$1.00 for prescriptions having a Medicaid allowable of \$29.99 or less.
- (ii) \$2.00 for prescriptions having a Medicaid allowable of \$30.00 or more.
- (F) Crossover claims. Dually eligible Medicare/Medicaid recipients must make a copayment of \$.50 per service for all Part B covered services.

This does not include dually eligible HCBW service recipients.

**PART 3. GENERAL MEDICAL PROGRAM INFORMATION**

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

The following are excluded from Medicaid coverage for adults:

- (1) Inpatient diagnostic studies that could be performed on an outpatient basis.
- (2) Services or any expense incurred for cosmetic surgery, including removal of benign skin lesions.
- (3) Services of two physicians for the same type of service to the same patient at the same time, except when warranted by the necessity of supplemental skills. When supplemental skills are warranted, the initial consultation is reported utilizing the appropriate CPT code for inpatient consultations. Follow-up consultations include monitoring progress, recommending management modifications or advising on a new plan of care in response to changes in the patient's status. If the consultant physician initiates treatment at the initial consultation and participates thereafter in the patient's care, the codes for subsequent hospital care should be used.
- (4) Refractions and visual aids.
- (5) Separate payment for pre and post-operative care when payment is made for surgery.
- (6) Reversal of sterilization procedures for the purposes of conception.
- (7) Treatment for obesity.
- (8) Non therapeutic hysterectomies. Therapeutic hysterectomies require that the following information to be attached to the claim:
  - (A) a copy of an acceptable acknowledgment form signed by the patient, or,
  - (B) an acknowledgment by the physician that the patient has already been rendered sterile, or,
  - (C) a physician's certification that the hysterectomy was performed under a life-threatening emergency situation.
- (9) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or that the pregnancy is the result of an act of rape or incest.
- (10) Medical services considered to be experimental.
- (11) Services of a Certified Surgical Assistant.
- (12) Services of a Chiropractor. Payment is made for Chiropractor services on Crossover claims for coinsurance and/or deductible only.
- (13) Services of a Registered Physical Therapist.
- (14) Services of a Psychologist.
- (15) Services of a Speech and Hearing Therapist.

- ~~(16) Physician and hospital services in a general acute care hospital beyond the 24 day compensable hospital period per person per State fiscal year.~~
- ~~(4716) Payment for more than four outpatient visits per month (home, office, outpatient hospital) per patient, except those visits in connection with family planning or emergency medical condition.~~
- ~~(4817) Payment for more than two nursing home visits per month.~~
- ~~(4918) More than one inpatient visit per day per physician.~~

**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**

**PART 1. PHYSICIANS**

**317:30-5-2. General coverage by category**

(a) **Adults.** Payment for adults is made to physicians for medical and surgical services within the scope of the Authority's medical programs, provided the services are reasonable and necessary for the diagnosis and treatment of illness or injury, or to improve the functioning of a malformed body member. Coverage of certain services may be based on a determination made by the medical consultant in individual circumstances.

- (1) Coverages include the following:
  - (A) ~~Effective August 1, 2000, all general acute care inpatient hospital services for all persons 21 years of age or older, will be limited to 24 days per person per state fiscal year (July 1 through June 30). This limitation does not apply to free standing psychiatric facilities providing inpatient treatment to persons under 21 years of age and 65 years of age and older. The 24 days limitation applies to both hospital and physician services. Payment will be made for up to 24 hospital days paid on hospital claims during a state fiscal year for each individual recipient. These days will be maintained on the recipient record. Physician claims for hospital visits will be paid until the last compensable hospital day is captured. After 24 hospital days have been captured, no inpatient physician services will be paid beyond the last compensable hospital day. No exceptions or extensions will be made to the 24 day inpatient services limitation. Medically appropriate inpatient hospital visits are covered for all Medicaid covered stays. All inpatient services are subject to post-payment review by the OHCA, or its designated agent. ~~Effective October 1, 1993, for all persons ages 21 to 65 years, there is no coverage for inpatient chemical dependency treatment and inpatient detoxification is limited to a maximum of five days per admission and subject to post payment review.~~~~
  - (B) Inpatient psychotherapy by a physician.
  - (C) Inpatient psychological testing by a physician.

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(D) One inpatient visit per day, per physician.

(E) Certain surgical procedures performed in a Medicare certified free-standing ambulatory surgical center or a Medicare certified hospital that offers outpatient surgical services. Refer to the List of Covered Surgical Procedures.

(F) Therapeutic radiology or chemotherapy on an outpatient basis without limitation to the number of treatments per month for persons with proven malignancies or opportunistic infections.

(G) Direct physicians' services are covered on an outpatient basis. A maximum payment of four visits are covered per month per patient in office or home regardless of the number of physicians providing treatment. Additional visits per month are allowed for those services related to emergency medical conditions and for services in connection with Family Planning.

(H) Direct physicians' services in a nursing facility for those patients approved for nursing care. Payment is made for a maximum of two nursing facility visits per month. To receive payment for a second nursing facility visit in a month denied by Medicare for a Medicare/Medicaid patient, attach the EOMB from Medicare showing denial and mark "carrier denied coverage".

(I) Payment is made for medically necessary diagnostic x-ray and laboratory work.

(J) One screening mammogram and one follow-up mammogram every year for women beginning at age 30. Additional follow-up mammograms are covered when medically necessary. A prior authorization by the Medical Professional Services Division of the Oklahoma Health Care Authority is required for additional follow-up mammograms. This includes interpretation and technical component.

(K) Obstetrical care.

(L) Pacemakers and prostheses inserted during the course of a surgical procedure. Payment is made based upon an invoice for the item.

(M) Prior authorized examinations for the purpose of determining medical eligibility for programs under the jurisdiction of the Authority. A copy of the authorization, DHS form ABCDM-16, Authorization for Examination and Billing, must accompany the claim.

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

(O) Family planning - including sterilization procedures for legally competent persons 21 years of age and over who voluntarily request such a procedure and, with their physician, execute the Federally mandated consent form (ADM-71). A copy of the consent form must be attached to the claim form. Separate payment is made for an I.U.D. inserted during an office visit. Certain family planning products may

be obtained through the Vendor Drug Program. Reversal of sterilization procedures for the purposes of conception are not covered. Reversal of sterilization procedures may be covered when medically indicated and substantiating documentation is attached to the claim. The Norplant System for birth control is covered; however, removal of the Norplant System prior to five years is covered only when documented as medically necessary. Reinsertion of Norplant contraceptive will be considered on a case by case basis.

(P) Genetic counseling (requires special medical review prior to approval).

(Q) Blood count weekly for persons receiving the drug Clozaril.

(R) Complete blood count and platelet count prior to receiving chemotherapeutic agents or radiation therapy and for persons receiving medication such as DPA-D-Penicillamine on a regular basis for treatment other than malignancies.

(S) Payment of ultrasounds for pregnant women as specified in OAC 317:30-5-22.

(T) Payment to the attending physician in a teaching medical facility for compensable services when the physician signs as claimant and renders personal and identifiable services to the patient in conformity with Federal regulations.

(U) Payment to clinical fellow or chief resident in an outpatient academic setting when the following conditions are met:

(i) Recognition as clinical faculty with participation in such activities as faculty call, faculty meetings, and having hospital privileges;

(ii) Board certification or completion of an accredited residency program in the fellowship specialty area;

(iii) Hold unrestricted license to practice medicine in Oklahoma;

(iv) If Clinical Fellow, practicing during second or subsequent year of fellowship;

(v) Seeing patients without supervision;

(vi) Services provided not for primary purpose of medical education for the clinical fellow or chief resident;

(vii) Submit billing in own name with appropriate Oklahoma Medicaid provider number.

(viii) Additionally if a clinical fellow practicing during the first year of fellowship, the clinical fellow must be practicing within their area of primary training. The services must be performed within the context of their primary specialty and only to the extent as allowed by their accrediting body.

(V) Payment to the attending physician for the services of a currently Oklahoma licensed physician in training when the following conditions are met.

(i) Attending physician performs chart review and sign off on the billed encounter;

(ii) Attending physician present in the clinic/or hospital setting and available for consultation;

- (iii) Documentation of written policy and applicable training of physicians in the training program regarding when to seek the consultation of the attending physician.
- (W) Payment to the attending physician for the outpatient services of an unlicensed physician in a training program when the following conditions are met:
  - (i) The patient must be at least minimally examined and reviewed by the attending physician or a licensed physician under the supervision of the attending physician;
  - (ii) This contact must be documented in the medical record.
- (X) Payment to a physician for supervision of CRNA services unless the CRNA bills directly.
- (Y) One pap smear per year for women of child bearing age. Two follow-up pap smears are covered when medically indicated.
- (Z) Organ and tissue transplantation services for children and adults, limited to bone marrow, stem cells, cornea, heart, kidney, liver, lung, SPK (simultaneous pancreas kidney), PAK (pancreas after kidney), and heart-lung, are covered services based upon the conditions listed in (i)-(iv) of this subparagraph:
  - (i) All transplantation services, except kidney and cornea, must be prior authorized to be compensable.
  - (ii) To be prior authorized all procedures are reviewed based on appropriate medical criteria.
  - (iii) To be compensable under the Medicaid program all organ transplants must be performed at a Medicare approved transplantation center.
  - (iv) Finally, procedures considered experimental or investigational are not covered.
- (AA) Total parenteral nutritional therapy for certain diagnoses and when prior authorized.
- (BB) Ventilator equipment.
- (CC) Home dialysis equipment and supplies.
- (DD) Ambulatory services for treatment of persons with tuberculosis (TB). This includes, but is not limited to, physician visits, outpatient hospital services, rural health clinic visits and prescriptions. Drugs prescribed for the treatment of TB not listed in OAC 317:30-3-46 require prior authorization by the University of Oklahoma College of Pharmacy using form "Petition for TB Related Therapy". Ambulatory services to persons infected with TB are not limited to the scope of the Medicaid program, but require prior authorization when the scope is exceeded.
- (2) General exclusions include the following:
  - (A) Inpatient diagnostic studies that could be performed on an outpatient basis.
  - (B) Services or any expense incurred for cosmetic surgery including removal of benign skin lesions.
  - (C) Services of two physicians for the same type of service to the same patient at the same time, except when warranted by the necessity of supplemental skills. When supplemental skills are warranted, the initial consultation is reported utilizing the appropriate CPT code for inpatient consultations. Follow-up consultations include monitoring progress, recommending management modifications or advising on a new plan of care in response to changes in the patient's status. If the consultant physician initiates treatment at the initial consultation and participates thereafter in the patient's care, the codes for subsequent hospital care should be used.
  - (D) Refractions and visual aids.
  - (E) Separate payment for pre and post-operative care when payment is made for surgery.
  - (F) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.
  - (G) Sterilization of persons who are under 21 years of age, mentally incompetent or institutionalized. Reversal of sterilization procedures for the purposes of conception.
  - (H) Non-therapeutic hysterectomy.
  - (I) Medical services considered to be experimental or investigational.
  - (J) Payment for more than four outpatient visits per month (home or office) per patient except those visits in connection with family planning, or related to emergency medical conditions.
  - (K) Payment for more than two nursing facility visits per month.
  - (L) More than one inpatient visit per day per physician.
  - (M) Physician supervision of hemodialysis or peritoneal dialysis.
  - (N) Physician services which are administrative in nature and not a direct service to the patient including such items as quality assurance, utilization review, treatment staffing, tumor board, dictation, and similar functions.
  - (O) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.
  - (P) Payment for the services of physicians' assistants, social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out.
  - (Q) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or that the pregnancy is the result of an act of rape or incest. (See OAC 317:30-5-6 or 317:30-5-50.)
  - (R) Night calls or unusual hours.
  - (S) Speech and Hearing services.
  - (T) Treatment for obesity, including weight reduction surgery.
  - (U) Mileage.

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(V) Other than routine hospital visit on date of discharge unless patient expired.

(W) Direct payment to perfusionist as this is considered part of the hospital cost.

(X) Inpatient chemical dependency treatment.

(Y) Fertility treatment.

(Z) Routine immunizations.

(b) **Children.** Payment is made to physicians 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 medically necessary for the diagnosis and treatment of illness or injury, or to improve the functioning of a malformed body member. Medical and surgical services for children are comparable to those listed for adults. In addition to those services listed for adults, the following services are covered for children.

(1) **Pre-authorization of inpatient psychiatric services.** All inpatient psychiatric services for patients under 21 years of age must be prior authorized by an agency designated by the Oklahoma Health Care Authority. All psychiatric services will be prior authorized for an approved length of stay. Non-authorized inpatient psychiatric services will not be Medicaid compensable.

(A) Effective October 1, 1993, all residential and acute psychiatric services will be authorized based on the medical necessity criteria as described in OAC 317:30-5-46.

(B) Out of state placements will not be authorized unless it is determined that the needed medical services are more readily available in another state or it is a general practice for recipients in a particular border locality to use resources in another state. If a medical emergency occurs while a client is out of the state, treatment for medical services will be covered in the same way as they would be covered within the state. A prime consideration for placements will be proximity to the family or guardian in order to involve the family or guardian in discharge and reintegration planning.

(2) **General acute care inpatient service limitations.** All general acute care inpatient hospital services for persons under the age of 21 are not limited. All inpatient care must be medically necessary.

(3) **Procedures for requesting extensions for inpatient services.** The physician and/or facility must provide necessary justification to enable OHCA, or its designated agent, to make a determination of medical necessity and appropriateness of treatment options.

(A) Extension requests for psychiatric admissions must be submitted to the OHCA or its designated agent. Extension requests must contain the appropriate documentation which validates the need for continued treatment in accordance with the medical necessity criteria described in OAC 317:30-5-46. Requests shall be made prior to the expiration of the approved inpatient stay.

(B) If a denial decision is made, a reconsideration request may be made directly to the OHCA, or its designated agent and should occur within 3 days of the denial notification due to the timeliness of processing such a request with the patient still in the facility. The request for reconsideration shall include new and/or additional medical information to justify the need for continued care.

(4) **Utilization control requirements for psychiatric beds.** Medicaid utilization control requirements for inpatient psychiatric services for persons under 21 years of age apply to all hospitals and residential psychiatric treatment facilities.

(5) **Early and periodic screening diagnosis and treatment program.** Payment is also made to eligible providers for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of individuals under age 21. The EPSDT program is a comprehensive child health program, designed for ensuring the availability of and access to required health care resources and helping parents and guardians of Medicaid eligible children effectively use these resources. An effective EPSDT program assures that health problems found are diagnosed and treated early before they become more complex and their treatment more costly. The physician plays a significant role in educating parents and guardians in all services available through the EPSDT program. The receipt of an identified EPSDT screening makes the Medicaid child eligible for all necessary follow-up care that is within the scope of the Medicaid Program. Federal regulations also require that diagnosis and treatment be provided for conditions identified during a screening whether or not they are covered under the Authority's current program. Such services must be allowable under the Federal Regulations. These services must be necessary to ameliorate or correct defects and physical or mental illnesses or conditions and will require prior authorization. The following services are covered under EPSDT:

(A) The Oklahoma Program adopted the following recommendations which includes at least:

- (i) Six screenings during the first year of life;
- (ii) Two screenings in the second year;
- (iii) One screening yearly for ages two thru five years; and
- (iv) One screening every other year for ages 6 thru 20 years.

(B) Periodicity schedules for screening, dental, vision and hearing, and other services include:

(i) **Screening services.** Comprehensive examinations performed by a licensed physician, dentist or other provider qualified under State law to furnish primary medical and health services are covered. See OAC 317:30-3-47 for EPSDT services. Screenings must include all of the following:

(I) A comprehensive health and developmental history (including assessment of both physical and mental health development);

- (II) A comprehensive unclothed physical exam;
  - (III) Appropriate immunizations according to age and health history;
  - (IV) Laboratory tests (including lead blood level assessment appropriate to age and risk); and
  - (V) Health education (including anticipatory guidance).
- (ii) **Vision services.** At a minimum, vision services include diagnosis and treatment for defects in vision, including eyeglasses. In addition, payment is made for glasses for children with congenital aphakia or following cataract removal.
- (iii) **Dental services.** At a minimum, dental services include relief of pain and infections, restoration of teeth and maintenance of dental health. Dental services may not be limited to emergency services. Coverage also includes inpatient services in an eligible participating hospital, outpatient dental screening every 12 months, two bite-wing x-rays, and/or oral prophylaxis one each 12 months; other restoration, repair and/or replacement of dental defects after the treatment plan submitted by a dentist has been authorized. This includes amalgam and composite restoration, pulpotomies, chrome steel crowns, anterior root canals, pulpectomies, band and loop space maintainers, cement bases, acrylic flippers, and lingual arch bars. (Refer to Dental Provider Manual for limitations.)
- (iv) **Hearing services.** At a minimum, hearing services include diagnosis and treatment for defects in hearing, including hearing aids. Hearing aid evaluation once every 12 months and purchase of a hearing aid when prescribed as a result of the hearing aid evaluation.
- (v) **Immunizations.** Federal legislation created the Vaccine for Children Program to be effective October 1, 1994. Vaccines will be provided free of charge to all enrolled providers for Medicaid eligible children. Participating providers may bill for an administration fee to be set by HCFA on a regional basis. They may not refuse to immunize based on inability to pay the administration fee. Medicaid will continue to pay non-participating providers for vaccines and an administration fee of \$2.10 until April 1, 1995, when Federal Financial Participation will no longer be available.
- (vi) **Appropriate laboratory tests.** Use medical judgement in determining the applicability of the laboratory tests or analyses to be performed. If any laboratory tests or analyses are medically contraindicated at the time of the screening, provide them when no longer medically contraindicated laboratory tests should only be given when medical judgement determines they are appropriate.

However, laboratory tests should not be routinely administered.

- (I) As appropriate, conduct the following laboratory tests: Anemia test; Sickle cell test. If a child has been properly tested once for sickle cell disease, the test need not be repeated. Tuberculin test. Give a tuberculin test to every child who has not received one within a year.
  - (II) Lead toxicity screening. Where age and risk factors indicate it is medically appropriate to perform a blood level assessment, a blood level assessment is mandatory. See OAC 317:30-3-50 for required lead screening guidelines.
- (vii) **Other necessary health care.** Other necessary health care, diagnostic services, treatment and other measures to correct or ameliorate defects, and physical and mental illnesses and conditions discovered by the screening services.
- (I) Interperiodic screenings outside the periodicity schedule for screening examinations are allowed at necessary intervals when a medical condition is suspected.
  - (II) Outpatient care for acute physical injury.
  - (III) Prescribed drugs beyond the prescription limitation.
  - (IV) Inpatient psychotherapy for individuals under 21 years of age when prior authorized. Payment is made to psychologists who are licensed to practice.
  - (V) Inpatient psychological testing. Limited to one hour per recipient each 12 months. If medically necessary, additional hours will be prior authorized. Payment is made to psychologists who are licensed to practice.
  - (VI) Outpatient psychological services for eligible individuals under 21 years of age when prior authorized. See (V) of this unit for limitations.
- (6) **Child abuse/neglect findings.** Instances of child abuse and/or neglect discovered through screenings and regular exams are to be reported in accordance with State Law. Title 21, Oklahoma Statutes, Section 846, as amended, states in part: *Every physician or surgeon, including doctors of medicine and dentistry, licensed osteopathic physicians, residents, and interns, examining, attending, or treating a child under the age of eighteen (18) years and every registered nurse examining, attending or treating such a child in the absence of a physician or surgeon, and every other person having reason to believe that a child under the age of eighteen (18) years has had physical injury or injuries inflicted upon him or her by other than accidental means where the injury appears to have been caused as a result of physical abuse or neglect, shall report the matter promptly to the county office of the Department of Human Services in the county wherein the suspected injury occurred. Providing it shall be a*

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*misdemeanor for any person to knowingly and willfully fail to promptly report an incident as provided above. Persons reporting such incidents of abuse and/or neglect in accordance with the law are exempt from prosecution in civil or criminal suits that might be brought as a result of the report.*

(7) **General exclusions.** The following are excluded from coverage for persons under the age of 21:

- (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) Services of two physicians for the same type of service to the same patient at the same time, except when warranted by the necessity of supplemental skills. When supplemental skills are warranted, the initial consultation is reported utilizing the appropriate CPT code for inpatient consultations. Follow-up consultations include monitoring progress, recommending management modifications or advising on a new plan of care in response to changes in the patient's status. If the consultant physician initiates treatment at the initial consultation and participates thereafter in the patient's care, the codes for subsequent hospital care should be used.
- (D) Separate payment for pre and post-operative care when payment is made for surgery.
- (E) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.
- (F) Sterilization of persons who are under 21 years of age.
- (G) Non-therapeutic hysterectomy.
- (H) Medical Services considered to be experimental or investigational.
- (I) More than one inpatient visit per day per physician.
- (J) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or that the pregnancy is the result of an act of rape or incest. (See OAC 317:30-5-6 or 317:30-5-50.)
- (K) Physician supervision of hemodialysis or peritoneal dialysis.
- (L) Physician services which are administrative in nature and not a direct service to the patient including such items as quality assurance, utilization review, treatment staffing, tumor board, dictation, and similar functions.
- (M) Payment for the services of physicians' assistants except as specifically set out.
- (N) Direct payment to perfusionist as this is considered part of the hospital cost.

- (O) Treatment of obesity including weight reduction surgery.
- (P) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.
- (Q) Night calls or unusual hours.
- (R) Mileage.
- (S) Other than routine hospital visit on date of discharge unless patient expired.
- (T) Tympanometry.

(c) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services. For in-State physicians, claims filed with Medicare Part B should automatically cross over to OHCA. The explanation of Medicare Benefits will reflect a message that the claim was referred to Medicaid. If such a message is not present, a claim for coinsurance and deductible must be filed with Medicaid within 90 days of the date of Medicare payment in order to be considered timely filed. The Medicare EOMB must be attached to the claim. If payment was denied by Medicare Part B, and the service is a Medicaid covered service, mark the claim "denied by Medicare".

