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Table of Contents

Agency/Action/Subject Index	iii
Rules Affected Index	v
Agency Index (Title numbers assigned)	x
Notices of Rulemaking Intent	
University Hospitals Trust (Title 753)	713
Cancelled Hearings/Comment Periods	
Central Services, Department of (Title 580)	715
Submissions for Review	
Chiropractic Examiners, Board of (Title 140)	717
Environmental Quality, Department of (Title 252)	718, 719, 720, 721, 722
Health, Oklahoma State Department of (Title 310)	722, 723, 724, 725, 726
Health Care Authority, Oklahoma (Title 317)	726, 727, 728, 729, 730, 731, 732
Human Services, Department of (Title 340)	732, 733, 734, 735, 736
Juvenile Affairs, Office of (Title 377)	737
Labor, Department of (Title 380)	737
Mental Health and Substance Abuse Services, Department of (Title 450)	737, 738
Motor Vehicle Commission, Oklahoma (Title 465)	738
Osteopathic Examiners, State Board of (Title 510)	738
Police Pension and Retirement System, Oklahoma (Title 550)	738, 739
Tax Commission, Oklahoma (Title 710)	739, 740, 741, 742
Teachers' Retirement System (Title 715)	742
Used Motor Vehicle and Parts Commission, Oklahoma (Title 765)	742, 743, 744, 745
Water Resources Board, Oklahoma (Title 785)	746, 747
Gubernatorial Approvals	
Agriculture, Food, and Forestry, Oklahoma Department of (Title 35)	749
Engineers and Land Surveyors, State Board of Registration for Professional (Title 245)	749
Firefighters Pension and Retirement System, Oklahoma (Title 270)	750
Health Care Authority, Oklahoma (Title 317)	750, 751, 752, 753, 754
Horse Racing Commission, Oklahoma (Title 325)	754
Human Services, Department of (Title 340)	754, 755, 756
Medical Licensure and Supervision, State Board of (Title 435)	756
Public Employees Retirement System, Oklahoma (Title 590)	756, 757
Emergency Adoptions	
Health Care Authority, Oklahoma (Title 317)	759, 761, 771, 807, 815, 817, 819
Medical Licensure and Supervision, State Board of (Title 435)	822
Executive Orders (Title 1)	825

Agency/Action/Subject Index

AGRICULTURE, Food, and Forestry, Oklahoma Department of (Title 35)

Gubernatorial Approvals

- Water Quality (Chapter 17) 749
- Agriculture Pollutant Discharge Elimination System
(Chapter 44) 749

CHIROPRACTIC Examiners, Board of (Title 140)

Submissions for Review

- Administrative Organization and Operations
(Chapter 1) 717
- Disciplinary Procedures (Chapter 3) 717
- Licensure of Chiropractic Physicians (Chapter 10) 717
- Special Certificates and Miscellaneous Provisions
(Chapter 15) 717

ENGINEERS and Land Surveyors, State Board of Registration for Professional (Title 245)

Gubernatorial Approvals

- Administrative Operations (Chapter 2) 749
- Licensure and Practice of Professional Engineers and Land
Surveyors (Chapter 15) 749

ENVIRONMENTAL Quality, Department of (Title 252)

Submissions for Review

- Emergency Planning and Community Right-To-Know
(Chapter 20) 718
- Air Pollution Control (Chapter 100) 718, 719
- Laboratory Accreditation (Chapter 300) 719
- Laboratory Services (Chapter 305) 719
- Radiation Management (Chapter 410) 719
- Management of Solid Waste (Chapter 515) 720
- Oklahoma Pollutant Discharge Elimination System (OPDES)
Standards (Chapter 606) 721
- General Water Quality (Chapter 611) 721
- Industrial Wastewater Systems (Chapter 616) 721
- Public Water Supply Operation (Chapter 631) 721
- Water Quality Standards Implementation
(Chapter 690) 722
- Waterworks and Wastewater Works Operator Certification
(Chapter 710) 722

FIREFIGHTERS Pension and Retirement System, Oklahoma (Title 270)

Gubernatorial Approvals

- Firefighters Pension and Retirement Plan (Chapter 10) ... 750

GOVERNOR

Executive Orders

- Ordering flags at half-staff to honor Chickasha firefighter
Destry Horton (06-8) 825
- Ordering Oklahoma Tax Commission to cease issuing
pre-determination letters (06-9) 825

HEALTH, Oklahoma State Department of (Title 310)

Submissions for Review

- Fee and Fine Schedule for Occupational Licensing
(Chapter 110) 722
- Alarm Industry (Chapter 205) 722
- Barbers (Chapter 210) 722
- Food Service Establishments [REVOKED]
(Chapter 256) 723
- Food Service Establishments (Chapter 257) 723
- Home Inspection Industry (Chapter 276) 723
- Smoking in Public Places And Indoor Workplaces
(Chapter 355) 723
- Licensed Marital and Family Therapists (Chapter 400) ... 724
- Licensed Behavioral Practitioners (Chapter 403) 724
- Licensed Professional Counselors (Chapter 405) 724
- Emergency Medical Services (Chapter 641) 725
- Certified Workplace Medical Plans (Chapter 657) 725

HEALTH, Oklahoma State Department of – continued

Submissions for Review – continued

- Hospice (Chapter 661) 725
- Nursing and Specialized Facilities (Chapter 675) 726
- Nurse Aide Training and Certification (Chapter 677) 726

HEALTH Care Authority, Oklahoma (Title 317)

Submissions for Review

- Administrative Operations (Chapter 1) 726
- Grievance Procedures and Process (Chapter 2) 726
- Medical Providers-Fee for Service (Chapter 30) 727,
728, 729, 730, 731
- Medical Assistance for Adults and Children-Eligibility
(Chapter 35) 731, 732
- Oklahoma Employer and Employee Partnership for Insurance
Coverage (Chapter 45) 732

Gubernatorial Approvals

- Medical Providers-Fee for Service (Chapter 30) 750,
751, 752
- Medical Assistance for Adults and Children-Eligibility
(Chapter 35) 752, 753
- Developmental Disabilities Services (Chapter 40) 753
- Oklahoma Employer and Employee Partnership for Insurance
Coverage (Chapter 45) 754

Emergency Adoptions

- Administrative Operations (Chapter 1) 759
- Grievance Procedures and Process (Chapter 2) 761
- Medical Providers-Fee for Service (Chapter 30) 771,
807, 815
- Medical Assistance for Adults and Children-Eligibility
(Chapter 35) 817
- Oklahoma Employer and Employee Partnership for Insurance
Coverage (Chapter 45) 819

HORSE Racing Commission, Oklahoma (Title 325)

Gubernatorial Approvals

- Racing Officials and Racing Personnel (Chapter 20) 754
- Medication and Equine Testing Procedures
(Chapter 45) 754
- Human Substance Abuse Testing (Chapter 50) 754
- Objections and Protests; Hearings and Appeals
(Chapter 70) 754

HUMAN Services, Department of (Title 340)

Submissions for Review

- Administrative Components (Chapter 2) 732, 733
- Temporary Assistance for Needy Families (TANF)
(Chapter 10) 733
- State Supplemental Payment (Chapter 15) 734
- Low Income Home Energy Assistance Program (LIHEAP)
(Chapter 20) 734
- Child Care Services (Chapter 40) 734
- Emergency Welfare Services [REVOKED]
(Chapter 45) 734
- Food Stamp Program (Chapter 50) 735
- Emergency Repatriation Program [REVOKED]
(Chapter 55) 735
- Refugee Resettlement Program (Chapter 60) 735
- Public Assistance Procedures (Chapter 65) 736
- Developmental Disabilities Services Division
(Chapter 100) 736

Gubernatorial Approvals

- Temporary Assistance for Needy Families (TANF)
(Chapter 10) 754
- Low Income Home Energy Assistance Program (LIHEAP)
(Chapter 20) 755

Agency/Action/Subject Index – continued

HUMAN Services, Department of – continued

Gubernatorial Approvals – continued

Emergency Welfare Services [REVOKED]
 (Chapter 45) 755
 Food Stamp Program (Chapter 50) 755
 Emergency Repatriation Program [REVOKED]
 (Chapter 55) 755
 Refugee Resettlement Program (Chapter 60) 756
 Developmental Disabilities Services Division
 (Chapter 100) 756

JUVENILE Affairs, Office of (Title 377)

Submissions for Review

Administrative Services (Chapter 3) 737

LABOR, Department of (Title 380)

Submissions for Review

Oklahoma Occupational Health and Safety Standards Act
 Rules (Chapter 40) 737

MEDICAL Licensure and Supervision, State Board of (Title 435)

Gubernatorial Approvals

Physical Therapists and Assistants (Chapter 20) 756

Emergency Adoptions

Respiratory Care Practitioner (Chapter 45) 822

MENTAL Health and Substance Abuse Services, Department of (Title 450)

Submissions for Review

Administration (Chapter 1) 737
 Standards and Criteria for Alcohol and Drug Treatment
 Programs (Chapter 18) 737
 Certification of Alcohol and Drug Substance Abuse
 Courses (ADSAC), Organizations and Facilitators
 (Chapter 21) 737
 Certification of Alcohol and Drug Assessment and
 Evaluations Related to Driver's License Revocation
 (Chapter 22) 738
 State-Operated Inpatient Services (Chapter 30) 738

MOTOR Vehicle Commission, Oklahoma (Title 465)

Submissions for Review

License (Chapter 10) 738

OSTEOPATHIC Examiners, State Board of (Title 510)

Submissions for Review

Licensure of Osteopathic Physicians and Surgeons
 (Chapter 10) 738

POLICE Pension and Retirement System, Oklahoma (Title 550)

Submissions for Review

Administrative Operations (Chapter 1) 738
 Oklahoma Police Deferred Option Plan (Chapter 15) 739
 Purchase of Transferred Credited Service (Chapter 20) ... 739

CENTRAL Services, Department of (Title 580)

Cancelled Hearings/Comment Periods

Central Purchasing (Chapter 15) 715

PUBLIC Employees Retirement System, Oklahoma (Title 590)

Gubernatorial Approvals

Public Employees Retirement System (Chapter 10) 756

PUBLIC Employees Retirement System, Oklahoma – continued

Gubernatorial Approvals – continued

Uniform Retirement System for Justices and Judges
 (Chapter 15) 757
 Qualified Domestic Relations Orders (Chapter 30) 757

TAX Commission, Oklahoma (Title 710)

Submissions for Review

Administrative Operations (Chapter 1) 739
 Alcohol, Mixed Beverages and Low-Point Beer
 (Chapter 20) 739
 Boats and Motors (Chapter 22) 739
 Coin Operated Vending Devices (Chapter 25) 740
 Franchise Tax (Chapter 40) 740
 Motor Vehicles (Chapter 60) 740
 Sales and Use Tax (Chapter 65) 741
 Miscellaneous Areas of Regulatory and Administrative
 Authority (Chapter 95) 742

TEACHERS' Retirement System (Title 715)

Submissions for Review

General Operations (Chapter 10) 742

UNIVERSITY Hospitals Trust (Title 753)

Notices of Rulemaking Intent

General Agency Rules (Chapter 1) 713

USED Motor Vehicle and Parts Commission, Oklahoma (Title 765)

Submissions for Review

Organization and Method of Operations (Chapter 1) 742
 Informal and Formal Procedures (Chapter 2) 742
 Promulgation, Amendment, and Repeal of Rules
 (Chapter 3) 743
 Used Motor Vehicle Dealers (Chapter 10) 743
 Used Motor Vehicle Rebuilders (Chapter 11) 743
 Used Motor Vehicle ~~Salesmen~~ Salespersons
 (Chapter 15) 743
 Advertising (Chapter 16) 744
 Wholesale Used Motor Vehicle Dealers (Chapter 20) 744
 Automotive Dismantler and Parts Recyclers
 (Chapter 25) 744
 Buyer's Identification Cards (Chapter 30) 744
 Manufactured Home Dealers (Chapter 35) 745
 Manufactured Home Manufacturers (Chapter 36) 745
 Manufactured Home Installers (Chapter 37) 745
Manufactured Home Salesperson (Chapter 38) 745

WATER Resources Board, Oklahoma (Title 785)

Submissions for Review

Organizations and Procedure of Oklahoma Water Resources
 Board (Chapter 1) 746
 Rules of Practice and Hearings (Chapter 4) 746
 Fees (Chapter 5) 746
 Appropriation and Use of Stream Water (Chapter 20) 746
 Taking and Use of Groundwater (Chapter 30) 747
 Well Driller and Pump Installer Licensing (Chapter 35) ... 747
 Financial Assistance (Chapter 50) 747

Rules Affected Index

[(E) = Emergency action]

Rule	Register Page	Rule	Register Page
35:15-11-20.	[AMENDED] (E) 11	38:10-11-3.	[NEW] (E) 137
35:15-47-6.	[AMENDED] (E) 105	38:10-13-1.	[NEW] (E) 137
35:15-47-18.	[AMENDED] (E) 106	38:10-13-2.	[NEW] (E) 137
35:44-3-1.	[NEW] (E) 505	38:10-13-3.	[NEW] (E) 137
35:44-3-2.	[NEW] (E) 505	38:10-13-4.	[NEW] (E) 137
35:44-3-3.	[NEW] (E) 506	38:10-13-5.	[NEW] (E) 137
38:1-1-1.	[NEW] (E) 123	38:10-13-6.	[NEW] (E) 137
38:1-1-2.	[NEW] (E) 123	75:1-1-1.	[NEW] (E) 329
38:1-1-3.	[NEW] (E) 124	75:1-1-1.1.	[NEW] (E) 329
38:1-1-4.	[NEW] (E) 124	75:1-1-2.	[NEW] (E) 330
38:1-1-5.	[NEW] (E) 125	75:1-1-3.	[NEW] (E) 330
38:1-1-6.	[NEW] (E) 125	75:1-1-4.	[NEW] (E) 330
38:1-1-7.	[NEW] (E) 125	75:1-1-5.	[NEW] (E) 330
38:1-1-8.	[NEW] (E) 125	75:1-1-6.	[NEW] (E) 330
38:1-1-9.	[NEW] (E) 125	75:1-1-7.	[NEW] (E) 330
38:1-1-10.	[NEW] (E) 125	75:1-1-8.	[NEW] (E) 331
38:1-1-11.	[NEW] (E) 125	75:1-1-9.	[NEW] (E) 331
38:1-1-12.	[NEW] (E) 126	75:1-1-10.	[NEW] (E) 331
38:1-1-13.	[NEW] (E) 126	75:1-3-1.	[NEW] (E) 332
38:1-1-14.	[NEW] (E) 126	75:1-3-2.	[NEW] (E) 332
38:1-1-15.	[NEW] (E) 126	75:1-3-3.	[NEW] (E) 332
38:1-1-16.	[NEW] (E) 126	75:1-3-14.	[NEW] (E) 332
38:1-3-1.	[NEW] (E) 126	75:1-3-15.	[NEW] (E) 332
38:1-3-2.	[NEW] (E) 127	75:1-3-16.	[NEW] (E) 332
38:1-3-3.	[NEW] (E) 127	75:1-3-17.	[NEW] (E) 332
38:1-3-4.	[NEW] (E) 127	75:1-3-18.	[NEW] (E) 332
38:1-3-5.	[NEW] (E) 127	75:1-3-19.	[NEW] (E) 332
38:1-3-6.	[NEW] (E) 127	75:1-3-20.	[NEW] (E) 333
38:10-1-1.	[NEW] (E) 128	75:1-5-1.	[NEW] (E) 333
38:10-1-2.	[NEW] (E) 128	75:1-5-2.	[NEW] (E) 333
38:10-1-3.	[NEW] (E) 129	75:1-5-3.	[NEW] (E) 333
38:10-1-4.	[NEW] (E) 129	75:1-5-4.	[NEW] (E) 333
38:10-1-5.	[NEW] (E) 129	75:1-5-4.	[NEW] (E) 334
38:10-1-6.	[NEW] (E) 129	75:1-5-5.	[NEW] (E) 334
38:10-1-7.	[NEW] (E) 129	75:1-5-5.	[NEW] (E) 334
38:10-1-8.	[NEW] (E) 129	75:1-5-5.1.	[NEW] (E) 334
38:10-1-9.	[NEW] (E) 130	75:1-5-5.2.	[NEW] (E) 334
38:10-3-1.	[NEW] (E) 130	75:1-5-5.3.	[NEW] (E) 334
38:10-3-2.	[NEW] (E) 130	75:1-5-6.	[NEW] (E) 334
38:10-3-3.	[NEW] (E) 130	75:1-5-7.	[NEW] (E) 334
38:10-3-4.	[NEW] (E) 131	75:1-5-8.	[NEW] (E) 335
38:10-3-5.	[NEW] (E) 131	75:1-5-9.	[NEW] (E) 335
38:10-3-6.	[NEW] (E) 132	75:1-5-10.	[NEW] (E) 335
38:10-5-1.	[NEW] (E) 132	75:1-5-11.	[NEW] (E) 336
38:10-5-2.	[NEW] (E) 132	75:1-5-12.	[NEW] (E) 336
38:10-5-3.	[NEW] (E) 132	75:1-7-1.	[NEW] (E) 336
38:10-7-1.	[NEW] (E) 132	75:1-7-2.	[NEW] (E) 336
38:10-7-2.	[NEW] (E) 132	75:1-7-3.	[NEW] (E) 336
38:10-7-3.	[NEW] (E) 133	75:1-7-4.	[NEW] (E) 336
38:10-7-4.	[NEW] (E) 134	75:1-7-5.	[NEW] (E) 336
38:10-7-5.	[NEW] (E) 134	75:1-7-6.	[NEW] (E) 337
38:10-7-6.	[NEW] (E) 134	75:1-7-7.	[NEW] (E) 338
38:10-7-7.	[NEW] (E) 134	75:1-7-8.	[NEW] (E) 339
38:10-7-8.	[NEW] (E) 135	75:1-7-9.	[NEW] (E) 339
38:10-7-9.	[NEW] (E) 135	75:1-7-10.	[NEW] (E) 339
38:10-9-1.	[NEW] (E) 135	75:1-7-11.	[NEW] (E) 339
38:10-9-2.	[NEW] (E) 135	75:15-1-1.	[AMENDED] (E) 340
38:10-9-3.	[NEW] (E) 135	75:15-1-2.	[AMENDED] (E) 340
38:10-9-4.	[NEW] (E) 135	75:15-1-4.	[AMENDED] (E) 342
38:10-11-1.	[NEW] (E) 136	75:15-1-6.	[AMENDED] (E) 342
38:10-11-2.	[NEW] (E) 136	75:15-3-1.	[AMENDED] (E) 343

Rules Affected Index – *continued*

75:15-3-2. [AMENDED] (E)	344	150:115-1-1. [NEW] (E)	106
75:15-3-7. [AMENDED] (E)	344	150:115-1-2. [NEW] (E)	106
75:15-3-8. [AMENDED] (E)	345	150:115-1-3. [NEW] (E)	107
75:15-3-9. [AMENDED] (E)	345	150:115-1-4. [NEW] (E)	107
75:15-3-10. [AMENDED] (E)	346	165:5-3-1. [AMENDED] (E)	506
75:15-5-2. [AMENDED] (E)	346	165:5-7-65. [AMENDED] (E)	508
75:15-5-3. [AMENDED] (E)	346	165:5-25-1. [NEW] (E)	508
75:15-5-3.1. [AMENDED] (E)	347	165:5-25-2. [NEW] (E)	508
75:15-5-4. [AMENDED] (E)	348	165:5-25-3. [NEW] (E)	509
75:15-5-5. [AMENDED] (E)	348	165:5-25-4. [NEW] (E)	509
75:15-5-6. [AMENDED] (E)	349	165:5-25-5. [NEW] (E)	509
75:15-5-10. [AMENDED] (E)	349	165:25-2-2. [AMENDED] (E)	138
75:15-7-1. [AMENDED] (E)	349	165:25-3-6. [AMENDED] (E)	139
75:15-7-2. [AMENDED] (E)	350	165:25-8-1. [AMENDED] (E)	140
75:15-7-3. [AMENDED] (E)	350	165:25-8-2. [NEW] (E)	140
75:15-7-4. [AMENDED] (E)	350	165:25-8-3. [NEW] (E)	141
75:15-7-5. [AMENDED] (E)	350	165:25-8-4. [NEW] (E)	141
75:15-7-6. [AMENDED] (E)	350	165:25-8-5. [REVOKED] (E)	141
75:15-7-7. [AMENDED] (E)	350	165:25-8-7. [REVOKED] (E)	142
75:15-9-1. [AMENDED] (E)	351	165:25-8-8. [REVOKED] (E)	142
75:15-9-2. [AMENDED] (E)	351	165:25-8-14. [AMENDED] (E)	143
75:15-9-7. [AMENDED] (E)	351	165:25-8-15. [AMENDED] (E)	143
75:15-9-8. [AMENDED] (E)	351	165:25-8-29. [AMENDED] (E)	143
75:15-9-9. [AMENDED] (E)	351	165:25-8-35. [AMENDED] (E)	143
75:15-9-10. [AMENDED] (E)	352	165:25-8-36. [AMENDED] (E)	144
75:15-11-1. [AMENDED] (E)	352	165:26-1-31. [AMENDED] (E)	145
75:15-11-2. [AMENDED] (E)	352	165:26-2-1.2. [NEW] (E)	146
75:15-11-3. [AMENDED] (E)	352	165:26-2-5. [AMENDED] (E)	146
75:15-13-1. [AMENDED] (E)	352	165:26-2-32. [AMENDED] (E)	146
75:15-13-2. [AMENDED] (E)	352	165:26-2-54. [AMENDED] (E)	146
75:15-13-3. [AMENDED] (E)	353	165:26-2-55. [AMENDED] (E)	147
75:15-13-4. [AMENDED] (E)	353	165:26-2-56. [AMENDED] (E)	147
75:15-13-5. [AMENDED] (E)	353	165:26-2-131. [AMENDED] (E)	148
75:15-13-8. [AMENDED] (E)	353	165:26-2-134. [AMENDED] (E)	148
75:15-13-9. [AMENDED] (E)	353	165:26-2-171. [AMENDED] (E)	149
75:15-13-10. [AMENDED] (E)	353	165:26-3-21. [AMENDED] (E)	149
75:15-13-20. [AMENDED] (E)	353	165:26-8-2. [AMENDED] (E)	150
75:15-13-20.1. [AMENDED] (E)	354	165:26-8-2.1. [NEW] (E)	150
75:15-13-20.2. [AMENDED] (E)	354	165:26-8-40. [REVOKED] (E)	150
75:15-13-24. [AMENDED] (E)	354	165:26-8-40.1. [NEW] (E)	151
75:15-13-26. [AMENDED] (E)	354	165:26-8-40.2. [NEW] (E)	151
75:15-13-27. [AMENDED] (E)	355	165:26-8-41. [REVOKED] (E)	151
75:15-13-28. [AMENDED] (E)	355	165:26-8-61. [AMENDED] (E)	152
75:15-13-29. [AMENDED] (E)	355	165:26-8-62. [AMENDED] (E)	152
75:15-13-30. [AMENDED] (E)	355	165:26-8-80. [AMENDED] (E)	152
75:15-15-1. [AMENDED] (E)	355	165:26-8-86. [AMENDED] (E)	153
75:15-15-2. [AMENDED] (E)	355	165:26-8-88. [AMENDED] (E)	153
75:15-15-3. [AMENDED] (E)	355	165:30-3-1. [AMENDED] (E)	510
75:15-15-4. [AMENDED] (E)	356	165:30-3-3. [AMENDED] (E)	511
75:15-17-1. [AMENDED] (E)	356	165:30-3-103. [AMENDED] (E)	511
75:15-17-2. [AMENDED] (E)	356	165:30-7-2. [AMENDED] (E)	512
75:15-17-3. [AMENDED] (E)	356	165:30-7-8. [AMENDED] (E)	512
75:15-17-4. [AMENDED] (E)	357	165:30-9-1. [AMENDED] (E)	512
87:1-3-14. [AMENDED] (E)	12	165:30-15-4. [AMENDED] (E)	513
87:10-17-3. [AMENDED] (E)	13	165:30-15-5. [AMENDED] (E)	514
87:10-19-1. [AMENDED] (E)	14	165:30-16-1. [NEW] (E)	514
87:10-25-2. [AMENDED] (E)	14	165:30-16-2. [NEW] (E)	514
87:10-25-9. [AMENDED] (E)	15	165:30-16-3. [NEW] (E)	514
87:10-25-10. [AMENDED] (E)	15	165:30-16-4. [NEW] (E)	515
87:10-27-2. [AMENDED] (E)	15	165:30-16-5. [NEW] (E)	515
87:10-27-4. [AMENDED] (E)	15	165:30-16-6. [NEW] (E)	515
87:10-27-9. [AMENDED] (E)	15	165:30-16-7. [NEW] (E)	515
87:10-27-10. [AMENDED] (E)	16	165:30-16-8. [NEW] (E)	515
87:10-35-1. [NEW] (E)	16	165:30-16-9. [NEW] (E)	515
87:20-1-1. [NEW] (E)	16	165:30-21-1. [NEW] (E)	515
87:20-1-2. [NEW] (E)	17	165:35-1-2. [AMENDED] (E)	701
87:20-1-3. [NEW] (E)	17	165:35-34-1. [NEW] (E)	703

165:35-34-2.	[NEW] (E)	703	252:100, App. O.	[NEW] (E)	21
165:35-34-3.	[NEW] (E)	703	270:10-1-5.	[AMENDED] (E)	22
165:35-35-1.	[NEW] (E)	705	310:675-7-9.1.	[AMENDED] (E)	156
165:35-37-1.	[NEW] (E)	705	310:675-9-1.1.	[AMENDED] (E)	157
165:35-37-2.	[NEW] (E)	706	310:675-9-5.1.	[AMENDED] (E)	158
165:35-37-3.	[NEW] (E)	706	310:675-13-5.	[AMENDED] (E)	159
165:35-37-4.	[NEW] (E)	706	310:675-19-1.	[NEW] (E)	557
165:35-38-1.	[NEW] (E)	707	310:675-19-2.	[NEW] (E)	557
165:35-38-2.	[NEW] (E)	707	310:675-19-3.	[NEW] (E)	557
165:35-38-3.	[NEW] (E)	707	310:675-19-4.	[NEW] (E)	558
165:35-38-4.	[NEW] (E)	707	310:675-19-5.	[NEW] (E)	558
165:35-38-5.	[NEW] (E)	708	310:675-19-6.	[NEW] (E)	558
210:15-3-22.	[AMENDED] (E)	61	310:675-19-7.	[NEW] (E)	558
210:15-3-23.	[AMENDED] (E)	65	310:675-19-8.	[NEW] (E)	558
210:15-8-1.	[NEW] (E)	70	310:677-13-1.	[AMENDED] (E)	560
210:15-8-2.	[NEW] (E)	70	310:677-13-2.	[AMENDED] (E)	560
210:15-27-1.	[AMENDED] (E)	70	310:677-13-3.	[AMENDED] (E)	560
210:15-31-1.	[NEW] (E)	153	310:677-13-4.	[AMENDED] (E)	561
210:15-31-2.	[NEW] (E)	153	310:677-13-5.	[AMENDED] (E)	562
210:20-9-172.	[AMENDED] (E)	358	310:677-13-6.	[NEW] (E)	563
210:20-9-188.	[RESERVED] (E)	72	310:677-13-7.	[NEW] (E)	563
210:20-17-3.	[AMENDED] (E)	72	310:677-13-8.	[NEW] (E)	563
210:20-19-2.	[AMENDED] (E)	154	310:677-13-9.	[NEW] (E)	564
210:20-19-3.	[AMENDED] (E)	155	310:677-13-10.	[NEW] (E)	564
210:20-19-4.	[AMENDED] (E)	155	310:677-13-11.	[NEW] (E)	565
210:20-26-1.	[NEW] (E)	73	317:1-3-5.	[REVOKED] (E)	759
210:20-26-2.	[NEW] (E)	73	317:1-7-6.	[AMENDED] (E)	760
210:20-26-3.	[NEW] (E)	73	317:1-7-6.1.	[AMENDED] (E)	760
210:35-3-186.	[AMENDED] (E)	47	317:1-9-7.	[REVOKED] (E)	760
210:35-7-43.	[AMENDED] (E)	661	317:1-9-8.	[REVOKED] (E)	761
210:35-9-31.	[AMENDED] (E)	74	317:2-1-1.	[AMENDED] (E)	761
210:35-9-43.	[AMENDED] (E)	661	317:2-1-2.	[AMENDED] (E)	761
230:10-3-8.	[AMENDED] (E)	76	317:2-1-2.1.	[REVOKED] (E)	763
230:10-3-28.1.	[AMENDED] (E)	76	317:2-1-2.2.	[REVOKED] (E)	763
230:10-3-33.	[AMENDED] (E)	77	317:2-1-2.3.	[REVOKED] (E)	764
230:10-3-34.	[AMENDED] (E)	77	317:2-1-4.	[REVOKED] (E)	766
230:10-3-35.	[AMENDED] (E)	77	317:2-1-5.	[NEW] (E)	766
230:15-11-5.	[AMENDED] (E)	78	317:2-1-6.	[NEW] (E)	767
230:30-7-13.	[AMENDED] (E)	78	317:2-1-7.	[NEW] (E)	767
230:30-11-6.1.	[AMENDED] (E)	79	317:2-1-8.	[NEW] (E)	768
230:35-3-3.	[AMENDED] (E)	80	317:2-1-9.	[NEW] (E)	768
230:35-3-30.	[AMENDED] (E)	81	317:2-1-10.	[NEW] (E)	768
230:35-3-91.	[AMENDED] (E)	82	317:2-1-11.	[NEW] (E)	769
230:35-3-130.	[AMENDED] (E)	83	317:2-1-12.	[NEW] (E)	770
230:35-3-131.	[AMENDED] (E)	84	317:2-1-13.	[NEW] (E)	770
230:35-5-175.	[AMENDED] (E)	84	317:30-3-5.	[AMENDED] (E)	239
230:35-5-176.	[AMENDED] (E)	85	317:30-3-19.	[AMENDED] (E)	771
230:35-5-177.	[AMENDED] (E)	85	317:30-3-20.	[AMENDED] (E)	773
230:35-9-7.	[AMENDED] (E)	86	317:30-3-21.	[AMENDED] (E)	774
230:40-3-1.1.	[AMENDED] (E)	87	317:30-3-59.	[AMENDED] (E)	241
230:40-5-5.	[AMENDED] (E)	87	317:30-3-74.	[REVOKED] (E)	263
230:40-5-18.	[AMENDED] (E)	555	317:30-5-2.	[AMENDED] (E)	241
230:40-5-46.	[AMENDED] (E)	556	317:30-5-9.	[AMENDED] (E)	246
230:40-5-46.1.	[NEW] (E)	556	317:30-5-14.	[AMENDED] (E)	28
230:40-7-4.	[NEW] (E)	88	317:30-5-25.	[AMENDED] (E)	774
252:100-41-1.1.	[NEW] (E)	18	317:30-5-41.	[AMENDED] (E)	248
252:100-41-13.	[NEW] (E)	18	317:30-5-41.	[AMENDED] (E)	774
252:100-41-14.	[NEW] (E)	18	317:30-5-42.	[AMENDED] (E)	29
252:100-42-1.	[NEW] (E)	18	317:30-5-47.	[AMENDED] (E)	251
252:100-42-1.1.	[NEW] (E)	18	317:30-5-47.	[AMENDED] (E)	807
252:100-42-2.	[NEW] (E)	18	317:30-5-47.2.	[NEW] (E)	259
252:100-42-3.	[NEW] (E)	19	317:30-5-47.3.	[NEW] (E)	260
252:100-42-4.	[NEW] (E)	19	317:30-5-47.4.	[NEW] (E)	260
252:100-42-20.	[NEW] (E)	19	317:30-5-47.5.	[NEW] (E)	261
252:100-42-30.	[NEW] (E)	19	317:30-5-48.	[REVOKED] (E)	262
252:100-42-31.	[NEW] (E)	20	317:30-5-62.	[AMENDED] (E)	778
252:100-42-32.	[NEW] (E)	20	317:30-5-95.2.	[AMENDED] (E)	779