- (1) Out of state claims will not "cross over". Providers must file a claim for coinsurance and/or deductible within 90 days of the Medicare payment. The Medicare EOMB must be attached to the claim.
- (2) Claims filed under Medicaid must be filed within one year from the date of service. For dually eligible individuals, to be eligible for payment of coinsurance and/or deductible under Medicaid, a claim must be filed with Medicare within one year from the date of service.

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

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

(b) **Covered office services.**

- (1) Payment is made for four office visits (or home) per month per patient, for adults (over age 21), regardless of the number of physicians involved. Additional visits per month are allowed for services related to emergency medical conditions.
- (2) Visits for the purpose of family planning are excluded from the four per month limitation.
- (3) Payment is allowed for insertion of IUD in addition to the office visit.
- (4) Separate payment will be made for the following supplies when furnished during a physician's office visit.
  - (A) Casting materials
  - (B) Dressing for burns
  - (C) Intrauterine device
  - (D) IV Fluids
  - (E) Medications administered by IV
  - (F) Glucose administered IV in connection with chemotherapy in office
- (5) Payment is made for routine physical exams only as prior authorized by the County DHS office and are not counted as an office visit.

- (6) Medically necessary office lab and X-rays are covered.
  - (7) Hearing exams by physician for persons between the ages of 21 and 65 are covered only as a diagnostic exam to determine type, nature and extent of hearing loss.
  - (8) Hearing aid evaluations are covered for persons under 21 years of age.
  - (9) IPPB (Intermittent Positive Pressure Breathing) is covered when performed in physician's office.
  - (10) Payment is made for both office visit and injection of joints performed during the visit.
  - (11) Payment is made for an office visit in addition to allergy testing.
  - (12) Separate payment is made for antigen.
  - (13) Eye exams are covered for persons between ages 21 and 65 for medical diagnosis only.
  - (14) If a physician personally sees a patient on the same day as a dialysis treatment, payment can be made for a separately identifiable service unrelated to the dialysis.
  - (15) The following specimen collection fees are covered:
    - (A) Catheterization for collection of specimen, multiple patients.
    - (B) Catheterization for collection of specimen, single patient, all places of service.
    - (C) Routine Venipuncture.
  - (16) The Professional Component for electrocardiograms, electroencephalograms, electromyograms, and similar procedures are covered on an inpatient basis as long as the interpretation is not performed by the attending physician.
  - (17) Cast removal is covered only when the cast is removed by a physician other than the one who applied the cast.
- (c) **Non-covered office services.**
- (1) Payment is not made separately for an office visit and rectal exam, pelvic exam or breast exam. Office visits including one of these types of exams should be coded with the appropriate office visit code.
  - (2) Payment cannot be made for prescriptions or medication dispensed by a physician in his office.
  - (3) Payment will not be made for completion of forms, abstracts, narrative reports or other reports, separate charge for use of office or telephone calls.
  - (4) Additional payment will not be made for night calls, unusual hours or mileage.
  - (5) Payment is not made for an office visit where the patient did not keep appointment.
  - (6) Refractive services are not covered for persons between the ages of 21 and 65.
  - (7) Removal of stitches is considered part of post-operative care.
  - (8) Payment is not made for a consultation in the office when the physician also bills for surgery.
  - (9) Separate payment is not made for oxygen administered during an office visit.
- (d) **Covered inpatient medical services.**
- (1) ~~For persons between ages 21 and 65, payment is made for 24 days hospital care per state fiscal year. For persons under 21 years of age, payment is made for medically necessary inpatient care. Payment is allowed for inpatient hospital visits for all Medicaid covered admissions.~~ Psychiatric admissions must be prior authorized.
  - (2) Payment is allowed for the services of two physicians when supplemental skills are required and different specialties are involved. When supplemental skills are warranted, the initial consultation is reported utilizing the appropriate CPT code for inpatient consultations. Follow-up consultations include monitoring progress, recommending management modifications or advising on a new plan of care in response to changes in the patient's status. If the consultant physician initiates treatment at the initial consultation and participates thereafter in the patient's care, the codes for subsequent hospital care should be used.
  - (3) Certain medical procedures are allowed in addition to office visits.
  - (4) Payment for critical care is all-inclusive and includes payment for all services that day. Payment for critical care, first hour is limited to one unit per day and 4 units per month. Payment for critical care, each additional 30 minutes is limited to two units per day/month.
- (e) **Non-covered inpatient medical services.**
- (1) For inpatient services, all visits to a patient on a single day are considered one service except where specified. Payment is made for only one visit per day.
  - (2) A hospital admit or visit and surgery on the same day would not be covered if post-operative days are included in the surgical procedure. If there are no post-operative days, a physician can be paid for visits.
  - (3) Drugs administered to inpatients are included in the hospital payment.
  - (4) Payment will not be made to a physician for an admission or new patient work-up when patient receives surgery in out-patient surgery or ambulatory surgery center.
  - (5) Payment is not made to the attending physician for interpretation of tests on his own patient.
- (f) **Other medical services.**
- (1) Payment will be made to physicians providing Emergency Department services.
  - (2) Payment is made for two nursing home visits per month. The appropriate CPT code should be used.
  - (3) When payment is made for "Evaluation of arrhythmias" or "Evaluation of sinus node", the stress study of the arrhythmia includes inducing the arrhythmia and evaluating the effects of drugs, exercise, etc. upon the arrhythmia.
  - (4) When the physician bills twice for the same procedure on the same day, it should be supported by a written report.

### PART 3. HOSPITALS

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### 317:30-5-41. Coverage for adults

For persons 21 years of age or older, payment is made to hospitals for services as described in this Section.

#### (1) Inpatient hospital services.

(A) Effective August 1, 2000, all general inpatient hospital services for all persons 21 years of age or older is limited to 24 days per person per state fiscal year (July 1 through June 30). The 24 day limitation applies to both hospital and physician services. No exceptions or extensions will be made to the 24 day inpatient services limitation.

~~(B) Effective October 1, 1993, inpatient chemical detoxification (alcohol or drugs) for persons age 21 and older is limited to a maximum of five days and subject to post payment review. No continued stay in inpatient chemical detoxification is allowed. Effective October 1, 2005, claims for inpatient admissions provided on or after October 1<sup>st</sup> in acute care hospitals will no longer be subject to the 24 days per person per fiscal year limit. Claims will be reimbursed utilizing a Diagnosis Related Groups (DRG) methodology.~~

~~(C) Effective October 1, 1993, inpatient chemical dependency treatment (alcohol or drugs) for persons age 21 and older is not covered.~~

~~(D)~~ All inpatient services are subject to post-payment utilization review by the Oklahoma Health Care Authority, or its designated agent. These reviews will be based on OHCA's, or its designated agent's, admission criteria on severity of illness and intensity of treatment.

(i) It is the policy and intent to allow hospitals and physicians the opportunity to present any and all documentation available to support the medical necessity of an admission and/or extended stay of a Medicaid recipient. If the OHCA, or its designated agent, upon their initial review determines the admission should be denied, a notice is sent to the facility and the attending physician(s) advising them of the decision. This notice also advises that a reconsideration request may be submitted within 60 days. Additional information submitted with the reconsideration request will be reviewed by the OHCA, or its designated agent, who utilizes an independent physician advisor. If the denial decision is upheld through this review of additional information, OHCA is informed. At that point, OHCA sends a letter to the hospital and physician requesting refund of the Medicaid payment previously made on the denied admission.

(ii) If the hospital or attending physician did not request reconsideration by the OHCA, or its designated agent, the OHCA, or its designated agent, informs OHCA that there has been no request for reconsideration and as a result their initial denial decision is final. OHCA, in turn, sends a letter to the hospital and physician requesting refund of the amount of Medicaid payment previously made on the denied admission.

(iii) If an OHCA, or its designated agent, review results in denial and the denial is upheld throughout the appeal process and refund from the hospital and physician is required, the Medicaid recipient cannot be billed for the denied services.

~~(E)~~ If a hospital or physician believes that an acute care hospital admission or continued stay is not medically necessary and thus not Medicaid compensable but the patient insists on treatment, the patient should be informed that he/she will be personally responsible for all charges. If a Medicaid claim is filed and paid and the service is later denied the patient is not responsible. If a Medicaid claim is not filed and paid the patient can be billed.

~~(F)~~ Payment is made to a participating hospital for hospital based physician's services. The hospital must have a Hospital-Based Physician's Contract with OHCA for this method of billing.

#### (2) Outpatient hospital services.

(A) **Emergency hospital services.** Emergency department services are covered. Payment is made at a case rate which includes all non-physician services provided during the visit.

(B) **Level I - Complete Ultrasound.** Payment will be made separately from the total obstetrical care for one complete ultrasound per pregnancy when the patient has been referred to a radiologist or maternal fetal specialist trained in ultrasonography. The patient's record must be documented as to the reason the ultrasound was requested and the components of the ultrasound. The appropriate HCPC code must be used.

(C) **Level II - Targeted Ultrasound.** Payment will be made separately from the total obstetrical care for one medically necessary targeted ultrasound per pregnancy for high risk pregnancies. Documentation as to the medical justification must be made a part of the patient's record. The targeted ultrasound must be performed:

(i) with equipment capable of producing targeted quality evaluations; and

(ii) by an obstetrician certified by the American Board of Obstetrics and Gynecology as a diplomat with special qualifications in maternal fetal medicine or an active candidate for certification in maternal fetal medicine.

(iii) a complete ultrasound code is used if during the procedure it is apparent that a targeted ultrasound is not medically necessary.

(D) **Dialysis.** Payment for dialysis is made at the Medicare allowable facility rate. This rate includes all services which Medicare has established as an integral part of the dialysis procedure, such as routing medical supplies, certain laboratory procedures, oxygen, etc. Payment is made separately for injections of Epoetin Alfa (EPO or Epogen).

(E) **Technical component.** Payment is made for the technical component of outpatient radiation therapy and compensable x-ray procedures.

(F) **Laboratory.** Payment is made for medically necessary outpatient services.

(G) **Blood.** Payment is made for outpatient blood and blood fractions when these products are required for the treatment of a congenital or acquired disease of the blood.

(H) **Ambulance.**

(I) **Pharmacy.**

(J) **Home health care.** Hospital based home health providers must be Medicare certified and have a current Home Health Agency contract with the Oklahoma Health Care Authority.

(i) Payment is made for home health services provided in a patient's residence to all categorically needy individuals.

(ii) Payment is made for a maximum of 36 visits per year per eligible recipient.

(iii) Payment is made for standard medical supplies.

(iv) Payment is made on a rental or purchase basis for equipment and appliances suitable for use in the home.

(v) Non-covered items include sales tax, enteral therapy and nutritional supplies, and electro-spinal orthosis systems (ESO).

(vi) Payment may be made at a statewide procedure based rate. Payment for any combination of skilled and home health aide visits shall not exceed 36 visits per year.

(vii) Payment may be made to home health agencies for prosthetic devices.

(I) Coverage of oxygen includes rental of liquid oxygen systems, gaseous oxygen systems and oxygen concentrators when prior authorized. A completed HCFA-484 must accompany the initial claim for oxygen. Purchase of oxygen systems may be made where unusual circumstances exist and purchase is considered most appropriate. Refer to the Medical Suppliers Manual for further information.

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

(III) Sterile tracheostomy trays are covered.

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

(V) Payment is made for hyperalimentation, including supplements, supplies and equipment rental in behalf of persons having permanently inoperative internal body organ dysfunction. CC-17 should be submitted to the Medical Authorization Unit. Information regarding the patient's medical condition that

necessitates the hyperalimentation and the expected length of treatment, should be attached.

(VI) Payment is made for ventilator equipment and supplies when prior authorized. CC-17 should be submitted to the Medical Authorization Unit.

(VII) Medical supplies, oxygen, and equipment should be billed using appropriate HCPCS codes which are included in the HCPCS Level II Coding Manual.

(K) **Outpatient hospital services, not specifically addressed.** Outpatient hospital services, not specifically addressed, are covered for adults only when prior authorized by the Medical Professional Services Unit of the Oklahoma Health Care Authority.

(L) **Outpatient chemotherapy and radiation therapy.** Payment is made for charges incurred for the administration of chemotherapy for the treatment of malignancies and opportunistic infections. Payment for radiation therapy is limited to the treatment of proven malignancies and benign conditions appropriate for stereotactic radiosurgery (e.g., gamma knife).

(M) **Ambulatory surgery.**

(i) **Definition of Ambulatory Surgical Center.** An ambulatory surgical center (ASC) is a distinct entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients and which enters into an agreement with HCFA to do so. An ASC may be either independent (i.e., not part of a provider of services or any other facility) or may be operated by a hospital (i.e., under the common ownership, licensure or control of a hospital). If an ASC is the latter type it has the option of being covered and certified under Medicare as an ASC, or of being covered as an outpatient hospital facility. In order to be covered as an ASC operated by a hospital, a facility must:

(I) elect to do so, and continue to be so covered unless HCFA determines there is good cause to do otherwise;

(II) be a separately identifiable entity, physically, administratively, and financially independent and distinct from other operations of the hospital; and

(III) meet all the requirements with regard to health and safety, and agree to the assignment, coverage and reimbursement rules applied to independent ASC's.

(ii) **Certification.** In order to be eligible to enter into an agreement with HCFA to be covered as an ASC, a facility must be surveyed and certified as complying with the conditions for coverage for ASC's in 42 CFR 416.39-49.

(N) **Outpatient surgery services.** The covered facility services are defined as those services furnished by an ASC or OHF in connection with a covered surgical procedure.

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(i) **Services included in the facility reimbursement rate.** Services included in the facility reimbursement rate are:

(I) Nursing, technical and other related services. These include all services in connection with covered procedures furnished by nurses and technical personnel who are employees of the facility. In addition to the nursing staff, this category would include orderlies and others involved in patient care.

(II) Use of the patient of the facility. This category includes operating and recovery rooms, patient preparation areas, waiting rooms, and other areas used by the patient or offered for use by the patient's relatives in connection with surgical services.

(III) Drugs, biologicals, surgical dressings, supplies, splints, casts, appliances and equipment. This category includes all supplies and equipment commonly furnished by the facility in connection with surgical procedures, including any drugs and biologicals administered while the patient is in the facility. Surgical dressings, other supplies, splints, and casts include those furnished by the facility at the time of surgery. Additional supplies and materials furnished later would generally be furnished as incident to a physician's service and not as a facility service. Supplies include those required for both the patient and facility personnel, i.e., gowns, masks, drapes, hoses, scalpels, etc., whether disposable or reusable.

(IV) Diagnostic or therapeutic items and services directly related to the surgical procedure. Payment to the facility includes items and services furnished by facility staff in connection with covered surgical procedures. These diagnostic tests include but are not limited to tests such as urinalysis, blood hemoglobin or hematocrit, CBC and fasting blood sugar, etc.

(V) Administrative, recordkeeping, and housekeeping items and services. These include the general administrative functions necessary to run the facility, such as scheduling, cleaning, utilities, rent, etc.

(VI) Blood, blood plasma, platelets, etc. Under normal circumstances, blood and blood products furnished during the course of the procedure will be included in the payment for the facility charge. In cases of patients with congenital or acquired blood disorders, additional payment can be made within the scope of the Authority's Medical Programs.

(VII) Materials for anesthesia. These include the anesthetic and any materials necessary for its administration.

(ii) **Services not included in facility reimbursement rates.** The following services are not included in the facility reimbursement rate:

(I) Physicians' services. This category includes most services performed in the facility which are not considered facility services. The term physicians' services includes any pre/post-operative services, such as office visits, consultations, diagnostic tests, removal of stitches, changing of dressings, or other services which the individual physician usually includes in a set "global" fee for a given surgical procedure.

(II) The sale, lease, or rental of durable medical equipment to facility patients for use in their homes. If the facility furnishes items of DME to patients it should be treated as a DME supplier and these services billed on a separate claim form. Coverage of DME is limited to the scope of the Authority's Medical Programs.

(III) Prosthetic devices. Prosthetic devices, whether implanted, inserted, or otherwise applied by covered surgical procedures are not included in the facility payment. One of the more common prosthesis is intra-ocular lenses (IOL's). Prosthetic devices should be billed as a separate line item using appropriate HCPCS code.

(IV) Ambulance services. If the facility furnishes ambulance services, they are covered separately as ambulance services if otherwise compensable under the Authority's Medical Programs.

(V) Leg, arm, back and neck braces. These items are not included in the facility payment. Payment is limited to the scope of the Authority's Medical Programs.

(VI) Artificial legs, arms, and eyes. This equipment is not considered part of the facility service and is not included in the facility payment rate. Payment is limited to the scope of the Authority's Medical Programs.

(VII) Services of an independent laboratory. Payment for laboratory services is limited to the scope of the Authority's Medical Programs.

(iii) **Reimbursement - facility services.** The facility services are reimbursed according to the group in which the surgical procedure is listed. If more than one surgical procedure is performed at the same setting, reimbursement will be made for only the major procedure. Reimbursement will be made at a state-wide payment rate based on Medicare's established groups as adapted for Medicaid.

(iv) **Compensable procedures.** The HCPCS codes identify the compensable procedures and should be used in billing.

(O) **Outpatient hospital services for persons infected with tuberculosis (TB).** Outpatient hospital

services are covered for persons infected with tuberculosis. Coverage includes, but may not be limited to, outpatient hospital visits, laboratory work and x-rays. Services to persons infected with TB are not limited to the scope of the Medicaid program; however, prior authorization is required for services that exceed the scope of coverage under Medicaid. Drugs prescribed for the treatment of TB not listed in OAC 317:30-3-46 require prior authorization by the University of Oklahoma College of Pharmacy using form "Petition for TB Related Therapy".

(P) **Mammograms.** Medicaid covers one screening mammogram and one follow-up mammogram every year for women beginning at age 30. Additional follow-up mammograms are covered when medically necessary. A prior authorization by the Medical Professional Services Division of the Oklahoma Health Care Authority is required for additional follow-up mammograms.

(Q) **Treatment/Observation.** Payment is made for the use of a treatment room, or for the room charge associated with outpatient observation services. Observation services must be ordered by a physician or other individual authorized by state law. Observation services are furnished by the hospital on the hospital's premises and include use of the bed and periodic monitoring by hospital staff. Payment is not made for treatment/observation on the same day as an emergency room visit. Observation services are limited to one 24 hour period per incident. Observation services are not covered in addition to an outpatient surgery.

(R) **Clinic charges.** Payment is made for a facility charge for services provided in non-emergency clinics operated by a hospital. This payment does not include the professional charges of the treating physician, nurse practitioner, physician assistant or charges for diagnostic testing. A facility charge is also allowed when drug and/or blood are administered outpatient.

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

- (A) Inpatient diagnostic studies that could be performed on an outpatient basis.
- (B) Procedures that result in sterilization which do not meet the guidelines set forth in this Chapter of rules.
- (C) Reversal of sterilization procedures for the purposes of conception are not covered.
- (D) Medical services considered to be experimental.
- (E) Services or any expense incurred for cosmetic surgery including removal of benign skin lesions.
- (F) Refractions and visual aids.
- (G) Payment for the treatment of obesity.
- (H) **Charges incurred while patient is in a skilled nursing or swing bed.**

**317:30-5-47. Reimbursement for inpatient hospital services**

~~Reimbursement for inpatient hospital services is made based on a prospective per diem level of care payment system. Reimbursement for inpatient care includes services provided to the patient within 72 hours of admission. This includes diagnostic testing, emergency room, observation room, and outpatient surgery charges. The per diem includes all non-physician services furnished either directly or under arrangements. When a patient is taken to another facility with a Medicaid contract for treatment not available at the admitting facility, reimbursement to the treating facility by the admitting facility will be limited to the Medicaid fee schedule. This does not include reimbursement for services in Residential Psychiatric Treatment Facilities.~~

~~(1) **Components.** There are two distinct payment components under this system. Total per diem reimbursement under the reimbursement system will equal the sum of:~~

- ~~(A) Level of care per diem; plus~~
- ~~(B) Fixed capital per diem.~~

~~(2) **Level of care per diem rates.** The level of care per diem rates are payments for operating costs and movable capital costs. Hospitals with actual costs above the statewide median level of care will be limited to reimbursement of the statewide median level of care rate. The median was calculated by level of care using FY 1988 base year operating and moveable capital costs trended forward to the beginning of the third quarter FY 1991. Beginning July 1, 1993, when a hospital's actual costs are less than the statewide median level of care, 25 percent of the difference between the statewide median level of care rate and the hospital's specific level of care cost will be added to each level of care rate.~~

- ~~(A) **Levels of care.** There are eight levels of care:~~
  - ~~(i) Burn Care (Level 1). Presence of burn unit revenue code charges (Revenue code 207);~~
  - ~~(ii) Neonatal intensive Care Unit (NICU) (Level 2). Presence of neonatal intensive care unit revenue code charges on NICU claims from Level III providers (Revenue code 174);~~
  - ~~(iii) Maternity care (Level 3). Diagnosis codes;~~
  - ~~(iv) Surgical care (Level 4). Presence of surgical revenue code charges (Revenue codes 360-369 including C Sections). (See (B)(ii) of this paragraph for exception to payment of minor surgical procedures);~~
  - ~~(v) Rehabilitation care (Level 5). Range of primary and secondary diagnosis codes (Diagnosis codes V57xx-V5799);~~
  - ~~(vi) Psychiatric care (Level 6). Range of primary diagnosis codes (Diagnosis codes 290-316);~~
  - ~~(vii) Intensive Care Unit/Coronary Care Unit (ICU/CCU) (Level 7). Presence of Intensive Care Unit/Coronary Care Unit revenue code charges (Revenue codes 200-206, 208-219);~~
  - ~~(viii) Routine care (Level 8). All remaining days (Revenue codes 101, 110-179, 186-189).~~

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(B) **Claims.** Claims will be classified into each of the eight levels of care based on the hierarchy shown in (A)(i) through (A)(viii) of this paragraph, with claims potentially classifying into Level 1 first, then Level 2, and so forth. Payment of claims classified into Levels 1–6 and Level 8 is made at a single level of care rate. For example, if a claim is classified into Level 3, the Maternity level of care, then all covered days submitted on that claim will be made at the Level 3 per diem rate. There are two exceptions to this rule:

(i) Payment of claims classified into Level 7 may be made at two level of care rates. This would occur if a claim is submitted for payment with both ICU/CCU revenue code charges and routine revenue code charges; payment is split between Levels 7 and 8. For example, if a claim is submitted with three covered ICU/CCU days and seven covered routine days, the claim shall be paid three days at the ICU/CCU per diem rate and seven days at the routine per diem rate. However, if a claim is submitted with ten covered ICU/CCU days and no routine days, ten days will be made at the ICU/CCU level of care rate. Claims for a single stay shall not be split and submitted as two claims solely for the purpose of obtaining two different level of care payment rates (except when patients receiving psychiatric care in acute care hospitals are transferred to medical units because their non-psychiatric medical needs become the primary cause of hospitalization). There are two restrictions on these levels of care:

(I) Only Level III neonatal units will be paid the NICU level of care per diem rate. For rate setting purposes a hospital is considered eligible to receive the level III NICU rate if it meets the criteria used by the Health Planning Commission (now part of the Oklahoma Department of Health) in its 1988 Hospital Utilization and Plan Survey.