Rules Affected Index – *continued*

317:30-5-110. [NEW] (E)	262	317:45-7-5. [NEW] (E)	281
317:30-5-111. [NEW] (E)	262	317:45-7-5. [NEW] (E)	821
317:30-5-112. [NEW] (E)	262	317:45-7-6. [NEW] (E)	281
317:30-5-113. [NEW] (E)	262	317:45-7-7. [NEW] (E)	281
317:30-5-114. [NEW] (E)	263	317:45-7-8. [NEW] (E)	281
317:30-5-122. [AMENDED] (E)	264	317:45-9-1. [NEW] (E)	282
317:30-5-123. [AMENDED] (E)	785	317:45-9-1. [NEW] (E)	821
317:30-5-124. [AMENDED] (E)	788	317:45-9-2. [NEW] (E)	282
317:30-5-131.1. [AMENDED] (E)	790	317:45-9-3. [NEW] (E)	282
317:30-5-131.2. [AMENDED] (E)	793	317:45-9-4. [NEW] (E)	282
317:30-5-133. [AMENDED] (E)	31	317:45-9-5. [NEW] (E)	282
317:30-5-225. [AMENDED] (E)	265	317:45-9-6. [NEW] (E)	282
317:30-5-241. [AMENDED] (E)	796	317:45-9-7. [NEW] (E)	283
317:30-5-327. [AMENDED] (E)	803	317:45-9-8. [NEW] (E)	283
317:30-5-335. [AMENDED] (E)	266	340:10-2-8. [AMENDED] (E)	626
317:30-5-336. [AMENDED] (E)	266	340:25-5-200. [AMENDED] (E)	627
317:30-5-342. [REVOKED] (E)	268	340:25-5-203.1. [NEW] (E)	628
317:30-5-343. [AMENDED] (E)	268	340:25-5-312. [AMENDED] (E)	629
317:30-5-375. [AMENDED] (E)	265	340:40-5-1. [AMENDED] (E)	35
317:30-5-412. [AMENDED] (E)	816	340:105-7-2. [AMENDED] (E)	394
317:30-5-530. [NEW] (E)	30	340:105-10-114. [AMENDED] (E)	396
317:30-5-531. [NEW] (E)	30	345:10-1-2. [NEW] (E)	630
317:30-5-532. [NEW] (E)	30	345:10-3-1. [AMENDED] (E)	630
317:30-5-555. [NEW] (E)	33	345:10-5-2. [AMENDED] (E)	631
317:30-5-556. [NEW] (E)	33	429:1-1-1. [NEW] (E)	171
317:30-5-557. [NEW] (E)	33	429:1-1-2. [NEW] (E)	171
317:30-5-558. [NEW] (E)	33	429:1-1-3. [NEW] (E)	171
317:30-5-559. [NEW] (E)	34	429:1-1-4. [NEW] (E)	173
317:30-5-560. [NEW] (E)	34	429:1-1-5. [NEW] (E)	173
317:30-5-560.1. [NEW] (E)	34	429:10-1-1. [NEW] (E)	174
317:30-5-560.2. [NEW] (E)	35	429:10-1-2. [NEW] (E)	174
317:30-5-586.1. [AMENDED] (E)	805	429:10-1-3. [NEW] (E)	177
317:30-5-596.1. [AMENDED] (E)	806	429:10-1-3. [NEW] (E)	179
317:30-5-746. [AMENDED] (E)	806	429:10-1-4. [NEW] (E)	177
317:30-5-763. [AMENDED] (E)	160	429:10-1-4. [NEW] (E)	180
317:35-1-2. [AMENDED] (E)	269	429:10-1-5. [NEW] (E)	177
317:35-3-2. [AMENDED] (E)	817	429:10-1-6. [NEW] (E)	178
317:35-5-2. [AMENDED] (E)	276	429:10-1-7. [NEW] (E)	178
317:35-5-7. [AMENDED] (E)	271	429:10-1-8. [NEW] (E)	178
317:35-5-26. [AMENDED] (E)	278	429:10-1-9. [NEW] (E)	178
317:35-6-60. [AMENDED] (E)	621	429:10-1-10. [NEW] (E)	178
317:35-6-61. [AMENDED] (E)	275	429:10-1-11. [NEW] (E)	179
317:35-6-61. [AMENDED] (E)	622	429:10-1-12. [NEW] (E)	179
317:35-7-16. [AMENDED] (E)	276	429:15-1-1. [NEW] (E)	180
317:35-7-17. [REVOKED] (E)	277	429:15-1-2. [NEW] (E)	180
317:35-9-75. [AMENDED] (E)	623	429:15-1-3. [NEW] (E)	183
317:35-15-8.1. [AMENDED] (E)	819	429:15-1-4. [NEW] (E)	183
317:35-17-3. [AMENDED] (E)	169	429:15-1-5. [NEW] (E)	183
317:35-19-16. [AMENDED] (E)	819	429:15-1-6. [NEW] (E)	183
317:35-19-22. [AMENDED] (E)	623	429:15-1-7. [NEW] (E)	184
317:40-7-2. [AMENDED] (E)	624	429:15-1-8. [NEW] (E)	184
317:40-7-12. [AMENDED] (E)	625	429:15-1-9. [NEW] (E)	184
317:45-1-1. [NEW] (E)	279	429:15-1-10. [NEW] (E)	184
317:45-1-2. [NEW] (E)	279	429:15-1-11. [NEW] (E)	184
317:45-1-2. [NEW] (E)	820	429:15-1-12. [NEW] (E)	184
317:45-1-3. [NEW] (E)	280	429:15-1-13. [NEW] (E)	184
317:45-3-1. [NEW] (E)	280	429:15-1-14. [NEW] (E)	185
317:45-3-1. [NEW] (E)	821	429:15, App. A. [NEW] (E)	186
317:45-3-2. [NEW] (E)	280	429:15, App. B. [NEW] (E)	187
317:45-5-1. [NEW] (E)	280	429:20-1-1. [NEW] (E)	188
317:45-5-2. [NEW] (E)	280	429:20-1-2. [NEW] (E)	188
317:45-7-1. [NEW] (E)	281	429:20-1-3. [NEW] (E)	190
317:45-7-1. [NEW] (E)	821	429:20-1-4. [NEW] (E)	190
317:45-7-2. [NEW] (E)	281	429:20-1-5. [NEW] (E)	190
317:45-7-2. [NEW] (E)	821	429:20-1-6. [NEW] (E)	191
317:45-7-3. [NEW] (E)	281	429:20-1-7. [NEW] (E)	191
317:45-7-4. [NEW] (E)	281	429:20-1-8. [NEW] (E)	191

429:20-1-9. [NEW] (E)	191	580:15-6-21. [NEW] (E)	91
429:20-1-10. [NEW] (E)	191	580:15-6-22. [NEW] (E)	91
429:20-1-11. [NEW] (E)	191	580:15-6-23. [NEW] (E)	91
429:20-1-12. [NEW] (E)	191	580:15-6-24. [NEW] (E)	91
429:20-1-13. [NEW] (E)	191	590:10-1-20. [NEW] (E)	516
429:20-1-14. [NEW] (E)	192	590:15-3-1. [NEW] (E)	108
429:20-1-15. [NEW] (E)	192	590:15-3-2. [NEW] (E)	108
429:20-1-16. [NEW] (E)	192	590:15-3-3. [NEW] (E)	108
429:20-1-17. [NEW] (E)	192	590:15-3-4. [NEW] (E)	109
429:20, App. A. [NEW] (E)	193	590:15-3-5. [NEW] (E)	109
429:20, App. B. [NEW] (E)	194	590:15-3-6. [NEW] (E)	109
435:45-5-1. [AMENDED] (E)	822	695:10-5-6. [AMENDED] (E)	639
530:10-3-22. [AMENDED] (E)	632	710:70-2-12. [NEW] (E)	639
530:10-5-52. [NEW] (E)	632	715:10-1-7. [AMENDED] (E)	641
530:10-7-19. [NEW] (E)	635	725:20-7-10. [NEW] (E)	38
530:10-7-24. [AMENDED] (E)	632	730:40-5-1. [NEW] (E)	429
530:10-13-35. [AMENDED] (E)	633	730:40-5-2. [NEW] (E)	429
530:10-15-11. [AMENDED] (E)	633	730:40-5-3. [NEW] (E)	430
530:10-17-31. [AMENDED] (E)	636	730:40-5-4. [NEW] (E)	430
530:15-1-1. [AMENDED] (E)	637	800:15-7-3. [AMENDED] (E)	709
530:15-1-2. [AMENDED] (E)	637	800:25-13-6. [AMENDED] (E)	565
530:15-1-9. [AMENDED] (E)	638	800:25-13-9. [AMENDED] (E)	566
530:15-3-8. [AMENDED] (E)	638	800:30-1-5. [AMENDED] (E)	662
580:15-2-2. [AMENDED] (E)	88		

Agency/Title Index

[Assigned as of 4-17-06]

Agency	Title	Agency	Title
Oklahoma ACCOUNTANCY Board	10	Oklahoma DEVELOPMENT Finance Authority	200
State ACCREDITING Agency	15	Board of Regents of EASTERN Oklahoma State	
AD Valorem Task Force (<i>abolished 7-1-93</i>)	20	College	205
Oklahoma AERONAUTICS Commission	25	State Department of EDUCATION	210
Board of Regents for the Oklahoma AGRICULTURAL and		EDUCATION Oversight Board	215
Mechanical Colleges	30	Oklahoma EDUCATIONAL Television Authority	220
Oklahoma Department of AGRICULTURE , Food, and		[RESERVED]	225
Forestry	35	State ELECTION Board	230
Oklahoma Board of Licensed ALCOHOL and Drug		Oklahoma FUNERAL Board (<i>Formerly:</i> Oklahoma State	
Counselors	38	Board of EMBALMERS and Funeral Directors)	235
Board of Tests for ALCOHOL and Drug Influence	40	Oklahoma Department of EMERGENCY Management	
ALCOHOLIC Beverage Laws Enforcement		(<i>Formerly:</i> Department of CIVIL Emergency	
Commission	45	Management) - <i>See</i> Title 145	
ANATOMICAL Board of the State of Oklahoma	50	Oklahoma EMPLOYMENT Security Commission	240
Board of Governors of the Licensed ARCHITECTS and		Oklahoma ENERGY Resources Board	243
Landscape Architects of Oklahoma	55	State Board of Licensure for Professional ENGINEERS and	
ARCHIVES and Records Commission	60	Land Surveyors (<i>Formerly:</i> State Board of Registration	
Board of Trustees for the ARDMORE Higher Education		for Professional Engineers and Land Surveyors)	245
Program	65	Board of Trustees for the ENID Higher Education	
Oklahoma ARTS Council	70	Program	250
ATTORNEY General	75	Department of ENVIRONMENTAL Quality	252
State AUDITOR and Inspector	80	State Board of EQUALIZATION	255
State BANKING Department	85	ETHICS Commission (<i>Title revoked</i>)	257
Oklahoma State Employees BENEFITS Council	87	ETHICS Commission	258
Council of BOND Oversight	90	Office of State FINANCE	260
Oklahoma Professional BOXING Commission	92	State FIRE Marshal Commission	265
State BURIAL Board (<i>abolished 7-1-92</i>)	95	Oklahoma Council on FIREFIGHTER Training	268
[RESERVED]	100	Oklahoma FIREFIGHTERS Pension and Retirement	
Oklahoma CAPITOL Investment Board	105	System	270
Oklahoma CAPITOL Improvement Authority	110	[RESERVED]	275
State CAPITOL Preservation Commission	115	State Board of Registration for FORESTERS	280
CAPITOL-MEDICAL Center Improvement and Zoning		FOSTER Care Review Advisory Board	285
Commission	120	Oklahoma FUNERAL Board (<i>Formerly:</i> Oklahoma State	
Oklahoma Department of CAREER and Technology		Board of Embalmers and Funeral Directors) - <i>See</i> Title	
Education (<i>Formerly:</i> Oklahoma Department of		235	
VOCATIONAL and Technical Education) - <i>See</i> Title		Oklahoma FUTURES	290
780		GOVERNOR	295
Board of Regents of CARL Albert State College	125	GRAND River Dam Authority	300
Department of CENTRAL Services (<i>Formerly:</i> Office of		Group Self-Insurance Association GUARANTY Fund	
PUBLIC Affairs) - <i>See</i> Title 580		Board	302
CEREBRAL Palsy Commission	130	Individual Self-Insured GUARANTY Fund Board	303
Commission on CHILDREN and Youth	135	STATE Use Committee (<i>Formerly:</i> Committee on	
Board of CHIROPRACTIC Examiners	140	Purchases of Products and Services of the Severely	
Oklahoma Department of EMERGENCY Management		HANDICAPPED)	304
(<i>Formerly:</i> Department of CIVIL Emergency		Office of HANDICAPPED Concerns	305
Management)	145	Oklahoma State Department of HEALTH	310
Oklahoma Department of COMMERCE	150	Oklahoma Basic HEALTH Benefits Board (<i>abolished</i>	
COMMUNITY Hospitals Authority	152	<i>11-1-97</i>)	315
COMPSOURCE Oklahoma (<i>Formerly:</i> State INSURANCE		Oklahoma HEALTH Care Authority	317
Fund) - <i>See</i> Title 370		HIGHWAY Construction Materials Technician Certification	
Oklahoma CONSERVATION Commission	155	Board	318
CONSTRUCTION Industries Board	158	Oklahoma HISTORICAL Society	320
Department of CONSUMER Credit	160	Oklahoma HORSE Racing Commission	325
CORPORATION Commission	165	Oklahoma HOUSING Finance Agency	330
Department of CORRECTIONS	170	Oklahoma HUMAN Rights Commission	335
State Board of COSMETOLOGY	175	Department of HUMAN Services	340
Oklahoma State CREDIT Union Board	180	Committee for INCENTIVE Awards for State	
CRIME Victims Compensation Board	185	Employees	345
Joint CRIMINAL Justice System Task Force		Oklahoma INDIAN Affairs Commission	350
Committee	190	Oklahoma INDIGENT Defense System	352
Board of DENTISTRY	195	Oklahoma INDUSTRIAL Finance Authority	355

Agency	Title	Agency	Title
Oklahoma State and Education Employees Group		PUBLIC Employees Relations Board	585
INSURANCE Board	360	Oklahoma PUBLIC Employees Retirement System	590
INSURANCE Department	365	Department of PUBLIC Safety	595
COMPSOURCE Oklahoma (<i>Formerly:</i>		REAL Estate Appraiser Board	600
State INSURANCE Fund)	370	Oklahoma REAL Estate Commission	605
Oklahoma State Bureau of INVESTIGATION	375	Board of Regents of REDLANDS Community College	607
Council on JUDICIAL Complaints	376	State REGENTS for Higher Education	610
Office of JUVENILE Affairs	377	State Department of REHABILITATION Services	612
Department of LABOR	380	Board of Regents of ROGERS State College	615
Department of the Commissioners of the LAND Office	385	Board of Regents of ROSE State College	620
Council on LAW Enforcement Education and Training	390	Oklahoma SAVINGS and Loan Board (<i>abolished</i>	
Oklahoma LAW Enforcement Retirement System	395	7-1-93)	625
Board on LEGISLATIVE Compensation	400	SCENIC Rivers Commission	630
Oklahoma Department of LIBRARIES	405	Oklahoma Commission on SCHOOL and County Funds	
LIEUTENANT Governor	410	Management	635
Oklahoma LINKED Deposit Review Board	415	Advisory Task Force on the Sale of SCHOOL Lands	
Oklahoma LIQUEFIED Petroleum Gas Board	420	(<i>functions concluded</i> 2-92)	640
Oklahoma LIQUEFIED Petroleum Gas Research, Marketing		The Oklahoma School of SCIENCE and Mathematics	645
and Safety Commission	422	Oklahoma Center for the Advancement of SCIENCE and	
LITERACY Initiatives Commission	425	Technology	650
LONG-RANGE Capital Planning Commission	428	SECRETARY of State	655
LOTTERY Commission, Oklahoma	429	Department of SECURITIES	660
Board of Trustees for the MCCURTAIN County Higher		Board of Regents of SEMINOLE State College	665
Education Program	430	SHEEP and Wool Commission	670
Commission on MARGINALLY Producing Oil and Gas		State Board of Licensed SOCIAL Workers	675
Wells	432	SOUTHERN Growth Policies Board	680
State Board of MEDICAL Licensure and Supervision	435	Oklahoma SOYBEAN Commission (<i>abolished</i> 7-1-97)	685
MEDICAL Technology and Research Authority of		Board of Examiners for SPEECH-LANGUAGE Pathology	
Oklahoma	440	and Audiology	690
Board of MEDICOLEGAL Investigations	445	STATE Agency Review Committee	695
Department of MENTAL Health and Substance Abuse		STATE Use Committee (<i>Formerly:</i> Committee on	
Services	450	Purchases of Products and Services of the Severely	
MERIT Protection Commission	455	HANDICAPPED) – <i>See</i> Title 304	
MILITARY Planning Commission, Oklahoma		Oklahoma STUDENT Loan Authority	700
Strategic	457	TASK Force 2000	705
Department of MINES	460	Oklahoma TAX Commission	710
Oklahoma MOTOR Vehicle Commission	465	Oklahoma Commission for TEACHER Preparation	712
Board of Regents of MURRAY State College	470	TEACHERS' Retirement System	715
Oklahoma State Bureau of NARCOTICS and Dangerous		State TEXTBOOK Committee	720
Drugs Control	475	Oklahoma TOURISM and Recreation Department	725
Board of Regents of NORTHERN Oklahoma College	480	Department of TRANSPORTATION	730
Oklahoma Board of NURSING	485	Oklahoma TRANSPORTATION Authority	731
Oklahoma State Board of Examiners for NURSING Home		State TREASURER	735
Administrators	490	Board of Regents of TULSA Community College	740
Board of Regents of OKLAHOMA City Community		Oklahoma TURNPIKE Authority (<i>name changed - see Title</i>	
College	495	731)	745
Board of Regents of OKLAHOMA Colleges	500	Board of Trustees for the UNIVERSITY Center	
Board of Examiners in OPTOMETRY	505	at Tulsa	750
State Board of OSTEOPATHIC Examiners	510	UNIVERSITY Hospitals Authority	752
PARDON and Parole Board	515	UNIVERSITY Hospitals Trust	753
Oklahoma PEANUT Commission	520	Board of Regents of the UNIVERSITY of Oklahoma	755
Oklahoma State PENSION Commission	525	Board of Regents of the UNIVERSITY of Science and Arts of	
State Board of Examiners of PERFUSIONISTS	527	Oklahoma	760
Office of PERSONNEL Management	530	Oklahoma USED Motor Vehicle and Parts Commission	765
Oklahoma State Board of PHARMACY	535	Oklahoma Department of VETERANS Affairs	770
PHYSICIAN Manpower Training Commission	540	Board of VETERINARY Medical Examiners	775
Board of PODIATRIC Medical Examiners	545	Oklahoma Department of CAREER and Technology	
Oklahoma POLICE Pension and Retirement System	550	Education (<i>Formerly:</i> Oklahoma Department of	
State Department of POLLUTION Control (<i>abolished</i>		VOCATIONAL and Technical Education)	780
1-1-93)	555	Oklahoma WATER Resources Board	785
POLYGRAPH Examiners Board	560	Board of Regents of WESTERN Oklahoma State	
Oklahoma Board of PRIVATE Vocational Schools	565	College	790
State Board for PROPERTY and Casualty Rates	570	Oklahoma WHEAT Commission	795
State Board of Examiners of PSYCHOLOGISTS	575	Department of WILDLIFE Conservation	800
Department of CENTRAL Services (<i>Formerly:</i> Office of		WILL Rogers and J.M. Davis Memorials Commission	805
PUBLIC Affairs)	580		

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 753. UNIVERSITY HOSPITALS TRUST CHAPTER 1. GENERAL AGENCY RULES

[OAR Docket #06-439]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

RULES:

Subchapter 1. General Provisions [NEW]

753:1-1-1. through 753:1-1-8. [NEW]

Subchapter 3. General Operations of the University Hospitals Trust [NEW]

753:1-3-1. through 753:1-3-5. [NEW]

Subchapter 5. Administrative Rules [NEW]

753:1-5-1. through 753:1-5-2. [NEW]

Subchapter 7. Formal and Informal Procedures [NEW]

753:1-7-1. through 753:1-7-4. [NEW]

AUTHORITY:

University Hospitals Trust. 63 O.S. § 3224; 75 O.S. § 302(A)

COMMENT PERIOD:

Persons wishing to present their view orally or in writing may do so before May 17, 2006, at the following address: Executive Director, University Hospitals Trust, 940 N.E. 13th Street, P. O. Box 26307, Oklahoma City, Oklahoma 73126, Telephone (405) 271-4962.

PUBLIC HEARING:

A public hearing will be held on May 17, 2006, at the following address: University Hospitals Trust, 940 N.E. 13th Street, P. O. Box 26307, Oklahoma City, Oklahoma 73126.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

The University Hospitals Trust requests that business entities affected by these proposed rules provide the Trust, within the comment period, in dollar amounts if possible, the increase in the level of direct services, revenue loss, or other costs expected to be incurred by the business entity due to the proposed rules. Business entities may submit this information in writing to : Executive Director, University Hospitals Trust, 940 N.E. 13th Street, P. O. Box 26307, Oklahoma City, Oklahoma 73126.

COPIES OF PROPOSED RULES:

Copies of the proposed rules may be obtained from the University Hospitals Trust, 940 N.E. 13th Street, P. O. Box 26307, Oklahoma City, Oklahoma 73126.

RULE IMPACT STATEMENT:

Pursuant to 75 O.S. § 303(D), a rule impact statement will be prepared and may be obtained from the University Hospitals Trust beginning on April 20, 2006.

CONTACT PERSON:

Dean Gandy, Executive Director, University Hospitals Trust, 940 N.E. 13th Street, P. O. Box 26307, Oklahoma City, Oklahoma 73126. Telephone: (405) 271-4962.

[OAR Docket #06-439; filed 3-24-06]

Cancelled Hearings/Comment Periods

If an agency cancels a hearing or comment period announced in a published Notice of Rulemaking Intent, the agency must submit a notice of such cancellation to the Office of Administrative Rules (OAR). The OAR publishes the cancellation notice in the next possible issue of the *Register*.

For additional information on cancelled hearings and comment periods, see OAC 655:10-7-27.

TITLE 580. DEPARTMENT OF CENTRAL SERVICES
CHAPTER 15. CENTRAL PURCHASING

[OAR Docket #06-327]

RULEMAKING ACTION:

Cancelled comment period and public hearing relating to a proposed PERMANENT rulemaking action.

PROPOSED RULES:

Chapter 15. Central Purchasing [AMENDED]

CANCELLED COMMENT PERIOD:

February 15, 2006 to March 20, 2006

CANCELLED PUBLIC HEARING:

11:00 a.m., March 20, 2006, Will Rogers Office Building, Suite 102/104, 2401 N. Lincoln Boulevard, Oklahoma City, OK.

ADDITIONAL INFORMATION:

None

CONTACT PERSON:

Gerry Smedley, Administrative Rules Liaison, (405) 521-2758

[OAR Docket #06-327; filed 3-20-06]

Submissions for Review

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

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

TITLE 140. BOARD OF CHIROPRACTIC EXAMINERS CHAPTER 1. ADMINISTRATIVE ORGANIZATION AND OPERATIONS

[OAR Docket #06-278]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 1. General Provisions

140:1-1-2. [AMENDED]

Subchapter 3. Board Purpose and Organization

140:1-3-6. [AMENDED]

SUBMITTED TO GOVERNOR:

March 8, 2006

SUBMITTED TO HOUSE:

March 8, 2006

SUBMITTED TO SENATE:

March 8, 2006

[OAR Docket #06-278; filed 3-10-06]

TITLE 140. BOARD OF CHIROPRACTIC EXAMINERS CHAPTER 3. DISCIPLINARY PROCEDURES

[OAR Docket #06-281]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 3. Filing and Disposition of Complaints

140:3-3-3. [AMENDED]

SUBMITTED TO GOVERNOR:

March 8, 2006

SUBMITTED TO HOUSE:

March 8, 2006

SUBMITTED TO SENATE:

March 8, 2006

[OAR Docket #06-281; filed 3-10-06]

TITLE 140. BOARD OF CHIROPRACTIC EXAMINERS CHAPTER 10. LICENSURE OF CHIROPRACTIC PHYSICIANS

[OAR Docket #06-280]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 1. General Provisions

140:10-1-2. [AMENDED]

Subchapter 5. Procedures for Renewal License

140:10-5-1. [AMENDED]

Subchapter 8. Administrative Fees

140:10-8-1. [AMENDED]

SUBMITTED TO GOVERNOR:

March 8, 2006

SUBMITTED TO HOUSE:

March 8, 2006

SUBMITTED TO SENATE:

March 8, 2006

[OAR Docket #06-280; filed 3-10-06]

TITLE 140. BOARD OF CHIROPRACTIC EXAMINERS CHAPTER 15. SPECIAL CERTIFICATES AND MISCELLANEOUS PROVISIONS

[OAR Docket #06-279]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 15. Chiropractic Specialties [NEW]

140:15-9-1. [NEW]

140:15-9-2. [NEW]

140:15-9-3. [NEW]

140:15-9-4. [NEW]

140:15-9-5. [NEW]

140:15-9-6. [NEW]

SUBMITTED TO GOVERNOR:

March 8, 2006

SUBMITTED TO HOUSE:

March 8, 2006

Submissions for Review

SUBMITTED TO SENATE:

March 8, 2006

[OAR Docket #06-279; filed 3-10-06]

**TITLE 252. DEPARTMENT OF ENVIRONMENTAL QUALITY
CHAPTER 20. EMERGENCY PLANNING AND COMMUNITY RIGHT-TO-KNOW**

[OAR Docket #06-343]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

252:20-1-3. [AMENDED]
252:20-1-4. [AMENDED]
252:20-1-6. [AMENDED]
252:20-1-7. [AMENDED]

SUBMITTED TO GOVERNOR:

March 3, 2006

SUBMITTED TO HOUSE:

March 3, 2006

SUBMITTED TO SENATE:

March 3, 2006

[OAR Docket #06-343; filed 3-20-06]

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

[OAR Docket #06-344]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 1. General Provisions
252:100-1-3. [AMENDED]
Subchapter 8. Permits for Part 70 Sources
Part 1. General Provisions
252:100-8-1.1. [AMENDED]
Part 5. Permits for Part 70 Sources
252:100-8-2. [AMENDED]
Part 7. Prevention of Significant Deterioration (PSD)
Requirements for Attainment Areas
252:100-8-30. [AMENDED]
252:100-8-31. [AMENDED]
252:100-8-32. [REVOKED]
252:100-8-32.1. [NEW]
252:100-8-32.2. [NEW]
252:100-8-32.3. [NEW]

252:100-8-33. [AMENDED]

252:100-8-34. [AMENDED]

252:100-8-35. [AMENDED]

252:100-8-35.1. [NEW]

252:100-8-35.2. [NEW]

252:100-8-36. [AMENDED]

252:100-8-36.1. [NEW]

252:100-8-36.2. [NEW]

252:100-8-37. [AMENDED]

252:100-8-38. [NEW]

252:100-8-39. [NEW]

Part 9. Major Sources Affecting Nonattainment Areas

252:100-8-50. [AMENDED]

252:100-8-50.1. [NEW]

252:100-8-51. [AMENDED]

252:100-8-51.1. [NEW]

252:100-8-52. [AMENDED]

252:100-8-53. [AMENDED]

252:100-8-54. [AMENDED]

252:100-8-55. [NEW]

252:100-8-56. [NEW]

252:100-8-57. [NEW]

SUBMITTED TO GOVERNOR:

March 3, 2006

SUBMITTED TO HOUSE:

March 3, 2006

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March 3, 2006

[OAR Docket #06-344; filed 3-20-06]

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

[OAR Docket #06-345]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 4. New Source Performance Standards

252:100-4-5. [AMENDED]

SUBMITTED TO GOVERNOR:

March 3, 2006

SUBMITTED TO HOUSE:

March 3, 2006

SUBMITTED TO SENATE:

March 3, 2006

[OAR Docket #06-345; filed 3-20-06]

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

[OAR Docket #06-346]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 41. Control of Emission of Hazardous Air Pollutants and Toxic Air Contaminants
Part 3. Hazardous Air Pollutants
252:100-41-15. [AMENDED]

SUBMITTED TO GOVERNOR:

March 3, 2006

SUBMITTED TO HOUSE:

March 3, 2006

SUBMITTED TO SENATE:

March 3, 2006

[OAR Docket #06-346; filed 3-20-06]

**TITLE 252. DEPARTMENT OF ENVIRONMENTAL QUALITY
CHAPTER 300. LABORATORY ACCREDITATION**

[OAR Docket #06-347]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 5. Laboratory Accreditation Process
252:300-5-1. [AMENDED]
Subchapter 7. General Operations
252:300-7-3. [AMENDED]
Subchapter 17. Quality Assurance/Quality Control
Part 1. Quality Assurance/Quality Control General Criteria [NEW]
Part 2. Standard Operating Procedures and Methods Manual [NEW]
252:300-17-21. [NEW]
252:300-17-22. [NEW]
252:300-17-23. [NEW]
252:300-17-24. [NEW]
252:300-17-25. [NEW]
Subchapter 19. Classifications
252:300-19-2. [AMENDED]
252:300-19-3. [AMENDED]
Appendix D. Analytes for Petroleum Hydrocarbon Laboratory Category [REVOKED]
Appendix D. Analytes for Petroleum Hydrocarbon Laboratory Category [NEW]