(II) All claims from free standing inpatient psychiatric hospitals will be paid at the Level 6, Psychiatric, level of care rate. (Psychiatric claims from acute care hospitals will also be paid at the Level 6 rate).

(ii) Certain surgical procedures are paid at a lower level of care than the surgery rate. These procedures do not require the same resources as most procedures paid at a surgical rate and are classified as minor surgeries and paid at a routine level of care. When a minor surgery is involved, but a level of care other than routine is indicated, payment will be made at the appropriate level of care. Minor procedures include:

(I) 03.31 Spinal Tap

(II) 03.90 Insertion of catheter into spinal canal for infusion of palliative or therapeutic substance

(III) 03.91 Injection of anesthesia into spinal canal

(IV) 03.92 Injection of other agent into spinal canal

(V) 04.80 Injection of peripheral nerve, NOS

(VI) 04.81 Injection of anesthetic into peripheral nerve for analgesia

(VII) 04.89 Injection of other agent (except neurolytic)

(VIII) 06.11 Closed (percutaneous) (needle) biopsy of thyroid gland

(IX) 08.81 Linear repair of laceration of eyelid

(X) 14.21 Destruction of chorioretinal lesion by diathermy

(XI) 14.22 Destruction of chorioretinal lesion by cryotherapy

(XII) 14.23 Destruction of chorioretinal lesion by xenon arc photocoagulation

(XIII) 14.24 Destruction of chorioretinal lesion by laser photocoagulation

(XIV) 14.25 Destruction of chorioretinal lesion, unspecified

(XV) 14.26 Destruction of chorioretinal lesion by radiation therapy

(XVI) 14.29 Destruction of chorioretinal lesion, NOS

(XVII) 16.21 Ophthalmoscopy

(XVIII) 18.02 Incision of external auditory canal

(XIX) 18.11 Otoscopy

(XX) 18.12 Biopsy of external ear

(XXI) 18.19 Other diagnostic procedure on external ear

(XXII) 18.4 Suture of laceration of external ear

(XXIII) 20.1 Removal of tympanostomy tube

(XXIV) 20.31 Electrocochliography

(XXV) 21.00 Control of epistaxis NOS

(XXVI) 21.01 Control of epistaxis by anterior nasal packing

(XXVII) 21.02 Control of epistaxis by posterior and anterior nasal packing

(XXVIII) 21.03 Control of epistaxis by cauterization and packing

(XXIX) 21.22 Biopsy of nose

(XXX) 21.29 Other diagnostic procedure on nose

(XXXI) 21.71 Closed reduction of nasal fracture

(XXXII) 21.81 Suture of laceration of nose

(XXXIII) 22.11 Closed (endoscopic) (needle) biopsy of nasal sinus

(XXXIV) 22.19 Other diagnostic procedure on nasal sinus

(XXXV) 23.2 Restoration of tooth by filling

(XXXVI) 23.3 Restoration of tooth by inlay

- (XXXVII) 23.41 Dental restoration by application of crown
- (XXXVIII) 23.42 Dental restoration by fixed bridge
- (XXXIX) 23.43 Dental restoration by removable bridge
- (XL) 23.49 Dental restoration, other
- (XLI) 24.11 Biopsy of the gum
- (XLII) 24.12 Biopsy of the alveolus
- (XLIII) 24.19 Other diagnostic procedures on teeth, gums, alveoli
- (XLIV) 24.7 Application of orthodontic appliance
- (XLV) 24.8 Other orthodontic operation
- (XLVI) 25.01 Closed (needle) biopsy of tongue
- (XLVII) 25.09 Other diagnostic procedure on tongue
- (XLVIII) 25.51 Suture of laceration of tongue
- (L) 25.91 Lingual frenotomy
- (L) 26.11 Closed (needle) biopsy of salivary gland or duct
- (L) 26.19 Other diagnostic procedures on salivary glands and ducts
- (LI) 26.91 Probing of salivary duct
- (LII) 27.21 Biopsy of bony palate
- (LIV) 27.22 Biopsy of uvula and soft palate
- (LV) 27.23 Biopsy of lip
- (LVI) 27.24 Biopsy of mouth, unspecified structure
- (LVII) 27.29 Other diagnostic procedures on oral cavity
- (LVIII) 27.51 Suture of laceration of lip
- (LIX) 27.52 Suture of laceration of other part of mouth
- (LX) 27.91 Labial frenotomy
- (LXI) 31.41 Tracheoscopy through artificial stoma
- (LXII) 31.42 Laryngoscopy and other tracheoscopy
- (LXIII) 31.43 Closed (endoscopic) biopsy of larynx
- (LXIV) 31.44 Closed (endoscopic) biopsy of trachea
- (LXV) 33.21 Bronchoscopy through artificial stoma
- (LXVI) 33.22 Fiberoptic bronchoscopy
- (LXVII) 33.23 Other bronchoscopy
- (LXVIII) 33.24 Closed (endoscopic) biopsy of bronchus
- (LXIX) 33.91 Bronchial dilation
- (LXX) 34.04 Insertion of intercostal catheter for drainage
- (LXXI) 34.25 Closed (percutaneous) (needle) biopsy of mediastinum
- (LXXII) 34.91 Thoracentesis
- (LXXIII) 34.92 Injection into thoracic cavity
- (LXXIV) 37.70-37.73 Insertion of leads: NOS, atrium, ventricle, atrium and ventricle
- (LXXV) 37.74-37.77 Replacement/revision of leads
- (LXXVI) 37.78 Insertion of temporary pacemaker
- (LXXVII) 38.91 Arterial catheterization
- (LXXVIII) 38.92 Umbilical vein catheterization
- (LXXIX) 38.93 Venous catheterization, NOS
- (LXXX) 38.94 Venous cutdown
- (LXXXI) 38.95 Venous catheterization for renal dialysis
- (LXXXII) 38.98 Other puncture of an artery
- (LXXXIII) 38.99 Other puncture of vein
- (LXXXIV) 39.95 Hemodialysis
- (LXXXV) 42.22 Esophagoscopy through artificial stoma
- (LXXXVI) 42.23 Other esophagoscopy
- (LXXXVII) 42.24 Closed (endoscopic) biopsy of esophagus
- (LXXXVIII) 42.92 Dilation of esophagus
- (LXXXIX) 44.12 Gastrosocopy through artificial stoma
- (XC) 44.13 Other gastrosocopy
- (XCI) 44.14 Closed (endoscopic) biopsy of stomach
- (XCII) 44.22 Endoscopic dilation of pylorus
- (XCIII) 45.12 Endoscopy of large intestine through artificial stoma
- (XCIV) 45.13 EGD
- (XCV) 45.14 Closed (endoscopic) biopsy of small intestine
- (XCVI) 45.16 EGD with biopsy
- (XCVII) 45.22 Endoscopy of large intestine through artificial stoma
- (XCVIII) 45.23 Colonoscopy
- (C) 45.24 Flexible sigmoidoscopy
- (C) 45.25 Colonoscopy with biopsy
- (CI) 45.42 Endoscopic polypectomy of large intestine
- (CII) 48.22 Proctosigmoidoscopy through artificial stoma
- (CIII) 48.23 Rigid proctosigmoidoscopy
- (CIV) 48.24 Closed (endoscopic) biopsy of rectum
- (CV) 54.91 Percutaneous abdominal paracentesis
- (CVI) 54.98 Peritoneal dialysis
- (CVII) 56.31 Ureteroscopy
- (CVIII) 56.32 Closed percutaneous biopsy of ureter
- (CIX) 56.33 Ureteroscopy with biopsy (endoscopic)
- (CX) 57.31 Cystoscopy through artificial stoma
- (CXI) 57.32 Other cystoscopy
- (CXII) 58.22 Other urethroscopy

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- (CXIII) 58.31 Urethroscopy with biopsy
  - (CXIV) 58.6 Dilation of urethra
  - (CXV) 60.11 Closed (percutaneous) biopsy of prostate
  - (CXVI) 62.11 Closed (percutaneous) biopsy of testis
  - (CXVII) 70.0 Culdocentesis
  - (CXVIII) 70.12 Culdotomy
  - (CXIX) 70.21 Vaginotomy
  - (CXX) 71.3 Other local excision or destruction of vulva and perineum
  - (CXXI) 79.00-79.09 Closed reduction of fracture (various sites)
  - (CXXII) 79.70-79.79 Closed reduction of dislocation (various sites)
  - (CXXIII) 81.91 Arthrocentesis
  - (CXXIV) 81.92 Injection of therapeutic substance into joint or ligament
  - (CXXV) 83.21 Biopsy of soft tissue
  - (CXXVI) 84.41 Fitting of prosthesis, upper arm and shoulder
  - (CXXVII) 84.42 Fitting of prosthesis, lower arm and hand
  - (CXXVIII) 84.43 Fitting of prosthesis, arm, NOS
  - (CXXIX) 84.45-84.47 Fitting of prosthesis, above knee, below knee, leg, NOS
  - (CXXX) 85.11 Closed (percutaneous) (needle) biopsy of breast
  - (CXXXI) 85.19 Other diagnostic procedure on breast
  - (CXXXII) 85.91 Aspiration of breast
  - (CXXXIII) 85.92 Injection of therapeutic agent into breast
  - (CXXXIV) 86.01 Aspiration of skin and subcutaneous tissue
  - (CXXXV) 86.03 Incision of pilonidal sinus or cyst
  - (CXXXVI) 86.04 Other incision with drainage of skin and subcutaneous tissue
  - (CXXXVII) 86.07 Insertion of VAD (infusaport)
  - (CXXXVIII) 86.09 Other incision of skin and subcutaneous tissue
  - (CXXXIX) 86.11 Biopsy of skin and subcutaneous tissue
  - (CXL) 86.19 Other diagnostic procedure on skin and subcutaneous tissue
  - (CXLI) 86.26 Ligation of dermal appendage
  - (CXLII) 86.28 Non-excisional debridement of wound
  - (CXLIII) 86.59 Suture of skin and subcutaneous tissue, other sites
  - (CXLIV) 87.01-99.99 Miscellaneous diagnostic and non-surgical procedures
- (iii) ICU/CCU (level 7) and routine (level 8) care are peer grouped based on hospital teaching

and nonteaching status. These two levels of care are peer grouped because a statistically significant difference in cost was found between teaching and nonteaching hospitals in these categories. Therefore, for payment purposes, hospitals that either belong to the Council on Teaching Hospitals or have a medical school affiliation qualify for the teaching peer-grouped rate for Levels 7 and 8. All other hospitals shall receive the nonteaching rate for Levels 7 and 8.

(C) **Adjustments.** Level of care per diem rates will be reviewed periodically and adjusted as necessary through a public process.

(3) **Fixed capital per diem.** The second rate component is the per diem capital component. Fixed capital per diem is calculated separately for acute care inpatient hospitals and freestanding inpatient psychiatric hospitals using different methodologies.

(A) ~~Fixed capital per diem methodology for freestanding psychiatric hospitals.~~ Inpatient psychiatric hospitals fixed rate capital cost will be reimbursed using the average fixed rate capital cost of all Medicaid-enrolled freestanding psychiatric inpatient hospitals from calendar year 1991 cost reports.

(B) ~~Fixed capital per diem methodology for acute care inpatient hospitals.~~ Inpatient hospital fixed capital per diem cost will be reimbursed using a peer group fixed capital weighted payment method.

(i) There are five peer groups based on level of care of the services offered:

(I) Teaching hospitals with burn and NICU units.

(II) Teaching hospitals with NICU units, but no burn unit.

(III) Teaching hospitals without NICU or burn unit.

(IV) Non-teaching hospitals with NICU units, but no burn unit.

(V) Non-teaching hospitals with no burn or NICU unit.

(ii) A value factor for each level of care within a peer group is determined by dividing each level of care per diem rate (peer group statewide level of care rate per diem) by the average of all the level of care rates within a peer group.

(iii) The peer group fixed capital per diem weighted payment component for each level of care is then determined by multiplying the statewide median fixed capital of all inpatient hospitals by the level of care value factor derived in (ii) of this subparagraph.

(C) **Adjustments.** The statewide fixed capital per diem average of all freestanding psychiatric hospitals and the statewide fixed capital per diem median of all inpatient hospitals will be reviewed periodically and adjusted as necessary through a public process.

Reimbursement will be made for inpatient hospital services rendered on or after October 1, 2005, in the following manner:

(1) Covered inpatient services (including organ transplants) provided to eligible Medicaid recipients admitted to in-state acute care and critical access hospitals will be reimbursed at a prospectively set rate which compensates hospitals an amount per discharge for discharges classified according to the Diagnosis Related Group (DRG) methodology. For each Medicaid recipient's stay, a peer group base rate is multiplied by the relative weighting factor for the DRG which applies to the hospital stay. In addition to the Drug payment, an outlier payment may be made to the hospital for very high cost stays. Additional outlier payment is applicable if the DRG payment is less than \$50,000 of the hospital cost. Each inpatient hospital claim is tested to determine whether the claim qualified for a cost outlier payment. Payment is equal to 70% of the cost after the \$50,000 threshold is met.

(2) The DRG payment and outlier, if applicable, represent full reimbursement for all non-physician services provided the inpatient. Payment includes but is not limited to:

(A) laboratory services;

(B) prosthetic devices, including pacemakers, lenses, artificial joints, Cochlear implants, implantable pumps;

(C) technical component on radiology services; and

(D) transportation, including ambulance, to and from another facility to receive specialized diagnostic and therapeutic services.

(3) Hospitals may submit a claim for payment only upon the final discharge of the patient or upon completion of a transfer of the patient to another hospital.

(4) Covered inpatient services provided to eligible recipients of the Oklahoma Medicaid program, when treated in out-of-state hospitals will be reimbursed in the same manner as in-state hospitals.

(5) Cases which indicate transfer from one acute care hospital to another will be monitored under a retrospective utilization review policy to help ensure that payment is not made for inappropriate transfers.

(6) If the transferring or discharge hospital or unit is exempt from the DRG, that hospital or unit will be reimbursed according to the method of payment applicable to the particular facility or units.

(7) Readmissions occurring within 15 days of prior acute care admission for a related condition will be reviewed under a retrospective utilization review policy to determine medical necessity and appropriateness of care. If it is determined that either or both admissions were unnecessary or inappropriate, payment for either or both admissions may be denied. Such review may be focused to exempt certain cases at the sole discretion of the OHCA.

(8) Hospital stays less than three days in length will be reviewed under a retrospective utilization review policy

for medical necessity and appropriateness of care. (Discharges involving healthy mother and healthy newborns may be excluded from this review requirement.) If it is determined that the inpatient stay was unnecessary or inappropriate, the prospective payment for the inpatient stay will be denied.

(9) Organ transplants must be performed at an institution approved by the OHCA for the type of transplant provided. The transplant must be reviewed for medical appropriateness.

(10) Covered inpatient services provided in out-of-state specialty hospitals may be reimbursed at a negotiated rate not to exceed 100% of the cost to provide the service. Negotiation of rates will only be allowed when the OHCA determines that the specialty hospital or specialty unit provides a unique (non-experimental) service required by Medicaid recipients and the provider will not accept the DRG payment rate. Prior authorization is required.

(11) New providers entering the Medicaid program will be assigned a peer group and will be reimbursed at the peer group base rate for the DRG payment methodology or the statewide median rate for per diem methods.

#### (4) **Disproportionate share hospitals (DSH).**

(A) **Eligibility.** A hospital shall be deemed a disproportionate share hospital, as defined by Section 1923 of the federal Social Security Act, if the hospital's Medicaid inpatient utilization rate is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the state or if the hospital's low income utilization rate exceeds 25%.

(i) Eligibility for disproportionate share hospital payments will be determined annually by the OHCA before the beginning of each federal fiscal year based on cost and revenue survey data completed by the hospitals. The survey must be received by OHCA each year by April 30. The information used to complete the survey must be extracted from the hospital's financial records and fiscal year cost report ending in the most recently completed calendar year, for entities that meet the Medicare Provider designation (refer to Medicare Program Memorandum No. A 96-7 for requirements). A hospital may not include costs or revenues on the survey which are attributable to services rendered in a separately licensed/certified entity. Hospitals found to be ineligible for disproportionate share status upon audit shall be required to reimburse the Authority for any disproportionate share payment adjustments paid for the period of ineligibility.

(ii) Beyond meeting either of the tests found in (i) of this subparagraph, there are three additional requirements which are:

(1) Any hospital offering non-emergency obstetrical services must have at least two obstetricians with staff privileges who have agreed to provide services to Medicaid beneficiaries.

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This requirement does not apply to children's hospitals.

(II) In the case of an urban hospital, a hospital located in an MSA, an "obstetrician" is defined as any board-certified obstetrician with staff privileges who performs non-emergency obstetrical services at the hospital. In the case of a rural hospital, an "obstetrician" is defined to include any physician with staff privileges who performs non-emergency obstetrical services at the hospital.

(III) A hospital must have a Medicaid inpatient utilization rate of at least one percent.

### (B) ~~Payment adjustment.~~

(i) ~~Beginning federal fiscal year 1993 and each year thereafter, DSH payment adjustments will be capped by the federal government. Financial participation from the federal government will not be allowed for expenditures exceeding the capped amount. Eligible DSH hospitals will be assigned to one of the three following categories:~~

(I) ~~public-private acute care teaching hospital which has 150 or more full-time equivalent residents enrolled in approved teaching programs (using the most recently completed annual cost report) and is licensed in the state of Oklahoma. Public-private hospital is a former state operated hospital that has entered into a joint operating agreement with a private hospital system;~~

(II) ~~other state hospitals; or~~

(III) ~~private hospitals and all out of state hospitals.~~

(ii) ~~Payment adjustments will be made on a quarterly basis for federal fiscal year 1994 and thereafter using the following formula that determines the hospital's annual allocation:~~

(I) ~~Step 1. The Medicaid revenue and imputed revenue for charity are totaled for each hospital qualifying for disproportionate share adjustments.~~

(II) ~~Step 2. A weight is assigned to each qualifying hospital by dividing each hospital's revenue total (Medicaid and charity) by the revenue total of the public-private acute care teaching hospital, which has the assigned weight of 1.0.~~

(III) ~~Step 3. A weighted value is then determined for each hospital by multiplying the hospital's assigned weight by the hospital's total Medicaid and charity revenue.~~

(IV) ~~Step 4. The weighted values of all hospitals qualifying for disproportionate share adjustments are totaled.~~

(V) ~~Step 5. The percentage of the public-private acute care teaching hospital's weighted value is determined in relation to the weighted~~

~~values of all qualifying disproportionate share hospitals.~~

(VI) ~~Step 6. The weighted values of all state hospitals (except public-private acute care teaching hospital) are totaled.~~

(VII) ~~Step 7. The weighted values of all private and out of state hospitals qualifying for disproportionate share adjustments are totaled.~~

(VIII) ~~Step 8. The percentage of the total weighted values of the hospitals included in Step 6 (State hospitals except public-private acute care teaching hospital) is calculated in relation to the total weighted values (sum of Step 6 and 7) of all remaining hospitals qualifying for disproportionate share adjustment.~~

(IX) ~~Step 9. The percentage of weighted values of the hospitals included in Step 7 (private hospitals and all out of state hospitals) is calculated in relation to the total weighted values (sum of Steps 6 and 7) of all remaining hospitals qualifying for disproportionate share adjustment.~~

(X) ~~Step 10. The weighted percentages for the three hospital groups are next applied to the capped disproportionate share amount allowed by HCFA for the federal fiscal year. The amount of disproportionate share to be paid to the public-private acute care teaching hospital is determined by multiplying the state disproportionate share allotment by the weighted percentage of the public-private acute care teaching hospital. Beginning FFY 96, the weighted percentage amount to be paid will not exceed 82.82%. Payment of disproportionate share funds to public/private hospitals will be made to the public entity that is organizationally responsible for indigent care. The weighted percentage amount is then subtracted from the state disproportionate share allotment. Once the public-private acute care teaching hospital's share of the state disproportionate share allotment has been subtracted, the state hospitals' weighted percentage is applied to the remainder. Beginning FFY 96, the State hospital's weighted percentage (from VIII of this subunit) will not be less than 75.3%. The balance of the disproportionate share allotment is distributed to private hospitals and all out of state hospitals. Distribution of funds within each group will be made according to the relationship of each hospital's weighted value to the total weighted value of the group.~~

(iii) ~~Payment adjustments to individual hospitals will be limited to 100 percent of the hospital's costs of providing services (inpatient and outpatient) to Medicaid recipients and the uninsured, net of payments received from Medicaid (other than DSH) and uninsured patients.~~

(5) **Critical Access Hospitals.** Critical Access Hospitals (CAHs) are rural public or non-profit hospitals which provide 24-hour emergency care services, are limited to 15 inpatient beds (can have 10 additional swing beds) and inpatient stays are limited to 96 hours. A payment adjustment will be made to hospitals certified by the Oklahoma State Department of Health as Critical Access Hospitals.