SUBMITTED TO GOVERNOR:

March 3, 2006

SUBMITTED TO HOUSE:

March 3, 2006

SUBMITTED TO SENATE:

March 3, 2006

[OAR Docket #06-347; filed 3-20-06]

**TITLE 252. DEPARTMENT OF ENVIRONMENTAL QUALITY
CHAPTER 305. LABORATORY SERVICES**

[OAR Docket #06-348]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Appendix A. Samples Submitted by Governmental Entities [REVOKED]
Appendix A. Samples Submitted by Governmental Entities [NEW]
Appendix B. Samples Submitted by Private Citizens [REVOKED]
Appendix B. Samples Submitted by Private Citizens [NEW]

SUBMITTED TO GOVERNOR:

March 3, 2006

SUBMITTED TO HOUSE:

March 3, 2006

SUBMITTED TO SENATE:

March 3, 2006

[OAR Docket #06-348; filed 3-20-06]

**TITLE 252. DEPARTMENT OF ENVIRONMENTAL QUALITY
CHAPTER 410. RADIATION MANAGEMENT**

[OAR Docket #06-349]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Appendix A. Fee Schedule for Radiation Management [REVOKED]
Appendix A. Application and Annual Fee Schedule for Radiation Machines [NEW]

SUBMITTED TO GOVERNOR:

March 3, 2006

SUBMITTED TO HOUSE:

March 3, 2006

SUBMITTED TO SENATE:

March 3, 2006

[OAR Docket #06-349; filed 3-20-06]

Submissions for Review

TITLE 252. DEPARTMENT OF ENVIRONMENTAL QUALITY CHAPTER 515. MANAGEMENT OF SOLID WASTE

[OAR Docket #06-350]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 1. General Provisions
252:515-1-4. [AMENDED]
Subchapter 3. Permit Provisions and Applications
Part 3. Permit Applications and Modifications
252:515-3-35. [AMENDED]
252:515-3-40. [AMENDED]
Subchapter 13. Leachate Collection and Management
Part 1. General Provisions
252:515-13-1. [AMENDED]
Subchapter 17. Stormwater Management
252:515-17-3. [AMENDED]
Subchapter 19. Operational Requirements
Part 5. Cover and Soil Borrow Requirements for Land Disposal Facilities
252:515-19-51. [AMENDED]
Part 7. Additional Operational Requirements for MSWLFs
252:515-19-73. [AMENDED]
Subchapter 23. Regulated Medical Waste Management
Part 1. General Provisions
252:515-23-1. [AMENDED]
Subchapter 25. Closure and Post-Closure Care
Part 5. Post-Closure
252:515-25-54. [AMENDED]
Subchapter 27. Cost Estimates and Financial Assurance
Part 1. General Provisions
252:515-27-4. [AMENDED]
Part 7. Financial Assurance Mechanisms
252:515-27-81.1. [NEW]
Subchapter 35. Oklahoma Recycling Initiative
252:515-35-1. [AMENDED]
Appendix B. Uppermost Aquifer Protective Values [REVOKED]
Appendix B. Uppermost Aquifer Protective Values [NEW]

SUBMITTED TO GOVERNOR:

March 3, 2006

SUBMITTED TO HOUSE:

March 3, 2006

SUBMITTED TO SENATE:

March 3, 2006

[OAR Docket #06-350; filed 3-20-06]

TITLE 252. DEPARTMENT OF ENVIRONMENTAL QUALITY CHAPTER 515. MANAGEMENT OF SOLID WASTE

[OAR Docket #06-351]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 3. Permit Provisions and Applications
Part 1. General Provisions
252:515-3-1. [AMENDED]
Part 3. Permit Applications and Modifications
252:515-3-39.1. [NEW]
Subchapter 21. Waste Tire Processing, Certification, Permits and Compensation
Part 1. General Provisions
252:515-21-2. [AMENDED]
252:515-21-3. [AMENDED]
252:515-21-5. [NEW]
Part 3. Waste Tire Facilities
252:515-21-31. [REVOKED]
252:515-21-32. [AMENDED]
252:515-21-32.1. [NEW]
Part 7. Compensation from the Waste Tire Indemnity Fund
252:515-21-71. [AMENDED]
252:515-21-73. [AMENDED]
Part 9. Erosion Control, River Bank Stabilization and Other Conservation Projects
252:515-21-91. [AMENDED]
252:515-21-92. [AMENDED]

SUBMITTED TO GOVERNOR:

March 3, 2006

SUBMITTED TO HOUSE:

March 3, 2006

SUBMITTED TO SENATE:

March 3, 2006

[OAR Docket #06-351; filed 3-20-06]

TITLE 252. DEPARTMENT OF ENVIRONMENTAL QUALITY CHAPTER 515. MANAGEMENT OF SOLID WASTE

[OAR Docket #06-352]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Appendix H. Procedure for Calculating Closure Cost Estimates for Financial Assurance [REVOKED]
Appendix H. Procedure for Calculating Closure Cost Estimates for Financial Assurance [NEW]

Appendix I. Procedure for Calculating Post-closure Cost Estimates for Financial Assurance [REVOKED]
Appendix I. Procedure for Calculating Post-closure Cost Estimates for Financial Assurance [NEW]

SUBMITTED TO GOVERNOR:

March 3, 2006

SUBMITTED TO HOUSE:

March 3, 2006

SUBMITTED TO SENATE:

March 3, 2006

[OAR Docket #06-352; filed 3-20-06]

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

[OAR Docket #06-353]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 1. Introduction
252:606-1-4. [AMENDED]

SUBMITTED TO GOVERNOR:

March 3, 2006

SUBMITTED TO HOUSE:

March 3, 2006

SUBMITTED TO SENATE:

March 3, 2006

[OAR Docket #06-353; filed 3-20-06]

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

[OAR Docket #06-354]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

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

SUBMITTED TO GOVERNOR:

March 3, 2006

SUBMITTED TO HOUSE:

March 3, 2006

SUBMITTED TO SENATE:

March 3, 2006

[OAR Docket #06-354; filed 3-20-06]

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

[OAR Docket #06-355]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 3. Permit Procedures
252:616-3-1. [AMENDED]

SUBMITTED TO GOVERNOR:

March 3, 2006

SUBMITTED TO HOUSE:

March 3, 2006

SUBMITTED TO SENATE:

March 3, 2006

[OAR Docket #06-355; filed 3-20-06]

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

[OAR Docket #06-356]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

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

SUBMITTED TO GOVERNOR:

March 3, 2006

SUBMITTED TO HOUSE:

March 3, 2006

SUBMITTED TO SENATE:

March 3, 2006

[OAR Docket #06-356; filed 3-20-06]

Submissions for Review

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

[OAR Docket #06-357]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

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

SUBMITTED TO GOVERNOR:

March 3, 2006

SUBMITTED TO HOUSE:

March 3, 2006

SUBMITTED TO SENATE:

March 3, 2006

[OAR Docket #06-357; filed 3-20-06]

TITLE 252. DEPARTMENT OF ENVIRONMENTAL QUALITY CHAPTER 710. WATERWORKS AND WASTEWATER WORKS OPERATOR CERTIFICATION

[OAR Docket #06-358]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 3. Certification
252:710-3-31. [AMENDED]
Subchapter 5. Duties and Responsibilities
252:710-5-54. [AMENDED]
252:710-5-59. [AMENDED]
Appendix A. Classification of Community and Nontransient Noncommunity Water Systems, Wastewater Systems and Laboratories [REVOKED]
Appendix A. Classification of Community and Nontransient Noncommunity Water Systems, Wastewater Systems and Laboratories [NEW]

SUBMITTED TO GOVERNOR:

March 3, 2006

SUBMITTED TO HOUSE:

March 3, 2006

SUBMITTED TO SENATE:

March 3, 2006

[OAR Docket #06-358; filed 3-20-06]

TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH CHAPTER 110. FEE AND FINE SCHEDULE FOR OCCUPATIONAL LICENSING

[OAR Docket #06-328]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 5. Administrative Fine Schedule
310:110-5-6 [AMENDED]

SUBMITTED TO GOVERNOR:

March 20, 2006

SUBMITTED TO HOUSE:

March 20, 2006

SUBMITTED TO SENATE:

March 20, 2006

[OAR Docket #06-328; filed 3-20-06]

TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH CHAPTER 205. ALARM INDUSTRY

[OAR Docket #06-329]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 1. General Provisions
310:205-1-2. [AMENDED]
Subchapter 3. License Requirements
310:205-3-1. [AMENDED]
310:205-3-2. [AMENDED]
310:205-3-3. [AMENDED]
310:205-3-4. [AMENDED]
310:205-3-6. [REVOKED]

SUBMITTED TO GOVERNOR:

March 20, 2006

SUBMITTED TO HOUSE:

March 20, 2006

SUBMITTED TO SENATE:

March 20, 2006

[OAR Docket #06-329; filed 3-20-06]

TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH CHAPTER 210. BARBERS

[OAR Docket #06-330]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

- Subchapter 3. Examinations
310:210-3-3 [AMENDED]
- Subchapter 5. Licensing
310:210-5-8 [AMENDED]
- Subchapter 7. General Sanitation
310:210-7-15 [NEW]
- Appendix A. Barber Student Curriculum and Hours
[REVOKED]
- Appendix A. Barber Student Curriculum and Hours [NEW]
- Appendix C. Barber Apprentice Curriculum and Hours
[REVOKED]
- Appendix C. Barber Apprentice Curriculum and Hours
[NEW]

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[OAR Docket #06-330; filed 3-20-06]

**TITLE 310. OKLAHOMA STATE
DEPARTMENT OF HEALTH
CHAPTER 256. FOOD SERVICE
ESTABLISHMENTS [REVOKED]**

[OAR Docket #06-331]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Chapter 256. Food Service Establishments [REVOKED]

SUBMITTED TO GOVERNOR:

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[OAR Docket #06-331; filed 3-20-06]

**TITLE 310. OKLAHOMA STATE
DEPARTMENT OF HEALTH
CHAPTER 257. FOOD SERVICE
ESTABLISHMENTS**

[OAR Docket #06-332]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Chapter 257. Food Service Establishments [NEW]

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[OAR Docket #06-332; filed 3-20-06]

**TITLE 310. OKLAHOMA STATE
DEPARTMENT OF HEALTH
CHAPTER 276. HOME INSPECTION
INDUSTRY**

[OAR Docket #06-333]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 1. General Provisions

310:276-1-3. [AMENDED]

Subchapter 9. Examination Applications, Examinations,
Course Approval Requirements, Instructor
Requirements, Continuing Education, Denied
Application Appeal, Submission of Records, and
Continuing Education Reciprocity

310:276-9-2. [AMENDED]

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**TITLE 310. OKLAHOMA STATE
DEPARTMENT OF HEALTH
CHAPTER 355. SMOKING IN PUBLIC
PLACES AND INDOOR WORKPLACES**

[OAR Docket #06-334]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Chapter 355. Smoking in Public Places and Indoor
Workplaces [AMENDED]

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Submissions for Review

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**TITLE 310. OKLAHOMA STATE
DEPARTMENT OF HEALTH
CHAPTER 400. LICENSED MARITAL AND
FAMILY THERAPISTS**

[OAR Docket #06-335]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 5. Rules of Professional Conduct

310:400-5-1. [AMENDED]

310:400-5-3. [AMENDED]

Subchapter 7. Application for Licensure

310:400-7-2. [AMENDED]

310:400-7-2.1. [AMENDED]

Subchapter 9. Licensure Examinations

310:400-9-1. [AMENDED]

Subchapter 11. Supervised Experience Requirements

310:400-11-1. [AMENDED]

310:400-11-2. [AMENDED]

310:400-11-3. [AMENDED]

310:400-11-4. [AMENDED]

310:400-11-5. [AMENDED]

Subchapter 15. Issuance and Maintenance of License

310:400-15-3. [AMENDED]

310:400-15-4. [AMENDED]

310:400-15-5. [AMENDED]

310:400-15-6. [AMENDED]

310:400-15-9. [AMENDED]

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[OAR Docket #06-335; filed 3-20-06]

**TITLE 310. OKLAHOMA STATE
DEPARTMENT OF HEALTH
CHAPTER 403. LICENSED BEHAVIORAL
PRACTITIONERS**

[OAR Docket #06-336]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 5. Forms

310:403-5-1. [AMENDED]

310:403-5-2. [AMENDED]

Subchapter 7. Rules of Professional Conduct

310:403-7-2. [AMENDED]

310:403-7-3. [AMENDED]

310:403-7-4.1. [NEW]

Subchapter 11. Application Procedures

310:403-11-6. [AMENDED]

310:403-11-7. [AMENDED]

310:403-11-8. [AMENDED]

310:403-11-9. [AMENDED]

310:403-11-10. [AMENDED]

310:403-11-11. [AMENDED]

Subchapter 15. Supervised Experience Requirement

310:403-15-2. [AMENDED]

310:403-15-3. [AMENDED]

310:403-15-4. [AMENDED]

310:403-15-7. [AMENDED]

Subchapter 19. Licensure Examination

310:403-19-1.1. [NEW]

310:403-19-6.1. [NEW]

Subchapter 21. Continuing Education Requirements

310:403-21-3.1. [NEW]

310:403-21-4. [AMENDED]

Subchapter 25. License and Specialty Renewal

310:403-25-11. [AMENDED]

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**TITLE 310. OKLAHOMA STATE
DEPARTMENT OF HEALTH
CHAPTER 405. LICENSED PROFESSIONAL
COUNSELORS**

[OAR Docket #06-337]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 3. Rules of Professional Conduct

310:405-3-2. [AMENDED]

310:405-3-3. [AMENDED]

310:405-3-4.1. [NEW]

Subchapter 7. Application Procedures

310:405-7-1. [AMENDED]

310:405-7-2. [AMENDED]

310:405-7-4. [AMENDED]

310:405-7-5. [AMENDED]

310:405-7-6. [AMENDED]

310:405-7-7. [AMENDED]
310:405-7-8. [AMENDED]
Subchapter 9. Academic Requirements
310:405-9-2. [AMENDED]
Subchapter 11. Supervised Experience Requirement
310:405-11-1. [AMENDED]
310:405-11-2. [AMENDED]
310:405-11-5. [AMENDED]
310:405-11-6. [AMENDED]
310:405-11-7. [AMENDED]
Subchapter 15. Licensure Examinations
310:405-15-1. [AMENDED]
310:405-15-4. [AMENDED]
310:405-15-8. [AMENDED]
Subchapter 17. Continuing Education Requirements
310:405-17-6.2. [AMENDED]
Subchapter 23. License and Specialty Late Renewal and Expiration
310:405-23-3. [AMENDED]

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**TITLE 310. OKLAHOMA STATE
DEPARTMENT OF HEALTH
CHAPTER 641. EMERGENCY MEDICAL
SERVICES**

[OAR Docket #06-338]

RULEMAKING ACTION:
Submission for gubernatorial and legislative review
RULES:
Chapter 641. Emergency Medical Services [AMENDED]
SUBMITTED TO GOVERNOR:
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[OAR Docket #06-338; filed 3-20-06]

**TITLE 310. OKLAHOMA STATE
DEPARTMENT OF HEALTH
CHAPTER 657. CERTIFIED WORKPLACE
MEDICAL PLANS**

[OAR Docket #06-339]

RULEMAKING ACTION:
Submission for gubernatorial and legislative review
RULES:
Chapter 657. Certified Workplace Medical Plans
[AMENDED]
SUBMITTED TO GOVERNOR:
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[OAR Docket #06-339; filed 3-20-06]

**TITLE 310. OKLAHOMA STATE
DEPARTMENT OF HEALTH
CHAPTER 661. HOSPICE**

[OAR Docket #06-340]

RULEMAKING ACTION:
Submission for gubernatorial and legislative review
RULES:
Subchapter 1. General Provisions
310:661-1-2. [AMENDED]
Subchapter 2. Licenses
310:661-2-1. [AMENDED]
310:661-2-2. [AMENDED]
310:661-2-4. [AMENDED]
310:661-2-5. [AMENDED]
310:661-2-6. [AMENDED]
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[OAR Docket #06-340; filed 3-20-06]

Submissions for Review

TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH CHAPTER 675. NURSING AND SPECIALIZED FACILITIES

[OAR Docket #06-341]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 7. Administration
310:675-7-9.1. [AMENDED]
Subchapter 9. Resident Care Services
310:675-9-1.1. [AMENDED]
310:675-9-5.1. [AMENDED]
Subchapter 13. Staff Requirements
310:675-13-5. [AMENDED]
Subchapter 15. Temporary Manager or Receiver
310:675-15-3.1. [NEW]
Subchapter 19. Feeding Assistants [NEW]
310:675-19-1. through 310:675-19-8. [NEW]

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TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH CHAPTER 677. NURSE AIDE TRAINING AND CERTIFICATION

[OAR Docket #06-342]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 13. Certified Medication Aides
310:677-13-1. [AMENDED]
310:677-13-2. [AMENDED]
310:677-13-3. [AMENDED]
310:677-13-4. [AMENDED]
310:677-13-5. [AMENDED]
310:677-13-6. [NEW]
310:677-13-7. [NEW]
310:677-13-8. [NEW]
310:677-13-9. [NEW]
310:677-13-10. [NEW]
310:677-13-11. [NEW]

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[OAR Docket #06-342; filed 3-20-06]

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY CHAPTER 1. ADMINISTRATIVE OPERATIONS

[OAR Docket #06-367]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

Subchapter 3. Formal and Informal Procedures
317:1-3-5. [REVOKED]
Subchapter 7. Compliance with the Americans with
Disabilities Act of 1990
317:1-7-6. through 317:1-7-6.1. [AMENDED]
Subchapter 9. Civil Rights and Nondiscrimination
317:1-9-7. through 317:1-9-8. [REVOKED]
(Reference APA WF # 05-24B)

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[OAR Docket #06-367; filed 3-21-06]

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY CHAPTER 2. GRIEVANCE PROCEDURES AND PROCESS

[OAR Docket #06-368]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

317:2-1-1. through 317:2-1-2. [AMENDED]
317:2-1-2.1. through 317:2-1-2.3. [REVOKED]
317:2-1-4. [REVOKED]
317:2-1-5. through 317:2-1-13. [NEW]
(Reference APA WF # 05-24C)

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[OAR Docket #06-368; filed 3-21-06]

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

[OAR Docket #06-362]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

Subchapter 3. General Provider Policies
Part 3. General Medical Program Information
317:30-3-59. [AMENDED]
Subchapter 5. Individual Providers and Specialties
Part 63. Ambulatory Surgical Centers
317:30-5-566. [AMENDED]
(Reference APA WF # 05-20)

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

[OAR Docket #06-363]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

Subchapter 5. Individual Providers and Specialties
Part 3. Hospitals
317:30-5-47. [AMENDED]
(Reference APA WF # 05-21)

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

[OAR Docket #06-364]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

Subchapter 5. Individual Providers and Specialties
Part 41. Family Support Services
317:30-5-412. [AMENDED]
(Reference APA WF # 05-22)

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

[OAR Docket #06-365]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

Subchapter 3. General Provider Policies
Part 3. General Medical Program Information
317:30-3-47. through 317:30-3-56. [REVOKED]
Part 4. Early and Periodic Screening, Diagnosis and
Treatment (EPSDT) Program/Child Health Services
[NEW]
317:30-3-65. through 317:30-3-65.11. [NEW]

Subchapter 5. Individual Providers and Specialties

Part 15. Child Health Centers
317:30-5-195. through 317:30-5-199. [AMENDED]
317:30-5-200. [REVOKED]

317:30-5-201. [AMENDED]

Part 35. Rural Health Clinics

317:30-5-356. [AMENDED]

Part 37. Advanced Practice Nurse

317:30-5-376. [AMENDED]

Part 45. Optometrists

317:30-5-431. [AMENDED]

(Reference APA WF # 05-23)

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Submissions for Review

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

[OAR Docket #06-366]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 3. General Provider Policies
Part 1. General Scope and Administration
317:30-3-19. through 317:30-3-21. [AMENDED]
Subchapter 5. Individual Providers and Specialties
Part 1. Physicians
317:30-5-25. [AMENDED]
Part 3. Hospitals
317:30-5-41. [AMENDED]
Part 4. Long Term Care Hospitals
317:30-5-62. [AMENDED]
Part 9. Long Term Care Facilities
317:30-5-124. [AMENDED]
317:30-5-131.1. through 317:30-5-131.2. [AMENDED]
Part 32. Soonerride Non-Emergency Transportation
317:30-5-327. [AMENDED]
Part 65. Case Management Services for Over 21
317:30-5-586.1. [AMENDED]
Part 83. Residential Behavior Management Services in
Foster Care Settings
317:30-5-746. [AMENDED]
(Reference APA WF # 05-24A)

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

[OAR Docket #06-370]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

Subchapter 3. General Provider Policies
Part 1. General Scope and Administration
317:30-3-25. [AMENDED]
(Reference APA WF # 05-25)

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

[OAR Docket #06-372]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

Subchapter 5. Individual Providers and Specialties
Part 89. Radiological Mammographer
317:30-5-901. [AMENDED]
317:30-5-904. [AMENDED]
(Reference APA WF # 05-28)

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

[OAR Docket #06-373]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

Subchapter 5. Individual Providers and Specialties
Part 105. Residential Behavioral Management Services
in Group Settings and Non-secure Diagnostic and
Evaluation Centers
317:30-5-1043. [AMENDED]
(Reference APA WF # 05-29)

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

[OAR Docket #06-374]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

Subchapter 5. Individual Providers and Specialties
Part 21. Outpatient Behavioral Health Services
317:30-5-240. through 317:30-5-241. [AMENDED]
317:30-5-248. [AMENDED]
(Reference APA WF # 05-30)

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

[OAR Docket #06-375]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

Subchapter 3. General Provider Policies
Part 1. General Scope and Administration
317:30-3-4.1. [AMENDED]
317:30-3-15. [AMENDED]
(Reference APA WF # 05-32)

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

[OAR Docket #06-376]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

Subchapter 5. Individual Providers and Specialties
Part 83. Residential Behavior Management Services in
Foster Care Settings
317:30-5-740. through 317:30-5-742. [AMENDED]
317:30-5-742.2. [AMENDED]
317:30-5-743.1. [NEW]
317:30-5-745. [AMENDED]
(Reference APA WF # 05-35)

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[OAR Docket #06-376; filed 3-21-06]

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

[OAR Docket #06-378]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

Subchapter 5. Individual Providers and Specialties
Part 73. Early Intervention Services
317:30-5-640. through 317:30-5-641.1. [AMENDED]
317:30-5-641.2. [REVOKED]
317:30-5-641.3. [AMENDED]
317:30-5-642. [REVOKED]
317:30-5-644. [AMENDED]
(Reference APA WF # 05-37)

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Submissions for Review

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[OAR Docket #06-378; filed 3-21-06]

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

[OAR Docket #06-379]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

Subchapter 5. Individual Providers and Specialties

Part 25. Psychologists

317:30-5-275. [AMENDED]

317:30-5-276. [AMENDED]

317:30-5-278.1. [AMENDED]

(Reference APA WF # 05-38)

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

[OAR Docket #06-380]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

Subchapter 5. Individual Providers and Specialties

Part 110. Indian Health Services, Tribal Programs, and

Urban Indian Clinics (I/T/Us) [NEW]

317:30-5-1085. through 317:30-5-1099. [NEW]

(Reference APA WF # 05-39)

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

[OAR Docket #06-381]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

Subchapter 3. General Provider Policies

Part 3. General Medical Program Information

317:30-3-57. [AMENDED]

Subchapter 5. Individual Providers and Specialties

Part 1. Physicians

317:30-5-2. [AMENDED]

Part 5. Pharmacists

317:30-5-77.2. [AMENDED]

(Reference APA WF # 05-40)

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

[OAR Docket #06-382]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

Subchapter 3. General Provider Policies

Part 5. Eligibility

317:30-3-78. [AMENDED]

Subchapter 5. Individual Providers and Specialties

Part 79. Dentists

317:30-5-695. [AMENDED]

317:30-5-695.1. [AMENDED]

317:30-5-695.2. [AMENDED]

317:30-5-696. [AMENDED]

317:30-5-698. through 317:30-5-701. [AMENDED]

317:30-5-703. through 317:30-5-705. [AMENDED]

(Reference APA WF # 05-42)

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[OAR Docket #06-382; filed 3-21-06]

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

[OAR Docket #06-383]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

Subchapter 5. Individual Providers and Specialties
Part 67. Behavioral Health Case Management Services for
Individuals under 21 Years of Age
317:30-5-595. through 317:30-5-596.2. [AMENDED]
317:30-5-597. through 317:30-5-598. [REVOKED]
317:30-5-599. [AMENDED]

(Reference APA WF # 05-44)

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

[OAR Docket #06-384]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

Subchapter 5. Individual Providers and Specialties
Part 9. Long Term Care Facilities
317:30-5-123. [AMENDED]
(Reference APA WF # 05-45A)

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

[OAR Docket #06-386]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

Subchapter 5. Individual Providers and Specialties
Part 6. Inpatient Psychiatric Hospitals
317:30-5-95. through 317:30-5-95.3. [AMENDED]
317:30-5-95.4. through 317:30-5-95.40. [NEW]
317:30-5-96. through 317:30-5-96.1. [AMENDED]
317:30-5-96.2. through 317:30-5-96.5. [NEW]

(Reference APA WF # 05-48)

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

[OAR Docket #06-369]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

Subchapter 3. Coverage and Exclusions
317:35-3-2. [AMENDED]
Subchapter 15. Personal Care Services
317:35-15-8.1. [AMENDED]

(Reference APA WF # 05-24E)

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[OAR Docket #06-369; filed 3-21-06]

Submissions for Review

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

[OAR Docket #06-377]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

Subchapter 18. Programs of All-Inclusive Care for the Elderly [NEW]

317:35-18-1. through 317:35-18-11. [NEW]

(Reference APA WF # 05-36)

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[OAR Docket #06-377; filed 3-21-06]

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

[OAR Docket #06-385]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

Subchapter 19. Nursing Facility Services

317:35-19-8. [AMENDED]

317:35-19-9. [AMENDED]

317:35-19-14. [AMENDED]

317:35-19-16. [AMENDED]

(Reference APA WF # 05-45B)

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

[OAR Docket #06-371]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

Subchapter 1. General Provisions [NEW]

317:45-1-2. [NEW]

Subchapter 3. Carriers [NEW]

317:45-3-1. [NEW]

Subchapter 7. Employer Eligibility [NEW]

317:45-7-1. through 317:45-7-2. [NEW]

317:45-7-5. [NEW]

Subchapter 9. Employee Eligibility [NEW]

317:45-9-1. [NEW]

(Reference APA WF # 05-27)

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[OAR Docket #06-371; filed 3-21-06]

TITLE 340. DEPARTMENT OF HUMAN SERVICES CHAPTER 2. ADMINISTRATIVE COMPONENTS

[OAR Docket #06-389]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

Subchapter 3. Office of Client Advocacy

Part 1. Administration

340:2-3-2. [AMENDED]

Part 3. Investigations

340:2-3-32. through 340:2-3-33. [AMENDED]

340:2-3-35. through 340:2-3-38. [AMENDED]

Part 5. Grievances

340:2-3-45. through 340:2-3-46. [AMENDED]

340:2-3-50. through 340:2-3-53. [AMENDED]

Part 7. Grievance and Abuse Review Committee

340:2-3-64. [AMENDED]

Part 9. Ombudsman Programs

340:2-3-71. [AMENDED]

(Reference APA WF # 05-26)

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**TITLE 340. DEPARTMENT OF HUMAN SERVICES
CHAPTER 2. ADMINISTRATIVE COMPONENTS**

[OAR Docket #06-392]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

Subchapter 21. Departmental Services Unit

Part 1. Open Records

340:2-21-12. through 340:2-21-13. [AMENDED]

340:2-21-14. [REVOKED]

340:2-21-15. through 340:2-21-16. [AMENDED]

Part 3. Records Management [REVOKED]

340: 2-21-20. through 340:2-21-35. [REVOKED]

(Reference APA WF 05-22)

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**TITLE 340. DEPARTMENT OF HUMAN SERVICES
CHAPTER 2. ADMINISTRATIVE COMPONENTS**

[OAR Docket #06-395]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

Subchapter 11. Finance

Part 8. General Provisions

340:2-11-79. [AMENDED]

340:2-11-79.1. [NEW]

340:2-11-80. through 340:2-11-84. [REVOKED]

340:2-11-85. through 340:2-11-87. [AMENDED]

340:2-11-88. through 340:2-11-90. [REVOKED]

340:2-11-91. through 340:2-11-92. [AMENDED]

340:2-11-93. through 340:2-11-96. [REVOKED]

340:2-11-97. through 340:2-11-98. [AMENDED]

340:2-11-99. [REVOKED]

340:2-11-100. [AMENDED]

Part 9. Travel Reimbursement

340:2-11-115. through 340:2-11-117. [AMENDED]

340:2-11-118. [REVOKED]

340:2-11-119. [AMENDED]

340:2-11-119.1. [NEW]

340:2-11-120. [REVOKED]

340:2-11-121. [AMENDED]

340:2-11-122. through 340:2-11-124. [REVOKED]

(Reference APA WF 05-06)

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[OAR Docket #06-395; filed 3-22-06]

**TITLE 340. DEPARTMENT OF HUMAN SERVICES
CHAPTER 10. TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF)**

[OAR Docket #06-397]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

Subchapter 2. Temporary Assistance for Needy Families (TANF) Work Program

340:10-2-2. [AMENDED]

340:10-2-7. through 340:10-2-8. [AMENDED]

Subchapter 3. Conditions of Eligibility - Need

Part 1. Resources

340:10-3-5. [AMENDED]

Part 3. Income

340:10-3-32. [AMENDED]

340:10-3-40. [AMENDED]

Part 5. Assistance Payments

340:10-3-56. through 340:10-3-57. [AMENDED]

Subchapter 10. Conditions of Eligibility - Deprivation

340:10-10-3. [AMENDED]

(Reference APA WF# 05-11 and 05-17)

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Submissions for Review

TITLE 340. DEPARTMENT OF HUMAN SERVICES CHAPTER 15. STATE SUPPLEMENTAL PAYMENT

[OAR Docket #06-393]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

340:15-1-4. [AMENDED]

(Reference APA WF 05-24)

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[OAR Docket #06-393; filed 3-22-06]

TITLE 340. DEPARTMENT OF HUMAN SERVICES CHAPTER 20. LOW INCOME HOME ENERGY ASSISTANCE PROGRAM (LIHEAP)

[OAR Docket #06-399]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

Subchapter 1. Low Income Home Energy Assistance Program

Appendix B. Declaration of Income Eligibility [REVOKED]