(6) **Indirect medical education (IME) adjustment.**

(A) Effective February 11, 1999, acute care hospitals that qualify as major teaching hospitals will receive an indirect medical education (IME) payment adjustment, which covers the increased operating, or patient care, costs that are associated with approved intern and resident programs.

(B) In order to qualify as a major teaching hospital and be deemed eligible for an IME adjustment, the hospital or hospitals of common ownership must:

- (i) belong to the Council on Teaching Hospitals or have a medical school affiliation; and
- (ii) be licensed by the State of Oklahoma; and
- (iii) have 150 or more full-time equivalent (FTE) residents enrolled in approved teaching programs.

(C) Eligibility for an IME adjustment will be determined by the OHCA, using the provider's most recently received annual cost report or the application [see paragraph (7) of this subsection] for the quarterly Direct Medical Education Supplemental payment adjustment.

(D) An annual fixed IME payment pool will be established based on the State matching funds made available by transfers from other State agencies. The pool of funds will be distributed annually each State fiscal year. The total pool of monies made available by funds transferred by any State agency will be limited to \$10,038,714, the 1999 base year amount. The base year payment amount will be updated annually each July 1 using the first quarter publication of the DRI PPS type Hospital market basket forecast for the midpoint of the upcoming fiscal year, if funds are available.

(E) The payments will be distributed equally. For hospitals that have public-private ownership, or have entered into a joint operating agreement, payment will be made to the public entity that is organizationally responsible for the public teaching mission.

(F) If payment causes total payments to exceed Medicare upper limits as required by 42 CFR 447.272, the payment will be reduced to not exceed the Medicare upper limit.

(7) **Direct medical education supplemental incentive payment adjustment.**

(A) Effective July 1, 1999, in-state hospitals that qualify as teaching hospitals will receive a supplemental payment adjustment for direct medical education (DME) expenses. These payments will be made in order to encourage training in rural hospital and primary care settings and to recognize the loss of support

for GME due to the advent of Managed Care capitated programs.

(B) In order to qualify as a teaching hospital and be deemed eligible for DME supplemental incentive payment adjustments, the hospital must:

- (i) be licensed by the State of Oklahoma;
- (ii) have costs associated with approved or certified Oklahoma medical residency programs in medicine, osteopathic medicine, and associated specialties and sub-specialties. An approved medical residency program is one approved by the Accrediting Council for Graduate Medical Education of the American Medical Association, by the Bureau of Professional Education of the American Osteopathic Association, or other professional accrediting associations. A resident is defined as a Post Graduate Year 1 (PGY1) and above resident who participates through hospital or hospital-based rotations in approved medical residency/internship programs in Family Medicine, Internal Medicine, Pediatrics, Surgery, Ophthalmology, Psychiatry, Obstetrics/Gynecology, Anesthesiology, Osteopathic medicine, or other Certified Medical Residencies, including specialties and sub-specialties as required in order to become certified by the appropriate board; and
- (iii) apply for certification by the OHCA prior to receiving payments for any quarter during a State Fiscal year. To qualify, a hospital must have a contract with the Oklahoma Health Care Authority (OHCA) to provide Medicaid services and belong to The Council on Teaching Hospitals or otherwise show proof of affiliation with an approved Medical Education Program. Affiliation means an agreement to support the costs of medical residency education in the approved programs.
- (iv) Federal and state hospitals, including Veteran's Administration, Indian Health Service/Tribal and Department of Mental Health Hospitals are not eligible for supplemental DME payments. Major teaching hospitals as defined in (5)(B)(i)(I) of this subsection are eligible.

(C) Determination of a hospital's eligibility for a DME supplemental payment adjustment will be done quarterly by the OHCA based on reports designed by the OHCA. The reports will detail the resident months of support provided by the hospital and the total eligible Medicaid days of service from the paid claims for the same quarter and be attested to by the hospital Administrator, or designated personnel. The annual application must be attested to by the hospital administrator and by the residency program director. All reports will be subject to audit and payments will be recouped for inaccurate or false data. The amount of resident months will also be compared to the annual budgets of the schools, the annual HCFA form 2552 (Cost Report) and the monthly assignment schedules.

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(D) An annual fixed DME payment pool will be established based on the State Matching funds made available by the University Hospitals Authority or other State agencies.

(E) The payments will be distributed based on the relative value of the weighted resident months at each participating hospital. A resident month is defined as a PGY1 and above resident full time equivalent (FTE) for that month. Resident is defined in (B)(ii) of this paragraph. An FTE is defined as a resident assigned by the residency program to a rotation that is hospital or hospital based. The resident must be assigned to a specific hospital for a supervised hospital based residency experience. Required residency clinical or educational experience will be allowed. The time residents spend in non provider settings such as free-standing clinics, nursing homes and physicians' offices in connection with approved programs may be included in determining the number of FTE's in the count if the following conditions are met:

(i) The resident spends his or her time in patient care activities.

(ii) The written agreement between the hospital and the non hospital site must indicate that the hospital will incur the cost of the resident's salary and fringe benefits while the resident is training in the non hospital site and the hospital is providing reasonable compensation to the non hospital site for supervisory teaching activities.

(iii) The hospital must incur all or substantially all of the costs for the training program in the non hospital setting, which means the residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of teaching physicians' salaries and fringe benefits attributable to direct graduate medical education.

(F) Training outside the formal residency program (moonlighting) is not eligible for this payment. The pool of available funds will be distributed quarterly based on the relative value of the eligible hospitals' resident months weighted for Medicaid services rendered.

(i) The weighted relative value is determined as follows:

(I) Annually (prior to each state fiscal year) the OHCA will determine each participating hospital's individual acuity factor from data taken from the Oklahoma MMIS system (or reported claims data) by using the days of services and weights determined for the levels of care.

(II) Determine the total resident months from the quarterly reports in (7)(C) of this subsection for each hospital.

(III) Determine the total eligible patient days for the quarter from the quarterly reports

in (7)(C) of this subsection for each hospital reporting.

(IV) Determine the relative value for each hospital. The relative value is defined as the product of the individual acuity factor [see (I) of this unit] times the total resident months [see (II) of this unit] times the eligible patient days [see III of this unit].

(ii) The pool of available funds will be allocated quarterly based on the prior quarter's relative value as determined in (i)(IV) of this subparagraph. The per resident month amount will be limited to \$11,000 and the total payments will be limited to and not exceed the upper payment limits described in (G) of this paragraph.

(G) If payment in (D) of this paragraph causes total payments to exceed Medicare upper limits as required by CFR 447.272, the payment will be reduced to not exceed the Medicare upper limit.

~~(8) **Non State Public Hospital Payment Adjustment.** Effective July 1, 2002, all Oklahoma non state publicly owned hospitals (i.e., City, County or Title 60 Trust hospitals within the state of Oklahoma that are neither owned nor operated by the state of Oklahoma) shall qualify for a public hospital rate adjustment. The adjustment shall be equal to each eligible hospital's pro rata share of a funding pool, based on the hospital's Medicaid utilization in the base year. The amount of the total pool will not be in excess of the aggregate Medicare related upper payment limit. The amount of the funding pool shall be determined by OHCA annually as follows:~~

~~(A) Using data from the most recently completed cost reports and Medicaid Management Information System data, the OHCA shall determine each non state publicly owned hospital's Medicaid cost (using Medicare allowable cost reimbursement principles) and Medicaid payments.~~

~~(B) The base Medicaid cost will be trended forward using an annual DRI PPS type hospital market basket index. Base year Medicaid payments will be trended by applicable updates to the payment rates.~~

~~(C) Once the Medicaid costs have been trended forward, the base Medicaid payments will be subtracted from the allowable costs. This difference for each hospital is their portion of the total available funding pool.~~

~~(D) The amount of each eligible hospital's payment adjustment shall be its pro rata percentage multiplied by the amount of the funding pool.~~

~~(E) Payment will be made on a quarterly basis.~~

~~(9) **Transplants.** In addition to the normal level of care per diem rate, an additional reimbursement amount may be negotiated, subject to the availability of services. The negotiated rate for the inpatient hospital charges associated with the transplant surgery shall not exceed 75 percent of the billed charges with a maximum payment of \$150,000.~~

~~(10) **Prosthetic devices.** Payment for prosthetic devices implanted during surgery is included within the level of~~

care per diem rates except for: Cochlear Implants, Vagus Nerve Stimulator, and implantable medication pumps. Additional payment will be considered on a case by case basis. A prior authorization from the Medical Professional Services Unit of the OHCA will be required.

**(11) Out of state hospitals.**

(A) Out of state hospitals, for which the Authority has on file a fiscal year 1989 or more recent cost report, shall be reimbursed as follows:

- (i) the level of care per diem rate
- (ii) a fixed capital per diem
- (iii) a hospital specific per diem direct medical education rate.

(B) Hospitals, for which the Authority does not have a fiscal year 1989 or more recent cost report on file, will also receive the level of care per diem rates; however, capital and direct medical education rate components will not be reimbursed on a hospital specific basis. Instead, these hospitals shall receive the statewide median capital per diem amount. The statewide median direct medical education per diem rate will be paid to qualifying hospitals.

(C) In the absence of substantiating information verifying eligibility for the teaching hospital peer group, an out of state hospital will be presumed to be a non teaching hospital and will be paid at the non teaching rate for levels 7 and 8.

(D) In the absence of substantiating information verifying the presence of a burn unit or a level III NICU, an out of state hospital will be presumed to be ineligible for burn and NICU level of care payments.

(E) Out of state hospitals shall submit to the Authority the following documentation (as appropriate):

- (i) Substantiating information verifying qualification as a teaching hospital
- (ii) Substantiating information verifying presence of a burn unit
- (iii) Substantiating information verifying presence of a NICU that meets Level III criteria established by the Health Planning Commission (now part of the Oklahoma Department of Health) in its 1988 Hospital Utilization and Plan Survey.

**317:30-5-47.2. Disproportionate share hospitals (DSH)**

(a) **Eligibility.** A hospital shall be deemed a disproportionate share hospital, as defined by Section 1923 of the federal Social Security Act, if the hospital's Medicaid inpatient utilization rate is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the state or if the hospital's low-income utilization rate exceeds 25%.

(1) Eligibility for disproportionate share hospital payments will be determined annually by the OHCA before the beginning of each federal fiscal year based on cost and revenue survey data completed by the hospitals. The survey must be received by OHCA each year by April 30. The information used to complete the survey must be extracted

from the hospital's financial records and fiscal year cost report ending in the most recently completed calendar year, for entities that meet the Medicare Provider designation (refer to Medicare Program Memorandum No. A-96-7 for requirements). A hospital may not include costs or revenues on the survey which are attributable to services rendered in a separately licensed/certified entity. Hospitals found to be ineligible for disproportionate share status upon audit shall be required to reimburse the Authority for any disproportionate share payment adjustments paid for the period of ineligibility.

(2) Beyond meeting either of the tests found in (1) of this subsection, there are three additional requirements which are:

(A) Any hospital offering non-emergency obstetrical services must have at least two obstetricians with staff privileges who have agreed to provide services to Medicaid beneficiaries. This requirement does not apply to children's hospitals.

(B) In the case of an urban hospital, a hospital located in a MSA, an "obstetrician" is defined as any board-certified obstetrician with staff privileges who performs non-emergency obstetrical services at the hospital. In the case of a rural hospital, an "obstetrician" is defined to include any physician with staff privileges who performs non-emergency obstetrical services at the hospital.

(C) A hospital must have a Medicaid inpatient utilization rate of at least one percent.

**(b) Payment adjustment.**

(1) Beginning federal fiscal year 1993 and each year thereafter, DSH payment adjustments will be capped by the federal government. Financial participation from the federal government will not be allowed for expenditures exceeding the capped amount. Eligible DSH hospitals will be assigned to one of the three following categories:

(A) public-private acute care teaching hospital which has 150 or more full-time equivalent residents enrolled in approved teaching programs (using the most recently completed annual cost report) and is licensed in the state of Oklahoma. Public-private hospital is a former state operated hospital that has entered into a joint operating agreement with a private hospital system;

(B) other state hospitals; or

(C) private hospitals and all out-of-state hospitals.

(2) Payment adjustments will be made on a quarterly basis for federal fiscal year 1994 and thereafter using the following formula that determines the hospital's annual allocation:

(A) Step 1. The Medicaid revenue and imputed revenue for charity are totaled for each hospital qualifying for disproportionate share adjustments.

(B) Step 2. A weight is assigned to each qualifying hospital by dividing each hospital's revenue total (Medicaid and charity) by the revenue total of the public-private acute care teaching hospital, which has the assigned weight of 1.0.

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(C) Step 3. A weighted value is then determined for each hospital by multiplying the hospital's assigned weight by the hospital's total Medicaid and charity revenue.

(D) Step 4. The weighted values of all hospitals qualifying for disproportionate share adjustments are totaled.

(E) Step 5. The percentage of the public-private acute care teaching hospital's weighted value is determined in relation to the weighted values of all qualifying disproportionate share hospitals.

(F) Step 6. The weighted values of all state hospitals (except public-private acute care teaching hospital) are totaled.

(G) Step 7. The weighted values of all private and out-of-state hospitals qualifying for disproportionate share adjustments are totaled.

(H) Step 8. The percentage of the total weighted values of the hospitals included in Step 6 (State hospitals except public-private acute care teaching hospital) is calculated in relation to the total weighted values (sum of Step 6 and 7) of all remaining hospitals qualifying for disproportionate share adjustment.

(I) Step 9. The percentage of weighted values of the hospitals included in Step 7 (private hospitals and all out-of-state hospitals) is calculated in relation to the total weighted values (sum of Steps 6 and 7) of all remaining hospitals qualifying for disproportionate share adjustment.

(J) Step 10. The weighted percentages for the three hospital groups are next applied to the capped disproportionate share amount allowed by CMS for the federal fiscal year. The amount of disproportionate share to be paid to the public-private acute care teaching hospital is determined by multiplying the state disproportionate share allotment by the weighted percentage of the public-private acute care teaching hospital. Beginning FFY 96, the weighted percentage amount to be paid will not exceed 82.82%. Payment of disproportionate share funds to public/private hospitals will be made to the public entity that is organizationally responsible for indigent care. The weighted percentage amount is then subtracted from the state disproportionate share allotment. Once the public-private acute care teaching hospital's share of the state disproportionate share allotment has been subtracted, the state hospitals' weighted percentage is applied to the remainder. Beginning FFY 96, the State hospital's weighted percentage [from (H) of this paragraph] will not be less than 75.3%. The balance of the disproportionate share allotment is distributed to private hospitals and all out-of-state hospitals. Distribution of funds within each group will be made according to the relationship of each hospital's weighted value to the total weighted value of the group.

(3) Payment adjustments to individual hospitals will be limited to 100 percent of the hospital's costs of providing

services (inpatient and outpatient) to Medicaid recipients and the uninsured, net of payments received from Medicaid (other than DSH) and uninsured patients.

### **317:30-5-47.3. Indirect medical education (IME) adjustment**

(a) Effective February 11, 1999, acute care hospitals that qualify as major teaching hospitals will receive an indirect medical education (IME) payment adjustment, which covers the increased operating, or patient care, costs that are associated with approved intern and resident programs.

(b) In order to qualify as a major teaching hospital and be deemed eligible for an IME adjustment, the hospital or hospitals of common ownership must:

- (1) belong to the Council on Teaching Hospitals or have a medical school affiliation; and
- (2) be licensed by the State of Oklahoma; and
- (3) have 150 or more full-time equivalent (FTE) residents enrolled in approved teaching programs.

(c) Eligibility for an IME adjustment will be determined by the OHCA, using the provider's most recently received annual cost report or the application (see OAC 317:30-5-47.3) for the quarterly Direct Medical Education Supplemental payment adjustment.

(d) An annual fixed IME payment pool will be established based on the State matching funds made available by transfers from other State agencies. The pool of funds will be distributed annually each State fiscal year. The total pool of monies made available by funds transferred by any State agency will be limited to \$10,038,714, the 1999 base year amount. The base year payment amount will be updated annually each July 1 using the first quarter publication of the DRI PPS-type Hospital market basket forecast for the midpoint of the upcoming fiscal year, if funds are available.

(e) The payments will be distributed equally. For hospitals that have public-private ownership, or have entered into a joint operating agreement, payment will be made to the public entity that is organizationally responsible for the public teaching mission.

(f) If payment causes total payments to exceed Medicare upper limits as required by 42 CFR 447.272, the payment will be reduced to not exceed the Medicare upper limit.

### **317:30-5-47.4. Direct medical education supplemental incentive payment adjustment**

(a) Effective July 1, 1999, in-state hospitals that qualify as teaching hospitals will receive a supplemental payment adjustment for direct medical education (DME) expenses. These payments will be made in order to encourage training in rural hospital and primary care settings and to recognize the loss of support for GME due to the advent of Managed Care capitated programs.

(b) In order to qualify as a teaching hospital and be deemed eligible for DME supplemental incentive payment adjustments, the hospital must:

- (1) be licensed by the State of Oklahoma;

- (2) have costs associated with approved or certified Oklahoma medical residency programs in medicine, osteopathic medicine, and associated specialties and sub-specialties. An approved medical residency program is one approved by the Accrediting Council for Graduate Medical Education of the American Medical Association, by the Bureau of Professional Education of the American Osteopathic Association, or other professional accrediting associations. A resident is defined as a Post-Graduate Year 1 (PGY1) and above resident who participates through hospital or hospital-based rotations in approved medical residency/internship programs in Family Medicine, Internal Medicine, Pediatrics, Surgery, Ophthalmology, Psychiatry, Obstetrics/Gynecology, Anesthesiology, Osteopathic medicine, or other Certified Medical Residencies, including specialties and sub-specialties as required in order to become certified by the appropriate board; and
- (3) apply for certification by the OHCA prior to receiving payments for any quarter during a State Fiscal year. To qualify, a hospital must have a contract with the Oklahoma Health Care Authority (OHCA) to provide Medicaid services and belong to The Council on Teaching Hospitals or otherwise show proof of affiliation with an approved Medical Education Program. Affiliation means an agreement to support the costs of medical residency education in the approved programs.
- (4) Federal and state hospitals, including Veteran's Administration, Indian Health Service/Tribal and Oklahoma Department of Mental Health and Substance Abuse Services Hospitals are not eligible for supplemental DME payments. Major teaching hospitals are eligible.
- (c) Determination of a hospital's eligibility for a DME supplemental payment adjustment will be done quarterly by the OHCA based on reports designed by the OHCA. The reports will detail the resident-months of support provided by the hospital and the total eligible Medicaid days of service from the paid claims for the same quarter and be attested to by the hospital Administrator, or designated personnel. The annual application must be attested to by the hospital administrator and by the residency program director. All reports will be subject to audit and payments will be recouped for inaccurate or false data. The amount of resident-months will also be compared to the annual budgets of the schools, the annual CMS form 2552 (Cost Report) and the monthly assignment schedules.
- (d) An annual fixed DME payment pool will be established based on the State Matching funds made available by the University Hospitals Authority or other State agencies.
- (e) The payments will be distributed based on the relative value of the weighted resident-months at each participating hospital. A resident-month is defined as a PGY1 and above resident full-time equivalent (FTE) for that month. Resident is defined in (b)(2) of this section. An FTE is defined as a resident assigned by the residency program to a rotation that is hospital or hospital-based. The resident must be assigned to a specific hospital for a supervised hospital-based residency experience. Required residency clinical or educational experience will be allowed. The time residents spend in non-provider settings such as freestanding clinics, nursing homes and physicians' offices in connection with approved programs may be included in determining the number of FTE's in the count if the following conditions are met:
- (1) The resident spends his or her time in patient care activities.
  - (2) The written agreement between the hospital and the non-hospital site must indicate that the hospital will incur the cost of the resident's salary and fringe benefits while the resident is training in the non-hospital site and the hospital is providing reasonable compensation to the non-hospital site for supervisory teaching activities.
  - (3) The hospital must incur all or substantially all of the costs for the training program in the non-hospital setting, which means the residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of teaching physicians' salaries and fringe benefits attributable to direct graduate medical education.
- (f) Training outside the formal residency program (moonlighting) is not eligible for this payment. The pool of available funds will be distributed quarterly based on the relative value of the eligible hospitals' resident-months weighted for Medicaid services rendered.
- (1) The weighted relative value is determined as follows:
    - (A) Annually (prior to each state fiscal year) the OHCA will determine each participating hospital's individual acuity factor from data taken from the Oklahoma MMIS system (or reported claims data) by using the days of services and weights determined for the levels of care.
    - (B) Determine the total resident-months from the quarterly reports in (c) of this section for each hospital.
    - (C) Determine the total eligible patient days for the quarter from the quarterly reports in (c) of this section for each hospital reporting.
    - (D) Determine the relative value for each hospital. The relative value is defined as the product of the individual acuity factor [see (A) of this paragraph] times the total resident-months [see (B) of this paragraph] times the eligible patient days [see (C) of this paragraph].
  - (2) The pool of available funds will be allocated quarterly based on the prior quarter's relative value as determined in (1)(D) of this subsection. The per resident-month amount will be limited to \$11,000 and the total payments will be limited to and not exceed the upper payment limits described in (g) of this section.
- (g) If payment in (d) of this section causes total payments to exceed Medicare upper limits as required by CFR 447.272, the payment will be reduced to not exceed the Medicare upper limit.
- 317:30-5-47.5. Critical Access Hospitals**  
Critical Access Hospitals (CAHs) are rural public or non-profit hospitals which have been certified by Medicare as a

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Critical Access Hospital. The facility must provide documentation to be determined eligible for the CAH peer group.