Appendix C. Authorization/Agreement/Claim Form [REVOKED]

Appendix F. Benefit Levels (Unsubsidized) [REVOKED]

(Reference APA WF# 05-13)

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

[OAR Docket #06-396]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

Subchapter 3. Initial Application

340:40-3-1. [AMENDED]

Subchapter 5. Plan of Service

340:40-5-1. [AMENDED]

Subchapter 7. Eligibility

340:40-7-3. [AMENDED]

340:40-7-3.1. [NEW]

340:40-7-4. [AMENDED]

340:40-7-6 through 340:40-7-9. [AMENDED]

340:40-7-11. [AMENDED]

Subchapter 9. Procedures Relating to Case Changes

340:40-9-1 through 340:40-9-2. [AMENDED]

Subchapter 13. Child Care Rates and Provider Issues

340:40-13-3. [AMENDED]

340:40-13-5. [AMENDED]

(Reference APA WF 05-04 and 05-28)

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[OAR Docket #06-396; filed 3-22-06]

TITLE 340. DEPARTMENT OF HUMAN SERVICES CHAPTER 45. EMERGENCY WELFARE SERVICES [REVOKED]

[OAR Docket #06-403]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

Subchapter 1. General Provisions [REVOKED]

340:45-1-1. through 340:45-1-8. [REVOKED]

Subchapter 3. Individual and Family Grant Program [REVOKED]

340:45-3-1. through 340:45-3-8. [REVOKED]

(Reference APA WF # 05-18)

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**TITLE 340. DEPARTMENT OF HUMAN SERVICES
CHAPTER 50. FOOD STAMP PROGRAM**

[OAR Docket #06-394]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

- Subchapter 7. Financial Eligibility Criteria
- Part 3. Income
- 340:50-7-30. [AMENDED]
- Subchapter 9. Eligibility and Benefit Determination Procedures
- 340:50-9-1. [AMENDED]
- 340:50-9-5. [AMENDED]
- Subchapter 11. Special Procedures
- Part 3. Simplified Application Processing (SAP) for Food Stamp Program (SFSP) for Temporary Assistance for Needy Families (TANF) and categorically needy Title XIX cases (ABCD) Companion State Supplemental Payment (SSP) recipient(s)
- 340:50-11-20. [AMENDED]
- 340:50-11-22. through 340:50-11-23. [AMENDED]
- 340:50-11-25. [AMENDED]
- 340:50-11-26. [REVOKED]
- 340:50-11-27. [AMENDED]
- (Reference APA WF # 05-03 and 05-23)

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**TITLE 340. DEPARTMENT OF HUMAN SERVICES
CHAPTER 50. FOOD STAMP PROGRAM**

[OAR Docket #06-409]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

- Subchapter 5. Non-Financial Eligibility Criteria
- Part 5. Students, Strikers, Resident Farm Laborers, Migrant Households, Sponsored Aliens, and School Employees
- 340:50-5-45. [AMENDED]

- Part 7. Related Provisions
- 340:50-5-64. [AMENDED]
- Subchapter 7. Financial Eligibility Criteria
- Part 1. Resources
- 340:50-7-2. [AMENDED]
- Part 3. Income
- 340:50-7-22. [AMENDED]
- (Reference APA WF# 05-14)

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[OAR Docket #06-409; filed 3-22-06]

**TITLE 340. DEPARTMENT OF HUMAN SERVICES
CHAPTER 55. EMERGENCY REPATRIATION PROGRAM [REVOKED]**

[OAR Docket #06-401]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

- 340:55-1-1. through 340:55-1-9. [REVOKED]
- (Reference APA WF # 05-19)

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[OAR Docket #06-401; filed 3-22-06]

**TITLE 340. DEPARTMENT OF HUMAN SERVICES
CHAPTER 60. REFUGEE RESETTLEMENT PROGRAM**

[OAR Docket #06-406]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

- 340:60-1-1. through 340:60-1-3. [AMENDED]
- 340:60-1-4. [REVOKED]
- 340:60-1-5. through 340:60-1-6. [AMENDED]
- 340:60-1-7. [REVOKED]
- (Reference APA WF # 05-20)

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**TITLE 340. DEPARTMENT OF HUMAN SERVICES
CHAPTER 65. PUBLIC ASSISTANCE PROCEDURES**

[OAR Docket #06-390]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

Subchapter 3. Eligibility for Benefits

340:65-3-1. through 340:65-3-2. [AMENDED]

Subchapter 5. Procedures Relating to Case Changes

Part 1. General Provisions

340:65-5-1. [AMENDED]

(Reference APA WF 05-25)

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**TITLE 340. DEPARTMENT OF HUMAN SERVICES
CHAPTER 100. DEVELOPMENTAL DISABILITIES SERVICES DIVISION**

[OAR Docket #06-391]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

Subchapter 3. Administration

Part 3. Operations

340:100-3-36. [NEW]

340:100-3-38. [AMENDED]

Subchapter 5. Client Services

Part 3. Service Provisions

340:100-5-22.6. [NEW]

Subchapter 6. Group Home Regulations

Part 17. Residents' Funds

340:100-6-76. [AMENDED]

(Reference APA WF 05-21)

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**TITLE 340. DEPARTMENT OF HUMAN SERVICES
CHAPTER 100. DEVELOPMENTAL DISABILITIES SERVICES DIVISION**

[OAR Docket #06-407]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

Subchapter 1. General Provisions

340:100-1-2. [AMENDED]

Subchapter 3. Administration

Part 1. General Administration

340:100-3-4. AMENDED]

340:100-3-4.1. [REVOKED]

340:100-3-5.1. [AMENDED]

Part 3. Operations

340:100-3-27. through 340:100-3-27.1. [AMENDED]

340:100-3-28. through 340:100-3-29. [AMENDED]

Subchapter 5. Client Services

Part 3. Service Provisions

340:100-5-22.1. [AMENDED]

340:100-5-22.3. [REVOKED]

340:100-5-26.3. [NEW]

340:100-5-29. [AMENDED]

Part 5. Individual Planning

340:100-5-52. [AMENDED]

Appendix D. Dyskinesia Identification System.

[REVOKED]

Appendix J. Application for Volunteer Guardianship.

[REVOKED]

Appendix K. Volunteer Reference Letter. [REVOKED]

(Reference APA WF# 05-07)

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**TITLE 377. OFFICE OF JUVENILE AFFAIRS
CHAPTER 3. ADMINISTRATIVE SERVICES**

[OAR Docket #06-361]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

- Subchapter 13. Office of Public Integrity
- Part 3. Requirements for Secure Juvenile Detention Centers
- 377:3-13-42. Juvenile rights [AMENDED]
- 377:3-13-43. Staff requirements [AMENDED]

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[OAR Docket #06-361; filed 3-20-06]

**TITLE 380. DEPARTMENT OF LABOR
CHAPTER 40. OKLAHOMA
OCCUPATIONAL HEALTH AND SAFETY
STANDARDS ACT RULES**

[OAR Docket #06-412]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

- 380:40-1-5. Recordkeeping [AMENDED]
- 380:40-1-14. Complaints by employees [AMENDED]
- 380:40-1-23. Safety Pays OSHA Consultation Services - Private Sector [NEW]

SUBMITTED TO GOVERNOR:

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[OAR Docket #06-412; filed 3-22-06]

**TITLE 450. DEPARTMENT OF MENTAL
HEALTH AND SUBSTANCE ABUSE
SERVICES
CHAPTER 1. ADMINISTRATION**

[OAR Docket #06-288]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

- Chapter 1. Administration [AMENDED]

SUBMITTED TO GOVERNOR:

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[OAR Docket #06-288; filed 3-14-06]

**TITLE 450. DEPARTMENT OF MENTAL
HEALTH AND SUBSTANCE ABUSE
SERVICES
CHAPTER 18. STANDARDS AND CRITERIA
FOR ALCOHOL AND DRUG TREATMENT
PROGRAMS**

[OAR Docket #06-289]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

- Chapter 18. Standards and Criteria for Alcohol and Drug Treatment Programs [AMENDED]

SUBMITTED TO GOVERNOR:

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[OAR Docket #06-289; filed 3-14-06]

**TITLE 450. DEPARTMENT OF MENTAL
HEALTH AND SUBSTANCE ABUSE
SERVICES
CHAPTER 21. CERTIFICATION OF
ALCOHOL AND DRUG SUBSTANCE ABUSE
COURSES (ADSAC), ORGANIZATIONS AND
FACILITATORS**

[OAR Docket #06-290]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

- Chapter 21. Certification of Alcohol and Drug Substance Abuse Courses (ADSAC), Organizations and Facilitators [AMENDED]

SUBMITTED TO GOVERNOR:

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SUBMITTED TO HOUSE:

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Submissions for Review

SUBMITTED TO SENATE:

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[OAR Docket #06-290; filed 3-14-06]

**TITLE 450. DEPARTMENT OF MENTAL
HEALTH AND SUBSTANCE ABUSE
SERVICES
CHAPTER 22. CERTIFICATION OF
ALCOHOL AND DRUG ASSESSMENT AND
EVALUATIONS RELATED TO DRIVER'S
LICENSE REVOCATION**

[OAR Docket #06-291]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Chapter 22. Certification of Alcohol and Drug Assessment
and Evaluations Related to Driver's License Revocation
[AMENDED]

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[OAR Docket #06-291; filed 3-14-06]

**TITLE 450. DEPARTMENT OF MENTAL
HEALTH AND SUBSTANCE ABUSE
SERVICES
CHAPTER 30. STATE-OPERATED
INPATIENT SERVICES**

[OAR Docket #06-292]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 15. Forensic Review Board [AMENDED]

SUBMITTED TO GOVERNOR:

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[OAR Docket #06-292; filed 3-14-06]

**TITLE 465. OKLAHOMA MOTOR VEHICLE
COMMISSION
CHAPTER 10. LICENSE**

[OAR Docket #06-323]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 7. Off Premise Sale and Display

465:10-7-4. [REVOKED]

465:10-7-5. [REVOKED]

SUBMITTED TO GOVERNOR:

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[OAR Docket #06-323; filed 3-17-06]

**TITLE 510. STATE BOARD OF
OSTEOPATHIC EXAMINERS
CHAPTER 10. LICENSURE OF
OSTEOPATHIC PHYSICIANS AND
SURGEONS**

[OAR Docket #06-413]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 7. Fee Schedule

510:10-7-1. Fees for Licensure [AMENDED]

SUBMITTED TO GOVERNOR:

March 23, 2006

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[OAR Docket #06-413; filed 3-23-06]

**TITLE 550. OKLAHOMA POLICE PENSION
AND RETIREMENT SYSTEM
CHAPTER 1. ADMINISTRATIVE
OPERATIONS**

[OAR Docket #06-324]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 7. Collections and Disbursements

550:1-7-2. [AMENDED]

SUBMITTED TO GOVERNOR:

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[OAR Docket #06-324; filed 3-17-06]

**TITLE 550. OKLAHOMA POLICE PENSION
AND RETIREMENT SYSTEM
CHAPTER 15. OKLAHOMA POLICE
DEFERRED OPTION PLAN**

[OAR Docket #06-325]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

550:15-1-2. [AMENDED]

SUBMITTED TO GOVERNOR:

March 17, 2006

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[OAR Docket #06-325; filed 3-17-06]

**TITLE 550. OKLAHOMA POLICE PENSION
AND RETIREMENT SYSTEM
CHAPTER 20. PURCHASE OF
TRANSFERRED CREDITED SERVICE**

[OAR Docket #06-326]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

550:20-1-2. [AMENDED]

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**TITLE 710. OKLAHOMA TAX
COMMISSION
CHAPTER 1. ADMINISTRATIVE
OPERATIONS**

[OAR Docket #06-282]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review.

RULES:

Subchapter 5. Practice and Procedure

Part 8. Settlement of Tax Liability

710:1-5-86. Review by Commission [AMENDED]

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[OAR Docket #06-282; filed 3-10-06]

**TITLE 710. OKLAHOMA TAX
COMMISSION
CHAPTER 20. ALCOHOL, MIXED
BEVERAGES AND LOW-POINT BEER**

[OAR Docket #06-283]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review.

RULES:

Subchapter 5. Mixed Beverages

710:20-5-6. Due dates for timely filing of monthly tax reports and paying gross receipts tax [AMENDED]

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**TITLE 710. OKLAHOMA TAX
COMMISSION
CHAPTER 22. BOATS AND MOTORS**

[OAR Docket #06-284]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review.

RULES:

Subchapter 1. General Provisions

710:22-1-17. State-owned boats or motors [AMENDED]

Submissions for Review

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[OAR Docket #06-284; filed 3-10-06]

**TITLE 710. OKLAHOMA TAX
COMMISSION
CHAPTER 25. COIN OPERATED VENDING
DEVICES**

[OAR Docket #06-285]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review.

RULES:

710:25-1-7. Special decals for limited use [AMENDED]

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[OAR Docket #06-285; filed 3-10-06]

**TITLE 710. OKLAHOMA TAX
COMMISSION
CHAPTER 40. FRANCHISE TAX**

[OAR Docket #06-286]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review.

RULES:

710:40-1-17. Reporting form to be used by taxpayers exempt from tax as a result of a tax of \$10.00 or less being due [NEW]

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**TITLE 710. OKLAHOMA TAX
COMMISSION
CHAPTER 60. MOTOR VEHICLES**

[OAR Docket #06-359]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review.

RULES:

Subchapter 3. Registration and Licensing

Part 3. Penalties

710:60-3-30. New vehicles purchased by Oklahoma residents [AMENDED]

710:60-3-32. Used vehicles brought in by owner moving to Oklahoma [AMENDED]

Part 11. Other Vehicles

710:60-3-112. Tax exempt license plates [AMENDED]

Part 14. All Terrain Vehicles and Off-Road Motorcycles [NEW]

710:60-3-140. All terrain vehicles and off-road motorcycles [NEW]

710:60-3-141. Titling of all terrain vehicles and off-road motorcycles [NEW]

710:60-3-142. Registration of all terrain vehicles and off-road motorcycles [NEW]

Part 15. Special License Plates

710:60-3-150. Special license plates, ~~general provisions~~ [AMENDED]

Part 19. Enforcement

710:60-3-210. Sale of vehicles seized for improper registration and/or plates [REVOKED]

710:60-3-211. Order of sale from administrative hearing [REVOKED]

710:60-3-212. Notice of sale to lienholders [REVOKED]

710:60-3-213. Return of sale to be filed [REVOKED]

Subchapter 5. Motor Vehicle Titles

Part 5. Certificates of Title

710:60-5-53. Salvage titles [AMENDED]

Part 7. Transfer of Title

710:60-5-71. General provisions; assignments; liens; registration; notice of transfer [AMENDED]

Part 9. Affidavits For Use In Titles

710:60-5-91. Affidavit of assembly and ownership [AMENDED]

710:60-5-92. Obtaining title for front end section or glider kit [AMENDED]

Part 11. Liens

710:60-5-116. ~~Mechanics'~~ Possessory liens under Title 42 of the Oklahoma Statutes [AMENDED]

Subchapter 7. Motor Vehicle Excise Tax

710:60-7-3. Excise tax levy and exemptions [AMENDED]

Subchapter 8. Rental Tax on Motor Vehicle Rentals

710:60-8-4. Collection, reporting, remittance of the tax; interest and penalties [AMENDED]

Subchapter 9. Motor Vehicle License Agents/Agencies

Part 9. Specific Fiscal Duties

710:60-9-95. Procedures for refunds to taxpayer [AMENDED]

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**TITLE 710. OKLAHOMA TAX COMMISSION
CHAPTER 65. SALES AND USE TAX**

[OAR Docket #06-360]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review.

RULES:

Subchapter 3. Reports and Returns; Payments and Penalties; Records

Part 1. General Provisions

710:65-3-4. Contents of monthly sales report [AMENDED]

710:65-3-8. Change in tax period [AMENDED]

Subchapter 7. Duties and Liabilities

710:65-7-15. Vendors' responsibility - sales to entities with other specific statutory exemptions [AMENDED]

710:65-7-17. Vendors' responsibility - sales to disabled veterans receiving compensation at the 100% rate [NEW]

710:65-7-18. Vendor's responsibility - sales to, by, or for the benefit of neighborhood watch organizations [NEW]

Subchapter 9. Permits

710:65-9-8. Special event permits and reporting [AMENDED]

Subchapter 13. Sales and Use Tax Exemptions

Part 1. Advertising in Media

710:65-13-1. Exemption for ~~advertising through the internet, newspapers, periodicals, billboards, and electronic broadcast media~~ sales of certain types of advertising [AMENDED]

Part 12. Aircraft [NEW]

710:65-13-63. Exemption for aircraft repair, modification and replacement parts [NEW]

Part 23. Gas and Electricity

710:65-13-123. Exemption for sales of electricity for use in enhanced recovery methods on a spacing unit or lease [NEW]

Part 29. Manufacturing

710:65-13-154. Limitations on credits [AMENDED]

710:65-13-156. Exemption of "qualified distributor" [NEW]

Part 31. Medicine, Medical Appliances, and Health Care Entities and Activities

710:65-13-176. Exemption for certain hospitals and nursing homes [NEW]

Part 35. Newspapers, Periodicals; Media

710:65-13-194. Exemption for sales of tangible personal property and services to a motion picture or television production company to be used or consumed in connection with an eligible production [AMENDED]

Part 42. Disabled Veterans in Receipt of Compensation at the 100% Rate [NEW]

710:65-13-275. Exemption for disabled veterans in receipt of compensation at the one hundred percent rate [NEW]

Part 43. Social, Charitable, and Civic Organizations and Activities

710:65-13-339. Qualifications for "Collection and Distribution Organization" exemption [AMENDED]

710:65-13-343. Exemption for qualified youth athletic teams [AMENDED]

710:65-13-344. Exemption for tax exempt, nonprofit organizations, which provide services during the day to homeless persons [NEW]

710:65-13-345. Exemption for tax exempt organizations, which provide funding for the preservation of wetlands and habitats for wild ducks or preservation and conservation of wild turkeys [NEW]

710:65-13-346. Exemption for tax exempt organizations which are a part of a network of community-based autonomous member organizations providing job training and employment services [NEW]

710:65-13-347. Exemption for specialized facilities, which provide services for physically and mentally handicapped persons [NEW]

710:65-13-348. Limited exemption for qualified neighborhood watch organizations [NEW]

Part 45. Modular Dwelling Units [NEW]

710:65-13-450. Modular Dwelling Units [NEW]

Subchapter 19. Specific Applications and Examples

Part 7. "D"

710:65-19-74. Discounts [AMENDED]

710:65-19-77. Dues and fees [AMENDED]

Part 15. "H"

710:65-19-142. Hospitals [AMENDED]

Part 23. "L"

710:65-19-195. Sales of lottery tickets [NEW]

Part 39. "T"

710:65-19-328. Transportation for hire [AMENDED]

710:65-19-330. Telecommunications services [AMENDED]

Subchapter 21. Use Tax

710:65-21-7. Reports, payments, and penalties [AMENDED]

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Submissions for Review

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**TITLE 710. OKLAHOMA TAX
COMMISSION
CHAPTER 95. MISCELLANEOUS AREAS
OF REGULATORY AND ADMINISTRATIVE
AUTHORITY**

[OAR Docket #06-287]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review.

RULES:

Subchapter 5. Waste Tire Recycling

710:95-5-2. Definitions [AMENDED]

710:95-5-13. Procedure to be used by waste tire facilities and "TDF facilities" to request compensation for the collection and transportation of waste tires and either the processing and sale of processed waste tires or the use of the tires as fuel or for the manufacture of new products [AMENDED]

710:95-5-14. Procedure to be used by businesses that utilize waste tires manufacture new products or derive energy benefits from processed waste tire material to request compensation [AMENDED]

710:95-5-20. Procedures to request compensation for use by entities which process and utilize waste tires in erosion control, bank stabilization or other conservation projects [AMENDED]

710:95-5-21. Procedure to be used by units of local or county government to request compensation for tires that are baled and used in approved engineering projects [AMENDED]

710:95-5-22. Apportionment of funds among claimants [NEW]

Subchapter 13. Out-of-State Attorney Registration [REVOKED]

710:95-13-1. Out-of-state attorney registration [REVOKED]

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**TITLE 715. TEACHERS' RETIREMENT
SYSTEM
CHAPTER 10. GENERAL OPERATIONS**

[OAR Docket #06-440]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

715:10-1-7. [AMENDED]

715: 10-3-4. [AMENDED]

715:10-9-7. [AMENDED]

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**TITLE 765. OKLAHOMA USED MOTOR
VEHICLE AND PARTS COMMISSION
CHAPTER 1. ORGANIZATION AND
METHOD OF OPERATIONS**

[OAR Docket #06-425]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review.

RULES:

765:1-1-2.1. [AMENDED]

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**TITLE 765. OKLAHOMA USED MOTOR
VEHICLE AND PARTS COMMISSION
CHAPTER 2. INFORMAL AND FORMAL
PROCEDURES**

[OAR Docket #06-426]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review.

RULES:

Subchapter 3. Formal Procedures

765:2-3-5.1. [NEW]

765:2-3-6. [AMENDED]

765:2-3-11. [AMENDED]

Subchapter 5. Arbitration
765:2-5-12. [AMENDED]

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**TITLE 765. OKLAHOMA USED MOTOR
VEHICLE AND PARTS COMMISSION
CHAPTER 3. PROMULGATION,
AMENDMENT, AND REPEAL OF RULES**

[OAR Docket #06-427]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review.

RULES:

765:3-1-6. [AMENDED]

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**TITLE 765. OKLAHOMA USED MOTOR
VEHICLE AND PARTS COMMISSION
CHAPTER 10. USED MOTOR VEHICLE
DEALERS**

[OAR Docket #06-428]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review.

RULES:

Subchapter 1. Licensing Qualifications, Procedures and Fees

765:10-1-3. [AMENDED]

Subchapter 3. Operation

765:10-3-1. [AMENDED]

765:10-3-3. [AMENDED]

765:10-3-4. [NEW]

765:10-3-5. [NEW]

Subchapter 5. Assessment of Fine or Denial, Suspension, or Revocation of License

765:10-5-1. [AMENDED]

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**TITLE 765. OKLAHOMA USED MOTOR
VEHICLE AND PARTS COMMISSION
CHAPTER 11. USED MOTOR VEHICLE
REBUILDERS**

[OAR Docket #06-429]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review.

RULES:

Subchapter 3. Authority

765:11-3-1. [AMENDED]

Subchapter 5. Assessment of Fine or Denial, Suspension, or Revocation of License

765:11-5-1. [AMENDED]

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**TITLE 765. OKLAHOMA USED MOTOR
VEHICLE AND PARTS COMMISSION
CHAPTER 15. USED MOTOR VEHICLE
SALESMEN SALESPERSONS**

[OAR Docket #06-430]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review.

RULES:

Subchapter 1. Licensing Qualifications, Procedures and Fees

765:15-1-1. [AMENDED]

765:15-1-2. [AMENDED]

765:15-1-3. [AMENDED]

765:15-1-4. [AMENDED]

765:15-1-5. [AMENDED]

765:15-1-7. [AMENDED]

Subchapter 3. Authority of Salesmen Salespersons

765:15-3-1. [AMENDED]

Subchapter 5. Assessment of Fine or Denial, Suspension, or Revocation of License

765:15-5-1. [AMENDED]

Submissions for Review

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**TITLE 765. OKLAHOMA USED MOTOR
VEHICLE AND PARTS COMMISSION
CHAPTER 16. ADVERTISING**

[OAR Docket #06-431]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review.

RULES:

Subchapter 1. General Provisions

765:16-1-2. [AMENDED]

Subchapter 3. Specific Advertising Regulations

765:16-3-7. [AMENDED]

765:16-3-11. [AMENDED]

765:16-3-12. [NEW]

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**TITLE 765. OKLAHOMA USED MOTOR
VEHICLE AND PARTS COMMISSION
CHAPTER 20. WHOLESALE USED MOTOR
VEHICLE DEALERS**

[OAR Docket #06-432]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review.

RULES:

Subchapter 1. Licensing Qualifications, Procedures and Fees

765:20-1-1. [AMENDED]

765:20-1-2. [AMENDED]

765:20-1-4. [AMENDED]

765:20-1-6. [AMENDED]

Subchapter 3. Operation

765:20-3-2. [AMENDED]

Subchapter 5. Assessment of Fine or Denial, Suspension, or Revocation of License [NEW]

765:20-5-1. [NEW]

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**TITLE 765. OKLAHOMA USED MOTOR
VEHICLE AND PARTS COMMISSION
CHAPTER 25. AUTOMOTIVE
DISMANTLER AND PARTS RECYCLERS**

[OAR Docket #06-433]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review.

RULES:

Subchapter 1. Licensing Qualifications, Procedures and Fees

765:25-1-3. [AMENDED]

765:25-1-4. [AMENDED]

765:25-1-5. [AMENDED]

765:25-1-6. [AMENDED]

Subchapter 3. Operation

765:25-3-1. [AMENDED]

765:25-3-4. [AMENDED]

Subchapter 5. Assessment of Fine or Denial, Suspension, or Revocation of License

765:25-5-1. [AMENDED]

765:25-5-2. [AMENDED]

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**TITLE 765. OKLAHOMA USED MOTOR
VEHICLE AND PARTS COMMISSION
CHAPTER 30. BUYER'S IDENTIFICATION
CARDS**

[OAR Docket #06-434]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review.

RULES:

Subchapter 3. Assessment of Fine or Denial, Suspension, or Revocation of Bid Card

765:30-3-1. [AMENDED]

765:30-3-2. [AMENDED]

Subchapter 7. Salvage Pools and Salvage Disposal Sales
765:30-7-2. [AMENDED]

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**TITLE 765. OKLAHOMA USED MOTOR
VEHICLE AND PARTS COMMISSION
CHAPTER 35. MANUFACTURED HOME
DEALERS**

[OAR Docket #06-435]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review.

RULES:

Subchapter 5. Operation

765:35-5-1. [AMENDED]

Subchapter 7. Assessment of Fine or Denial, Suspension, or
Revocation of License

765:35-7-1. [AMENDED]

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**TITLE 765. OKLAHOMA USED MOTOR
VEHICLE AND PARTS COMMISSION
CHAPTER 36. MANUFACTURED HOME
MANUFACTURERS**

[OAR Docket #06-436]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review.

RULES:

Subchapter 7. Assessment of Fine or Denial, Suspension, or
Revocation of License

765:36-7-1. [AMENDED]

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**TITLE 765. OKLAHOMA USED MOTOR
VEHICLE AND PARTS COMMISSION
CHAPTER 37. MANUFACTURED HOME
INSTALLERS**

[OAR Docket #06-437]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review.

RULES:

Subchapter 9. Assessment of Fine or Denial, Suspension, or
Revocation of License [NEW]

765:37-9-1. [NEW]

765:37-9-2. [NEW]

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[OAR Docket #06-437; filed 3-24-06]

**TITLE 765. OKLAHOMA USED MOTOR
VEHICLE AND PARTS COMMISSION
CHAPTER 38. MANUFACTURED HOME
SALESPERSON**

[OAR Docket #06-438]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review.

RULES:

Subchapter 1. Licensing Qualifications, Procedures and
Fees [NEW]

765:38-1-1. [NEW]

765:38-1-2. [NEW]

765:38-1-3. [NEW]

765:38-1-4. [NEW]

765:38-1-5. [NEW]

765:38-1-6. [NEW]

Subchapter 3. Authority of Salespersons [NEW]

765:38-3-1. [NEW]

Subchapter 5. Assessment of Fine or Denial, Suspension, or
Revocation of License [NEW]

765:38-5-1. [NEW]

765:38-5-2. [NEW]

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**TITLE 785. OKLAHOMA WATER
RESOURCES BOARD
CHAPTER 1. ORGANIZATIONS AND
PROCEDURE OF OKLAHOMA WATER
RESOURCES BOARD**

[OAR Docket #06-418]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 1. General Provisions

785:1-1-2. Definitions [AMENDED]

Subchapter 9. Time Periods for Permit and License
Issuance and Denial

785:1-9-2. Permit and license applications subject to rule
[AMENDED]

Subchapter 11. Complaints and Complaint Resolution

785:1-11-1. Complaint evaluation and resolution
procedures [AMENDED]

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**TITLE 785. OKLAHOMA WATER
RESOURCES BOARD
CHAPTER 4. RULES OF PRACTICE AND
HEARINGS**

[OAR Docket #06-419]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 5. Pre-Hearing Actions and Proceedings

785:4-5-4 Application protests; comments and objections
[AMENDED]

785:4-5-6 Electronic mail notice [NEW]

785:4-5-7 Copies of motions, requests and orders [NEW]

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**TITLE 785. OKLAHOMA WATER
RESOURCES BOARD
CHAPTER 5. FEES**

[OAR Docket #06-420]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 1. General Provisions

785:5-1-6. Stream water permit application and water
rights administration fees [AMENDED]

785:5-1-10. Groundwater application and water rights
administration fees [AMENDED]

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**TITLE 785. OKLAHOMA WATER
RESOURCES BOARD
CHAPTER 20. APPROPRIATION AND USE
OF STREAM WATER**

[OAR Docket #06-421]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 9. Actions After Stream Water Right Obtained

785:20-9-5. Reports [AMENDED]

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**TITLE 785. OKLAHOMA WATER
RESOURCES BOARD
CHAPTER 30. TAKING AND USE OF
GROUNDWATER**

[OAR Docket #06-422]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 5. Groundwater Permits

785:30-5-9. Annual reports of water use [AMENDED]

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[OAR Docket #06-422; filed 3-24-06]

**TITLE 785. OKLAHOMA WATER
RESOURCES BOARD
CHAPTER 35. WELL DRILLER AND PUMP
INSTALLER LICENSING**

[OAR Docket #06-423]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 1 General Provisions

785-35-1-2. Definitions [AMENDED]

Subchapter 3. Licensing and Certifications

785:35-3-1.1. Activities authorized; electrician and plumbers license [NEW]

Subchapter 7. Minimum Standards for Construction of Wells

785:35-7-1. Minimum standards for construction of groundwater wells, fresh water observation wells, and water well test holes [AMENDED]

785:35-7-2. Minimum standards for construction of monitoring wells and geotechnical borings [AMENDED]

SUBMITTED TO GOVERNOR:

March 23, 2006

SUBMITTED TO HOUSE:

March 23, 2006

SUBMITTED TO SENATE:

March 23, 2006

[OAR Docket #06-423; filed 3-24-06]

**TITLE 785. OKLAHOMA WATER
RESOURCES BOARD
CHAPTER 50. FINANCIAL ASSISTANCE**

[OAR Docket #06-424]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Chapter 50. Financial Assistance [AMENDED]

SUBMITTED TO GOVERNOR:

March 23, 2006

SUBMITTED TO HOUSE:

March 23, 2006

SUBMITTED TO SENATE:

March 23, 2006

[OAR Docket #06-424; filed 3-24-06]

Gubernatorial Approvals

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

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

TITLE 35. OKLAHOMA DEPARTMENT OF AGRICULTURE, FOOD, AND FORESTRY CHAPTER 17. WATER QUALITY

[OAR Docket #06-322]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 9. Agricultural Compost Facilities [NEW]

GUBERNATORIAL APPROVAL:

March 9, 2006

[OAR Docket #06-322; filed 3-16-06]

TITLE 35. OKLAHOMA DEPARTMENT OF AGRICULTURE, FOOD, AND FORESTRY CHAPTER 44. AGRICULTURE POLLUTANT DISCHARGE ELIMINATION SYSTEM

[OAR Docket #06-321]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 1. [RESERVED]

Subchapter 3. Concentrated Animal Feeding Operations [NEW]

35:44-3-1. through 35:44-3-3. [NEW]

GUBERNATORIAL APPROVAL:

March 9, 2006

[OAR Docket #06-321; filed 3-16-06]

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

[OAR Docket #06-441]

RULEMAKING ACTION:

Gubernatorial approval

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]

GUBERNATORIAL APPROVAL:

March 9, 2006

[OAR Docket #06-441; filed 3-24-06]

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

[OAR Docket #06-442]

RULEMAKING ACTION:

Gubernatorial approval

RULES:

Subchapter 1. General Provisions

245:15-1-1. [AMENDED]

245:15-1-3. [AMENDED]

245:15-1-4. [AMENDED]

Subchapter 3. Application and Eligibility for Licensing

245:15-3-2. [AMENDED]

245:15-3-3. [AMENDED]

245:15-3-4. [AMENDED]

245:15-3-5. [AMENDED]

245:15-3-6. [AMENDED]

245:15-3-7. [AMENDED]

245:15-3-8. [AMENDED]

245:15-3-9. [AMENDED]

245:15-3-10. [AMENDED]

Subchapter 5. Examinations

245:15-5-1. [AMENDED]

245:15-5-2. [AMENDED]

245:15-5-4. [AMENDED]

245:15-5-5. [AMENDED]

245:15-5-6. [REVOKED]

245:15-5-7. [AMENDED]

Subchapter 7. Licensure

245:15-7-1. [AMENDED]

245:15-7-2. [AMENDED]

245:15-7-3. [AMENDED]

245:15-7-4. [AMENDED]

245:15-7-5. [AMENDED]

Subchapter 9. Rules of Professional

- 245:15-9-1. [AMENDED]
- 245:15-9-3. [AMENDED]
- 245:15-9-4. [AMENDED]
- 245:15-9-5. [AMENDED]
- 245:15-9-6. [AMENDED]
- 245:15-9-7. [AMENDED]

Subchapter 11. Continuing Education

- 245:15-11-1. [AMENDED]
- 245:15-11-2. [AMENDED]
- 245:15-11-3. [AMENDED]
- 245:15-11-5. [AMENDED]
- 245:15-11-6. [AMENDED]
- 245:15-11-7. [AMENDED]
- 245:15-11-8. [AMENDED]
- 245:15-11-9. [AMENDED]
- 245:15-11-10. [AMENDED]
- 245:15-11-11. [AMENDED]
- 245:15-11-12. [AMENDED]
- 245:15-11-13. [AMENDED]

Subchapter 13. Minimum Standards For Land Surveying

- 245:15-13-2. [AMENDED]
- 245:15-13-3. [AMENDED]

Subchapter 15. Ethical Marketing of Services

- 245:15-15-1. [AMENDED]
- 245:15-15-2. [AMENDED]
- 245:15-15-3. [AMENDED]

Subchapter 17. Licensee's Seal

- 245:15-17-1. [AMENDED]
- 245:15-17-2. [AMENDED]

Subchapter 19. Organizational Practice

- 245:15-19-2. [AMENDED]
- 245:15-19-3. [AMENDED]
- 245:15-19-4. [AMENDED]
- 245:15-19-5. [AMENDED]
- 245:15-19-6. [AMENDED]
- 245:15-19-7. [AMENDED]
- 245:15-19-8. [AMENDED]

Subchapter 21. Corner Perpetuation and Filing Act Requirements

- 245:15-21-1. [AMENDED]
- 245:15-21-3. [AMENDED]
- 245:15-21-6. [AMENDED]

Subchapter 23. Violations

- 245:15-23-1. [AMENDED]
- 245:15-23-2. [AMENDED]
- 245:15-23-3. [AMENDED]
- 245:15-23-4. [AMENDED]
- 245:15-23-5. [AMENDED]
- 245:15-23-6. [AMENDED]
- 245:15-23-7. [AMENDED]
- 245:15-23-8. [AMENDED]
- 245:15-23-9. [AMENDED]
- 245:15-23-10. [AMENDED]
- 245:15-23-11. [AMENDED]

- 245:15-23-12. [AMENDED]
- 245:15-23-13. [AMENDED]
- 245:15-23-14. [AMENDED]
- 245:15-23-15. [AMENDED]
- 245:15-23-16. [AMENDED]
- 245:15-23-17. [AMENDED]
- 245:15-23-18. [AMENDED]
- 245:15-23-21. [AMENDED]
- 245:15-23-22. [AMENDED]
- 245:15-23-23. [AMENDED]
- 245:15-23-24. [AMENDED]
- 245:15-23-25. [AMENDED]

GOVERNATORIAL APPROVAL:

March 9, 2006

[OAR Docket #06-442; filed 3-24-06]

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

[OAR Docket #06-411]

RULEMAKING ACTION:

Gubernatorial approval

RULES:

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

GOVERNATORIAL APPROVAL:

March 16, 2006

[OAR Docket #06-411; filed 3-22-06]

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

[OAR Docket #06-302]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

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)**

GOVERNATORIAL APPROVAL:

March 9, 2006

[OAR Docket #06-302; filed 3-16-06]

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

[OAR Docket #06-303]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

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

GUBERNATORIAL APPROVAL:

March 9, 2006

[OAR Docket #06-303; filed 3-16-06]

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

[OAR Docket #06-304]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

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)

GUBERNATORIAL APPROVAL:

March 9, 2006

[OAR Docket #06-304; filed 3-16-06]

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

[OAR Docket #06-305]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 5. Individual Providers and Specialties
Part 1. Physicians
317:30-5-14. [AMENDED]
(Reference APA WF # 05-05)

GUBERNATORIAL APPROVAL:

March 9, 2006

[OAR Docket #06-305; filed 3-16-06]

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

[OAR Docket #06-306]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

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)

GUBERNATORIAL APPROVAL:

March 9, 2006

[OAR Docket #06-306; filed 3-16-06]

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

[OAR Docket #06-310]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

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

GUBERNATORIAL APPROVAL:

March 9, 2006

[OAR Docket #06-310; filed 3-16-06]

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

[OAR Docket #06-312]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 5. Individual Providers and Specialties
Part 9. Long Term Care Facilities

Gubernatorial Approvals

317:30-5-122. [AMENDED]

(Reference APA WF # 05-12)

GUBERNATORIAL APPROVAL:

March 9, 2006

[OAR Docket #06-312; filed 3-16-06]

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

[OAR Docket #06-313]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

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)

GUBERNATORIAL APPROVAL:

March 9, 2006

[OAR Docket #06-313; filed 3-16-06]

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

[OAR Docket #06-314]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

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)

GUBERNATORIAL APPROVAL:

March 9, 2006

[OAR Docket #06-314; filed 3-16-06]

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

[OAR Docket #06-315]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 3. General Provider Policies

Part 1. General Scope and Administration

317:30-3-5. [AMENDED]

Subchapter 5. Individual Providers and Specialties

Part 3. Hospitals

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)

GUBERNATORIAL APPROVAL:

March 9, 2006

[OAR Docket #06-315; filed 3-16-06]

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

[OAR Docket #06-301]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 17. ADvantage Waiver Services

317:35-17-3. [AMENDED]

317:35-17-14. [AMENDED]

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

GUBERNATORIAL APPROVAL:

March 9, 2006

[OAR Docket #06-301; filed 3-16-06]

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

[OAR Docket #06-307]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

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)

GUBERNATORIAL APPROVAL:
March 9, 2006

[OAR Docket #06-307; filed 3-16-06]

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

[OAR Docket #06-308]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

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)

GUBERNATORIAL APPROVAL:
March 9, 2006

[OAR Docket #06-308; filed 3-16-06]

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

[OAR Docket #06-309]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 5. Eligibility and Countable Income
Part 3. Non-Medical Eligibility Requirements
317:35-5-26. [AMENDED]
(Reference APA WF # 05-09A)

GUBERNATORIAL APPROVAL:
March 9, 2006

[OAR Docket #06-309; filed 3-16-06]

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

[OAR Docket #06-311]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 7. Waiver Employment Services
317:40-7-2. [AMENDED]
317:40-7-12. [AMENDED]
(Reference APA WF # 05-10)

GUBERNATORIAL APPROVAL:
March 9, 2006

[OAR Docket #06-311; filed 3-16-06]

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

[OAR Docket #06-317]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

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. Other Community Residential Supports
317:40-5-150. [AMENDED]
317:40-5-152. [AMENDED]
(Reference APA WF # 05-19)

GUBERNATORIAL APPROVAL:
March 9, 2006

[OAR Docket #06-317; filed 3-16-06]

Gubernatorial Approvals

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

[OAR Docket #06-316]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

- Subchapter 1. General Provisions [NEW]
317:45-1-1. [NEW]
317:45-1-3. [NEW]
 - Subchapter 3. Carriers [NEW]
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]
317:45-7-3. through 317:45-7-4. [NEW]
317:45-7-6. through 317:45-7-8. [NEW]
 - Subchapter 9. Employee Eligibility [NEW]
317:45-9-2. through 317:45-9-8. [NEW]
- (Reference APA WF # 05-16)

GUBERNATORIAL APPROVAL:

March 9, 2006

[OAR Docket #06-316; filed 3-16-06]

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

[OAR Docket #06-414]

RULEMAKING ACTION:

Gubernatorial approval

RULES:

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

GUBERNATORIAL APPROVAL:

March 16, 2006

[OAR Docket #06-414; filed 3-23-06]

TITLE 325. OKLAHOMA HORSE RACING COMMISSION
CHAPTER 45. MEDICATION AND EQUINE TESTING PROCEDURES

[OAR Docket #06-415]

RULEMAKING ACTION:

Gubernatorial approval

RULES:

- 325:45-1-2. Definitions [AMENDED]

GUBERNATORIAL APPROVAL:

March 16, 2006

[OAR Docket #06-415; filed 3-23-06]

TITLE 325. OKLAHOMA HORSE RACING COMMISSION
CHAPTER 50. HUMAN SUBSTANCE ABUSE TESTING

[OAR Docket #06-416]

RULEMAKING ACTION:

Gubernatorial approval

RULES:

- 325:50-1-2. Definitions [AMENDED]

GUBERNATORIAL APPROVAL:

March 16, 2006

[OAR Docket #06-416; filed 3-23-06]

TITLE 325. OKLAHOMA HORSE RACING COMMISSION
CHAPTER 70. OBJECTIONS AND PROTESTS; HEARINGS AND APPEALS

[OAR Docket #06-417]

RULEMAKING ACTION:

Gubernatorial approval

RULES:

- 325:70-1-2. Definitions [AMENDED]

GUBERNATORIAL APPROVAL:

March 16, 2006

[OAR Docket #06-417; filed 3-23-06]

TITLE 340. DEPARTMENT OF HUMAN SERVICES
CHAPTER 10. TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF)

[OAR Docket #06-398]

RULEMAKING ACTION:

Gubernatorial approval

RULES:

- Subchapter 2. Temporary Assistance for Needy Families (TANF) Work Program
340:10-2-2. [AMENDED]
340:10-2-7. through 340:10-2-8. [AMENDED]
- Subchapter 3. Conditions of Eligibility - Need
Part 1. Resources

340:10-3-5. [AMENDED]
Part 3. Income
340:10-3-32. [AMENDED]
340:10-3-40. [AMENDED]
Part 5. Assistance Payments
340:10-3-56. through 340:10-3-57. [AMENDED]
Subchapter 10. Conditions of Eligibility - Deprivation
340:10-10-3. [AMENDED]
(Reference APA WF# 05-11 and 05-17)

GUBERNATORIAL APPROVAL:
March 9, 2006

[OAR Docket #06-398; filed 3-22-06]

**TITLE 340. DEPARTMENT OF HUMAN SERVICES
CHAPTER 20. LOW INCOME HOME ENERGY ASSISTANCE PROGRAM (LIHEAP)**

[OAR Docket #06-400]

RULEMAKING ACTION:

Gubernatorial approval

RULES:

Subchapter 1. Low Income Home Energy Assistance Program
Appendix B. Declaration of Income Eligibility [REVOKED]
Appendix C. Authorization/Agreement/Claim Form [REVOKED]
Appendix F. Benefit Levels (Unsubsidized) [REVOKED]
(Reference APA WF# 05-13)

GUBERNATORIAL APPROVAL:

March 9, 2006

[OAR Docket #06-400; filed 3-22-06]

**TITLE 340. DEPARTMENT OF HUMAN SERVICES
CHAPTER 45. EMERGENCY WELFARE SERVICES [REVOKED]**

[OAR Docket #06-404]

RULEMAKING ACTION:

Gubernatorial approval

RULES:

Subchapter 1. General Provisions [REVOKED]
340:45-1-1. through 340:45-1-8. [REVOKED]
Subchapter 3. Individual and Family Grant Program [REVOKED]

340:45-3-1. through 340:45-3-8. [REVOKED]
(Reference APA WF # 05-18)

GUBERNATORIAL APPROVAL:

March 9, 2006

[OAR Docket #06-404; filed 3-22-06]

**TITLE 340. DEPARTMENT OF HUMAN SERVICES
CHAPTER 50. FOOD STAMP PROGRAM**

[OAR Docket #06-410]

RULEMAKING ACTION:

Gubernatorial approval

RULES:

Subchapter 5. Non-Financial Eligibility Criteria
Part 5. Students, Strikers, Resident Farm Laborers, Migrant Households, Sponsored Aliens, and School Employees
340:50-5-45. [AMENDED]
Part 7. Related Provisions
340:50-5-64. [AMENDED]
Subchapter 7. Financial Eligibility Criteria
Part 1. Resources
340:50-7-2. [AMENDED]
Part 3. Income
340:50-7-22. [AMENDED]
(Reference APA WF# 05-14)

GUBERNATORIAL APPROVAL:

March 9, 2006

[OAR Docket #06-410; filed 3-22-06]

**TITLE 340. DEPARTMENT OF HUMAN SERVICES
CHAPTER 55. EMERGENCY REPATRIATION PROGRAM [REVOKED]**

[OAR Docket #06-402]

RULEMAKING ACTION:

Gubernatorial approval

RULES:

340:55-1-1. through 340:55-1-9. [REVOKED]
(Reference APA WF # 05-19)

GUBERNATORIAL APPROVAL:

March 9, 2006

[OAR Docket #06-402; filed 3-22-06]

Gubernatorial Approvals

TITLE 340. DEPARTMENT OF HUMAN SERVICES CHAPTER 60. REFUGEE RESETTLEMENT PROGRAM

[OAR Docket #06-405]

RULEMAKING ACTION:

Gubernatorial approval

RULES:

340:60-1-1. through 340:60-1-3. [AMENDED]

340:60-1-4. [REVOKED]

340:60-1-5. through 340:60-1-6. [AMENDED]

340:60-1-7. [REVOKED]

(Reference APA WF # 05-20)

GUBERNATORIAL APPROVAL:

March 9, 2006

[OAR Docket #06-405; filed 3-22-06]

TITLE 340. DEPARTMENT OF HUMAN SERVICES CHAPTER 100. DEVELOPMENTAL DISABILITIES SERVICES DIVISION

[OAR Docket #06-408]

RULEMAKING ACTION:

Gubernatorial approval

RULES:

Subchapter 1. General Provisions

340:100-1-2. [AMENDED]

Subchapter 3. Administration

Part 1. General Administration

340:100-3-4. AMENDED]

340:100-3-4.1. [REVOKED]

340:100-3-5.1. [AMENDED]

Part 3. Operations

340:100-3-27. through 340:100-3-27.1. [AMENDED]

340:100-3-28. through 340:100-3-29. [AMENDED]

Subchapter 5. Client Services

Part 3. Service Provisions

340:100-5-22.1. [AMENDED]

340:100-5-22.3. [REVOKED]

340:100-5-26.3. [NEW]

340:100-5-29. [AMENDED]

Part 5. Individual Planning

340:100-5-52. [AMENDED]

Appendix D. Dyskinesia Identification System.
[REVOKED]

Appendix J. Application for Volunteer Guardianship.
[REVOKED]

Appendix K. Volunteer Reference Letter. [REVOKED]

(Reference APA WF# 05-07)
GUBERNATORIAL APPROVAL:

March 9, 2006

[OAR Docket #06-408; filed 3-22-06]

TITLE 435. STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION CHAPTER 20. PHYSICAL THERAPISTS AND ASSISTANTS

[OAR Docket #06-387]

RULEMAKING ACTION:

Gubernatorial approval.

RULES:

Subchapter 3. Licensure of Physical Therapists and Assistants

435:20-3-6. ~~Re-entry requirements~~ Requirements for renewal and re-entry [AMENDED]

GUBERNATORIAL APPROVAL:

March 16, 2006

[OAR Docket #06-387; filed 3-22-06]

TITLE 590. OKLAHOMA PUBLIC EMPLOYEES RETIREMENT SYSTEM CHAPTER 10. PUBLIC EMPLOYEES RETIREMENT SYSTEM

[OAR Docket #06-318]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 1. General Provisions

590:10-1-4. Health insurance contribution [AMENDED]

590:10-1-20. Actuarial cost to withdraw from system [NEW]

Subchapter 3. Credited Service

590:10-3-6. Full-time-equivalent employment [AMENDED]

Subchapter 7. Retirement Benefits

590:10-7-16. Rollovers [AMENDED]

Subchapter 19. Medicare Gap Benefit Option

590:10-19-14. Payments to an alternate payee under a QDRO [AMENDED]

GUBERNATORIAL APPROVAL:

March 9, 2006

[OAR Docket #06-318; filed 3-16-06]

**TITLE 590. OKLAHOMA PUBLIC
EMPLOYEES RETIREMENT SYSTEM
CHAPTER 15. UNIFORM RETIREMENT
SYSTEM FOR JUSTICES AND JUDGES**

[OAR Docket #06-319]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

- Subchapter 1. General Provisions [NEW]
- 590:15-1-5. Final benefit and Death benefit [AMENDED]
- 590:15-1-6. Revoking survivor benefits [REVOKED]
- Subchapter 3. Excess Contributions [NEW]
- 590:15-3-1. Purpose and intent [NEW]
- 590:15-3-2. Definitions [NEW]
- 590:15-3-3. Transfer of excess contributions [NEW]
- 590:15-3-4. Limitations on transfer of excess contributions [NEW]
- 590:15-3-5. Initial and residual transfers [NEW]
- 590:15-3-6. Deceased Eligible Members [NEW]

GUBERNATORIAL APPROVAL:

March 9, 2006

[OAR Docket #06-319; filed 3-16-06]

**TITLE 590. OKLAHOMA PUBLIC
EMPLOYEES RETIREMENT SYSTEM
CHAPTER 30. QUALIFIED DOMESTIC
RELATIONS ORDERS**

[OAR Docket #06-320]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

- 590:30-1-4. Contents of qualified domestic relations order [AMENDED]

GUBERNATORIAL APPROVAL:

March 9, 2006

[OAR Docket #06-320; filed 3-16-06]

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 1. ADMINISTRATIVE OPERATIONS

[OAR Docket #06-299]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 3. Formal and Informal Procedures

317:1-3-5. [REVOKED]

Subchapter 7. Compliance with the Americans with Disabilities Act of 1990

317:1-7-6. through 317:1-7-6.1. [AMENDED]

Subchapter 9. Civil Rights and Nondiscrimination

317:1-9-7. through 317:1-9-8. [REVOKED]

(Reference APA WF # 05-24B)

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:

January 12, 2006

Approved by Governor:

March 9, 2006

Effective:

Immediately upon Governor's approval or March 1, 2006 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 insure compliance with federal regulations, thereby avoiding any potential economic impact caused by noncompliance with federal regulations and rule inconsistencies.

ANALYSIS:

Agency appeal rules are being revised to accurately reflect the agency which will hear various employer and employee eligibility appeals for the Oklahoma Employer and Employee Partnership for Insurance Coverage (O-EPIC) Program. Rules regarding the various appeal processes are relocated to individual sections to help clarify the correct procedures to be followed. In addition, rules are amended to correct various rule citations. Revisions are needed to provide appeal guidelines for the O-EPIC program and clarify appeal procedures.

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 MARCH 1, 2006, WHICHEVER IS LATER:

SUBCHAPTER 3. FORMAL AND INFORMAL PROCEDURES

317:1-3-5. General complaints [REVOKED]

(a) ~~Anyone may complain to the Authority about any matter under its authority. A complaint shall be in writing, and it shall include the following information:~~

- ~~(1) The name, address and telephone number of the person making the complaint;~~
- ~~(2) The name, address and telephone number of the organization the person represents, if applicable;~~
- ~~(3) The name, address, telephone number and title of any representative of the person filing the complaint;~~
- ~~(4) A brief, clear description of each charge, problem or issue that is the basis for the complaint including names, dates, places and actions;~~
- ~~(5) The numbers and headings of the laws and rules that may apply;~~
- ~~(6) The remedy, if any, the person making the complaint seeks;~~
- ~~(7) The signature of the person making the complaint; and~~
- ~~(8) The date.~~

(b) ~~If the complaint is repetitive, concerns a matter that has already been resolved, or a matter outside the Authority's authority, the Authority may reject the complaint.~~

(c) ~~The Authority may provide others with written notice of the complaint and give them an opportunity to respond in writing within 15 days. The response must contain all of the following information:~~

- ~~(1) The name, address, and telephone number of the person responding;~~
- ~~(2) The name, address, and telephone number of the organization the person represents, if applicable;~~

Emergency Adoptions

- (3) The name, address, telephone number and title of any representative of the person responding;
- (4) A specific admission, denial or explanation of each charge;
- (5) A brief, clear description of the facts including names, dates, places and actions;
- (6) A brief, clear explanation of the reasons for the action (or inaction) that is the basis for the complaint if the person admits to any charge;
- (7) The numbers and headings of the laws and rules that may apply;
- (8) The signature of the person responding; and
- (9) The date.

(d) The Authority or the Administrator may refer complaints to informal proceedings in cases where all parties agree to informal procedures or in instances involving standard procedures uniformly applied, and which involve no discretion on the part of the Authority or a Health Plan. Telephone calls, letters, meeting, mediation, investigations or other appropriate procedures may be utilized as a part of the process. Provided that, the Authority may make a determination to allow a client to disenroll for cause from a Health Plan in an informal proceeding without agreement of the Health Plan.

(e) The Authority shall make a decision about a complaint within 60 days after its receipt, unless the Authority needs more time. Provided that, in a case on appeal by a client from an adverse determination in an informal proceeding involving a request to disenroll from a Health Plan for cause, the Authority shall make a decision within 20 days after receipt. In that case, the Administrator shall notify the person filing the complaint and persons filing any responses to the complaint.

SUBCHAPTER 7. COMPLIANCE WITH THE AMERICANS WITH DISABILITIES ACT OF 1990

317:1-7-6. Requests for reasonable accommodation

(a) An employee who wishes to file a request for reasonable accommodation should do so through a supervisor who will secure the proper forms from the Personnel Department Human Resources Division. An employee who disagrees with the proposed resolution to the request should contact his or her supervisor and mechanisms for resolving the dispute will be instituted through the Personnel Department Human Resources Division. All steps in the process should be documented completely by involved personnel. All requests and records related to the request will be maintained in an appropriate manner by the Personnel Human Resources Division. If there is a dispute between the Oklahoma Health Care Authority and an employee regarding reasonable accommodation, the employee may file a complaint with any state or federal agency which has jurisdiction over ADA complaints.

(b) A client requesting reasonable accommodation should be directed to the Office of the Chief Executive Officer General Counsel, Oklahoma Health Care Authority, Suite 124, 4545 N. Lincoln Blvd., Oklahoma City, OK, 73105, or such address in

the future which is the official mailing address of the Authority. The Chief Executive Officer or a designated Director subject to OAC 317:1-7-7 will attempt to comply with the request and will notify the client of the resolution. If there is a dispute between the Authority and an employee regarding reasonable accommodation, the employee may file a complaint with any state or federal agency which has jurisdiction over ADA complaints. The employee may also file for an administrative hearing with OHCA under OAC 317:2-1-2(b)(5) or file a complaint with the Personnel Department. The General Counsel will confer with the appropriate Director regarding the client's request for accommodation and notify the client of the resolution.

317:1-7-6.1. Requests to make services accessible

In the case a client or applicant for OHCA is denied a request to OHCA to make services more accessible under the Americans with Disabilities Act, the client may appeal the denial to an OHCA Administrative Law Judge under OAC 317:2-1-2(b)(5) 317:2-1-2(c)(1)(A) or may appeal to the Department of Health and Human Services under 28 C.F.R. §35.190(3) or may seek any other remedy provided under law.

SUBCHAPTER 9. CIVIL RIGHTS AND NONDISCRIMINATION

317:1-9-7. Dissemination of rules [REVOKED]

The Authority will inform all employees, clients, applicants and the general public that all services, and all other benefits under its programs are provided on a nondiscriminatory basis. The methods of disseminating policy include the following:

- (1) Written notice on all application and admission forms;
- (2) A nondiscrimination statement in all invoices, financial transaction forms contracts and agreements, business communications, and other related documentation;
- (3) A statement in all brochures and pamphlets which are distributed to beneficiaries, applicants, and the public on the Authority's policy of nondiscrimination;
- (4) Official posters for distribution to vendor recipients to be placed in prominent public places;
- (5) Information to the general public on its right to file complaints, and of the address of the Authority to which complaints may be sent;
- (6) In areas where there are significant number of non-English speaking minorities, the Authority will communicate its policy, including complaint rights, in the appropriate languages;
- (7) For persons with impaired sensory, manual, or speaking skills, the Authority will provide special assistance or, when appropriate, auxiliary aids to afford such persons and equal opportunity to learn of its policies or to benefit from its programs or services.

**317:1-9-8. Execution of compliance reviews
[REVOKED]**

The Authority will make periodic compliance reviews to ensure that practices being utilized conform with Title VI, its regulations and Section 504 of the Rehabilitation Act of 1973 and its regulations. These reviews will elicit information which will provide facts related to:

- (1) desegregation of physical facilities and the accessibility of facilities to handicapped persons;
- (2) availability of notices to clients, potential clients, and the public concerning the facility's policy of compliance;
- (3) extent of participation in programs by minorities and handicapped persons;
- (4) procedures for the delivery of services;
- (5) uniform use of courtesy titles;
- (6) utilization of minority groups and handicapped persons as staff members;
- (7) referral practices;
- (8) employment practices as they relate to the delivery of services; and
- (9) the bilingual cultural capability of the staff for delivering services.

[OAR Docket #06-299; filed 3-15-06]

**TITLE 317. OKLAHOMA HEALTH CARE
AUTHORITY
CHAPTER 2. GRIEVANCE PROCEDURES
AND PROCESS**

[OAR Docket #06-298]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

- 317:2-1-1. through 317:2-1-2. [AMENDED]
- 317:2-1-2.1. through 317:2-1-2.3. [REVOKED]
- 317:2-1-4. [REVOKED]
- 317:2-1-5. through 317:2-1-13. [NEW]

(Reference APA WF # 05-24C)

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:

January 12, 2006

Approved by Governor:

March 9, 2006

Effective:

Immediately upon Governor's approval or March 1, 2006 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 insure compliance with federal regulations, thereby avoiding any potential economic impact caused by noncompliance with federal regulations and rule inconsistencies.

ANALYSIS:

Agency appeal rules are being revised to accurately reflect the agency which will hear various employer and employee eligibility appeals for the Oklahoma Employer and Employee Partnership for Insurance Coverage (O-EPIC) Program. Rules regarding the various appeal processes are relocated to individual sections to help clarify the correct procedures to be followed. In addition, rules are amended to correct various rule citations. Revisions are needed to provide appeal guidelines for the O-EPIC program and clarify appeal procedures.

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 MARCH 1, 2006, WHICHEVER IS LATER:

317:2-1-1. Purpose

The purpose of this Chapter is to describe the different types of grievances addressed by the Oklahoma Health Care Authority (OHCA). The rules explain the step by step processes that must be followed by a party seeking redress from the Authority OHCA. All hearings on eligibility issues for recipients are conducted by the Oklahoma Department of Human Services, and are not contained in this Chapter. Hearings will not be granted when the sole issue to be determined is a Federal or State law requiring an automatic change adversely affecting some or all recipients.

317:2-1-2. Grievance hearings Appeals

(a) **Recipient Process Overview.**

(1) The grievance procedure appeals process allows a recipient to appeal a decision which adversely affects their rights. Examples are decisions involving medical services, prior authorizations for medical services, or discrimination complaints. Appealable reviews are listed at Section 317:2-1-2(b).

(2) In order to file an appeal, the recipient files a LD-1 form within 20 days of the triggering event. The triggering event occurs at the time when the Appellant (Appellant is the person who files a grievance) knew or should have known of such condition or circumstance for appeal.

(3) If the LD-1 form is not received within 20 days of the triggering event, OHCA sends the Appellant a letter stating the appeal will not be heard because it is untimely. In the case of tax warrant intercept appeals, if the LD-1 form is not received within 30 days of written notice sent by OHCA according to Title 68 O.S. § 205.2, OHCA sends the Appellant a letter stating the appeal will not be heard because it is untimely.

(4) If the LD-1 form is not completely filled out and necessary documentation not included, then the appeal will not be heard.

(5) The staff advises the Appellant that if there is a need for assistance in reading or completing the grievance form that arrangements will be made.