### **317:30-5-48. Cost reports [REVOKED]**

~~Each hospital shall submit to the Authority its Medicare Cost Report (HCFA 2552), including Medicaid-specific information (as appropriate), for the annual cost reporting period. Failure to submit the required completed cost report shall be grounds for the Authority to determine that a provider is not in compliance with its contractual requirements. The Authority shall enter into a Common Audit Agreement with a designated fiscal intermediary to audit Medicaid cost reports. Hospitals shall submit a copy of their cost reports to this designated fiscal intermediary. All payments made to providers are subject to adjustment based upon final (audited) cost report information.~~

## **PART 8. REHABILITATION HOSPITALS**

### **317:30-5-110. Eligible providers**

To be eligible for reimbursement, all licensed rehabilitation hospitals must be Medicare certified and have a current contract on file with the Oklahoma Health Care Authority (OHCA).

### **317:30-5-111. Coverage for adults**

For persons 21 years of age or older, payment is made to hospitals for inpatient services as described in this section.

(1) All general inpatient hospital services which are not provided under the Diagnosis Related Group (DRG) payment methodology for all persons 21 years of age or older is limited to 24 days per person per state fiscal year (July 1 through June 30). The 24 day limitation applies to both hospital and physician services. No exceptions or extensions will be made to the 24 day inpatient services limitation.

(2) All inpatient services are subject to post-payment utilization review by the Oklahoma Health Care Authority, or its designated agent. These reviews will be based on OHCA's, or its designated agent's, admission criteria on severity of illness and intensity of treatment.

(A) It is the policy and intent to allow hospitals and physicians the opportunity to present any and all documentation available to support the medical necessity of an admission and/or extended stay of a Medicaid recipient. If the OHCA, or its designated agent, upon their initial review determines the admission should be denied, a notice is sent to the facility and the attending physician(s) advising them of the decision. This notice also advises that a reconsideration request may be submitted within 60 days. Additional information submitted with the reconsideration request will be reviewed by the OHCA, or its designated agent, who utilizes an independent physician advisor. If the denial decision is upheld through this review of additional information, OHCA is informed. At that point,

OHCA sends a letter to the hospital and physician requesting refund of the Medicaid payment previously made on the denied admission.

(B) If the hospital or attending physician did not request reconsideration by the OHCA, or its designated agent, the OHCA, or its designated agent, informs OHCA that there has been no request for reconsideration and as a result their initial denial decision is final. OHCA, in turn, sends a letter to the hospital and physician requesting refund of the amount of Medicaid payment previously made on the denied admission.

(C) If an OHCA, or its designated agent, review results in denial and the denial is upheld throughout the appeal process and refund from the hospital and physician is required, the Medicaid recipient cannot be billed for the denied services.

(3) If a hospital or physician believes that a hospital admission or continued stay is not medically necessary and thus not Medicaid compensable but the patient insists on treatment, the patient should be informed that he/she will be personally responsible for all charges. If a Medicaid claim is filed and paid and the service is later denied, the patient is not responsible. If a Medicaid claim is not filed and paid, the patient can be billed.

(4) Payment is made to a participating hospital for hospital based physician's services. The hospital must have a Hospital-Based Physician's contract with OHCA for this method of billing.

### **317:30-5-112. Coverage for children**

Payment is made to rehabilitation hospitals for medical 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 all medically necessary inpatient hospital services, other than psychiatric services, for all persons under the age of 21 will not be limited.

### **317:30-5-113. Medicare eligible individuals**

Payment is made to hospitals for services to Medicare eligible individuals as set forth in this section.

#### **(1) Individuals eligible for Part A and Part B.**

(A) Payment is made utilizing the Medicaid allowable for comparable Part B services.

(B) Payment is made for the coinsurance and/or deductible for Part A services for categorically needy individuals.

#### **(2) Individuals who are not eligible for Part A services.**

(A) The Part B services are to be filed with Medicare. Any monies received from Medicare and any coinsurance and/or deductible monies received from OHCA must be shown as a third party resource on the

appropriate claim form for inpatient per diem. The inpatient per diem should be filed with the fiscal agent along with a copy of the Medicare Payment Report. (B) For individuals who have exhausted Medicare Part A benefits, claims must be accompanied by a statement from the Medicare Part A intermediary showing the date benefits were exhausted.

**317:30-5-114. Reimbursement**

Payment is made at the lesser of the facilities usual and customary fee or the OHCA fixed per diem rate.

*[OAR Docket #05-1310; filed 11-2-05]*

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

*[OAR Docket #05-1312]*

**RULEMAKING ACTION:**

EMERGENCY adoption

**RULES:**

Subchapter 3. General Provider Policies

Part 5. Eligibility

317:30-3-74. [REVOKED]

(Reference APA WF # 05-09B)

**AUTHORITY:**

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR 435.1008 and 435.1009; Section 1905(a)(27)(A) and (B) of the Social Security Act

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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 allow the state to use federal Medicaid funds to offset expenditures for medical care provided to certain individuals who are inpatients in an institution for mental disease, in the custody of the Office of Juvenile Affairs, or inmates in a correctional facility.

**ANALYSIS:**

Eligibility rules are revised to provide Medicaid benefits to certain groups of individuals who previously have been determined ineligible as they were inmates of a public institution. Section 1905(a)(27)(A) of the Social Security Act (SSA) specifically excludes Federal Financial Participation (FFP) for medical care provided to inmates of a public institution, and SSA 1905(a)(27)(B) excludes FFP for inpatients in an institution for mental disease (IMD). Current agency rules prohibit individuals in the custody of the Department of Mental Health or Corrections from qualifying for Medicaid. This revision is needed to remove duplicate information from Medicaid rules and allows consistency with agency rules. In order to support the Oklahoma Department of Corrections (DOC), the Office of Juvenile Affairs (OJA), and

the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) in their efforts to limit expenditures, revisions are proposed to extend Medicaid coverage to individuals who become inpatients of a hospital, nursing facility, juvenile psychiatric facility or an intermediate care facility for the mentally retarded and who are either in the custody of the Office of Juvenile Affairs or the Department of Corrections or who are adults (age 21 through 64) who are patients in an institution for mental disease. These individuals would have to meet all eligibility requirements such as categorical relationship, citizenship, and income the same as other Medicaid recipients. The DOC, OJA, and ODMHSAS will be responsible for the state share and Medicaid will only reimburse for services rendered while the clients are inpatients of a medical institution subject to amount, scope or duration of existing service definitions. Eligibility rules are in need of revision to allow Medicaid coverage for these individuals.

**CONTACT PERSON:**

Joanne Terlizzi at (405)522-7272

**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 SEPTEMBER 1, 2005, WHICHEVER IS LATER:**

**SUBCHAPTER 3. GENERAL PROVIDER  
POLICIES**

**PART 5. ELIGIBILITY**

**317:30-3-74. Persons not eligible for medical assistance [REVOKED]**

~~Individuals who are in the custody of the Department of Mental Health or the Department of Corrections are not eligible for medical assistance.~~

*[OAR Docket #05-1312; filed 11-2-05]*

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

*[OAR Docket #05-1314]*

**RULEMAKING ACTION:**

EMERGENCY adoption

**RULES:**

Subchapter 5. Individual Providers and Specialties

Part 9. Long Term Care Facilities

317:30-5-122. [AMENDED]

(Reference APA WF # 05-12)

**AUTHORITY:**

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; House Bill 1088 of the 1<sup>st</sup> Session of the 50<sup>th</sup> Legislature

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# Emergency Adoptions

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**SUPERSEDED EMERGENCY ACTIONS:**

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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 to comply with House Bill 1088 of the 1<sup>st</sup> Session of the 50<sup>th</sup> Legislature, which provided funding to increase provider reimbursement rates for Medicare coinsurance and deductible payments.

**ANALYSIS:**

Long Term Care Facilities rules are revised to increase the Medicaid payment for Part A coinsurance for Medicare covered skilled nursing facility care for dually eligible individuals. Current rules provide for payment at 50% of the Part A coinsurance for Medicare covered skilled nursing facility care. Additional funds appropriated to the Oklahoma Health Care Authority by House Bill 1088 were mandated to increase certain provider reimbursement rates. The agency is proposing to increase the Medicare skilled nursing facility payment to 100% of the Part A coinsurance. Rule revisions are needed in order to comply with the provisions of House Bill 1088 to increase the Medicaid provider reimbursement rate for Medicare skilled nursing facility care.

**CONTACT PERSON:**

Joanne Terlizzi at (405)522-7272

**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 OCTOBER 1, 2005, WHICHEVER IS LATER:**

## SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

### PART 9. LONG TERM CARE FACILITIES

**317:30-5-122. Levels of care**

The level of care provided by a long term care facility to a patient is based on the nature of the health problem requiring care and the degree of involvement in nursing services/care needed from personnel qualified to give this care.

- (1) **Skilled Nursing facility.** Payment is made ~~at 50% of~~ for the Part A coinsurance for Medicare covered skilled nursing facility care for dually eligible, categorically needy individuals.
- (2) **Nursing Facility.** Care provided by a nursing facility to patients who require professional nursing supervision and a maximum amount of nonprofessional nursing care due to physical conditions or a combination of physical and mental conditions.
- (3) **Intermediate Care Facility for the Mentally Retarded.** Care provided by a nursing facility to patients who require care and active treatment due to mental retardation or developmental disability combined with one or

more handicaps. The mental retardation or developmental disability must have originated during the patient's developmental years (prior to 22 years of chronological age).

*[OAR Docket #05-1314; filed 11-2-05]*

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

*[OAR Docket #05-1313]*

**RULEMAKING ACTION:**

EMERGENCY adoption

**RULES:**

Subchapter 5. Individual Providers and Specialties

Part 19. Nurse Midwives

317:30-5-225. [AMENDED]

Part 37. Advanced Practice Nurse

317:30-5-375. [AMENDED]

(Reference APA WF # 05-13)

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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 remove discrepancies in rules which prevent the agency from reimbursing certain providers who provide services to recipients of Oklahoma Medicaid in states other than Oklahoma.

**ANALYSIS:**

Nurse Midwives and Advanced Practice Nurses rules are revised to clarify provider requirements for providers who practice in states other than Oklahoma. Current rules state that reimbursement may only be made to Advances Practice Nurses and Nurse Midwives who are registered with the Oklahoma Board of Nursing which prevents payments to qualified providers who serve Oklahoma's Medicaid eligible recipients in border states. Revisions will allow reimbursement to out of state providers who are appropriately licensed in the state in which they practice and who have a current contract with the agency.

**CONTACT PERSON:**

Joanne Terlizzi at (405)522-7272

**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 OCTOBER 1, 2005, WHICHEVER IS LATER:**

**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**

**PART 19. NURSE MIDWIVES**

**317:30-5-225. Eligible providers**

The Nurse-Midwife must be a qualified professional nurse registered with the Oklahoma Board of Nurse Registration and Nursing Education who possesses evidence of certification according to the requirement of the American College of Nurse-Midwives, and has the right to use the title Certified Nurse-Midwife and the abbreviation C.N.M. Nurse Midwives who practice in states other than Oklahoma must be appropriately licensed in the state in which they practice. In addition, all providers must have a current contract on file with the Oklahoma Health Care Authority.

(1) In accordance with the Omnibus Budget Reconciliation Act of 1993, effective October 1, 1993, certified nurse midwife services include maternity services, as well as services outside the maternity cycle within the scope of their practice under state law.

(2) The signature of the Nurse-Midwife on Form MS-MA-5, Notification of Needed Medical Services, will be acceptable as medical verification of pregnancy. Form MS-MA-5 should be filed after the first prenatal visit with the local county Oklahoma Department of Human Services office in the county where the patient resides. If Form MS-MA-5 is not completed, a written statement from the Nurse-Midwife verifying the applicant is pregnant and the expected date of delivery is acceptable.

**PART 37. ADVANCED PRACTICE NURSE**

**317:30-5-375. Eligible providers**

The Advanced Practice Nurse must be a registered nurse in good standing with the Oklahoma Board of Nursing, and ~~has have~~ acquired knowledge and clinical skills through the completion of a formal program of study approved by the Oklahoma Board of Nursing Registration and ~~has have~~ obtained professional certification through the appropriate National Board recognized by the Oklahoma Board of Nursing. Advanced Practice Nurse services are limited to ~~primary care health services, within~~ the scope of their practice. ~~"Primary care health services" are as defined in accordance with 59 O.S. 567.3a and corresponding rules and regulations subchapter 15,485; 10-15-1 thru 485 10-16-9 of Oklahoma Nursing Practice Act. Rules regarding Nurse Midwives are referenced in OAC 317:30-5-225. Advanced Practice Nurses who practice in states other than Oklahoma must be appropriately licensed in the state in which they practice. In addition, all providers must have a current contract on file with the Oklahoma Health Care Authority.~~

*[OAR Docket #05-1313; filed 11-2-05]*

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

*[OAR Docket #05-1315]*

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**RULES:**  
Subchapter 5. Individual Providers and Specialties  
Part 33. Transportation by Ambulance  
317:30-5-335. through 317:30-5-336. [AMENDED]  
317:30-5-342. [REVOKED]  
317:30-5-343. [AMENDED]  
**(Reference APA WF # 05-14)**

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**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 Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to comply with House Bill 1088 of the 1<sup>st</sup> Session of the 50<sup>th</sup> Legislature, which provided funding to increase provider reimbursement rates.

**ANALYSIS:**  
Ambulance rules are revised to add coverage by stretcher service, clarify coverage issues, and allow for the adoption of the payment methodology currently utilized by Medicare. The adoption of the Medicare payment methodology which wraps all services, except mileage, into the base rate will simplify billing and bring the Agency more in line with established practices. Clarification of coverage issues will enable ambulance entities to better understand the Agency's policies and is expected to result in less need for inquiries concerning coverage. These changes also clarify that the Agency's Non-Emergency Transportation Waiver, SoonerRide, is the first source of non-emergency transportation for medical services unless the patient's medical status requires transportation by ambulance or stretcher.

**CONTACT PERSON:**  
Joanne Terlizzi at (405)522-7272

**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 OCTOBER 1, 2005, WHICHEVER IS LATER:**

**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**

# Emergency Adoptions

## PART 33. TRANSPORTATION BY AMBULANCE

### 317:30-5-335. Eligible providers

To be eligible for reimbursement, an ambulance company or a stretcher service must be licensed by the State Department of Health. Ambulance companies and all other transportation providers must have a current contract on file with the Oklahoma Health Care Authority (OHCA).

### 317:30-5-336. Coverage for adults

Ambulance transportation for adults is covered as set forth in this Section

#### (1) Covered services.

(A) Ambulance and stretcher transportation is covered only when medically necessary and when due to the patient's condition any other method of transportation is contraindicated. ~~Indicate on the claim what emergency exists, i.e., auto accident. Also indicate patient's condition that requires ambulance level of transportation, i.e., bedfast, comatose, heart attack, etc. Payment for base rate includes payment for all supplies. There is no separate payment for supplies except as set out in this section. Stretcher service is limited to those situations within the scope of the license extended to the entity. The OHCA's Non-Emergency Transportation (NET) Waiver, known as SoonerRide, is the first choice for non-emergency transportation for scheduled medical services. SoonerRide provides non-emergency transportation in accordance with all applicable criteria set forth in the American's with Disabilities Act (ADA). Regularly scheduled non-emergency medical services, such as outpatient dialysis, must be scheduled through SoonerRide unless the patient's condition requires transportation by stretcher or ambulance. All claims for scheduled trips for outpatient services which cannot be provided by SoonerRide must be accompanied by medical documentation to substantiate the need for the higher level of transportation and will be reviewed prior to payment by OHCA staff. Ambulance or stretcher transport for unscheduled emergent medical care will be covered if the trip meets all applicable criteria.~~

(B) As a general rule, only ambulance or stretcher transportation within the ambulance locality is covered. Ambulance locality means the service area surrounding the facility from which the patient seeks service individuals normally travel or are expected to travel to seek medical care. OHCA utilizes the locality areas as defined by Medicare. If ambulance transportation is provided out of the ambulance locality, the claim must be documented with the reason for the trip outside of the service area. If it is determined the patient was transported out of locality and the closest facility could have cared for the patient, payment will be made only for the distance to the nearest medical institution with appropriate facilities.

(C) Appropriate facilities means that the institution is generally equipped to provide the needed hospital or skilled nursing care for the illness or injury involved. In the case of a hospital, it also means that a physician or physician specialist is available to provide the necessary care required to treat the patient's condition. However, the fact that a particular physician does or does not have staff privileges in a hospital is not a consideration in determining whether the hospital has appropriate facilities. Thus, ambulance service to a more distant hospital solely to avail a patient of the service of a specific physician or physician specialist does not make the hospital in which the physician has staff privileges the nearest hospital with appropriate facilities.

(D) The fact that a more distant institution is better equipped to care for the patient does not mean that a closer institution does not have "appropriate facilities". Such a finding is warranted, however, if the beneficiary's condition requires a higher level of trauma care or other specialized service available only at the more distant hospital. However, a legal impediment barring a patient's admission would mean that the institution did not have "appropriate facilities". For example, the nearest ~~tuberculosis hospital transplant center~~ may be in another state and that state's law precludes admission of nonresidents.

(E) An institution is also not considered an appropriate facility if no bed is available. However, ~~if the claim is not medical records must be properly documented, the fiscal agent will assume that a bed was available.~~

(F) Transportation to the outpatient facilities of a hospital, free-standing Ambulatory Surgery Center, Independent Diagnostic Testing Facility (IDTF), physician's office, or other outpatient facility is compensable only if the patient is admitted, has surgery in the ambulatory surgery department, or receives x rays or a cast check for a fractured hip, pelvis, or back patient's condition necessitates ambulance transportation. See definition of bed confined in (P) of this paragraph.

(G) ~~Payment will be made for waiting time or return trip, not both. If a beneficiary is transported to a destination and returned to their original point of pickup, coverage will include payment for the primary transport and return transport. If the provider is required to remain and attend the patient between transports, the provider may claim waiting time. Waiting time shall be paid in half hour increments and shall not include the first half hour. The first 30 minutes of waiting time is included in the base rates.~~

(H) Ambulance transportation from a hospital with a higher level of care to a hospital in the locality is covered.

(I) Transportation from a hospital to a hospital with a lower level of care is covered only if the ~~first hospital lacks appropriate facilities to care for the~~

~~patient and the admitting hospital was the nearest one with appropriate facilities patient is expected to be inpatient for a period greater than one week and the transfer will afford the patient greater access to family and/or caregivers.~~

(J) Ambulance transportation from nursing home to nursing home (skilled or intermediate care) is covered only if the discharging institution is not certified and the admitting nursing home is certified. Nursing home to nursing home transfers are also covered if the patient requires care not available at the discharging facility, i.e., secure Alzheimer's Unit, and the patient's medical status requires ambulance transport.

(K) Transportation for residents of nursing facilities to hospital and back home on same day is covered if medical necessity is documented.

(L) Ambulance transportation to a Veteran's Administration Hospital is covered when the trip has not been authorized by the VA.

~~(M) Transportation to and from a Free Standing Ambulatory Surgery Center is covered when transportation by any other method is contraindicated. If the patient refuses treatment after immediate aid has been provided, the ambulance may bill for waiting time and the base rate.~~

(N) When twins are transported, payment is made for only one trip as twins are considered as one passenger.

~~(O) Electrocardiogram monitoring enroute is covered only when the following conditions are met:~~

~~(i) The ambulance company assures that any state or local laws applicable to EKG monitoring are met.~~

~~(ii) A physician must order the EKG and the same physician must be in communication with the ambulance during the trip.~~

~~(iii) The EKG is reasonable and necessary for the care of the patient.~~

(O) Payment is made according to the medically necessary services actually furnished. That is, payment is based on the level of service furnished, not simply on the vehicle used.

~~(P) Payment for oxygen includes oxygen set up, cannulas, tubing and airways. Payment is based on each 15 minutes or portion thereof. The number of units for each 15 minute increment should be entered in Number of Services column on the claim form using Code A0070.~~

(P) Medical necessity is established when the patient's condition is such that use of any other method of transportation is contraindicated. Non-emergency transports are not covered unless the patient is bed confined or has a medical condition that requires medical expertise not available with a less specialized method of transportation. Bed confined means that the patient is unable to get up from bed without assistance, unable to ambulate, and unable to sit in a chair

or wheelchair. The term bed confined is not synonymous with bed rest or non-ambulatory.

(Q) If the patient dies before dispatch, no payment is available. If the patient dies after dispatch, but before the patient is loaded, payment is allowed for the base rate but no mileage. If the patient dies after pickup, payment is available for the base rate and mileage. Time of death is the point at which the patient is pronounced dead by an individual authorized by the State to make such pronouncements.