Emergency Adoptions

- (6) Recipient appeals are first reviewed by a three person program panel that may or may not contact the recipient [Section OAC 317:2-1-2.2(a) 317:2-1-5]. The recipient appeal next goes to may then request a fair hearing before the ALJ. The recipient must appear at this hearing and it is conducted according to Section OAC 317:2-1-2(e) 317:2-1-5. The recipient ALJ's decision may then be appeal appealed to the CEO, which is a record review at which the recipient parties does do not appear (Section OAC 317:2-1-4 317:2-1-13). Provider appeals generally go to the ALJ (see Section OAC 317:2-1-2.1) and generally follow the procedure at OAC 317:2-1-2(e).
- (7) Recipient appeals are to be decided within 90 days from the date OHCA receives the recipient's timely request for a fair hearing of the program panel's decision unless the recipient waives this requirement. [Title 42 U.S.C. Section 431.244(f)]
- (8) Tax warrant intercept appeals will be heard directly by the ALJ. A decision will be rendered by the ALJ within 20 days of the hearing before the ALJ.
- (b) **Receipt of grievances Provider Process Overview.**
- (1) The proceedings as described in this Section contain the hearing process for those appeals filed by providers. These appeals encompass all subject matter cases contained in OAC 317:2-1-2(c)(2).
- (2) All provider appeals are initially heard by the OHCA Administrative Law Judge under OAC 317:2-1-2(c)(2).
- (A) The Appellant (Appellant is the person or provider who files a grievance) shall file files an LD form requesting a grievance hearing within 20 days of the triggering event. The triggering event occurs at the time when the Appellant knew or should have known of such condition or circumstance for appeal. (LD-1 forms are for recipient complaints, LD-2 forms are for provider grievances and LD-3 forms are for nursing home wage enhancement grievances.) In the case of tax warrant intercept appeals, the Appellant shall file a LD form requesting a grievance hearing within 30 days of written notice sent by the OHCA according to Title 68, Oklahoma Statutes, Section 205.2.
- (2B) If the LD form is not received within 20 days of the triggering event, OHCA shall send sends the Appellant a letter stating the appeal will not be heard because it is untimely. In the case of tax warrant intercept appeals, if the LD form is not received within 30 days of written notice sent by OHCA according to Title 68, Oklahoma Statutes, Section 205.2, OHCA shall send the Appellant a letter stating the appeal will not be heard because it is untimely.
- (3C) The staff shall advise advises the Appellant that if there is a need for assistance in reading or completing the grievance form that arrangements will be made.
- (D) A decision will be rendered by the ALJ within 45 days of the close of all evidence in the case.
- (E) The Administrative Law Judge's decision is appealable to OHCA's CEO under OAC 317:2-1-13.
- (4) The docket clerk will send the Appellant and any other necessary party notice which states the hearing location, date, and time.
- (c) **ALJ jurisdiction.** The administrative law judge shall have has jurisdiction of the following matters:
- (1) Recipient Appeals:
- (1) Whether Pre-admission Screening and Resident Review (PASRR) was completed as required by law;
- (2) Disputes involving the SoonerCare contracts and all contracts or subcontracts with health care providers;
- (3) Appeals by Long Term Care facilities for nonpayment of wage enhancements, determinations of overpayment or underpayment of wage enhancements, and administrative penalty determinations as a result of findings made under OAC 317:30-5-131.2(b)(5)(B), (e)(8), and (e)(12);
- (4) Petitions for Rulemaking;
- (5A) Discrimination complaints regarding the Medicaid program;
- (6) Appeals to the decision made by the Business Contracts manager related to Purchasing as found at OAC 317:10-1-5, 317:10-1-13, 317:25-1-5, and 317:25-1-12, and other appeal rights granted by contract;
- (7B) Appeals which relate to the scope of services, covered services, complaints regarding service or care, enrollment, disenrollment, and reenrollment in the SoonerCare Program;
- (8C) Fee for Service appeals regarding the furnishing of services, including prior authorizations;
- (9) Nursing home contracts which are terminated, denied, or nonrenewed;
- (10) Drug rebate appeals;
- (11D) Appeals which relate to the tax warrant intercept system through the Oklahoma Health Care Authority. Tax warrant intercept appeals will be heard directly by the ALJ. A decision will be rendered by the Administrative Law Judge within 20 days of the hearing before the ALJ;
- (12E) Complaints regarding the possible violation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA); and
- (13) Proposed administrative sanction appeals pursuant to OAC 317:35-13-7.
- (2) Provider Appeals:
- (A) Whether Pre-admission Screening and Resident Review (PASRR) was completed as required by law;
- (B) Denial of request to dis-enroll recipient from provider's SoonerCare panel;
- (C) Appeals by Long Term Care facilities for nonpayment of wage enhancements, determinations of overpayment or underpayment of wage enhancements, and administrative penalty determinations as a result of findings made under OAC 317:30-5-131.2(b)(5), (e)(8), and (e)(12);
- (D) Petitions for Rulemaking;

(E) Appeals of insureds participating in O-EPIC which are authorized by OAC 317:45-9-8(a);

(F) Appeals to the decision made by the Business Contracts manager related to Purchasing as found at OAC 317:10-1-5, 317:10-1-13, 317:25-1-5, 317:25-1-12, and other appeal rights granted by contract;

(G) Drug rebate appeals;

(H) Nursing home contracts which are terminated, denied, or non-renewed; and

(I) Proposed administrative sanction appeals pursuant to OAC 317:35-13-7. Proposed administrative sanction appeals will be heard directly by the ALJ. A decision will be rendered by the ALJ within 20 days of the hearing before the ALJ. This is the final and only appeals process for proposed administrative sanctions.

(d) Hearing, ALJ, and Burden of Proof.

(1) Hearings shall be conducted in an informal manner without formal rules of evidence or procedure.

(2) No party is required to be represented by an attorney. Recipients may represent themselves or be represented by another party. Corporate entities must authorize a representative to represent a corporation in a hearing.

(3) The OHCA Administrative Law Judge or designee may:

(A) Rule on any requests for extension of time;

(B) Hold pre hearing conferences to settle, simplify, or identify issues in a proceeding or to consider other matters that may end in the expeditious disposition of the proceeding;

(C) Require the parties to state their positions concerning the various issues in the proceeding;

(D) Require the parties to produce for examination those relevant witnesses and documents under their control;

(E) Rule on motions and other procedural items;

(F) Regulate the course of the hearing and conduct of the participants;

(G) Establish time limits for the submission of motions or memoranda;

(H) Impose appropriate sanctions against any person failing to obey an order of the ALJ or authorized under the rules in this Chapter which may include:

(i) Refusing to allow the person to assert or oppose designated claims or defenses, or prohibiting that person from introducing designated matters in evidence;

(ii) Excluding all testimony of an unresponsive or evasive witness; or

(iii) Expelling the person from further participation in the hearing;

(I) Take official notice of any material fact not appearing as evidence in the record, if the fact is among traditional matters of judicial notice;

(J) Administer oaths or affirmations;

(K) Determine the location of the hearing;

~~(L) Require the parties to be present and tape record the proceedings. In the event of the failure of a party to appear, the ALJ shall determine if good cause exists for the failure to appear. If good cause does not exist the ALJ may find in favor of the party who was present;~~

~~(M) Allow either party to request that the hearing be recorded by a court reporter with costs to be borne by the requesting party. The original of such transcription, if ordered, shall be given to the ALJ with a copy to be given to the requesting party;~~

~~(N) Recess and reconvene the hearing;~~

~~(O) Set and/or limit the time frame of the hearing;~~

~~(P) Reconsider or rehear a matter for good cause shown; and~~

~~(Q) Send a copy of the decision by the ALJ to both parties outlining their rights to appeal the decision. The decision letter need not contain findings of fact or conclusions of law.~~

(4) The burden of proof during the hearing shall be upon the appellant and the ALJ shall decide the case based upon a preponderance of evidence standard as defined by the Oklahoma Supreme Court.

(5) A copy of the decision will be forwarded to the docket clerk.

317:2-1-2.1. Provider appeals and jurisdictional grounds [REVOKED]

~~(a) The proceedings as described in this Section contain the hearing process for those appeals filed by providers. These appeals encompass all subject matter cases contained in OAC 317:2-1-2(b) except those referred to in OAC 317:2-1-2.3(1) (Surveillance, Utilization and Review System appeals) and 317:2-1-2.3(3) (decisions rendered by the Oklahoma Foundation for Medical Quality);~~

~~(b) All provider appeals are initially heard by the OHCA Administrative Law Judge under OAC 317:2-1-2(b);~~

~~(c) A decision shall be rendered by the ALJ within 45 days of the close of all evidence in the case.~~

~~(d) The Administrative Law Judge's decision is appealable to OHCA's CEO under OAC 317:2-1-4(1).~~

317:2-1-2.2. Recipient appeals [REVOKED]

~~(a) Hearings will be by a Program Panel, except in the case of tax warrant intercept appeals and proposed administrative sanction appeals (refer to OAC 317:35-13-7).~~

~~(1) The Program Panel will be composed of three or more members selected by the ALJ.~~

~~(2) The Program Panel may conduct a paper review of the complaint, or, at their option, hold a personal interview with the appellant to discuss the complaint. The Panel has the power to gather information it finds necessary from any available source, and thereafter, render a decision.~~

~~(3) The Panel must complete their paper review or conduct their formal personal interview and issue a majority decision within 25 days of the date stamped on the request for hearing.~~

Emergency Adoptions

(4) The Panel's decision shall be in writing and shall be signed by each of the Panel members. The decision shall contain a summary of the complaint and an explanation of the reasoning of the Panel in making their decision. A copy of the decision will be sent to the member outlining the right to appeal the decision. Any appeal of the Panel decision must be instituted within 15 days of the mailing of the adverse ruling, excepting recipient denials which are automatically appealed to the ALJ.

(5) A copy of the decision shall be forwarded to the docket clerk.

(b) Appeal from a decision of the Program Panel will be heard by the Administrative Law Judge. A decision will be rendered by the Administrative Law Judge within twenty (20) days of the appeal to the ALJ.

(c) Tax warrant intercept appeals will be heard directly by the ALJ. A decision will be rendered by the Administrative Law Judge within twenty (20) days of the hearing before the ALJ.

(d) Proposed administrative sanction appeals will be heard directly by the ALJ. A decision will be rendered by the ALJ within 20 days of the hearing before the ALJ. This is the final and only appeals process for proposed administrative sanctions.

317:2-1-2.3. Other grievance procedures and processes [REVOKED]

Other grievance procedures and processes include:

(1) Surveillance, Utilization and Review System (SURS) appeals to the Medical Advisory Committee (MAC).

(A) If a provider disagrees with a decision of the Surveillance, Utilization and Review System Unit (SURS) which has determined that the provider has received an overpayment, the provider may appeal, within twenty (20) days of the date of that decision, the decision to a six member subcommittee of the Medical Advisory Committee (MAC). The subcommittee shall be selected by the chairman of the MAC.

(B) The appeal from the SURS decision shall be commenced by the receipt of a letter from the appellant provider. The letter must set out with specificity, the overpayment decision to which the provider objects along with the grounds for appeal. The letter should explain in detail, the factual and/or legal basis for disagreement with the allegedly erroneous decision. The letter shall also include all relevant exhibits the provider believes necessary to decide the appeal.

(C) Upon the receipt of the appeal by the docket clerk, the matter shall be docketed for the next meeting of the MAC. Any appeal received less than four weeks before a scheduled MAC meeting will be set for the following MAC meeting.

(D) The appeal shall be forwarded to the SURS unit by the docket clerk for distribution to the members of the subcommittee and for preparation of the OHCA's case.

(E) At the discretion of the MAC, witnesses may be called and information may be solicited from any party by letter, telephonic communication, fax, or other means. The subcommittee may request that members of the Authority be present during their consideration of the appeal. Members of the Authority's Legal Division may be asked to answer legal questions regarding the appeal.

(F) The subcommittee shall issue a recommendation regarding the appeal, in writing, within 30 days of the hearing. An exception to the 30 day rule will apply in cases where the subcommittee sets the case over until its next scheduled meeting in order to gather additional evidence. The written recommendation shall list the members of the subcommittee who participated in the decision. In cases where an appeal must be continued, the subcommittee shall issue a letter within 30 days of the initial hearing to inform the appellant of the continuance.

(G) The recommendation, after being formalized, shall be sent to the docket clerk for review by the State Medicaid Director. The State Medicaid Director shall issue a decision regarding the appeal within 10 days of the docket clerk's receipt of the recommendation from the MAC. The decision shall be issued to the appellant or his/her authorized agent.

(H) If the provider is dissatisfied with the Medicaid Director's decision, it may be appealed to the CEO under OAC 317:2-1-4(1).

(2) This paragraph explains the appeal process to be accorded all nursing home providers whose contracts are terminated, denied or nonrenewed. No procedure is afforded a nursing facility whose contract is limited in any other fashion.

(A) If a nursing home provider's contract is terminated, nonrenewed or denied prior to the action's effective date the provider will be afforded an informal reconsideration in accordance with 42 C.F.R. 431.154.

(B) The notice of termination, nonrenewal or, denial of contract shall include the findings it was based upon. The letter will be sent by certified mail to the provider.

(C) The provider will have 20 days to respond to the notice. The response should outline the reasons why the Authority's decision to terminate, nonrenew, or deny the contract is wrong. The response by the provider must include a detailed position addressing the findings set out in the Authority's letter. The provider may request an extension of the 20 day limit if "good cause" exists that prevents the provider from refuting the findings in 20 days. A finding of "good cause" is in OHCA's discretion.

(D) Based upon the provider's response, the Authority shall affirm or deny the notice of nonrenewal, termination or denial.

(E) If the Oklahoma Health Care Authority affirms the notice of termination, nonrenewal, or denial or

the provider files no timely response, the effective date shall pass and upon affirmation of the notice the process described in OAC 317:2-1-2.1 and 317:2-1-2(b) & (c) shall apply.

(F) The hearing afforded the provider after the effective date shall satisfy the requirements of 42 C.F.R. 431.153.

(G) If the facility is a skilled nursing facility, the facility shall receive a notice as required by 42 C.F.R. 431.153(d)(1) and (d)(2).

(3) This subparagraph explains the administrative processes available to providers who have reviews completed by the Oklahoma Foundation for Medical Quality (OFMQ). The OFMQ conducts an administrative process for those providers it reviews. The process afforded providers by OFMQ is the only administrative remedy available to providers. The decision issued by the OFMQ is considered by the OHCA to be a final administrative determination. The final OFMQ determination is not appealable to the OHCA for any further administrative hearings. After OFMQ's decision, OHCA will recoup the monies paid the provider related to the review.

(4) The purpose of this subparagraph is to afford a process to both the manufacturer and the state to administratively resolve drug rebate discrepancies. These rules anticipate discrepancies between the manufacturer and OHCA which would require the manufacturer to pay a higher rebate or a lower rebate. These regulations provide a mechanism for both informal dispute resolution of drug rebate discrepancies between the manufacturer and OHCA and a mechanism for appeals of drug rebate discrepancies between the manufacturer and OHCA.

(A) The process begins at the end of each calendar quarter when the Authority shall mail a copy of the state's past quarter's utilization data to the manufacturer. Utilization data and a billing for rebates shall be mailed to the manufacturer within 60 days after the end of each quarter. It is this data which dictates the application of the federal drug rebate formula.

(B) Within 30 days from the date utilization data is sent to the manufacturer, the manufacturer may edit state data and resolve data inconsistencies with the state. The manufacturer may utilize telephone conferences, letters and any other mechanism to resolve data inconsistencies in mutual agreement with the state.

(C) Within 30 days after the utilization data is mailed to the manufacturer, the manufacturer may;

- (i) pay the same amount as billed by the state with the quarterly utilization data;
- (ii) pay an amount which differs from the amount billed by the state with the utilization data and send disputed data information;
- (iii) pay nothing and send no disputed data information;
- (iv) pay nothing and send disputed data information.

(D) In the event the state receives the rebate amount billed by the thirtieth day, the dispute ends.

(E) If after 30 days one of the following events occurs, the state shall acknowledge the receipt of the correspondence and review the disputed data;

- (i) the receipt of an amount lower than that billed to the manufacturer;
- (ii) the receipt of disputed data.

(F) In the event no disputed data is received and no payment is received, interest shall be computed in accordance with the provisions of federal law found at 42 U.S.C. Section 1396b (d)(5) and shall be compounded upon the amount billed from 38 days after the date utilization data is sent.

(G) In the event a lower amount than billed is paid or in the event disputed data is sent, and no money is received, interest shall be computed in accordance with 42 U.S.C. Section 1396b (d)(5) and shall be computed from 38 days from the date utilization data is sent to the manufacturer.

(H) Within 70 days from the date utilization data is sent to the manufacturer, the state shall make its final informal review of the disputed data. OHCA shall mail a second notice to the manufacturer which shall include:

- (i) receipt of the rebate, if any;
- (ii) receipt of the dispute;
- (iii) a statement regarding the interest amount; and
- (iv) a statement regarding the appeal rights of the manufacturer with a copy of the appeal form.

(I) Within 90 days of the date utilization data is sent to the manufacturer or within 20 days of the date a second notice is mailed to the manufacturer, whichever is sooner, the state or the manufacturer may request a hearing to administratively resolve the matter.

(J) The administrative appeal of drug rebate discrepancies includes:

- (i) The appeal process shall begin by the filing of a form LD 2 by the manufacturer or OHCA.
- (ii) The process afforded the parties shall be the process found at OAC 317:2-1-2.1. The process provided by OAC 317:2-1-2(b) and (c) shall also apply to these hearings.
- (iii) With respect to the computation of interest, interest shall continue to be computed from the 38 day based upon the policy contained in the informal dispute resolution rules above.
- (iv) The ALJ's decision shall constitute the final administrative decision of the Oklahoma Health Care Authority.

(v) If the decision of the ALJ affirms the decision of the Authority in whole or in part, payment from the manufacturer must be made within 30 days of the decision. If the decision of the ALJ reverses the decision of the Authority, the Authority shall make such credit or action within 30 days of the decision of the ALJ.

(vi) The nonpayment of the rebate by the manufacturer within 30 days after the ALJ's decision shall be reported to the Health Care Financing Administration and may be the basis of an exclusion action by OHCA.

(5) This subparagraph explains the appeal process, pursuant to 63 O.S. (Supp. 1999) §5030.3(B), accorded any party aggrieved by a decision of the OHCA Board or Administrator (CEO) concerning a proposed recommendation of the Medicaid Drug Utilization Review Board (DUR):

(A) The aggrieved party may appeal pursuant to OAC 317:2-1-2 et seq. (OHCA grievance rules).

(B) The Board finds that the prescription of Title 63 §5030.3(B) (Supp. 1999) is somewhat contradictory with the functions of the DUR Board. More specifically, in most instances, the DUR Board suggests policies that must be rulemade. Rules promulgated by the OHCA Board do not lend to an "individual proceeding notice" as contemplated by Article II of the Oklahoma Administrative Procedures Act, specifically, Title 75 §309. Thus, in instances where the OHCA Board promulgates rules as a result of policy recommendations by the DUR Board, this Board will consider a party aggrieved by these rules to have filed a Petition for Rulemaking under 75 §305. In making this interpretation of 63 §5030.1, the Board will not enforce the last sentence of 74 §305. In making this interpretation, the Board finds that it is taking two somewhat conflicting provisions, and combining them to effectuate the intent of the legislature—to provide a hearing to those aggrieved by recommendations by the DUR Board and accepted by the OHCA Board.

(C) In instances where the DUR Board makes a recommendation accepted by the Board against an individual provider [for example, a recommendation under 42 U.S.C. §1396r-8(g)(3)(c)(iii)(IV)], OHCA will provide an individual proceeding under the Oklahoma Administrative Procedures Act.

(D) In any appeal under subparagraphs (B) or (C) of this paragraph, the OHCA Board delegates the OHCA ALJ to preside over the above hearing and present the Board with proposed findings of fact and conclusions of law in accordance with Article II of the Administrative Procedures Act. The OHCA Board shall either accept the ALJ's written decision, reject it, or amend the recommendations.

(E) Appeals filed pursuant to subparagraphs (B) or (C) of this paragraph, shall be made within twenty (20) days of the OHCA Board's acceptance of the recommendation by the DUR Board.

(F) After Proposed Findings of Fact and Conclusions of Law are presented to the OHCA Board, the Board shall have a period of 120 days to issue a final administrative order.

(G) The Agency's legal division shall construct a form called the LD-3, which shall be used for parties

to file an action under subparagraphs (B) and (C) of this paragraph.

317:2-1-4. Appeal to the Chief Executive Officer [REVOKED]

Appeal to the Chief Executive Officer (CEO) of the Oklahoma Health Care Authority shall include:

(1) Within 20 days of decisions made pursuant to provider or SURS appeals found at this Chapter, either party may appeal a decision to the CEO of the Authority. Such appeal shall be commenced by a letter or fax received by the CEO within 20 days of the receipt of the prior decision made by the ALJ or Medicaid Director. The appeal shall concisely and fully explain the reasons for the request. No new evidence may be presented to the CEO. Evidence presented must be confined to the records below.

(2) Appeals to the CEO under recipient proceedings shall be commenced by a letter received no later than ten (10) days of the receipt of the decision by the ALJ. Should the appellant request a transcription to prosecute its appeal to the CEO, the appellant shall be required to execute a waiver relieving the OHCA from completing a hearing within 90 days.

(3) For provider and SURS proceedings the CEO shall have 45 days to render a written decision.

(4) For recipient proceedings, the CEO shall have five days to render a decision.

(5) The only appeal for proposed administrative sanctions is before the ALJ and the ALJ decision is not appealable to the CEO.

317:2-1-5. Hearing procedures

(a) Program Panel Hearings. Program Panel Hearings will be by a Program Panel, except in the case of tax warrant intercept appeals and proposed administrative sanction appeals [refer to OAC 317:2-1-2(c)].

(1) The Program Panel will be composed of three or more members selected by the ALJ.

(2) The Program Panel may conduct a paper review of the complaint, or, at their option, hold a personal interview with the appellant to discuss the complaint. The Panel has the power to gather information it finds necessary from any available source, and thereafter, render a decision.

(3) The Panel must complete their paper review or conduct their formal personal interview and issue a majority decision within 25 days of the date stamped on the request for hearing.

(4) The Panel's decision will be in writing and will be signed by each of the Panel members. The decision will contain a summary of the complaint and an explanation of the reasoning of the Panel in making their decision. A copy of the decision will be sent to the member outlining the right to appeal the decision. Any appeal of the Panel decision must be instituted within 20 days of the mailing of the adverse ruling.

(5) A copy of the decision will be forwarded to the docket clerk.

(6) Appeal from a decision of the Program Panel will be heard by the Administrative Law Judge. A decision will be rendered by the Administrative Law Judge within forty days of the appeal to the ALJ.

(b) Administrative Law Judge.

(1) Hearings will be conducted in an informal manner without formal rules of evidence or procedure.

(2) No party is required to be represented by an attorney. Recipients may represent themselves or authorize another party to represent them. A person or entity desiring to represent a recipient must provide documentation of the consent of the recipient to be represented by that person or entity. An appeal will be rejected without documentation of representation. Individuals appearing for corporate entities will be deemed to be authorized to represent the corporation in a hearing.

(3) The docket clerk will send the Appellant and any other necessary party notice which states the hearing location, date, and time.

(4) The OHCA Administrative Law Judge or designee may:

(A) Rule on any requests for extension of time;

(B) Hold pre-hearing conferences to settle, simplify, or identify issues in a proceeding or to consider other matters that may end in the expeditious disposition of the proceeding;

(C) Require the parties to state their positions concerning the various issues in the proceeding;

(D) Require the parties to produce for examination those relevant witnesses and documents under their control;

(E) Rule on motions and other procedural items;

(F) Regulate the course of the hearing and conduct of the participants;

(G) Establish time limits for the submission of motions or memoranda;

(H) Impose appropriate sanctions against any person failing to obey an order of the ALJ or authorized under the rules in this Chapter which may include:

(i) Refusing to allow the person to assert or oppose designated claims or defenses, or prohibiting that person from introducing designated matters in evidence;

(ii) Excluding all testimony of an unresponsive or evasive witness; or

(iii) Expelling the person from further participation in the hearing;

(I) Take official notice of any material fact not appearing as evidence in the record, if the fact is among traditional matters of judicial notice;

(J) Administer oaths or affirmations;

(K) Determine the location of the hearing;

(L) Allow either party to request that the hearing be recorded by a court reporter with costs to be borne by

the requesting party. The original of such transcription, if ordered, will be given to the ALJ with a copy to be given to the requesting party;

(M) Recess and reconvene the hearing;

(N) Set and/or limit the time frame of the hearing;

(O) Reconsider or rehear a matter for good cause shown; and

(P) Send a copy of the decision by the ALJ to both parties outlining their rights to appeal the decision. The decision letter need not contain findings of fact or conclusions of law.

(5) The burden of proof during the hearing will be upon the appellant and the ALJ will decide the case based upon a preponderance of evidence standard as defined by the Oklahoma Supreme Court. Parties who fail to appear at a hearing, after notification of said hearing date, will have their cases dismissed for failure to prosecute.

(6) Parties may file preliminary motions in the case. Any such motions must be filed within 15 calendar days prior to the hearing date. Response to preliminary motions must be made within 7 calendar days of the date the motion is filed with OHCA. Preliminary motions will be ruled upon 3 days prior to the hearing date.

(7) In any case in which a recipient requests a continuance, OHCA will not be prejudiced to complete the case within 90 days.

317:2-1-6. Other grievance procedures and processes

Other grievance procedures and processes include those set out in OAC 317:2-1-7 [Surveillance, Utilization and Review System (SURS) and Program Integrity Audits/Reviews Appeals]; OAC 317:2-1-8 (Nursing Home Provider Contract Appeals); OAC 317:2-1-9 [Oklahoma Foundation for Medical Quality (OMFQ) Appeals Process]; OAC 317:2-1-10 (Drug Rebate Appeal Process); OAC 317:2-1-11 [Medicaid Drug Utilization Review Board (DUR) Appeal Process]; and OAC 317:2-1-12 (For Cause Provider Contract Suspension/Termination Appeals Process).

317:2-1-7. Surveillance, Utilization and Review System (SURS) and Program Integrity Audits/Reviews appeals

SURS and Program Integrity Audits/Reviews appeals are made to the State Medicaid Director.

(1) If a provider disagrees with a decision of the Surveillance, Utilization and Review System Unit (SURS) or Program Integrity Audit/Review which has determined that the provider has received an overpayment, the provider may appeal, within 20 days of the date of that decision to the State Medicaid Director.

(2) The appeal from the SURS or Program Integrity Audit/Review decision will be commenced by the receipt of a letter from the appellant provider. The letter must set out with specificity, the overpayment decision to which the provider objects along with the grounds for appeal. The letter should explain in detail, the factual and/or legal

Emergency Adoptions

basis for disagreement with the allegedly erroneous decision. The letter will also include all relevant exhibits the provider believes necessary to decide the appeal.

(3) Upon the receipt of the appeal by the docket clerk, the matter will be docketed for the next meeting of the MAC. Any appeal received less than four weeks before a scheduled MAC meeting will be set for the following MAC meeting.

(4) The appeal will be forwarded to the SURS unit or Program Integrity Audit/Review unit by the docket clerk for distribution to the members of the subcommittee and for preparation of the OHCA's case. A subcommittee of the MAC will be formed and render a recommendation to the State Medicaid Director.

(5) At the discretion of the MAC, witnesses may be called and information may be solicited from any party by letter, telephonic communication, fax, or other means. The subcommittee may request that members of the Authority be present during their consideration of the appeal. Members of the Authority's Legal Division may be asked to answer legal questions regarding the appeal.

(6) The subcommittee will issue a recommendation regarding the appeal, in writing, within 30 days of the hearing. An exception to the 30 day rule will apply in cases where the subcommittee sets the case over until its next scheduled meeting in order to gather additional evidence. The written recommendation will list the members of the subcommittee who participated in the decision. In cases where an appeal must be continued, the subcommittee will issue a letter within 30 days of the initial hearing to inform the appellant of the continuance.

(7) The recommendation, after being formalized, will be sent to the docket clerk for review by the State Medicaid Director. The State Medicaid Director will issue a decision regarding the appeal within 60 days of the docket clerk's receipt of the recommendation from the MAC. The decision will be issued to the appellant or his/her authorized agent.

(8) If the provider is dissatisfied with the Medicaid Director's decision, it may be appealed to the CEO under OAC 317:2-1-13.

317:2-1-8. Nursing home provider contract appeals

This Section explains the appeal process to be accorded all nursing home providers whose contracts are terminated, denied or non-renewed. No procedure is afforded a nursing facility whose contract is limited in any other fashion.

(1) If a nursing home provider's contract is terminated, non-renewed or denied prior to the action's effective date, the provider will be afforded an informal reconsideration in accordance with 42 C.F.R. 431.154.

(2) The notice of termination, non-renewal or, denial of contract will include the findings it was based upon. The letter will be sent by certified mail to the provider.

(3) The provider will have 20 days to respond to the notice. The response should outline the reasons why the Authority's decision to terminate, non-renew, or deny the

contract is wrong. The response by the provider must include a detailed position addressing the findings set out in the Authority's letter. The provider may request an extension of the 20 day limit if "good cause" exists that prevents the provider from refuting the findings in 20 days. A finding of "good cause" is in OHCA's discretion.

(4) Based upon the provider's response, the Authority will affirm or deny the notice of non-renewal, termination or denial.

(5) If the Oklahoma Health Care Authority affirms the notice of termination, non-renewal, or denial or the provider files no timely response, the effective date will pass and upon affirmation of the notice, the process described in OAC 317:2-1-2(b), 317:2-1-2(c)(2) and 317:2-1-5(b) will apply.

(6) The hearing afforded the provider after the effective date will satisfy the requirements of 42 C.F.R. 431.153.

(7) If the facility is a skilled nursing facility, the facility will receive a notice as required by 42 C.F.R. 431.153(d)(1) and (2).

317:2-1-9. Oklahoma Foundation for Medical Quality (OFMQ) appeals process

This Section explains the administrative processes available to providers who have reviews completed by the Oklahoma Foundation for Medical Quality (OFMQ). The OFMQ conducts an administrative process for those providers it reviews. The process afforded providers by OFMQ is the only administrative remedy available to providers. The decision issued by the OFMQ is considered by the OHCA to be a final administrative determination. The final OFMQ determination is not appealable to the OHCA for any further administrative hearings. After OFMQ's decision, OHCA will recoup the monies paid the provider related to the review.

317:2-1-10. Drug Rebate appeal process

The purpose of this Section is to afford a process to both the manufacturer and the state to administratively resolve drug rebate discrepancies. These rules anticipate discrepancies between the manufacturer and OHCA which would require the manufacturer to pay a higher rebate or a lower rebate. These regulations provide a mechanism for both informal dispute resolution of drug rebate discrepancies between the manufacturer and OHCA and a mechanism for appeals of drug rebate discrepancies between the manufacturer and OHCA.

(1) The process begins at the end of each calendar quarter when the Authority will mail a copy of the State's past quarter's utilization data to the manufacturer. Utilization data and a billing for rebates will be mailed to the manufacturer within 60 days after the end of each quarter. It is this data which dictates the application of the federal drug rebate formula.

(2) Within 30 days from the date utilization data is sent to the manufacturer, the manufacturer may edit state data and resolve data inconsistencies with the state. The manufacturer may utilize telephone conferences, letters and any

other mechanism to resolve data inconsistencies in mutual agreement with the state.

(3) Within 30 days after the utilization data is mailed to the manufacturer, the manufacturer may:

(A) pay the same amount as billed by the state with the quarterly utilization date;

(B) pay an amount which differs from the amount billed by the state with the utilization data and send disputed data information;

(C) pay nothing and send no disputed data information;

(D) pay nothing and send disputed data information.

(4) In the event the state receives the rebate amount billed by the 30th day, the dispute ends.

(5) If after 30 days one of the following events occurs, the state will acknowledge the receipt of the correspondence and review the disputed data:

(A) the receipt of an amount lower than that billed to the manufacturer;

(B) the receipt of disputed data.

(6) In the event no disputed data is received and no payment is received, interest will be computed in accordance with the provisions of federal law found at 42 U.S.C. Section 1396b(d)(5) and will be compounded upon the amount billed from 38 days after the date utilization data is sent.

(7) In the event a lower amount than billed is paid or in the event disputed data is sent, and no money is received, interest will be computed in accordance with 42 U.S.C. Section 1396(d)(5) and will be computed from 38 days from the date utilization data is sent to the manufacturer.

(8) Within 70 days from the date utilization data is sent to the manufacturer, the state will make its final informal review of the disputed data. OHCA will mail a second notice to the manufacturer which will include:

(A) receipt of the rebate, if any;

(B) receipt of the dispute;

(C) a statement regarding the interest amount; and

(D) a statement regarding the appeal rights of the manufacturer with a copy of the appeal form.

(9) Within 90 days of the date utilization data is sent to the manufacturer or within 20 days of the date a second notice is mailed to the manufacturer, whichever is sooner, the state or the manufacturer may request a hearing to administratively resolve the matter.

(10) The administrative appeal of drug rebate discrepancies includes:

(A) The appeal process will begin by the filing of a form LD-2 by the manufacturer or OHCA.

(B) The process afforded the parties will be the process found at OAC 317:2-1-5(b). The process provided by OAC 317:2-1-2(b) and (c) will also apply to these hearings.

(C) With respect to the computation of interest, interest will continue to be computed from the 38 day based upon the policy contained in the informal dispute resolution rules above.

(D) The ALJ's decision will constitute the final administrative decision of the OHCA.

(E) If the decision of the ALJ affirms the decision of OHCA in whole or in part, payment from the manufacturer must be made within 30 days of the decision. If the decision of the ALJ reverses the decision of the OHCA, the OHCA will make such credit or action within 30 days of the decision of the ALJ.

(F) The nonpayment of the rebate by the manufacturer within 30 days after the ALJ's decision will be reported to the Centers for Medicare and Medicaid Services and may be the basis of an exclusion action by the OHCA.

317:2-1-11. Medicaid Drug Utilization Review Board (DUR) appeal process

This Section explains the appeal process, pursuant to 63 O.S. §5030.3(8) (Supp. 1999), accorded any part aggrieved by a decision of the OHCA Board or Administrator (CEO) concerning a proposed recommendation of the Medicaid Drug Utilization Review Board (DUR).

(1) The aggrieved party may appeal pursuant to OAC 317:2-1-2 et seq. OHCA Appeals).

(2) The Board finds that the prescription of Title 63 O.S. § 5030.3(B) is somewhat contradictory with the functions of the DUR Board. More specifically, in most instances, the DUR Board suggests policies that must be rule made. Rules promulgated by the OHCA Board do not lend to an "individual proceeding notice" as contemplated by Article II of the Oklahoma Administrative Procedures Act, specifically, Title 75 O.S. §309. Thus, in instances where the OHCA Board promulgates rules as a result of policy recommendations by the DUR Board, this Board will consider a party aggrieved by these rules to have filed a Petition for Rulemaking under 75 O.S. §305. In making this interpretation of 63 O.S. §5030.1, the Board will not enforce the last sentence of 74 O.S. §305. In making this interpretation, the Board finds that it is taking two somewhat conflicting provisions, and combining them to effectuate the intent of the legislature - to provide a hearing to those aggrieved by recommendations by the DUR Board and accepted by the OHCA Board.

(3) In instances where the DUR Board makes a recommendation accepted by the Board against an individual provider [for example, a recommendation under 42 U.S.C. §1396a8(g)(3)(c)(iii)(IV)], OHCA will provide an individual proceeding under the Oklahoma Administrative Procedures Act.

(4) In any appeal under (1) and (2) of this subsection, the OHCA Board delegates the OHCA ALJ to preside over the above hearing and present the Board with proposed findings of fact and conclusions of law in accordance with Article II of the Administrative Procedures Act. The OHCA Board may accept the ALJ's written decision, reject it, or amend the recommendations.

(5) Appeals filed pursuant to (1) and (2) of this subsection, will be made within 20 days of the OHCA Board's acceptance of the recommendation by the DUR Board.

Emergency Adoptions

(6) After Proposed Findings of Fact and Conclusions of Law are presented to the OHCA Board, the Board will have a period of 120 days to issue a final administrative order.

(7) The Agency's Legal Services Division will construct a form called the LD-3, which will be used for parties to file an action under (1) and (2) of this subsection.

317:2-1-12. For Cause provider contract suspension/termination appeals process

This Section explains the appeals process for providers whose Medicaid contracts have been suspended/terminated by the OHCA for cause. Those providers whose contracts have been affected by other OHCA actions cannot request an appeal of those measures.

(1) Procedure for suspending/terminating provider's contract.

(A) Notice of proposed suspension or termination. The OHCA will provide notice to the medical services provider of the proposed suspension or termination of provider contract. The written notice of suspension/termination will state:

- (i) the reasons for the proposed suspension/termination;
- (ii) the date upon which the suspension/termination will be effective; and
- (iii) a statement that the medical services provider has a right to review prior to the suspension/termination of the provider's contract (refer to subparagraph (B) of this paragraph).

(B) Right to review prior to suspension/termination of provider contract. Before the medical services provider's contract is suspended or terminated, the OHCA will give the medical services provider the opportunity to submit documents and written arguments against the suspension/termination of the provider's contract.

(C) Notice of Suspension or Termination.

(i) After the review of the medical services provider's written response, the OHCA will make a final administrative decision subject to a post-suspension or termination hearing.

(ii) After the review of the medical services provider's written response, the OHCA will make a final administrative decision subject to a post-sanction hearing. Should the OHCA decide not to suspend or terminate the provider's contract, the medical services provider will be notified of the reasons for the decision.

(iii) Should the OHCA make a decision to suspend or terminate the medical services provider's contract, the OHCA will send a notice stating:

- (I) the reasons for the decision;
- (II) the effective date of the suspension or termination of the contract;
- (III) the medical services provider's right to request a post-suspension or termination hearing;

(IV) the earliest date in which the agency will accept a request for reinstatement; and

(V) the requirements and procedures for reinstatement.

(2) **Post-suspension/termination hearing.** After the effective date of the suspension or termination of the provider's contract, the medical services provider is entitled to receive a post-suspension or termination hearing. The hearing committee for the OHCA will be comprised of three members of the OHCA and two other members as appointed. The representative who investigated the case will not be a representative if an investigation was initiated or completed.

(A) After the provider's request for the post-suspension/termination hearing is made, a hearing date will be established. A certified letter will be sent to the provider giving notification of the hearing date and naming the contact person. The contact person will answer procedural questions about the hearing.

(B) Ten days prior to the hearing, the medical services provider will submit a brief written statement detailing the evidence which will be presented by the provider at the hearing. Such statement must detail the facts which will be refuted by the provider. The purpose of the hearing will be limited to issues raised in the letter of suspension or termination as the cause of suspending or terminating the provider contract.

(C) The provider may be represented by an authorized representative, with documentation to that effect, at the informal hearing and/or the provider may present testimony himself or herself and have witnesses present.

(D) At the conclusion of the hearing, a decision will be made by the Hearing Committee. The provider will be notified in writing of the decision within 20 days of the final day of the hearing. The decision letter will constitute the agency's final decision regarding the matter.

317:2-1-13. Appeal to the Chief Executive Officer

An appeal to the Chief Executive Officer (CEO) of the Oklahoma Health Care Authority includes:

(1) Within 20 days of decisions made pursuant to provider or SURS/Program Integrity Audits/Reviews appeals found at this Chapter, either party may appeal a decision to the CEO of the Authority. Such appeal will be commenced by a letter or fax received by the CEO within 20 days of the receipt of the prior decision made by the ALJ or Medicaid Director. The appeal will concisely and fully explain the reasons for the request. No new evidence may be presented to the CEO. Evidence presented must be confined to the records below.

(2) Appeals to the CEO under recipient proceedings will be commenced by a letter received no later than 10 days of the receipt of the decision by the ALJ. Should the appellant request a transcription to prosecute its appeal to the CEO, the appellant will be required to execute a waiver

relieving the OHCA from completing its fair process hearing within 90 days.

(3) For provider and SURS/Program Integrity Audits/Reviews proceedings, the CEO will have 90 days from receipt of the appeal to render a written decision.

(4) For recipient proceedings, the CEO will have 30 days from receipt of the appeal to render a written decision.

(5) The only appeal for proposed administrative sanctions is before the ALJ and the ALJ decision is not appealable to the CEO.

[OAR Docket #06-298; filed 3-15-06]

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

[OAR Docket #06-297]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

- Subchapter 3. General Provider Policies
 - Part 1. General Scope and Administration
317:30-3-19. through 317:30-3-21. [AMENDED]
 - Subchapter 5. Individual Providers and Specialties
 - Part 1. Physicians
317:30-5-25. [AMENDED]
 - Part 3. Hospitals
317:30-5-41. [AMENDED]
 - Part 4. Long Term Care Hospitals
317:30-5-62. [AMENDED]
 - Part 6. Inpatient Psychiatric Hospitals
317:30-5-95.2. [AMENDED]
 - Part 9. Long Term Care Facilities
317:30-5-123. through 317:30-5-124. [AMENDED]
 - 317:30-5-131.1 through 317:30-5-131.2. [AMENDED]
 - Part 21. Outpatient Behavioral Health Services
317:30-5-241. [AMENDED]
 - Part 32. Soonerride Non-Emergency Transportation
317:30-5-327. [AMENDED]
 - Part 65. Management Services for Over 21
317:30-5-586.1. [AMENDED]
 - Part 67. Behavioral Health Case Management Services for Individuals Under 21 Years of Age
317:30-5-596.1. [AMENDED]
 - Part 83. Residential Behavior Management Services in Foster Care Settings
317:30-5-746. [AMENDED]
- (Reference APA WF # 05-24A)

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:

January 12, 2006

Approved by Governor:

March 9, 2006

Effective:

Immediately upon Governor's approval or March 1, 2006 whichever is later

Expiration:

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

SUPERSEDED EMERGENCY ACTIONS:

Superseded rules:

317:30-5-41. [AMENDED]

(Reference APA WF # 05-15)

Gubernatorial approval:

October 3, 2005

Register publication:

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Docket number:

05-1310

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 insure compliance with federal regulations, thereby avoiding any potential economic impact caused by noncompliance with federal regulations and rule inconsistencies.

ANALYSIS:

Agency appeal rules are being revised to accurately reflect the agency which will hear various employer and employee eligibility appeals for the Oklahoma Employer and Employee Partnership for Insurance Coverage (O-EPIC) Program. Rules regarding the various appeal processes are relocated to individual sections to help clarify the correct procedures to be followed. In addition, rules are amended to correct various rule citations. Revisions are needed to provide appeal guidelines for the O-EPIC program and clarify appeal procedures.

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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 MARCH 1, 2006, WHICHEVER IS LATER:

**SUBCHAPTER 3. GENERAL PROVIDER
POLICIES**

**PART 1. GENERAL SCOPE AND
ADMINISTRATION**

317:30-3-19. Administrative sanctions

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

- (1) **"Abuse"** means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also recognizes recipient practices that result in unnecessary cost to the Medicaid program.
- (2) **"Conviction" or "Convicted"** means a judgment of conviction has been entered by a Federal, State, or local court, regardless of whether an appeal from that judgment is pending.
- (3) **"Exclusion"** means items or services which will not be reimbursed under Medicaid because they were furnished by a specific provider who has defrauded or abused the Medicaid program.

Emergency Adoptions

- (4) **"Fraud"** means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.
- (5) **"Knowingly"** means that a person, with respect to information:
- (A) has actual knowledge of the information;
 - (B) acts in deliberate ignorance of the truth or falsity of the information; or
 - (C) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.
- (6) **"Medical Services Providers"** means:
- (A) **"Practitioner"** means a physician or other individual licensed under State law to practice his or her profession or a physician who meets all requirements for employment by the Federal Government as a physician and is employed by the Federal Government in an IHS facility or affiliated with a 638 Tribal facility.
 - (B) **"Supplier"** means an individual or entity, other than a provider or practitioner, who furnishes health care services under Medicaid or other medical services programs administered by the Oklahoma Health Care Authority.
 - (C) **"Provider"** means:
 - (i) A hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, or a hospice that has in effect an agreement to participate in Medicaid, or any other medical services program administered by the Oklahoma Health Care Authority, or
 - (ii) a clinic, a rehabilitation agency, or a public health agency that has a similar agreement.
 - (D) **"Laboratories"** means any laboratory or place equipped for experimental study in science or for testing or analysis which has an agreement with the Oklahoma Health Care Authority to receive Medicaid monies.
 - (E) **"Pharmacy"** means any pharmacy or place where medicines are compounded or dispensed or any pharmacist who has an agreement with OHCA to receive Medicaid monies for the dispensing of drugs.
 - (F) **"Any other provider"** means any provider who has an agreement with OHCA to deliver health services, medicines, or medical services for the receipt of Medicaid monies.
- (7) **"OIG"** means Office of Inspector General of the Department of Health and Human Services.
- (8) **"Sanctions"** means any administrative decision by OHCA to suspend or exclude a medical service provider(s) from the Medicaid program or any other medical services program administered by the Oklahoma Health Care Authority.
- (9) **"Suspension"** means items or services furnished by a specified provider will not be reimbursed under the Medicaid program.
- (10) **"Willfully"** means proceeding from a conscious motion of the will; voluntary, intending the result which comes to pass; intentional.
- (b) **Basis for sanctions.**
- (1) The Oklahoma Health Care Authority may sanction a medical provider who has an agreement with OHCA for the following reasons:
- (A) Knowingly or willfully made or caused to be made any false statement or misrepresentation of material fact in claiming, or use in determining the right to, payment under Medicaid; or
 - (B) Furnished or ordered services under Medicaid that are substantially in excess of the recipient's needs or that fail to meet professionally recognized standards for health care; or
 - (C) Submitted or caused to be submitted to the Medicaid program bills or requests for payment containing charges or costs that are substantially in excess of customary charges or costs. However, the agency must not impose an exclusion under this section if it finds the excess charges are justified by unusual circumstances or medical complications requiring additional time, effort, or expense in localities in which it is accepted medical practice to make an extra charge in such case.
- (2) The agency may base its determination that services were excessive or of unacceptable quality on reports, including sanction reports, from any of the following sources:
- (A) The PRO for the area served by the provider or the PRO contracted by OHCA;
 - (B) State or local licensing or certification authorities;
 - (C) Peer review committees of fiscal agents or contractors;
 - (D) State or local professional societies;
 - (E) Surveillance and Utilization Review Section Reports done by OHCA; or
 - (F) Other sources deemed appropriate by the Medicaid agency or the OIG.
- (3) OHCA must suspend from the Medicaid program any medical services provider who has been suspended from participation in Medicare or Medicaid due to a conviction of a program related crime. This suspension must be at a minimum the same period as the Medicare suspension.
- (4) OHCA must also suspend any convicted medical services provider who is not eligible to participate in Medicare or Medicaid whenever the OIG directs such action. Such suspension must be, at a minimum, the same period as the suspension by the OIG.
- (c) **Procedure for imposing sanctions.** The procedure for imposing a sanction under this section and the due process accorded in this section is provided at OAC 317:2-1-5.
- (1) **Notice of proposed administrative sanction.**
- (A) ~~If the Oklahoma Health Care Authority proposes to sanction, it will send the medical services provider a written notice stating:~~

- (i) the reasons for the proposed sanction;
 - (ii) the date upon which the sanction will be effective;
 - (iii) the result of the sanction should it be imposed; and
 - (iv) a statement that the medical services provider has a right to review (See (2) of this subsection) prior to the imposition of the sanction.
- (B) A copy of this section of the rules will be attached to the letter of proposed action.
- (2) **Right to review prior to the imposition of the sanction.** Before imposing the sanction, the agency will give the medical services provider the opportunity to submit documents and written arguments against the exclusion.
- (3) **Notice of sanction.**
- (A) After the review of the medical services provider's written response, the agency will make a final administrative decision subject to a post sanction hearing. Should OHCA make a decision to sanction the medical services provider, it shall send a notice which must state:
- (i) the reasons for the decision;
 - (ii) the effective date of the sanction;
 - (iii) the effect of the sanction on the party's participation in the Medicaid program;
 - (iv) the medical services party's right to request a post-sanction hearing;
 - (v) the earliest date in which the agency will accept a request for reinstatement; and
 - (vi) the requirements and procedures for reinstatement.
- (B) After the review of the medical services provider's written response, the agency will make a final administrative decision subject to a post sanction hearing. Should OHCA decide not to impose a sanction, the medical services provider will be notified of the reasons for the decision.
- (d) **Effect of sanction.**
- (1) OHCA must not make payment under its plan for services furnished directly by a suspended or excluded party during the period of suspension or exclusion.
- (2) Any decision to allow payment for up to thirty (30) days is in the total discretion of the Oklahoma Health Care Authority. Payment is available for up to 30 days after the effective date of the suspension for:
- (A) Inpatient hospital services (including inpatient psychiatric hospital services) and skilled nursing facility and intermediate care facility services furnished to a beneficiary who was admitted before the effective date of the suspension; and
- (B) Home health services and hospital care furnished under a plan established before the effective date of the suspension.
- (e) **Post-sanction hearing.** After the effective date of the sanction, the medical services provider is entitled to receive a post-sanction hearing. The hearing committee for OHCA will be comprised of three members of the Authority and two other

members as appointed. The representative who investigated the case shall not be a representative if an investigation was initiated or completed.

- (1) After request is made for the post exclusion hearing, a hearing date shall be established. A certified letter will be sent to the provider giving notification of the hearing date and naming the contact person. The contact person will answer procedural questions about the hearing. Ten (10) days prior to the hearing the medical services provider shall submit a brief written statement detailing the evidence which will be presented by the provider at the hearing. Such statement must detail the facts which will be refuted by the provider. The provider may be represented at the informal hearing and the provider may also present testimony himself or herself and have witnesses present.
- (2) At the conclusion of the hearing, a decision will be made by the Hearing Committee. The provider will be notified in writing of the decision within 20 days of the final day of the hearing. The decision letter shall constitute the agency's final decision regarding the matter.
- (f) **Criteria for reinstatement.**
- (1) Upon the request for reinstatement made by the medical services provider, OHCA may consider the following factors to reinstate the provider:
- (A) The number and nature of the program violations and other related offenses;
 - (B) The nature and extent of any adverse impact the violations have had on recipients;
 - (C) The amount of any damages;
 - (D) Whether there are any mitigating circumstances;
 - (E) Other facts bearing on the nature and seriousness of the program violations and related offenses;
 - (F) Whether the party has been convicted in a federal, state, or local court of other offenses related to participation in the Medicare or Medicaid program which were not considered during the development of the exclusion; and
 - (G) Whether the state or local licensing authorities have taken any adverse action against the party for offenses related to participation in the Medicare or Medicaid program which were not considered during the development of the exclusion.
- (2) Regardless of the applicability of one or many of the factors in (1) of this subsection, reinstatement shall not be granted unless it is reasonably certain that the violation(s) that led to the exclusion will not be repeated.

317:30-3-20. Appeals procedures (excluding nursing homes and hospitals)

OHCA has established administrative procedures whereby a medical provider may appeal request a review of the decision of the amount paid or the non-payment of medical services provided an eligible recipient. The appeal process is also available to providers who have received notice of sanction from OHCA.

- (1) If the medical provider does not agree with the original payment from the Fiscal Agent, he/she may submit

Emergency Adoptions

a written explanation as to why the adjustment is being requested and what action is to be taken, a copy of the paid remittance statement and/or detailed explanation of the paid information and a copy of the original claim with the corrections to be made for consideration of additional payment. The claim should be filed in accordance with the instructions in the OAC 317:30-7 for the type of medical provider involved.

~~(2) If, after full adjudication of the claim, the medical provider is not satisfied with the payment or disagrees with the denial of payment from the Fiscal Agent, he/she may file an appeal with OHCA pursuant to OAC 317:2-1.~~

317:30-3-21. Appeals procedures for nursing facilities

~~If a nursing facility disagrees with the amount allowed for nursing care for an eligible individual, the nursing facility may appeal in the same manner as described for other medical providers see OAC 317:2-1 for grievance procedures and process).~~—Appeal procedures for denial, failure to renew, or termination of a nursing facility agreement are described at ~~OAC 317:2-1 2.3(2) 317:2-1-8.~~ The Health Oklahoma State Department of Health, by agreement, continues to be responsible for hearings for licensure and certification as the survey agency.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 1. PHYSICIANS

317:30-5-25. Oklahoma Foundation for Medical Quality

All inpatient services are subject to post-payment utilization review by the Oklahoma Foundation for Medical Quality (OFMQ). These reviews will be based on severity of illness and intensity of treatment.

(1) 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 OFMQ upon their initial review determines the admission should be denied, a notice is issued to the facility and the attending physician advising them of the decision. This notice also advises that a reconsideration request may be submitted in accordance with the Medicare time frame. Additional information submitted with the reconsideration request will be reviewed by the OFMQ 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.

(2) If the hospital or attending physician did not request reconsideration by the OFMQ, the OFMQ informs OHCA 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 informing of recoupment of Medicaid payment previously made on the denied admission.

(3) If an OFMQ review results in denial and the denial is upheld throughout the ~~appeal review~~ process and refund from the hospital and physician is required, the Medicaid recipient cannot be billed for the denied services.

(4) If a hospital or physician believes 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 the patient can be billed.

PART 3. HOSPITALS

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 1st 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)~~ (C) 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 review process and refund from the hospital and physician is required, the Medicaid recipient cannot be billed for the denied services.

(~~E~~D) 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~~E) 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

Emergency Adoptions

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.

(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

Emergency Adoptions

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.

PART 4. LONG TERM CARE HOSPITALS

317:30-5-62. Coverage by category

- (a) **Adults.** There is no coverage for adults.
- (b) **Children.** Payment is made to long term care hospitals for subacute medical and rehabilitative 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.
- (1) **Inpatient services.**
- (A) 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 of the Oklahoma Health Care Authority 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 Title XIX 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 Title XIX payment previously made on the denied admission.

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

(B) If a hospital or physician believes that a long term care facility admission or continued stay is not medically necessary and thus not Medicaid compensable but the patient insists on treatment, the patient must 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.

(2) **Utilization control requirements.**

(A) **Certification and recertification of need for inpatient care.** The certification and recertification of need for inpatient care must be in writing and must be signed and dated by the physician who has knowledge of the case that continued inpatient care is required. The certification and recertification documents for all Medicaid patients must be maintained in the patient's medical records or in a central file at the facility where the patient is or was a resident.

(i) **Certification.** A physician must certify for each applicant or recipient that inpatient services in a long term care hospital were needed. The certification must be made at the time of admission or, if an individual applies for assistance while in a hospital, before the Medicaid agency authorizes payment.

(ii) **Recertification.** A physician must recertify for each applicant or recipient that inpatient services in the long term care hospital are needed. Recertification must be made at least every 60 days after certification.

(B) **Individual written plan of care.**

(i) Before admission to a long term care hospital, an interdisciplinary team including the attending physician or staff physician must establish a written plan of care for each applicant or recipient. The plan of care must include:

- (I) Diagnoses, symptoms, complaints, and complications indicating the need for admission,
- (II) the acuity level of the individual,

- (III) Objectives,
- (IV) Any order for medication, treatments, restorative and rehabilitative services, activities, therapies, social services, diet and special procedures recommended for the health and safety of the patient,
- (V) Plans for continuing care, including review and modification to the plan of care, and
- (VI) Plans for discharge.
- (ii) The attending or staff physician and other personnel involved in the recipient's care must review each plan of care at least every 90 days.
- (iii) All plans of care and plan of care reviews must be clearly identified as such in the patient's medical records. All must be signed and dated by the physician and other treatment team members in the required review interval.
- (iv) The plan of care must document appropriate patient and/or family participation in the development and implementation of the treatment plan.
- (C) **Continued stay review.** The facility must complete a continued stay review at least every 90 days.
 - (i) The methods and criteria for the continued stay review must be contained in the facility utilization review plan.
 - (ii) Documentation of the continued stay review must be clearly identified as such, signed and dated by the committee chairperson, and must clearly state the continued stay dates and time period approved.

PART 6. INPATIENT PSYCHIATRIC HOSPITALS

317:30-5-95.2. Coverage for children

The following apply to coverage for inpatient services for persons under age 21 in acute care hospitals, freestanding psychiatric hospitals and residential psychiatric treatment facilities:

- (1) **Pre-authorization of inpatient psychiatric services.** All inpatient psychiatric services for patients under 21 years of age must be prior authorized by an agent designated by the Oklahoma Health Care Authority. All inpatient acute and residential psychiatric services will be prior authorized for an approved length of stay. Non-authorized inpatient psychiatric services will not be Medicaid compensable.
 - (A) **Length of stay.** The designated agent will prior authorize all services for an approved length of stay based on the medical necessity criteria described in (2)(A)-(G) of this subsection.
 - (B) **Facility placements.** Out of state placements must be approved by the agent Designated by OHCA and subsequently approved by OHCA Medicaid/Medical Services Division. Requests for admission to Residential Treatment Centers or Acute

Care Units will be reviewed for consideration of level of care, availability, suitability and proximity of suitable services. A prime consideration for placements will be proximity to the family or guardian in order to involve the family or guardian in Active Treatment, including discharge and reintegration planning. Out of state facilities are responsible for insuring appropriate medical care as needed under Oklahoma Medicaid provisions as part of the per-diem rate.

- (2) **Inpatient services.**
 - (A) **Inpatient service limitations.** Inpatient psychiatric services in all hospitals and residential psychiatric treatment facilities are limited to the approved length of stay. The Agent designated by OHCA will approve lengths of stay using the current OHCA Behavioral Health medical necessity criteria and following the current gatekeeping manual approved by the OHCA. The approved length of stay applies to both hospital and physician services.
 - (B) **Medical necessity criteria for acute psychiatric admissions.** Acute psychiatric admissions for children 13 or older must meet the terms and conditions contained in (i),(ii),(iii) and two of the (iv)(I) to (v)(III) of this subparagraph. Children 12 or younger must meet the terms or conditions contained in (i),(ii),(iii) and one of (iv)(I) to (iv)(IV), and one of (v)(I) to (v)(III) of this subparagraph.
 - (i) Any DSM-IV-R Axis I primary diagnosis with the exception of V-codes, adjustment disorders, and substance related disorders, accompanied by a detailed description of the symptoms supporting the diagnosis. In lieu of a qualifying Axis I diagnosis, children 18-21 years of age may have an Axis II diagnosis of any personality disorder.
 - (ii) Conditions are directly attributable to a mental disorder as the primary need for professional attention (this does not include placement issues, criminal behavior, status offenses). Adjustment or substance related disorder may be a secondary Axis I diagnosis.
 - (iii) It has been determined by the Gatekeeper that the current disabling symptoms could not have been managed or have not been manageable in a lesser intensive treatment program.
 - (iv) Within the past 48 hours the behaviors present an imminent life threatening emergency such as evidenced by:
 - (I) Specifically described suicide attempts, suicide intent, or serious threat by the patient.
 - (II) Specifically described patterns of escalating incidents of self-mutilating behaviors.
 - (III) Specifically described episodes of unprovoked significant physical aggression and patterns of escalating physical aggression in intensity and duration.

Emergency Adoptions

- (IV) Specifically described episodes of incapacitating depression or psychosis that result in an inability to function or care for basic needs.
 - (v) Requires secure 24-hour nursing/medical supervision as evidenced by:
 - (I) Stabilization of acute psychiatric symptoms.
 - (II) Needs extensive treatment under physician direction.
 - (III) Physiological evidence or expectation of withdrawal symptoms which require 24-hour medical supervision.
- (C) Medical necessity criteria for continued stay - acute psychiatric admission.** Continued stay - acute psychiatric admissions must meet all of the conditions set forth in (i) to (iv) of this subparagraph.
- (i) Any DSM-IV-R axis I primary diagnosis with the exception of V-Codes, adjustment disorders, and substance abuse related disorders, accompanied by a detailed description of the symptoms supporting the diagnosis. In lieu of a qualifying Axis I diagnosis, children 18-20 years of age may have an Axis II diagnosis of any personality disorder. Adjustment or substance related disorders may be a secondary Axis I diagnosis.
 - (ii) Patient continues to manifest a severity of illness that requires an acute level of care as defined in the admission criteria and which could not be provided in a less restrictive setting.
 - (I) Documentation of regression is measured in behavioral terms.
 - (II) If condition is unchanged, evidence of re-evaluation of treatment objectives and therapeutic interventions.
 - (iii) Conditions are directly attributable to a mental disorder as the primary need for professional attention (this does not include placement issues, criminal behavior, status offenses).
 - (iv) Documented efforts of working with child's family, legal guardians and/or custodians and other human service agencies toward a tentative discharge date.

(D) Medical necessity criteria for admission - inpatient chemical dependency detoxification. Inpatient chemical dependency detoxification admissions must meet the terms and conditions contained in (i),(ii),(iii), and one of (iv)(I)-(iv)(IV) of this subparagraph.

- (i) Any psychoactive substance dependency disorder described in DSM-IV-R with detailed symptoms supporting the diagnosis and need for medical detoxification, except for cannabis, nicotine, or caffeine dependencies.
- (ii) Conditions are directly attributable to a substance dependency disorder as the primary

need for professional attention (this does not include placement issues, criminal behavior, status offenses).

(iii) It has been determined by the gatekeeper that the current disabling symptoms could not be managed or have not been manageable in a lesser intensive treatment program.

(iv) Requires secure 24-hour nursing/medical supervision as evidenced by:

- (I) Need for active and aggressive pharmacological interventions.
- (II) Need for stabilization of acute psychiatric symptoms.
- (III) Need extensive treatment under physician direction.
- (IV) Physiological evidence or expectation of withdrawal symptoms which require 24-hour medical supervision.

(E) Medical necessity criteria for continued stay - inpatient chemical dependency program. No continued stay in inpatient chemical dependency program is allowed. Initial certification for admission is limited to up to five days; exceptions may be made up to seven to eight days based on a case-by-case review.