~~(QR) Air Ambulance Services, which includes fixed and rotary wing transportation, are covered only where:~~

~~(i) The point of pickup is inaccessible by land vehicle; or~~

~~(ii) Great distances or other obstacles are involved in getting the patient to the nearest hospital with appropriate facilities and speedy admission is essential; i.e., in cases where transportation by land ambulance is contraindicated; and~~

~~(iii) Instances where the patient's condition and other circumstances of the case necessitated the use of this type of transportation. However, where land ambulance service would have sufficed, payment should be based on the amount payable for land ambulance, if this is less costly.~~

~~(iv) Base rate includes the lift off, professional intensive care, transport isolette, ventilator setup, and respiratory setup, using Code A0040 and all other medical services provided during the flight.~~

~~(v) If the accident scene is inaccessible by air and a land ambulance must pick up the patient to transport to a site where the air ambulance can land, the land ambulance trip is covered.~~

~~(vi) Air transportation is covered only to a hospital.~~

~~(vii) If the patient dies before takeoff, no payment is made. This includes situations in which the air ambulance has taxied to the runway, has been cleared for takeoff, but has not actually taken off. Failure of the dispatcher to notify the pilot of the death does not negate this rule. If the patient dies after takeoff but before the patient is loaded, payment is made for the base rate but no mileage. If the patient dies after the patient is loaded, payment is made for the base rate and mileage. Time of death is defined as the point at which the patient has been pronounced dead by an individual authorized by the State to make such pronouncements.~~

~~(viii) Only one base rate is allowed per trip.~~

~~(R) Helicopter ambulance transportation is covered only if it is determined to be medically necessary as set out in (Q) of this paragraph.~~

~~(S) If the accident scene is inaccessible by the helicopter and a land ambulance must pick up the patient to transport them to a site where the helicopter can land, the land ambulance trip is covered.~~

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- (F) Base rate includes the lift off, professional intensive care, transport isolette and all supplies.
- (U) Special Ambulance Transportation (A0050) requires review to determine medical necessity prior to payment.
- (V) Only one base rate is allowed per trip; use the single appropriate code for the base rate.
- (2) **Non-covered services.**
- (A) Transportation by ambulance when patient's condition did not require that level of transportation and another mode of transportation would suffice.
- (B) Ambulance transportation from residence to residence is not covered except for transfers from nursing home to nursing home when the transferring facility is not certified.
- (C) ~~Payment is not made for ambulance transportation provided an individual who has purchased a membership from the ambulance company.~~
- (D) Payment will not be made for ambulance transportation determined not to be medically necessary.
- (E) ~~Transportation of a deceased patient is not covered if the patient was pronounced dead prior to the calling of the ambulance. If the patient expires after the ambulance is called, payment can be made to the point of pick up. If the patient expires while being transported, the entire trip can be covered.~~
- (FD) Transportation to a funeral home, mortuary, or morgue is not covered.
- (G) ~~Transportation by non-certified ambulance, "wheelchair coach", or "aid car", is not covered.~~
- (H) ~~Payment is not made for transportation to a physician's office, unless necessary for emergency treatment, prior to continuing on to the hospital.~~
- (I) ~~Charges for reusable items are not paid. The following are examples of reusable items:~~
- (i) ~~Esophageal obturator~~
  - (ii) ~~Needle retractor~~
  - (iii) ~~Cervical collars and similar immobilization devices~~
  - (iv) ~~Inverters~~
  - (v) ~~Blood pressure cuffs~~
  - (vi) ~~Fracture boards~~
  - (vii) ~~Back boards~~
  - (viii) ~~Neck boards~~
  - (ix) ~~Inflatable leg and arm splints~~
  - (x) ~~Sandbags~~
  - (xi) ~~Airways~~
  - (xii) ~~Orthopedic stretchers~~
  - (xiii) ~~Oxygen tanks~~
- (J) ~~Service charges for late payments are not allowed.~~
- (KE) Ambulance transportation is not covered when provided while the patient was an inpatient. For example, transportation to and from another facility for tests, x-rays, etc., while still an inpatient of another

facility is not compensable. All non-physician services furnished an inpatient are part of the inpatient bill.

(L) ~~Payment is not made for services which can only be administered by a physician such as cannula insertion, airway insertion, intubation, cardioversion, drug administration, prescription drugs, CPR, etc.~~

(MF) ~~Payment is not made for more than one base rate per trip.~~

### 317:30-5-342. Public transportation [REVOKED]

~~Payment is made to public transportation companies for transportation for eligible individuals and an escort, if necessary, when authorized by OHCA.~~

(1) ~~Transportation is authorized by Form F 1, Authorization for Bus Transportation, for Adults, Children and individuals eligible under Vocational Rehabilitation. Form F 1 must be attached to the invoice.~~

(2) ~~An invoice and form F 1 should be submitted directly to OHCA, Attention: Finance Division, P.O. Box 25352, Oklahoma City, Oklahoma 73125.~~

### 317:30-5-343. Reimbursement

~~Reimbursement for emergency ambulance transportation is based on a previously estimated statewide reimbursement system. Reimbursement for transportation includes a \$14.51 add on to base rates for non-reusable supplies. Reusable supplies are not reimbursed. Payment is made at the lower of the provider's usual and customary charge or the OHCA's fee schedule.~~

*[OAR Docket #05-1315; filed 11-2-05]*

## TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

### CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY

*[OAR Docket #05-1316]*

#### RULEMAKING ACTION:

EMERGENCY adoption

#### RULES:

Subchapter 1. General Provisions

317:35-1-2. [AMENDED]

Subchapter 5. Eligibility and Countable Income

Part 1. Determination of Qualifying Categorical Relationships

317:35-5-7. [AMENDED]

Subchapter 6. SoonerCare Health Benefits for Categorically Needy Pregnant Women and Families with Children

Part 7. Certification, Redetermination and Notification

317:35-6-61. [AMENDED]

(Reference APA WF # 05-08)

#### AUTHORITY:

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

#### DATES:

#### Adoption:

July 14, 2005

#### Approved by Governor:

September 1, 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:**

The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to expand Medicaid eligibility to include low income, two parent families. Revised rules eliminate the existing marriage penalty and extend health care coverage to low income children and their parents.

**ANALYSIS:**

Eligibility rules are revised to remove deprivation as a condition of Medicaid eligibility for low income families. Under existing rules, in order to qualify for Medicaid, a child who is not disabled must be deprived of parental support due to death, continued absence, physical or mental incapacity, or unemployment. Therefore, low income families with both parents present in the home are generally not eligible for health benefits through the Medicaid program. Rule revisions are needed to eliminate the existing marriage penalty and extend health care coverage to low income children and their parents.

**CONTACT PERSON:**

Joanne Terlizzi at (405)522-7272

**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 SEPTEMBER 1, 2005, WHICHEVER IS LATER:**

**SUBCHAPTER 1. GENERAL PROVISIONS**

**317:35-1-2. Definitions**

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

**"Administrative agent"** means the Long-Term Care Authority who is under contract with the Oklahoma Department of Human Services (OKDHS) to perform certain administrative functions related to the ADvantage Waiver.

**"AFDC"** means Aid to Families with Dependent Children.

**"Aged"** means an individual whose age is established as 65 years or older.

**"Aid to Families with Dependent Children"** means the group of low income families with children described in Section 1931 of the Social Security Act. The Personal Responsibility and Work Opportunity Act of 1996 established the new eligibility group of low income families with children and linked eligibility income and resource standards and methodologies and the requirement for deprivation for the new group to the State plan for Aid to Families with Dependent Children in effect on July 16, 1996. Oklahoma has elected to be less restrictive for all Medicaid clients related to AFDC.

**"Area nurse"** means a registered nurse in the OKDHS Aging Services Division, designated according to geographic areas who evaluates the UCAT and determines medical eligibility for Personal Care, ADvantage Waiver, and Nursing Facility services. The area nurse also approves care plan and service plan implementation for Personal Care services.

**"Area nurse designee"** means a registered nurse selected by the area nurse who evaluates the UCAT and determines medical eligibility for Personal Care, ADvantage Waiver, and Nursing Facility services.

**"Authority"** means the Oklahoma Health Care Authority (OHCA).

**"Blind"** means an individual who has central visual acuity of 20/200 or less in the better eye with the use of a correcting lens.

**"Board"** means the Oklahoma Health Care Authority Board.

**"Buy-in"** means the procedure whereby the Authority pays the client's Medicare premium.

(A) **"Part A Buy-in"** means the procedure whereby the Authority pays the Medicare Part A premium for individuals determined eligible as Qualified Medicare Beneficiaries Plus (QMBP) who are enrolled in Part A and are not eligible for premium free enrollment as explained under Medicare Part A. This also includes individuals determined to be eligible as Qualified Disabled and Working Individuals (QDWI).

(B) **"Part B Buy-in"** means the procedure whereby the Authority pays the Medicare Part B premium for categorically needy individuals who are eligible for Part B Medicare. This includes individuals who receive TANF or the State Supplemental Payment to the Aged, Blind or Disabled, and those determined to be Qualified Medicare Beneficiary Plus (QMBP)/Specified Low Income Medicare Beneficiaries (SLMB) or Qualifying Individual-1 (QI-1). Also included are individuals who continue to be categorically needy under the PICKLE amendment and those who retain eligibility after becoming employed.

**"Caretaker relative"** means a person other than the biological or adoptive parent with whom the child resides who meets the specified degree of relationship within the fifth degree of kinship.

**"Case management"** means the activities performed for client's to assist them in accessing services, advocacy and problem solving related to service delivery.

**"Categorically needy"** means that income and when applicable, resources are within the standards for the category to which the client is related.

**"Categorically related" or "related"** means the individual is:

- (A) aged, blind, or disabled;
- (B) pregnant;
- (C) an adult individual who has a minor dependent child under the age of 18 ~~and who is deprived of parental support due to absence, death, incapacity, unemployment; or~~

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(D) a child under 19 years of age.

**"Certification period"** means the period of eligibility extending from the effective date of certification to the date of termination of eligibility or the date of the next periodic redetermination of eligibility.

**"County"** means the Oklahoma Department of Human Services' office or offices located in each county within the State.

**"CSED"** means the Oklahoma Department of Human Services' Child Support Enforcement Division.

**"Custody"** means the custodial status, as reported by the Oklahoma Department of Human Services.

**"Deductible/Coinsurance"** means the payment that must be made by or on behalf of an individual eligible for Medicare before Medicare payment is made. The coinsurance is that part of the allowable medical expense not met by Medicare, which must be paid by or on behalf of an individual after the deductible has been met.

(A) For Medicare Part A (Hospital Insurance), the deductible relates to benefits for in-patient services while the patient is in a hospital or nursing facility. After the deductible is met, Medicare pays the remainder of the allowable cost.

(B) For Medicare Part B (Supplemental Medical Insurance), the deductible is an annual payment that must be made before Medicare payment for medical services. After the deductible is met, Medicare pays 80% of the allowable charge. The remaining 20% is the coinsurance.

**"Disabled"** means an individual who is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or which has lasted (or can be expected to last) for a continuous period of not less than 12 months.

**"Disabled child"** means for purposes of Medicaid Recovery a child of any age who is blind, or permanently and totally disabled according to standards set by the Social Security Administration.

**"Estate"** means all real and personal property and other assets included in the recipient's estate as defined in Title 58 of the Oklahoma Statutes.

**"Gatekeeping"** means the performance of a comprehensive assessment by the LTC nurse utilizing the Uniform Comprehensive Assessment Tool (UCAT) for the determination of Medical eligibility, care plan development, and the determination of Level of Care for Personal Care, ADvantage Waiver and Nursing Facility services.

**"Local office"** means the Oklahoma Department of Human Services' office or offices located in each county within the State.

**"LOCEU"** means the Oklahoma Health Care Authority's Level of Care Evaluation Unit.

**"LTC nurse"** means a registered nurse in the OKDHS Aging Services Division who meets the certification requirements for UCAT Assessor and case manager, and who conducts the uniform assessment of individuals utilizing the Uniform Comprehensive Assessment Tool (UCAT) for the purpose of

medical eligibility determination. The LTC nurse also develops care plans and service plans for Personal Care services based on the UCAT.

**"Medicare"** means the federally funded health insurance program also known as Title XVIII of the Social Security Act. It consists of two separate programs. Part A is Hospital Insurance (HI) and Part B is Supplemental Medical Insurance (SMI).

(A) **"Part A Medicare (HI)"** means Hospital Insurance that covers services for inpatient services while the patient is in a hospital or nursing facility. Premium free enrollment is provided for all persons receiving OASDI or Railroad Retirement income who are age 65 or older and for those under age 65 who have been receiving disability benefits under these programs for at least 24 months.

(i) Persons with end stage renal disease who require dialysis treatment or a kidney transplant may also be covered.

(ii) Those who do not receive OASDI or Railroad Retirement income must be age 65 or over and pay a large premium for this coverage. Under Authority rules, these individuals are not required to enroll for Part A to be eligible for Medicaid benefits as categorically needy. They must however, enroll for Medicare Part B. Individuals eligible as a QMBP or as a Qualified Disabled and Working Individual (QDWI) under Medicaid are required to enroll for Medicare Part A. The Authority will pay Part A premiums for QMBP individuals who do not qualify for premium free Part A and for all QDWI's.

(B) **"Part B Medicare (SMI)"** means Supplemental Medical Insurance that covers physician and related medical services other than inpatient or nursing facility care. Individuals eligible to enroll in Medicare Part B are required to do so under Authority policy. A monthly premium is required to keep this coverage in effect.

**"Minor child"** means a child under the age of 18.

**"Nursing Care"** for the purpose of Medicaid Recovery is care received in a nursing facility, an intermediate care facility for the mentally retarded or other medical institution providing nursing and convalescent care, on a continuing basis, by professional personnel who are responsible to the institution for professional medical services.

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

**"OKDHS"** means the Oklahoma Department of Human Services.

**"Qualified Disabled and Working Individual (QDWI)"** means individuals who have lost their Title II OASDI benefits due to excess earnings, but have been allowed to retain Medicare coverage.

**"Qualified Medicare Beneficiary Plus (QMBP)"** means certain aged, blind or disabled individuals who may or may not be enrolled in Medicare Part A, meet the Medicaid QMBP income and resource standards and meet all other Medicaid eligibility requirements.

"Qualifying Individual" means certain aged, blind or disabled individuals who are enrolled in Medicare Part A, meet the Medicaid Qualifying Individual income and resource standards and meet all other Medicaid eligibility requirements.

"Qualifying Individual-1" means a Qualified Individual who meets the Qualifying Individual-1 income and resource standards.

"Recipient lock-in" means when a recipient is restricted to one primary physician and/or one pharmacy. It occurs when the OHCA determines that a Medicaid recipient has used multiple physicians and/or pharmacies in an excessive manner over a 12-month period.

"Scope" means the covered medical services for which payment is made to providers on behalf of eligible individuals. The Oklahoma Health Care Authority Provider Manual (OAC 317:30) contains information on covered medical services.

"Specified Low Income Medicare Beneficiaries (SLMB)" means individuals who, except for income, meet all of the eligibility requirements for QMBP eligibility and are enrolled in Medicare Part A.

"Worker" means the OKDHS worker responsible for Medicaid eligibility determinations.

**SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME**

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

**317:35-5-7. Determining categorical relationship to AFDC**

(a) All individuals under age 19 are automatically related to AFDC and further determination is not required. Adults age 19 or older are related to AFDC when there is a minor dependent child(ren) in the home and the individual is the parent, or is the caretaker relative other than the parent who meets the proper degree of relationship. A minor dependent child is any child who meets the AFDC eligibility requirements of age, ~~and relationship and deprivation of parental support due to death, continued absence, physical or mental incapacity or unemployment.~~

(1) ~~Death of a natural or adoptive parent.~~ Deprivation by reason of death exists when it is determined that either parent is deceased.

(2) ~~Continued absence of a natural or adoptive parent from the home.~~ Continued absence exists when the parent's function as a provider of maintenance, physical care or guidance is interrupted or terminated. It must be anticipated that the absence will continue for at least 30 days or more. The decision as to whether a child is deprived of parental support or care due to his/her parent's continued absence from the home is made in accordance with the assessment procedures in (A) — (E) of this paragraph.

(A) ~~Physical absence from the home.~~ In determining if deprivation due to continued absence exists,

it must be established that the parent is physically absent from the home, i.e., does not reside in the home with the child. The physical absence of the parent may be for any reason except for the sole purpose of employment or seeking employment, education or the performance of active duty in the United States Uniformed Services. "Uniformed Services" is defined as the Army, Navy, Air Force, Marine Corps, Coast Guard, National Oceanographic and Atmospheric Administration and Public Health Services of the United States.

(i) If a parent does not currently reside with the child because of employment, seeking employment in another locality, education or active service duty but would reside with the child were it not for the employment, education or service duty, then such parent is not considered physically absent from the home. However, if the parent would not reside in the home regardless of employment, education or service duty, then such parent is considered physically absent.

(ii) A separate place of residence for the parent may be used to establish physical absence.

(iii) Incarceration of a parent in a penal institution establishes continued absence. A parent who is a "convicted offender" but who is permitted to live at home while serving a court imposed sentence by performing unpaid public work or unpaid community service during the workday is considered absent from the home for purposes of deprivation. Once "convicted offender" status is verified, deprivation is met and further action to determine continued absence is not required. This does not include the "House Arrest Program".

(iv) In situations where joint custody of the child(ren) has been granted and is being carried out, the child(ren) is/are not considered to be deprived of parental support or care by reason of continued absence from the home.

(v) In determining whether the absence from the home is such as to interrupt the parent's functioning as a parent is whether the parent has daily in person contact with the child(ren). If the absent parent does not have daily in person contact with the child(ren), his/her functioning as a parent is considered interrupted and the child(ren) is deprived. Further action to determine deprivation due to continued absence is not necessary. In person contact means that the parent and child(ren) are physically together. The length of time they are together is not a factor in determining in person contact. Daily contact means that the contact occurs each day of the week (Sunday-Saturday). The determination of whether the contact is daily must be made based on the parent's normal pattern of visitation/contact. For example, if the parent normally has daily in person contact with the child(ren) but is out of town on vacation for two

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weeks, he/she would still be considered to have daily contact since this interruption of contact is not a regular occurrence.

~~(B) **Support and maintenance.** If physical absence is determined and daily in person contact has been maintained, then provision of support and maintenance (as defined in (2) of this subsection) becomes a factor in determining whether parental functioning has been interrupted.~~

~~(i) Support and maintenance are defined as payments, in cash or kind, made to the household or other entities (including the Child Support Enforcement Division), which are intended to meet, in whole or in part, the day to day expenses of the child(ren). This may include the provision of goods (food, clothing, diapers, etc.), shelter, utilities, daily transportation, or other items. If the absent parent normally provides support and maintenance (as described in this unit) on a monthly basis and expects to continue in the future, the child(ren) would not be deprived on the support and maintenance requirement. This would be true even if the absent parent had missed the previous month's payment. If, however, he/she has had a change in circumstances (e.g., employment ended) and does not expect to pay support for some indefinite period of time, he/she would not be considered to be providing support and maintenance.~~

~~(ii) If the absent parent does not provide support and maintenance, the child(ren) is considered deprived.~~

~~(C) **Physical care.** If the absent parent has daily in person contact with the child(ren) and provides regular support and maintenance, then the worker must determine if the parent participates in the provision of physical care for the child(ren). Although the length of time the parent and child(ren) are together is not a factor in determining daily in person contact, it could be a factor in determining whether the parent provides physical care as described in (i) of this subparagraph.~~

~~(i) Physical care includes the actual provision of physical care (e.g., feeding, bathing, dressing the child(ren), etc.) or, as in the case of an older child, the supervision of the child in providing his/her own physical care. It may also include other types of parental supervision such as granting or denying permission for activities, etc.~~

~~(ii) If it is determined that the absent parent does not provide physical care, the child(ren) are considered deprived and further consideration is not necessary.~~

~~(D) **Guidance.** Guidance is providing advice to the child(ren) in such areas as school matters, leisure or sports activities, relationships with other children or adults, etc. Guidance may also include participation in decision making regarding the child(ren)'s well-~~

~~being, discipline, etc. It is not expected that the parent actually provides this type of guidance to a very small child. However, it should be ascertained whether the parent would provide guidance if the child were older. If the absent parent does not provide guidance or it is determined that he/she would not if the child were older, the child(ren) is considered deprived.~~

~~(E) **Continued absence decision.** If there is any question as to whether absence actually exists, the client is advised that it may be necessary to obtain further evidence from persons acquainted with the situation. The child is considered deprived if any one of the items listed in (i) (iv) of this subparagraph exists. The absent parent does not:~~

- ~~(i) have daily in person contact with the child;~~
- ~~(ii) provide regular support and maintenance;~~
- ~~(iii) provide physical care; **OR**~~
- ~~(iv) provide guidance.~~

~~(Fb) **CSED Requirement.** As a condition of eligibility, when the reason for deprivation is absence both the parent or caretaker and minor child(ren) are receiving Medicaid benefits and a parent is absent from the home, the parent or caretaker relative must agree to cooperate with CSED. However, federal regulations provide for a waiver of this requirement when cooperation with CSED is not in the best interest of the child. CSED is responsible for making the good cause determination. If the parent or caretaker relative is claiming good cause, his/her needs cannot be included in the benefit group unless CSED has determined good cause exists. There is no requirement of cooperation with CSED for a child(ren) only Medicaid case.~~

~~(3) **Physical or mental incapacity of natural or adoptive parent.**~~

~~(A) **Definition of physical or mental incapacity.**~~

~~(i) Physical or mental incapacity of a natural or adoptive parent is deemed to exist when one parent has a physical or mental defect, illness or impairment that:~~

- ~~(I) is of such a debilitating nature as to reduce substantially or eliminate the parent's ability to support or care for the otherwise eligible child;~~
- ~~(II) can be expected to last for a period of at least 30 days; and~~
- ~~(III) is supported by competent medical and social evidence.~~

~~(ii) Both parents may be included in the benefit group if either parent is incapacitated due to a reduced ability to provide support or care, regardless of the incapacitated parent's usual function as homemaker or wage earner. The criterion for incapacity is the reduced ability of the parent to provide support or care, not the parent's employability.~~

~~(B) **Determination of substantial reduction or elimination of ability to provide support or care.**~~

The Level of Care Evaluation Unit (LOCEU) determines substantial reduction or elimination of a parent's ability to provide support or care for a dependent child based on:

- (i) the parent's inability to perform any type of gainful employment;
- (ii) the parent's inability to provide care for the child without help from others. Child care includes feeding, cleaning, and supervision of the child;
- (iii) the number of hours the parent is able to work being substantially reduced; or
- (iv) the wages the parent is able to earn being substantially reduced.

**(C) Determination of incapacity at the time of application.** The determination of incapacity of one of the parents is made by LOCEU, except in those instances where the individual is currently eligible for SSA disability benefits, SSI benefits, and/or Aid to the Blind or Aid to the Disabled. In such instances, the determination of blindness or disability is accepted as establishing incapacity. If a parent is not already receiving such SSA or SSI benefits and/or Aid to the Blind or Aid to the Disabled, the OKDHS worker makes a referral to LOCEU for a determination of incapacity.

**(D) Determination of incapacity when disability or blindness has not been pre-determined.**

- (i) **Responsibility of the LOCEU for incapacity determinations.** If disability or blindness has not already been determined, the OKDHS worker must make a referral to LOCEU for a decision on incapacity. The LOCEU determines:
  - (I) whether the parent is incapacitated; and
  - (II) sets an effective date of eligibility from the standpoint of incapacity.

(ii) **Responsibility of the OKDHS worker for incapacity determinations.** The worker submits medical information from hospitals, physicians, and other agencies. All pertinent clinical evidence necessary to substantiate or explain the medical diagnosis and medical summary shall be included, such as results of physical examination, psychiatric evaluations, x ray reports, laboratory tests, or any other pertinent medical data. Medical information, along with OKDHS form ABCDM 80 D, Medical Social Summary, is sent to LOCEU. The Medical Social Summary contains the medical social information which will enable LOCEU to make a proper decision.

**(4) Unemployment.**

**(A) Applicability.** Deprivation for the child may be established when both the natural or adoptive parents are residing with the child and the parent determined to be the principal wage earner (PWE) meets the conditions to qualify as unemployed. The parent's citizenship status is not a factor in determining which parent is the PWE.

**(B) Principal wage earner (PWE).** The principal wage earner is defined as the parent who earned the greater amount of gross income during the 24 month period ending with the month prior to the application. This determination is made regardless of when the parent(s) relationship began or when the parent(s) began residing with the children. The employment or receipt of unemployment insurance benefits of the parent not determined to be the PWE is not a factor in determining deprivation. The amount, dates, and sources of earnings used in determining which parent is the PWE must be documented. It is the parent's responsibility to provide the documentation to the best of their ability. The worker provides assistance, when necessary, to obtain the needed information. Acceptable documentation includes OKDHS records, employer(s) contact, wage stubs for the 24 month period, Income Eligibility Verification System (IEVS), Oklahoma Wage Link (OWL), Oklahoma Wage (OWG), and, if self employed, gross and net earnings from tax returns or business records. Documentation must be recorded in the case record as to which parent was determined to be the PWE and the circumstances used in that determination.

- (i) If both parents earned an identical amount of income in the 24 month period, the PWE is the parent who earned the greater amount of income in the last six months of the 24 month period.
- (ii) If the income in the six month period is identical, either parent may be designated the PWE. The designation should be the one most advantageous to the benefit group.
- (iii) The designation of the PWE is permanent and remains effective as long as the deprivation remains unemployment and the parent remains eligible for and continues to receive health benefits. If the health benefit case is closed and a new application is filed at a later date, the PWE must be redetermined.

**(C) Conditions PWE must meet prior to certification.** The PWE must meet specific conditions for deprivation to be established for the child(ren) and for the needs of the PWE to be included in the benefit group.

- (i) **Qualifications as unemployed.** For the PWE to be considered unemployed, the PWE must not be employed or must be employed less than 100 hours per month. The PWE must meet the definition of unemployed prior to the date of the health benefit application and during the application process. To qualify as an unemployed parent, the PWE must be unemployed for 30 days prior to the date of application. The PWE is considered to meet the status of unemployed if the PWE is not employed or the PWE is employed fewer than 100 hours per month. Employment may exceed the 100 hour standard for a particular month if the work is intermittent and the excess

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hours are of a temporary nature. The 100 hour requirement is also considered to have been met if the PWE worked fewer than 100 hours in each of the prior two months and is expected to work fewer than 100 hours in the next month. The 100 hour rule is not applicable to Domestic Volunteer Service Act of 1973 (VISTA) volunteers.

(I) Any hours spent working to earn income, regardless of whether the PWE receives the income, are considered in computing the 100 hours standard. Only those hours spent actually performing services for the employer should be counted in determining the 100 hours. Hours the PWE is on call are not to be considered in determining the 100 hour standard. The hours of self employment for an individual are based on the actual hours worked in a month, to the extent possible.

(II) Current employment information must be used in determining if the PWE is working more than 100 hours per month. It is recognized that the number of hours worked in connection with selling the product, traveling or buyer contact can not be verified. Acceptable evidence of actual hours worked will be a written statement from a disinterested third party, insofar as possible. A person who contracted the labor of the PWE is considered a disinterested third party. An employee of the PWE, a member of the PWE's household or a relative of the PWE is not considered a disinterested third party. The statement of the PWE, if consistent with information known to the worker, is acceptable verification in these situations. If the PWE is unable to adequately verify the actual number of hours worked and the current net monthly income is representative of the PWE's number of hours worked, the current net monthly income is to be divided by the federal minimum wage.

(ii) **Work history requirement.** The PWE must have a verified work history. Undocumented employment cannot be used to establish quarters of work. The work history exists when the PWE meets one of the following conditions:

(I) The PWE was employed for six or more calendar quarters within a 13 consecutive calendar quarter period. The 13 consecutive calendar quarter period must end within 12 months prior to the application date. Calendar quarter means a period of three consecutive calendar months ending on March 31, June 30, September 30, or December 31. To be considered employed, the PWE must have received gross earnings of at least \$50 in a calendar quarter or earned the minimum amount required for covered quarter as defined by the Social Security Administration. The Social

Security Administration states an individual qualifies for a quarter of coverage for any quarter that the individual earns a designated amount for that calendar year. An individual could have earnings in one quarter to qualify for a full year's coverage.

(II) The PWE is receiving or has received Unemployment Insurance Benefits (UIB) within the 12 calendar months prior to the application date. If the PWE has a pending UIB application, the work history determination is delayed until the UIB determination is made.

(III) The PWE would have qualified for UIB for 1 week or more during the 12 calendar month period prior to the application date had the PWE made application for UIB based on earned wages, both covered and uncovered. Covered employment generally includes employment in construction, plants, stores, restaurants, offices, or other places of business which employ one or more persons. Uncovered employment generally includes employment from farm labor, odd jobs, and non profit organizations. A PWE who had sufficient earnings to meet the UIB earnings requirement is "deemed" eligible for UIB even though all or a portion of the PWE's earnings were from uncovered employment. To be eligible or "deemed eligible" for UIB, the PWE must have earned at least the Qualifying Wages during the base period. The base period consists of the first four of the last five completed quarters immediately preceding the quarter of the UIB application. The earnings must be in more than one quarter. The quarter with the highest earnings is the "high quarter". The total gross earnings of the remaining three quarters must equal at least one half of the "high quarter" earnings. If the earnings do not meet this test, the PWE is ineligible for UIB. If the PWE earned an amount equal to the Total Taxable Wages in one quarter of the base period, the PWE is "deemed" eligible for UIB based on that quarter alone.

(D) **Unemployment insurance benefits eligibility.** The PWE is required to apply for and/or accept UIB which the PWE is eligible or potentially eligible to receive. The PWE must apply for such benefits and the worker allows 30 days for verification of a UIB application to be furnished.

(E) **Ineligible alien status.** If the PWE is an ineligible alien, the PWE's needs are not included in the assistance unit.

(F) **Changes after certification.** If after initial certification, the PWE begins working more than 100 hours per month, the parents are no longer eligible for health benefits based on unemployment.

SUBCHAPTER 6. SOONERCARE HEALTH BENEFITS FOR CATEGORICALLY NEEDY PREGNANT WOMEN AND FAMILIES WITH CHILDREN

PART 7. CERTIFICATION, REDETERMINATION AND NOTIFICATION

317:35-6-61. Redetermination of eligibility for persons receiving SoonerCare Health Benefits.

(a) A periodic redetermination of eligibility for SoonerCare Health Benefits is required on all categorically needy cases categorically related to AFDC. The redetermination is made prior to the end of the initial certification period and each six months thereafter.

(b) In every instance in which LOCEU originally determined incapacity, the MEDATS file specifies a date on which incapacity is to be redetermined or that further redetermination is not needed. Regardless of which of these is designated by LOCEU, any time that the worker's personal observations of the client's actions leads the worker to believe that marked improvement in the client's physical and/or mental condition has occurred, the worker prepares OKDHS form ABCDM 80 D, Medical Social Summary, and transmits it to LOCEU. This summary sets forth the reasons for the worker's opinion that the client's physical and/or mental condition has improved, such as the worker's personal observations of the client's actions in the home, the office, on the street, etc.; what the client says about his/her condition; whether the client is receiving treatment; etc. The decision for LOCEU will be entered by MEDATS.

(c) When LOCEU's original incapacity decision sets a redetermination for a specified time and required a Medical Social Summary, the worker submits the OKDHS form ABCDM 80 D. The information is submitted timely to obtain a decision by the end of the month of the due date. The client is considered incapacitated until LOCEU renders a decision stating otherwise, even if the decision is delayed past the redetermination. If the client chooses not to cooperate in obtaining information to determine continued incapacity, both parents needs are removed from the health benefit.

[OAR Docket #05-1316; filed 11-2-05]

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

[OAR Docket #05-1318]

RULEMAKING ACTION: EMERGENCY adoption

RULES:

Subchapter 5. Eligibility and Countable Income Part 1. Determination of Qualifying Categorical Relationships 317:35-5-2. [AMENDED]

Subchapter 7. Medical Services Part 3. Application Procedures 317:35-7-16. [AMENDED] 317:35-7-17. [REVOKED] (Reference APA WF # 05-07)

AUTHORITY:

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; The Foster Care Independence Act of 1999

DATES:

Adoption:

July 14, 2005

Approved by Governor:

September 1, 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:

The Agency finds that an imminent peril exists to the preservation of the public health, safety, and welfare which necessitates promulgation of emergency rules and requests emergency approval of revisions that will allow young people who leave custody and foster care on their 18th birthday to continue to receive Medicaid benefits until they reach age 21. Without Medicaid, the majority of these youth will have no health care coverage or families to help them should they become sick, have an accident or become the victim of violence.

ANALYSIS:

The Foster Care Independence Act of 1999, P.L. NO. 106-169 created a new optional Medicaid eligibility group for young individuals who leave state custody and foster care upon reaching age 18. Typically, young people aging out of the foster care system have significant health concerns but no insurance and limited access to health and mental health services. These young people often need health services more than other youth who have not been in foster care. Studies have shown that children in foster care suffer more frequent and more serious medical, developmental, and psychological problems than nearly any other group of children. Young people who have been in foster care may be at high risk for continuing health problems because of the circumstances that brought them into foster care, as well as the ongoing instability fo their lives. Revisions are needed to the OHCA rules to allow these children access to medical care. OHCA rules are revised, consistent with the Foster Care Independence Act and the Centers for Medicare and Medicaid directions, to provide Medicaid coverage to these individuals who leave custody and foster care on their 18th birthday and transition into independent living, until they reach age 21.

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 SEPTEMBER 1, 2005, WHICHEVER IS LATER:

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME

PART 1. DETERMINATION OF QUALIFYING CATEGORICAL RELATIONSHIPS

## Emergency Adoptions

### 317:35-5-2. Categorically related programs

(a) Categorical relationship is established using the same definitions of age, disability and blindness as are used by the Social Security Administration (SSA) in determining eligibility for Supplemental Security Income (SSI) or SSA benefits. If the individual is a SSA/SSI recipient in current payment status (including presumptive eligibility), a TANF recipient, or is low-income under age 19, categorical relationship is automatically established. Categorical relationship to pregnancy-related services is established when the determination is made by medical evidence that the individual is or has been pregnant. Pregnancy-related services include all medical services provided within the scope of the program during the prenatal, delivery and post-partum periods. For an individual age 19 or over to be related to AFDC, the individual must have a minor dependent child who is deprived of parental support. Categorical relationship to Refugee services is established in accordance with OAC 317:35-5-25. Categorical relationship for the Breast and Cervical Cancer Treatment program is established in accordance with OAC 317:35-21. Categorical relationship for the Family Planning Waiver Program is established in accordance with OAC 317:35-5-8. To be eligible for Medicaid benefits, an individual must be related to one of the following:

- (1) Aged
- (2) Disabled
- (3) Blind
- (4) Pregnancy
- (5) Aid to Families ~~With~~ with Dependent Children
- (6) Refugee
- (7) Breast and Cervical Cancer Treatment program
- (8) Family Planning Waiver Program

(b) The Authority may provide Medicaid to reasonable categories of individuals under age 21 who are not receiving cash assistance under any program but who meet the income requirement of the State's approved AFDC plan. ~~Individuals eligible for Medicaid benefits include individuals between the ages of 19 and 21:~~

(1) Individuals eligible for Medicaid benefits include individuals between the ages of 19 and 21:

~~(1A)~~ for whom a public agency is assuming full or partial financial responsibility who are in ~~the~~ custody of ~~the State~~ as reported by the Oklahoma Department of Human Services (OKDHS) and in foster homes, private institutions or public facilities; or

~~(2B)~~ in adoptions subsidized in full or in part by a public agency; or

~~(3C)~~ individuals under age 21 receiving active treatment as inpatients in public psychiatric facilities or programs if inpatient psychiatric services for individuals under age 21 are provided under the State Plan and the individuals are supported in full or in part by a public agency; ~~;~~ or

(2) Individuals eligible for Medicaid benefits include individuals between the ages of 18 and 21 if they are in custody as reported by OKDHS on their 18<sup>th</sup> birthday and living in an out of home placement.

## SUBCHAPTER 7. MEDICAL SERVICES

### PART 3. APPLICATION PROCEDURES

#### 317:35-7-16. Special application procedures for children in ~~DHS~~ OKDHS custody

~~In determining initial eligibility for short term medical care for children for whom DHS has custody, the following procedures are used. The rules in this section apply when determining eligibility for health benefits for children who are reported by OKDHS as being in custody.~~

(1) When a child placed in ~~DHS~~ custody as reported by ~~OKDHS is not placed outside~~ remains in the parent's home and there is not an active medical case:

(A) ~~The DHS Division of Children, Youth and Family Services (DCYFS) worker~~ OKDHS child welfare specialist advises the family that an application for medical services, ~~if needed,~~ may be made at the local ~~DHS~~ OKDHS office.

(B) ~~The DHS OKDHS Family Support Services (FSS) worker is responsible for completing Form PS-3 and OAC 340:10 Appendix T when application is made and processing the application SC-1, SoonerCare Health Benefits application or FSS-1, Comprehensive Application and Review, whichever is appropriate. The date of application is the date of the request for medical services.~~

(2) When a child placed in ~~DHS~~ custody as reported by ~~OKDHS~~ has an active case and a change in placement is made to a home or facility outside the parent's home:

(A) ~~The DHS DCYFS worker~~ OKDHS child welfare specialist completes Form ~~K-13-CWS-KIDS-4, Eligibility Determination,~~ and forwards it to the ~~DHS FSS worker~~ OKDHS custody specialist advising of this change, including the date the child was placed outside the home. This referral is made within ~~ten~~ five working days of the placement.

(B) ~~The DHS FSS worker~~ OKDHS custody specialist makes the appropriate change to ~~a one child only~~ remove the child from the family case and opens a child only case ~~to be effective at the next effective date.~~

(3) When a child in ~~DHS~~ custody as reported by ~~OKDHS~~ is placed outside the home and there is not an active case, the ~~DHS DCYFS worker~~ OKDHS child welfare specialist is responsible for ~~the completion of Form PS-3 and OAC 340:10 Appendix T~~ completing and forwarding the CWS-KIDS-4, Eligibility Determination, to the OKDHS custody specialist. The CWS-KIDS-4 must be sent within five working days of removal from the home. The application must include type and date of custody and placement plan (e.g., foster home, institution). The date of application is the date the child is placed in DHS custody. The OKDHS custody specialist is responsible for processing the application.

(A) For a child who has been in DHS custody and remained in his/her own home but is later placed outside the home, the date on the application is the date the child is placed outside the parent's home;

(B) When the child's date of placement in DHS care precedes the court order date, the earlier date is the date of application. The application is forwarded to the local DHS office for determination of eligibility and case number assignment within ten working days of the placement and/or custody.

(4) When a child in DHS custody as reported by OKDHS placed outside the home is later returned to the home but remains in DHS custody:

(A) The DHS DCYFS worker OKDHS child welfare specialist forwards Form K-13 to the county office OKDHS custody specialist advising of the change in placement and whether the child is currently receiving medical services. If immediate medical needs are not indicated, the responsible DCYFS worker advises the family to request application at the county office if medical services are needed at a future date. The DCYFS worker's responsibility must be completed within ten working days of the placement. The OKDHS child welfare specialist advises the family that a Medicaid application may be made at the local OKDHS office for medical benefits to continue, if the family meets eligibility criteria.

(B) The DHS FSS worker closes the Title XIX case OKDHS custody specialist is responsible for sending a SC-1 to the family so the child's Medicaid eligibility can be redetermined. If the family does not return the completed SC-1, the OKDHS custody specialist closes the child's Medicaid case. If Form K-13 indicates there is not a need for medical services, further action is not required unless the family later contacts the office for medical assistance. If Form K-13 indicates continued medical services are needed, the FSS worker must contact the family and complete Form PS-3 and OAC 340:10 Appendix T considering the total family composition, income and resources. Case actions are coordinated and the certification must be completed within a 30 day period.

(5) When a child in DHS custody has a disability which appears to meet the SSI disability qualification in addition to applying for Title XIX:

(A) The local DHS DCYFS worker is responsible for submitting the necessary information to DCYFS State Office within ten working days after placement so that an application for SSI can be made on behalf of the child. SSI application must be made by State Office within 30 working days of placement.

(B) Within five working days of receipt of notice from the SSA of approval or denial of the SSI application, DHS DCYFS State Office advises the local DCYFS worker of the decision via memorandum. The local DCYFS worker notifies the DHS FSS worker via Form K-13 of the decision within five

working days of receipt of notice from State Office DCYFS.

(C) The DHS DCYFS worker reports to DCYFS State Office any changes in living arrangement and/or custody within ten working days of the change. Such changes are reported by DCYFS State Office to SSA within ten working days of receipt from the local DCYFS worker. Within five working days of receipt of notice from the SSA that a change in benefits has occurred, DCYFS State Office advises the local DCYFS worker of the decision via memorandum. The local DCYFS worker advises the DHS FSS worker of any change via Form K-13 within five working days of receipt of notice from State Office DCYFS.

(5) When a child in custody as reported by OKDHS and living in an out of home placement attains age 18, he/she may still be eligible for medical benefits until the age of 21 under the Foster Care Independence Act if his/her income is below the standard on OKDHS Appendix C-1, Schedule 1.A. The individual must complete a new application and have eligibility redetermined in accordance with OAC 317:35-6.

**317:35-7-17. Special application procedures for children in emergency shelters [REVOKED]**

When a child is placed in any emergency shelter, the DHS DCYFS worker completes the application for medical assistance. The application is then sent to the local office where a case number is obtained, a case record is established, and a certification teleprocessed into the computer system. A child placed in the shelter may be in emergency custody up to 90 days before a disposition is made at the adjudicatory hearing. When the child is expected to remain in the emergency shelter over 60 days, certification may be made for a maximum of three months.

[OAR Docket #05-1318; filed 11-2-05]

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

[OAR Docket #05-1317]

**RULEMAKING ACTION:**  
EMERGENCY adoption

**RULES:**  
Subchapter 5. Eligibility and Countable Income  
Part 3. Non-Medical Eligibility Requirements  
317:35-5-26. [AMENDED]  
(Reference APA WF # 05-09A)

**AUTHORITY:**  
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR 435.1008 and 435.1009; Section 1905(a)(27)(A) and (B) of the Social Security Act

# Emergency Adoptions

**DATES:****Adoption:**

July 14, 2005

**Approved by Governor:**

September 1, 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:**

The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to allow the state to use federal Medicaid funds to offset expenditures for medical care provided to certain individuals who are inpatients in an institution for mental disease, in the custody of the Office of Juvenile Affairs, or inmates in a correctional facility.

**ANALYSIS:**

Eligibility rules are revised to provide Medicaid benefits to certain groups of individuals who previously have been determined ineligible as they were inmates of a public institution. Section 1905(a)(27)(A) of the Social Security Act (SSA) specifically excludes Federal Financial Participation (FFP) for medical care provided to inmates of a public institution, and SSA 1905(a)(27)(B) excludes FFP for inpatients in an institution for mental disease (IMD). Current agency rules prohibit individuals in the custody of the Department of Mental Health or Corrections from qualifying for Medicaid. In order to support the Oklahoma Department of Corrections (DOC), the Office of Juvenile Affairs (OJA), and the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) in their efforts to limit expenditures, revisions are proposed to extend Medicaid coverage to individuals who become inpatients of a hospital, nursing facility, juvenile psychiatric facility or an intermediate care facility for the mentally retarded and who are either in the custody of the Office of Juvenile Affairs or the Department of Corrections or who are adults (age 21 through 64) who are patients in an institution for mental disease. These individuals would have to meet all eligibility requirements such as categorical relationship, citizenship, and income the same as other Medicaid recipients. The DOC, OJA, and ODMHSAS will be responsible for the state share and Medicaid will only reimburse for services rendered while the clients are inpatients of a medical institution subject to amount, scope or duration of existing service definitions. Eligibility rules are in need of revision to allow Medicaid coverage for these individuals.

**CONTACT PERSON:**

Joanne Terlizzi at (405)522-7272

**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 SEPTEMBER 1, 2005, WHICHEVER IS LATER:**

## SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME

### PART 3. NON-MEDICAL ELIGIBILITY REQUIREMENTS

#### **317:35-5-26. Residence requirements; residents of public institutions; homeless persons**

(a) **Residence.** To be eligible for Medicaid services, the applicant must be residing in the State of Oklahoma with intent to remain at the time the medical service is received. A durational residence requirement is not imposed.

(1) Temporary absence from the State, with subsequent returns to the State, or intent to return when the purposes of the absence have been accomplished, does not interrupt continuity of Oklahoma residence.

(2) Oklahoma residence does not include transients or visitors passing through the state but does not preclude persons who do not have a fixed address if intent is established.

(3) Intent to remain or return is defined as a clear statement of plans to remain or return in addition to other evidence and/or corroborative statements of others.

(4) When a non-resident makes application for Medicaid benefits, the local office provides services necessary to make available to the applicant any Medicaid services for which he/she might be eligible from his/her state of residence. The local office contacts the state or county of the applicant's residence to explore possible eligibility for medical benefits from the state and to obtain information needed for the determination of medical eligibility for the services received while in Oklahoma.

(b) **Individuals residing in institutions (correctional facilities and institutions for mental disease).** The Medicaid program will only pay for services rendered to adults (21 through 64 years of age) who are inpatients in an institution for mental disease (IMD), juveniles in the custody of the Office of Juvenile Affairs who are inmates in a state-owned and operated facility, or inmates in a correctional facility, when these individuals are admitted as an inpatient to a hospital, nursing facility, juvenile psychiatric facility or an intermediate care facility for the mentally retarded and meet all other eligibility requirements.

(bc) **Homeless individuals.** Individuals are not required to have a fixed address in order to be eligible for assistance. Individuals who lack a fixed or regular residence, who have temporary accommodations, i.e., supervised shelters, residence of other individuals, a hallway, bus station, car or other similar places, are considered as "homeless".

[OAR Docket #05-1317; filed 11-2-05]

## **TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**

### **CHAPTER 45. OKLAHOMA EMPLOYER AND EMPLOYEE PARTNERSHIP FOR INSURANCE COVERAGE**

[OAR Docket #05-1311]

**RULEMAKING ACTION:**

EMERGENCY adoption

**RULES:**

Subchapter 1. General Provisions [NEW]  
317:45-1-1. through 317:45-1-3. [NEW]

Subchapter 3. Carriers [NEW]  
317:45-3-1. through 317:45-3-2. [NEW]  
Subchapter 5. Qualified Health Plans [NEW]  
317:45-5-1. through 317:45-5-2. [NEW]  
Subchapter 7. Employer Eligibility [NEW]  
317:45-7-1. through 317:45-7-8. [NEW]  
Subchapter 9. Employee Eligibility [NEW]  
317:45-9-1. through 317:45-9-8. [NEW]

(Reference APA WF # 05-16)

**AUTHORITY:**

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; House Bill 2660 of the 2<sup>nd</sup> Session of the 49<sup>th</sup> Oklahoma Legislature

**DATES:**

**Adoption:**

August 24, 2005

**Approved by Governor:**

October 3, 2005

**Effective:**

Immediately upon Governor's approval or October 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:**

The Agency finds that an imminent peril to the preservation of the health, safety and welfare of the public exists which necessitates promulgation of emergency rules and requests emergency approval of rules to help small businesses offer health coverage to low income, uninsured employees.

**ANALYSIS:**

Agency rules are being issued to establish criteria that implements the Oklahoma Employer and Employee Partnership for Insurance Coverage Program (O-EPIC). The program establishes access to affordable health coverage for approximately 25,000 low-income working adults and their spouses. The Program is funded through a portion of monthly proceeds from the Tobacco Tax that are collected and dispersed through the Health Employee and Economy Improvement Act (HEEIA) Revolving Fund. Revisions will allow the state to provide health insurance premium assistance to small Oklahoma's business employers with 25 employees or less and their employees whose family income is at or below 185% of the Federal Poverty Level. The employer will be responsible for contributing a minimum of 25% of the eligible employee's monthly health plan premium.

**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 OCTOBER 1, 2005, WHICHEVER IS LATER:**

**SUBCHAPTER 1. GENERAL PROVISIONS**

**317:45-1-1. Purpose and general program provisions**

The purpose of this Chapter is to provide rules, in compliance with all applicable federal and state regulations, for the Oklahoma Employer and Employee Partnership for Insurance Coverage (O-EPIC) program that establishes access to affordable health coverage for low-income working adults and their

spouses. The Oklahoma Health Care Authority (OHCA) contracts with a Third Party Administrator (TPA) for administration of the Program.

**317:45-1-2. Program limitations**

(a) The O-EPIC program is contingent upon sufficient funding that is collected and dispersed through a revolving fund within the State Treasury designated as the "Health Employee and Economy Improvement Act (HEEIA) Revolving Fund". This fund is a continuing fund, not subject to fiscal year limitations.

(b) All monies accruing to the credit of the fund are budgeted and expended by the OHCA to implement the Program.

(c) The Program is funded through a portion of monthly proceeds from the Tobacco Tax, House Bill 2660, that are collected and dispersed through the HEEIA revolving fund.

(d) The Program is limited in scope such that budgetary limits are not exceeded. If at any time it becomes apparent there is risk the budgetary limits may be exceeded, OHCA must take action to ensure the O-EPIC program continues to operate within its fiscal capacity.

(1) O-EPIC may limit eligibility based on:

- (A) the federally-approved capacity of the O-EPIC services for the Health Insurance Flexibility and Accountability (HIFA) Waiver/1115 Waiver; and
- (B) Tobacco Tax collections.

(2) The O-EPIC program may limit eligibility when the utilization of services is projected to exceed the spending authority, or, may suspend new eligibility determinations instead, establishing a waiting list of employers.

(A) Employers, not previously enrolled and participating in the program, submitting new applications for the O-EPIC program are placed on a waiting list. These applications are date and time stamped when received by the TPA.

(B) The waiting list utilizes a "first in - first out" method of selecting eligible employers.

(C) When an employer group is determined eligible and moves from the waiting list to active participation, the employer must submit a new application. All eligible employees of that employer will have an opportunity to participate in O-EPIC during the employer's eligibility period.

(D) Only employers will be subject to the waiting list.

(E) Enrolled employers who are currently participating in the O-EPIC program are not subject to the waiting list.

(i) If the employer hires a new employee after the employer's program eligibility begins, the new employee is allowed to participate in O-EPIC during the employer's current eligibility period.

(ii) If the employer has an employee who has a Qualifying Event after the employer's program eligibility begins, the employee is allowed to make changes pertaining to the Qualifying Event.

# Emergency Adoptions

## 317:45-1-3. Definitions

The following words or terms, when used in this Chapter, will have the following meanings unless the context clearly indicates otherwise:

**"Carrier"** means:

(A) an insurance company, group health service or Health Maintenance Organization (HMO) that provides health benefits pursuant to Title 36 O.S., Section 6512;

(B) A Multiple Employer Welfare Arrangement (MEWA) licensed by the Oklahoma Insurance Department; or

(C) A domestic MEWA exempt from licensing pursuant to Title 36 O.S., Section 634(B) that otherwise meets or exceeds all of the licensing and financial requirements of MEWAs as set out in Article 6A of Title 36.

**"Eligibility period"** means the period of eligibility extending from an approval date to an end date.

**"O-EPIC"** means the Oklahoma Employer and Employee Partnership for Insurance Coverage program.

**"OESC"** means the Oklahoma Employment Security Commission.

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

**"OKDHS"** means the Oklahoma Department of Human Services.

**"Oklahoma Employer and Employee Partnership for Insurance Coverage"** means a health plan purchasing strategy in which a state uses public funds to pay for a portion of the premium costs of employer-sponsored health plans for eligible populations.

**"Premium"** means a monthly payment to a Carrier for health plan coverage.

**"Qualified Health Plan"** means a health plan that has been approved by the OHCA for participation in the O-EPIC program.

**"Qualifying Event"** means the occurrence of an event that permits individuals to join a group health plan outside of the "open enrollment period" and/or that allows individuals to modify the coverage they have had in effect. Qualifying Events are defined by the employer's health plan and meet federal requirements under Public Law 104-191 (HIPAA), and 42 U.S.C. 300bb-3.

**"State"** means the State of Oklahoma, acting by and through the Oklahoma Health Care Authority or its designee.

**"TPA"** means the Third Party Administrator.

**"Third Party Administrator"** means the entity contracted by the State to provide the administration of the Oklahoma Employer and Employee Partnership for Insurance Coverage program.

## SUBCHAPTER 3. CARRIERS

## 317:45-3-1. Carrier eligibility

Carriers must file a quarterly financial statement with the Oklahoma Insurance Department and submit requested information to OHCA for each health plan to be considered for qualification.

## 317:45-3-2. Audits

Carriers are subject to audits related to health plan qualifications. These audits may be conducted periodically to determine if Qualified Health Plans continue to meet all requirements as defined in OAC 317:45-5-1.

## SUBCHAPTER 5. QUALIFIED HEALTH PLANS

### 317:45-5-1. Qualified Health Plan requirements

(a) Qualified Health Plans participating in O-EPIC must offer, at a minimum, benefits that include:

- (1) hospital services;
- (2) physician services;
- (3) clinical laboratory and radiology;
- (4) pharmacy; and
- (5) office visits.

(b) The health plan, if required, must be approved by the Oklahoma Department of Insurance for participation in the Oklahoma market. All health plans must share in the cost of covered services and pharmacy products in addition to any negotiated discounts with network providers, pharmacies, or pharmaceutical manufacturers. If the health plan requires co-payments or deductibles, the co-payments or deductibles cannot exceed the limits described in this subsection.

- (1) An annual out-of-pocket maximum cannot exceed \$3,000 per individual. This amount includes any individual, annual deductible amount, except for pharmacy.
- (2) Office visits cannot require a co-payment exceeding \$50 per visit.
- (3) Annual pharmacy deductibles cannot exceed \$500 per individual.

(c) Qualified Health Plans may provide an Explanation of Benefits (EOB) for paid or denied claims subject to member co-insurance or member deductible calculations. If an EOB is provided it must contain, at a minimum, the:

- (1) provider's name;
- (2) patient's name;
- (3) date(s) of service;
- (4) code(s) and/or description(s) indicating the service(s) rendered, the amount(s) paid or the denied status of the claim(s);
- (5) reason code(s) and description(s) for any denied service(s); and
- (6) amount due from the patient or responsible party.

### 317:45-5-2. Closure criteria for health plans

Eligibility for the Carrier's health plans ends when:

- (1) changes to the design or benefits of the Qualified Health Plan such that it no longer meets O-EPIC requirements for Qualified Health Plans. Carriers are required to

report to OHCA any changes in health plans potentially affecting its qualification for participation in the O-EPIC program not less than 90 days prior to the effective date of such change(s).

(2) the Carrier no longer meets the definition set forth in OAC 317:45-1-3.

(3) the health plan is no longer an available product in the Oklahoma market.

(4) the health plan fails to meet or comply with all requirements for a Qualified Health Plan as defined OAC 317:45-5-1.

**SUBCHAPTER 7. EMPLOYER ELIGIBILITY**

**317:45-7-1. Employer application and eligibility requirements for O-EPIC**

(a) In order for an employer to be eligible to participate in the O-EPIC program the employer must:

(1) have no more than a total of 25 employees on its payroll, including those working at the corporate level and within all subsidiaries.

(A) Subsidiaries are defined as:

(i) a company effectively controlled by another or associated with others under common ownership or control; or

(ii) two or more employers sharing common ownership, management, or control, all for the purpose of achieving a common business interest.

(B) The number of employees is determined based on the third month employee count of the most recently filed OES-3 form with the Oklahoma Employment Security Commission (OESC) and that is in compliance with all requirements of the OESC;

(2) have a business that is physically located in Oklahoma;

(3) be currently offering or contracted to offer within 30 calendar days an O-EPIC Qualified Health Plan;

(4) offer Qualified Health Plan coverage to employees in accordance with Oklahoma Small Business Statutes, Oklahoma Department of Insurance, and all other regulatory agencies;

(5) contribute a minimum 25 percent of the eligible employee monthly health plan premium;

(b) An employer who meets all requirements listed in subsection (a) of this Section must complete and submit an employer enrollment packet to the TPA.

(c) The employer must provide its Federal Employee Identification Number (FEIN).

(d) The employer must notify the TPA, within 5 working days from occurrence, of any changes in an employee's employment status.

**317:45-7-2. Employer eligibility determination**

Eligibility for employers is determined by the TPA using the eligibility requirements listed in OAC 317:45-7-1. An employer determined eligible for O-EPIC is approved for a 12

month period. The eligibility period begins on the first day of the month following the date of approval. The TPA notifies the employer of the eligibility decision for employer and employees.

**317:45-7-3. Employer cost sharing**

Employers are responsible for a portion of the eligible employee's monthly health plan premium as defined in OAC 317:45-7-1. Employers are not required to contribute to an eligible spouse's coverage.

**317:45-7-4. Qualifying Event**

Employers must allow an employee to enroll or change coverage following a Qualifying Event. The employer files form OEPIC-4, Small Business Employer Change Form, with the TPA for that employee experiencing the Qualifying Event.

**317:45-7-5. Reimbursement**

In order to receive a premium subsidy, the employer must submit the current health plan invoice to the TPA via electronic submission, fax or mail.

**317:45-7-6. Credits and adjustments**

When an overpayment has occurred, the employer must immediately refund the TPA, by check, to the attention of the Finance Division. The TPA system has the capability of automatic credits and debits. When an erroneous payment occurs, that results in an overpayment, an automatic recoupment is made to the employer's account against monies owed to the employer on behalf of their employee(s).

**317:45-7-7. Audits**

Employers are subject to audits related to eligibility status and subsidy payments. Eligibility may be revoked at any time if inconsistencies are found. Any monies paid in error are subject to recoupment.

**317:45-7-8. Closure**

Eligibility provided under the O-EPIC program ends during the eligibility period when:

(1) the employer terminates its contract with all Qualified Health Plan;

(2) the employer fails to pay premiums to the Carrier;

(3) the employer fails to provide an invoice verifying the monthly health plan premium has been paid;

(4) an audit indicates a discrepancy that makes the employer ineligible;

(5) the employer no longer has a business location in Oklahoma;

(6) the Qualified Health Plan or Carrier no longer qualifies for O-EPIC; or

(7) the employer's eligibility period ends and is not renewed.

# Emergency Adoptions

## **SUBCHAPTER 9. EMPLOYEE ELIGIBILITY**

### **317:45-9-1. Employee eligibility requirements**

(a) Employee premium assistance applications are made with the TPA. Employees of an O-EPIC eligible employer must apply within 30 days from the date the employer is approved for O-EPIC or within 30 days from the date they are hired to work for a participating employer. Employees may also apply during the employer's health plan open enrollment period.

(b) The TPA electronically submits the application to the Oklahoma Department of Human Services (OKDHS) for a determination of eligibility. The eligibility determination is processed within 30 days from the date the application is received by the TPA. The employee is notified in writing of the eligibility decision.

(c) All O-EPIC eligible employees described in this Section are enrolled through their Employer Sponsored Health Plan (ESHP). Employees eligible for O-EPIC must:

- (1) have a household income at or below 185% of the Federal Poverty Level;
- (2) be US citizens or aliens as described in OAC 317:35-5-27;
- (3) be Oklahoma residents;
- (4) provide his/her social security number;
- (5) be otherwise ineligible for Medicaid/Medicare;
- (6) be employed with a qualified employer at a business location in Oklahoma;
- (7) be age 19 or older;
- (8) be eligible for enrollment in the employer's Qualified Health Plan;
- (9) be working for employers (if multiple) who all meet the eligible employer guidelines;
- (10) select one of the Qualified Health Plans the employer is offering; and
- (11) make application within 30 days of the employer being approved or have a Qualifying Event.

(d) An employee's spouse is eligible for O-EPIC if:

- (1) the employer's health plan includes coverage for spouses;
- (2) the employee is eligible for O-EPIC;
- (3) if employed, the spouse's employer meets O-EPIC employer guidelines listed in OAC 317:45-7-1(a)(1)-(2); and
- (4) the spouse is enrolled in the same health plan as the employee.

(e) If an employee or spouse is eligible for multiple O-EPIC Qualified Health Plans, each may receive a subsidy under only one health plan.

### **317:45-9-2. Employee eligibility period**

(a) Employee eligibility is contingent upon the employer's program eligibility.

(b) The employee's eligibility is determined by the TPA using the eligibility requirements listed in OAC 317:45-9-1.

(c) If the employee is determined eligible for O-EPIC, he/she is approved for a period not greater than 12 months.

The length of the eligibility period is based on the remaining number of months the employer has left in its eligibility period.

(d) The employee's eligibility period begins on the first day of the month following the date of approval.

### **317:45-9-3. Qualifying Event**

(a) Employees are allowed 30 calendar days to apply for O-EPIC following a Qualifying Event.

(b) An employee's spouse may become eligible for coverage and is allowed 30 calendar days to apply for O-EPIC following a Qualifying Event of the employee or spouse.

### **317:45-9-4. Employee cost sharing**

Employees are responsible for up to 15% percent of their health plan premium. The employees are also responsible for up to 15% of their spouse's health plan premium if the spouse is included in the program. The combined portion of the employee's cost sharing for health plan premiums cannot exceed three percent of his/her gross annual household income computed monthly.

### **317:45-9-5. Reimbursement for out-of-pocket medical expenses**

(a) Employees are responsible for all out-of-pocket expenses. Out-of-pocket expenses for services covered by the health plan, as defined by the health plan's benefit summary and policies, that exceed 5% of the employee's gross annual household income during the current eligibility period may be reimbursable.

(b) The employee must submit a reimbursement claim form with appropriate documentation to the TPA. Information may be submitted at any time but no later than 90 days after the close of their eligibility period. Appropriate supporting documentation includes an original EOB or paid receipt. Both EOB and paid receipts must include required information listed in OAC 317:45-5-1(c)(1)-(6). Reimbursement for out-of-pocket medical expenses is made for the amount indicated as the member's responsibility on the EOB or receipt reflecting the amount paid for medical expenses, including prescribed prescriptions.

(c) Reimbursement for qualified medical expenses are subject to a fixed cap amount. The fixed cap for reimbursement is established annually and is calculated using local and national data concerning individual out-of-pocket health care expenses. The objective of the fixed cap is to set the amount high enough such that, in the great majority of households, all of the costs above the 5% threshold would be absorbed.

### **317:45-9-6. Audits**

Individuals participating in the O-EPIC program are subject to audits related to their eligibility, subsidy payments, and out-of-pocket reimbursements. Eligibility may be reversed at any time if inconsistencies are found. Any monies paid in error will be subject to recoupment.

### **317:45-9-7. Closure**

(a) Employer and employees eligibility are tied together. If the employer no longer meets the requirements for O-EPIC then eligibility for the associated employees enrolled under that employer are also ineligible. Employees are mailed a written notice 10 days prior to closure of eligibility.

(b) The employee's certification period may be terminated when:

- (1) termination of employment, either voluntary or involuntary, occurs;
- (2) the employee moves out-of-state;
- (3) the covered employee dies;
- (4) the employer ends its contract with the Qualified Health Plan;
- (5) the employer's eligibility ends;
- (6) an audit indicates a discrepancy that makes the employee or employer ineligible;
- (7) the employer is terminated from O-EPIC;
- (8) the employer fails to pay the premium;
- (9) the Qualified Health Plan or Carrier is no longer qualified;

(10) the employee becomes eligible for Medicaid/Medicare;

(11) the employee or employer reports to the OHCA or the TPA any change affecting eligibility; or

(12) the employee is no longer listed as a covered person on the employer's health plan invoice.

### **317:45-9-8. Appeals**

(a) Employee appeal procedures based on denial of eligibility due to income are described at OAC 317:2-1-2.

(b) Employee appeals regarding out-of-pocket expenses are made to the TPA. If the employee disagrees with the TPA's findings, reconsideration of the finding may be made to the OHCA. The decision of the OHCA is final.

*[OAR Docket #05-1311; filed 11-2-05]*



# 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

**1:2005-29.**

### EXECUTIVE ORDER 2005-29

I, Brad Henry, Governor of the State of Oklahoma, hereby direct the appropriate steps be taken to fly all American and Oklahoma flags at the State Capital Building at half-staff from 8:00 a.m. until 5:00 p.m. on Saturday, November 5, 2005, to honor Judge Audre Yvonne Cravens Nichols, who died on Monday, October 31, 2005.

Yvonne Cravens Nichols was born October 27, 1930 in Oklahoma City and graduated from Classen High School where she gained state and national recognition as a debater. Judge Nichols served on the Oklahoma Industrial Court for six years in the 1970's. Later, she served as the General Counsel of the Oklahoma Employment Securities Commission and then as the Administrator of the Appellate Division for the Commission. For many years, she co-wrote and directed the Oklahoma City Gridiron Club's annual show.

This executive order shall be forwarded to the Director of Central Services 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, Oklahoma, this 4th day of November, 2005.

BY THE GOVERNOR OF THE  
STATE OF OKLAHOMA

Brad Henry

ATTEST:  
M.Susan Savage  
Secretary of State

*[OAR Docket #05-1339; filed 11-4-05]*

**1:2005-30.**

### EXECUTIVE ORDER 2005-30

I, Brad Henry, Governor of the State of Oklahoma, in observation of Veterans' Day, hereby direct the appropriate steps be taken to fly all American and Oklahoma flags on State property at half-staff from 8:00 a.m. until 5:00 p.m. on Friday, November 11, 2005, in appreciation for the sacrifices that Oklahoma men and women have made in defense of this great nation in all wars from the First World War to the wars in Korea and Vietnam to those we fight today.

This executive order shall be forwarded to the Director of Central Services 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 9th day of November, 2005.

BY THE GOVERNOR OF THE  
STATE OF OKLAHOMA

Brad Henry

ATTEST:  
M. Susan Savage  
Secretary of State

*[OAR Docket #05-1367; filed 11-9-05]*