(F) Medical necessity criteria for admission - residential treatment (psychiatric and chemical dependency). Residential Treatment Center admissions must meet the terms and conditions in (i) to (iv) and one of (v)(I)-(v)(IV), and one of (vi)(I)-(vi)(III) of this subparagraph.

(i) Any DSM-IV-R Axis I primary diagnosis with the exception of V-codes, adjustment disorders, and substance related disorders, accompanied by detailed symptoms supporting the diagnosis. In lieu of a qualifying Axis I diagnosis, children 18-20 years of age may have an Axis II diagnosis of any personality disorder. Adjustment or substance related disorders may be a secondary Axis I diagnosis.

(ii) Conditions are directly attributed to a mental disorder as the primary reason for professional attention (this does not include placement issues, criminal behavior, status offenses).

(iii) Patient has either received treatment in an acute care setting or it has been determined by the gatekeeper that the current disabling symptoms could not or have not been manageable in a less intensive treatment program.

(iv) Child must be medically stable.

(v) Patient demonstrates escalating pattern of self injurious or assaultive behaviors as evidenced by:

- (I) Suicidal ideation and/or threat.
- (II) History of or current self-injurious behavior.
- (III) Serious threats or evidence of physical aggression.

- (IV) Current incapacitating psychosis or depression.
- (vi) Requires 24-hour observation and treatment as evidenced by:
 - (I) Intensive behavioral management.
 - (II) Intensive treatment with the family/guardian and child in a structured milieu.
 - (III) Intensive treatment in preparation for re-entry into community.
- (G) **Medical necessity criteria for continued stay - residential treatment center.** Continued stay residential treatment center admissions must meet the terms and conditions contained in (i), (ii), (v), (vi), and either (iii) or (iv) of this subparagraph.
 - (i) Any DSM-IV-R Axis I primary diagnosis with the exception of V codes, adjustment disorders, and substance abuse related disorders, accompanied by detailed symptoms supporting the diagnosis. In lieu of a qualifying Axis I diagnosis, children 18-20 years of age may have an Axis II diagnosis of any personality disorder.
 - (ii) Conditions are directly attributed to a mental disorder as the primary reason for continued stay (this does not include placement issues, criminal behavior, status offenses).
 - (iii) Patient is making measurable progress toward the treatment objectives specified in the treatment plan.
 - (I) Progress is measured in behavioral terms and reflected in the patient's treatment and discharge plans.
 - (II) Patient has made gains toward social responsibility and independence.
 - (III) There is active, ongoing psychiatric treatment and documented progress toward the treatment objective and discharge.
 - (IV) There are documented efforts and evidence of active involvement with the family, guardian, child welfare worker, extended family, etc.
 - (iv) Child's condition has remained unchanged or worsened.
 - (I) Documentation of regression is measured in behavioral terms.
 - (II) If condition is unchanged, there is evidence of re-evaluation of the treatment objectives and therapeutic interventions.
 - (v) There is documented continuing need for 24-hour observation and treatment as evidenced by:
 - (I) Intensive behavioral management.
 - (II) Intensive treatment with the family/guardian and child in a structured milieu.
 - (III) Intensive treatment in preparation for re-entry into community.
 - (vi) Documented efforts of working with child's family, legal guardian and/or custodian and other human service agencies toward a tentative discharge date.
- (3) **Pre-authorization and extension procedures.**
 - (A) Pre-admission authorization for inpatient psychiatric services must be requested from the OHCA designated agent. The OHCA or designated agent will evaluate and render a decision within 24 hours of receiving the request. A Certificate of Need will be issued by the OHCA or its designated agent, if the recipient meets medical necessity criteria.
 - (B) Extension requests (psychiatric) must be made through the OHCA designated agent. All requests shall be made prior to the expiration of the approved extension following the guidelines in the Gatekeeping Manual. Extension requests for the continued stay of a child who has been in an acute psychiatric program for a period of 30 days will require an evaluation by the gatekeeper and/or OHCA designated agent to determine the efficacy of treatment. Requests for the continued stay of a child who has been in an acute psychiatric program for a period of 60 days will require a review of all treatment documentation completed by the OHCA designated agent.
 - (C) ~~If a denial decision is made, a reconsideration request may be made directly to the OHCA designated agent within 10 working days of notification of the denial. The agent will return a decision within 10 working days from the time of receiving the reconsideration request. If the denial decision is up held, the denial can be appealed to the Oklahoma Health Care Authority within 20 working days of notification of the denial by the OHCA designated agent. Providers seeking prior authorization will follow OHCA's designated agent's prior authorization process guidelines for submitting behavioral health case management requests on behalf of the Medicaid recipient.~~
- (4) **Appeal and Review Procedures.** In the event a recipient disagrees with the decision by OHCA's contractor, it receives an evidentiary hearing under OAC 317:2-1-2(a). The recipient's request for such an appeal must commence within 20 calendar days of the initial decision. Providers may access a reconsideration process by OHCA's designated agent, whose decision is final. The provider has ten business days of receipt of the decision to request the contractor to reconsider its decision. The agent will return a decision within ten working days from the time of receiving the provider's reconsideration request. The reconsideration process will end on July 1, 2006.
- (4.5) **Quality of care requirements.**
 - (A) **Admission requirements.**
 - (i) At the time of admission to an inpatient psychiatric program, the admitting facility will provide the patient and their family or guardian with written explanation of the facility's policy regarding the following:
 - (I) Patient rights.

Emergency Adoptions

- (II) Behavior Management of patients in the care of the facility.
 - (III) Patient Grievance procedures.
 - (IV) Information for contact with the Office of Client Advocacy.
 - (V) Seclusion and Restraint Policy.
 - (ii) At the time of admission to an inpatient psychiatric program, the admitting facility will provide the patient and their family or guardian with the guidelines for the conditions of family or guardian participation in the treatment of their child. The written Conditions of Participation are provided for the facility by the Oklahoma Health Care Authority. These guidelines specify the conditions of the family or guardian's participation in "Active Treatment". The signature of the family member or guardian acknowledges their understanding of the conditions of their participation in "Active Treatment" while the patient remains in the care of the facility. The conditions include provisions of participation required for the continued Medicaid compensable treatment.
- (B) **Individual plan of care.**
- (i) "Individual plan of Care" means a written plan developed for each recipient within four days of any admission to an inpatient program which includes:
 - (I) the complete record of the DSM-IV five-axis diagnosis, including the corresponding symptoms, complaints, and complications indicating the need for admission,
 - (II) the current functional level of the individual,
 - (III) treatment goals and measurable time limited objectives,
 - (IV) any orders for psychotropic medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet and special procedures recommended for the health and safety of the patient,
 - (V) plans for continuing care, including review and modification to the plan of care, and
 - (VI) plan for discharge, all of which is developed to improve the child's condition to the extent that the inpatient care is no longer necessary.
 - (ii) The individual plan of care:
 - (I) must be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the individual patient and reflects the need for inpatient psychiatric care;
 - (II) must be developed by a team of professionals as specified in (D) of this paragraph in collaboration with the recipient, and his/her parents, legal guardians, or others in whose care he/she will be released after discharge;
 - (III) must establish treatment goals that are general outcome statements and reflective of informed choices of the patient served. Additionally, the treatment goal must be appropriate to the patient's age, culture, strengths, needs, abilities, preferences and limitations;
 - (IV) must establish measurable and time limited treatment objectives that reflect the expectations of the patient served and parent/legal guardian as well as being age, developmentally and culturally appropriate. The treatment objectives must be achievable and understandable to the patient and the parent/guardian. The treatment objectives also must be appropriate to the treatment setting and list the frequency of the service;
 - (V) must prescribe an integrated program of therapies, activities and experiences designed to meet the objectives;
 - (VI) must include specific discharge and after care plans that are appropriate to the patient's needs and effective on the day of discharge. At the time of discharge, after care plans will include the specific appointment date(s), names and addresses of service provider(s) and related community services to ensure continuity of care and reintegration for the recipient into their family school, and community.
 - (VII) must be reviewed at least every seven days by the team specified to determine that services are being appropriately provided and to recommend changes in the individual care plan as indicated by the recipient's overall adjustment, progress, symptoms, behavior, and response to treatment;
 - (VIII) development and review must satisfy the utilization control requirements for physician re-certification and establishment of periodic reviews of the individual plan of care; and,
 - (IX) and each individual plan of care review must be clearly identified as such and be signed and dated by the physician, licensed mental health professional, patient, parent/guardian, registered nurse, and other required team members. Individual plans of care and individual plan of care reviews not completed and appropriately signed will merit a penalty recoupment or will render those days non-compensable for Medicaid.
- (C) **Active treatment.** Inpatient psychiatric programs must provide "Active Treatment". "Active Treatment" involves the patient and their family or guardian from the time of an admission throughout the treatment and discharge process. "Active Treatment" also includes an ongoing program of assessment, diagnosis, intervention, evaluation of care and treatment, and planning for discharge and

aftercare under the direction of a physician. "Active Treatment" consists of integrated therapy components that are provided on a regular basis and will remain consistent with the patient's ongoing needs for care. The following components meet the minimum standards required for "Active Treatment", although an individual child's needs for treatment may exceed this minimum standard:

(i) Individual treatment provided by the physician. Individual treatment provided by the physician, is required three times per week for acute care and one time a week for residential care. Weekly residential treatment provided by the physician will never exceed 10 days between sessions. Individual treatment provided by the physician may consist of therapy or medication management intervention for acute and residential programs.

(ii) Individual therapy. Individual therapy is defined as a method of treating existing primary mental health disorders and/or any secondary alcohol and other drug (AOD) disorders using face to face, one on one interaction between a Mental Health Professional (MHP) and a patient to promote emotional or psychological change to alleviate disorders. MHP's performing this service must use and document an approach to treatment such as cognitive behavioral treatment, narrative therapy, solution focused brief therapy or another widely accepted theoretical framework for treatment. Ongoing assessment of the patient's status and response to treatment as well as psycho-educational intervention are appropriate components of individual therapy. Individual therapy must be provided in a confidential setting. The therapy must be goal directed utilizing techniques appropriate to the individual patient's plan of care and the patient's developmental and cognitive abilities. Individual therapy must be provided two hours per week in acute care and one hour per week in residential treatment by a mental health professional as described in OAC 317:30-5-240(c). One hour of family therapy may be substituted for one hour of individual therapy at the treatment teams discretion.

(iii) Family therapy. Family therapy is defined as interaction between a MHP, patient and family member(s) to facilitate emotional, psychological or behavioral changes and promote successful communication and understanding. The focus of family therapy must be directly related to the goals and objectives on the individual patient's plan of care. Family therapy must be provided one hour per week for acute care and residential treatment. One hour of individual therapy addressing relevant family issues may be substituted for a family session in an instance in which the family is unable to

attend a scheduled session by a mental health professional as described in OAC 317:30-5-240(c).

(iv) Process group therapy. Process group therapy is defined as a method of treating existing primary mental health disorders and/or any secondary AOD disorders using the interaction between a mental health professional as defined in OAC 317:30-5-240(c), and two or more patients to promote positive emotional or behavioral change. The focus of the group must be directly related to goals and objectives on the individual patient's plan of care. The individual patient's behavior and the focus of the group must be included in each patient's medical record. This service does not include social skills development or daily living skills activities and must take place in an appropriate confidential setting, limited to the therapist, appropriate hospital staff, and group members. Group therapy must be provided three hours per week in acute care and two hours per week in residential treatment by a mental health professional as defined in OAC 317:30-5-240(c). In lieu of one hour of process group therapy, one hour of expressive group therapy may be substituted.

(v) Expressive group therapy. Expressive group therapy is defined as art, music, dance, movement, poetry, drama, psychodrama, structured therapeutic physical activities, experiential (ROPES), recreational, or occupational therapies. Through active expression, inner-strengths are discovered that can help the patient deal with past experiences and cope with present life situations in more beneficial ways. The focus of the group must be directly related to goals and objectives on the individual patient's plan of care. Documentation must include how the patient is processing emotions/feelings. Expressive therapy must be a planned therapeutic activity, facilitated by staff with a relevant Bachelor's degree and/or staff with relevant training, experience, or certification to facilitate the therapy. Expressive group therapy must be provided four hours per week in acute care and three hours per week in residential treatment. In lieu of one hour of expressive group therapy, one hour of process group therapy may be substituted.

(vi) Group Rehabilitative treatment. Group rehabilitative treatment is defined as behavioral health remedial services, as specified in the individual treatment plan which are necessary for the treatment of the existing primary mental health disorders and/or any secondary AOD disorders. Examples of educational and supportive services, which may be covered under the definition of group rehabilitative treatment services, are basic living skills, social skills (re)development, interdependent living, self-care, lifestyle changes and recovery principles. Each service provided under group rehabilitative treatment services must have

Emergency Adoptions

goals and objectives, directly related to the individual plan of care. Group rehabilitative treatment services will be provided two hours each day for all inpatient psychiatric care. In lieu of two hours of group rehabilitative services per day, one hour of individual rehabilitative services per day may be substituted.

(vii) Individual rehabilitative treatment. Individual rehabilitative treatment is defined as a face to face service which is performed to assist patients who are experiencing significant functional impairment due to the existing primary mental disorder and/or any secondary AOD disorder in order to increase the skills necessary to perform activities of daily living. Services will be for the reduction of psychiatric and behavioral impairment and the restoration of functioning consistent with the requirements of independent living and enhanced self-sufficiency. This service includes educational and supportive services regarding independent living, self-care, social skills (re)development, lifestyle changes and recovery principles and practices. Each individual rehabilitative treatment service provided must have goals and objectives directly related to the individualized plan of care and the patient's diagnosis. One hour of individual rehabilitative treatment service may be substituted daily for the two hour daily group rehabilitative services requirement.

(D) **Credentialing requirements for treatment team members.** The team developing the individual plan of care must include, at a minimum, the following:

- (i) Allopathic or Osteopathic Physician with a current license and a board certification/eligible in psychiatry, or a current resident in psychiatry practicing as described in OAC 317:30-5-2(a)(1)(U), and
- (ii) a mental health professional licensed to practice by one of the following boards: Psychology (health service specialty only); Social Work (clinical specialty only); Licensed Professional Counselor, Licensed Behavioral Practitioner, (or) Licensed Marriage and Family Therapist or Advanced Practice Nurse (certified in a psychiatric mental health specialty, licensed as a registered nurse with a current certification of recognition from the Board of Nursing in the state in which the services are provided), and
- (iii) a registered nurse with a minimum of two years of experience in a mental health treatment setting.

(E) **Treatment team.** An interdisciplinary team of a physician, mental health professionals, registered nurse, patient, parent/legal guardian, and other personnel who provide services to patients in the facility must develop the individual plan of care, oversee all components of the active treatment and provide the

services appropriate to their respective discipline. Based on education and experience, preferably including competence in child psychiatry, the teams must be capable of:

- (i) Assessing the recipient's immediate and long range therapeutic needs, developmental priorities and personal strengths and liabilities,
- (ii) Assessing the potential resources of the recipient's family, and actively involving the family in the ongoing plan of care,
- (iii) Setting treatment objectives,
- (iv) Prescribing therapeutic modalities to achieve the plan objectives, and
- (v) Developing appropriate discharge criteria and plans.

(F) **Medical, psychiatric and social evaluations.** The patient's medical record must contain complete medical, psychiatric and social evaluations.

- (i) The evaluations must be completed as follows:
 - (I) History and physical evaluation must be completed within 60 hours of admission by a licensed independent practitioner (M.D., D.O., A.P.N.P., or P.A.).
 - (II) Psychiatric evaluation must be completed within 60 hours of admission by a M.D. or D.O.
 - (III) Psychosocial evaluation must be completed within seven days of admission by a licensed independent practitioner (M.D., D.O., A.P.N.P., or P.A.) or a mental health professional as defined in OAC 317:30-5-240(c).
- (ii) Each of the evaluations must be clearly identified as such and must be signed and dated by the evaluators.
- (iii) Each of the evaluations must be completed when the patient changes levels of care if the existing evaluation is more than 30 days from admission. Evaluations remain current for 12 months from the date of admission and must be updated annually.

(G) **Nursing services (inpatient psychiatric acute only).** Each facility must have a qualified Director of Psychiatric Nursing. In addition to the Director of Nursing, there must be adequate numbers of registered nurses, licensed practical nurses, and mental health workers to provide nursing care necessary under the active treatment program and to maintain progress notes on each patient. A registered nurse must document patient progress at least weekly. The progress note must contain recommendations for revisions in the treatment plan, as needed, as well as an assessment of the patient's progress as it relates to the treatment plan goals and objectives.

(H) **Seclusion and restraint incident reporting requirements.** The process by which a facility is required to inform the OHCA of a death, serious injury, or suicide attempt is as follows:

- (i) The hospital administrator, executive director, or designee is required to contact the OHCA Behavioral Health Unit by phone no later than 5:00 p.m. on the business day following the incident.
- (ii) Information regarding the Medicaid recipient involved, the basic facts of the incident, and follow-up to date must be reported. The agency will be asked to supply, at a minimum, follow-up information with regard to patient outcome, staff debriefing and programmatic changes implemented (if applicable).
- (iii) Within three days, the OHCA Behavioral Health Unit must receive the above information in writing (example: Facility Critical Incident Report).
- (iv) Patient death must be reported to the OHCA as well as to the Center for Medicare/Medicaid Regional office in Dallas, Texas.
- (v) Compliance with seclusion and restraint reporting requirements will be verified during the onsite inspection of care (Section 5, Quality of Care), or using other methodologies.

(I) **Other required standards.** The provider is required to maintain all programs and services according to applicable Code of Federal Regulations (CFR) requirements, JCAHO/AOA standards for Behavioral Health Care, State Department of Health Hospital Standards for Psychiatric Care, and State Department of Human Services Licensing Standards for Residential Treatment Facilities. Residential treatment facilities may substitute CARF accreditation in lieu of JCAHO or AOA accreditation.

(56) Documentation of records.

(A) All documentation for services provided under active treatment must be documented in an individual note and reflect the content of each session provided. Individual, Family, Process Group, Expressive Group, Individual Rehabilitative and Group Rehabilitative Services documentation must include, at a minimum, the following:

- (i) date;
- (ii) start and stop time for each session;
- (iii) signature of the therapist and/or staff;
- (iv) credentials of the therapist;
- (v) specific problem(s) addressed (problems must be identified on the plan of care);
- (vi) method(s) used to address problems;
- (vii) progress made towards goals;
- (viii) patient's response to the session or intervention; and
- (ix) any new problem(s) identified during the session.

(B) Signatures of the patient, parent/ guardian, doctor, MHP, and RN are required on the Master Plan of Care and all plan of care reviews. The plan of care and plan of care review are not valid until signed and separately dated by the patient, parent/legal guardian, doctor, RN, MHP, and all other requirements are met.

(67) Inspection of care.

(A) There will be an on site inspection of care of each psychiatric facility that provides care to recipients which will be performed by the OHCA or its designated agent. The Oklahoma Health Care Authority will designate the members of the Inspection of Care team. This team will consist of a Licensed Mental Health Professional, a Registered Record Administrator, and a Registered Nurse. At the team's discretion, an additional Mental Health Professional may be substituted for the Registered Record Administrator. The inspection will include observation and contact with recipients. The Inspection of Care Review will consist of recipients present or listed as facility residents at the beginning of the Inspection of Care visit as well as recipients on which claims have been filed with OHCA for acute or RTC levels of care. The review includes validation of certain factors, all of which must be met for the Medicaid Services to be compensable. Following the on-site inspection, the Inspection of Care Team will report its findings to the facility. The facility will be provided with written notification if the findings of the inspection of care have resulted in any deficiencies. Deficiencies may result in a monetary penalty, (partial per-diem) or a total (full per-diem) recoupment of the compensation received. If the review findings have resulted in a penalty status, a penalty (partial per-diem) of \$50.00 per event and the days of service involved will be reported in the notification. If the review findings have resulted in full (full per-diem) recoupment status, the non-compensable days of services will be reported in the notification. In the case of non-compensable days (full per-diem) or penalties (partial per-diem) the facility will be required to refund the amount.

(B) Penalties or non-compensable days which are the result of the facility's failure to appropriately provide and document the services described herein, or adhere to applicable accreditation, certification, and/or state licensing standards, are not Medicaid compensable or billable to the patient or the patient's family.

(C) If a denial decision is made, a reconsideration request may be made directly to the OHCA designated agent within 10 working days of notification of the denial. The agent will return a decision within 10 working days from the time of receiving the reconsideration request. If the denial decision is up held, the denial can be appealed to the Oklahoma Health Care Authority within 20 working days of notification of the denial by the OHCA designated agent.

PART 9. LONG TERM CARE FACILITIES

317:30-5-123. Patient certification for long term care

(a) **Medical eligibility.** Initial approval of medical eligibility for long-term care is determined by the OKDHS area nurse,

Emergency Adoptions

or nurse designee. The certification is obtained by the facility at the time of admission.

(1) **Pre-admission screening.** Federal Regulations govern the State's responsibility for Preadmission Screening and Resident Review (PASRR) for individuals with mental illness and mental retardation. PASRR applies to the screening or reviewing of all individuals for mental illness or mental retardation or related conditions who apply to or reside in Title XIX certified nursing facilities regardless of the source of payment for the nursing facility services and regardless of the individual's or resident's known diagnoses. The NF must independently evaluate the Level I PASRR Screen regardless of who completes the form and determine whether or not to admit an individual to the facility. NFs which inappropriately admit a person without a PASRR Screen are subject to recoupment of funds. There are no PASRR requirements for individuals seeking residency in an intermediate care facility for the mentally retarded (ICF/MR) or in Medicare Skilled beds.

(2) **PASRR Level I screen.**

(A) Form LTC-300A, Long Term Care Pre-admission Screen, must be completed by an authorized official of OKDHS, of the nursing facility, of the hospital or a physician. An authorized official is defined as:

- (i) A licensed nurse from OKDHS;
- (ii) The nursing facility administrator or co-administrator;
- (iii) A licensed nurse from the nursing facility, hospital, or physician's office;
- (iv) A social service director from the nursing facility or hospital; or
- (v) A social worker from the nursing facility, or the hospital.

(B) The authorized official as defined in (1) of this subsection must evaluate the properly completed OHCA Form LTC-300A and/or the Uniform Comprehensive Assessment Tool and/or the Minimum Data Set (MDS). Any other readily available medical and social information is also used to determine if there currently exists any indication of mental illness (MI), mental retardation (MR), or other related condition, or if such condition existed in the applicant's past history. This evaluation constitutes the Level I PASRR Screen and is utilized in determining whether or not a Level II Assessment is necessary prior to allowing the patient to be admitted.

(C) The nursing facility is responsible for determining from the evaluation whether or not the patient can be admitted to the facility. A "yes" response to any question from Form LTC-300A, Section I, will result in a consultation with the Level of Care Evaluation Unit (LOCEU) to determine if a Level II Assessment is needed. If there is any question as to whether or not there is evidence of MI, MR, or related condition, LOCEU should be contacted prior to admission.

(D) Upon receipt and review of the medical eligibility information packet, the LOCEU may, in coordination with the OKDHS area nurse, re-evaluate whether a Level II PASRR assessment may be required. If a Level II Assessment is not required, the process of determining medical eligibility continues. If a Level II is required, a medical decision is not made until the results of the Level II Assessment are known.

(3) **Level II Assessment for PASRR.**

(A) Any one of the following three circumstances will allow a patient to enter the nursing facility without being subjected to a Level II PASRR Assessment.

(i) The patient has no current indication of mental illness or mental retardation or other related condition and there is no history of such condition in the patient's past.

(ii) The patient does not have a diagnosis of mental retardation or related condition, and a primary or secondary diagnosis of dementia including dementia of the Alzheimer's type is documented in writing by a physician.

(iii) The patient has indications of mental illness or mental retardation or other related condition, but is not a danger to self and/or others, and is being released from an acute care hospital as part of a medically prescribed period of recovery. If an individual is admitted to an NF based on **Exempted Hospital Discharge**, it is the responsibility of the NF to ensure that the individual is either discharged by the 30th day or that a Level II has been requested and is in process. Exempted Hospital Discharge is allowed if the following three conditions are met:

(I) The individual must be admitted to the NF directly from a hospital after receiving acute inpatient care at the hospital (not including psychiatric facilities);

(II) The individual must require NF services for the condition for which he/she received care in the hospital; and

(III) The attending physician must certify in writing before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

(B) If the patient has current indications of mental illness or mental retardation or other related condition, or if there is a history of such condition in the patient's past, the patient cannot be admitted to the nursing facility. Instead, a Level II PASRR Assessment must be performed and the results must indicate that nursing facility care is appropriate prior to allowing the patient to be admitted.

(C) The State Mental Retardation (MR) (OKDHS/Developmental Disabilities Services Division) and Mental Illness (MI) (Department of Mental Health and Substance Abuse Services) authorities have developed **Advance Group Determinations**

by category that take into account certain diagnoses, levels of severity of illness, or need for a particular service which clearly indicate that admission to an NF is normally needed, and that the provision of specialized services is not normally needed. These determinations are actual Level II decisions and not exemptions from the screening process. For those for whom a categorical determination is made, both the level of care determination and the specialized services determination must be addressed. All positive determinations concerning the need for specialized services must be based on a more extensive individualized evaluation.

(D) The OHCA, LOCEU, authorizes Advance Group Determinations for the MI and MR Authorities in the following categories:

(i) **Provisional admission in cases of delirium.** Any person with mental illness, mental retardation or related condition that is not a danger to self and or others, may be admitted to a Title XIX certified NF if the individual is experiencing a condition that precludes screening, i.e., effects of anesthesia, medication, unfamiliar environment, severity of illness, or electrolyte imbalance.

(I) A Level II evaluation is completed immediately after the delirium clears. The LOCEU must be provided with written documentation by a physician that supports the individual's condition which allows provisional admission as defined in (i) of this subparagraph.

(II) Payment for NF services will not be made after the provisional admission ending date. If an individual is determined to need a longer stay, the individual must receive a Level II evaluation before continuation of the stay may be permitted and payment made for days beyond the ending date.

(ii) **Provisional admission in emergency situations.** Any person with a mental illness, mental retardation or related condition, who is not a danger to self and/or others, may be admitted to a Title XIX certified nursing facility for a period not to exceed seven days pending further assessment in emergency situations requiring protective services. The request for Level II evaluation must be made immediately upon admission to the NF if a longer stay is anticipated. The LOCEU must be provided with written documentation from OKDHS Adult Protective Services, or the NF, which supports the individual's emergency admission. Payment for NF services will not be made beyond the emergency admission ending date.

(iii) **Respite care admission.** Any person with mental illness, mental retardation or related condition, who is not a danger to self and/or others, may be admitted to a Title XIX certified nursing facility to provide respite to in-home caregivers to whom the individual is expected to return following the

brief NF stay. Respite care may be granted up to 15 consecutive days per stay, not to exceed 30 days per calendar year.

(I) In rare instances, such as illness of the caregiver, an exception may be granted to allow 30 consecutive days of respite care. However, in no instance can respite care exceed 30 days per calendar year.

(II) Respite care must be approved by LOCEU staff prior to the individual's admission to the NF. The NF provides the LOCEU with written documentation concerning circumstances surrounding the need for respite care, the date the individual wishes to be admitted to the facility, and the date the individual is expected to return to the caregiver. Payment for NF services will not be made after the respite care ending date.

(4) **Resident Review.**

(A) The nursing facility's routine resident assessment will identify those individuals previously undiagnosed as MR or MI. A new condition of MR or MI must be referred to LOCEU by the NF for determination of the need for the Level II Assessment. The facility's failure to refer such individuals for a Level II Assessment will result in recoupment of funds.

(B) A Level II Resident Review must be conducted the following year for each resident of a nursing facility who was found to experience a serious mental illness on their pre-admission Level II, to determine whether, because of the resident's physical and mental condition, the resident requires the level of services provided by a nursing facility and whether the resident requires specialized services.

(C) A significant change in a resident's physical or mental condition could trigger a Level II Resident Review. If such a change should occur in a resident's condition, it is the responsibility of the nursing facility to notify the LOCEU of the need to conduct a resident review.

(5) **Results of Level II Pre-Admission Assessment and Resident Review.** Through contractual arrangements between the OHCA and the MI/MR authorities, individualized assessments are conducted and findings presented in written evaluations. The evaluations determine if nursing facility services are needed, if specialized services or lesser than specialized services are needed and what types, and if the individual meets the federal PASRR definition of mental illness or mental retardation or related conditions. Evaluations are delivered to the LOCEU to process formal, written notification to patient, guardian, NF and interested parties.

(6) **Readmissions, and interfacility transfers.** The Preadmission Screening process does not apply to readmission of an individual to an NF after transfer for a continuous hospital stay, and then back to the NF. There is no specific time limit on the length of absence from the nursing facility for the hospitalization. Inter-facility transfers

Emergency Adoptions

are subject to Resident Reviews rather than preadmission screening. In the case of transfer of a resident from an NF to a hospital or to another NF, the transferring NF is responsible for ensuring that copies of the resident's most recent LTC-300A and any PASRR evaluations accompany the transferring resident. The receiving NF must submit an updated LTC-300A that reflects the resident's current status to LOCEU within 30 days of the transfer. Failure to do so could result in possible recoupment of funds.

(7) **PASRR appeals process.**

(A) Any individual who has been adversely affected by any PASRR determination made by the State in the context of either a preadmission screening or an annual resident review may appeal that determination by requesting a fair hearing. If the individual does not consider the PASRR decision a proper one, the individual or their authorized representative must contact the local county OKDHS office to discuss a hearing. Any request for a hearing must be made no later than ~~30~~ 20 days following the date of written notice. Appeals of these decisions are available under OAC 317:2-1-2. All individuals seeking an appeal have the same rights, regardless of source of payment. Level I determinations are not subject to appeal.

(B) When the individual is found to experience MI, MR, or related condition through the Level II Assessment, the PASRR determination made by the MR/MI authorities cannot be countermanded by the state Title XIX agency, either in the claims process or through other utilization control/review processes, or by the state survey and certification agency. Only appeals determinations made through the fair hearing process may overturn a PASRR determination made by the MR/MI authorities.

(b) **Determination of Title XIX medical eligibility for long term care.** The determination of medical eligibility for care in a nursing facility is made by the OKDHS area nurse, or nurse designee. The procedures for determining Nursing Facility (NF) program medical eligibility are found in OAC 317:35-19. Determination of ICF/MR medical eligibility is made by LOCEU. The procedures for obtaining and submitting information required for a decision are outlined below.

(1) **Pre-approval of medical eligibility.** Pre-approval of medical eligibility for private ICF/MR care is based on results of a current comprehensive psychological evaluation by a licensed psychologist or state staff psychologist, documentation of MR or related condition prior to age 22, and the need for active treatment according to federal standards. Pre-approval is made by LOCEU analysts.

(2) **Medical eligibility for ICF/MR services.** Within 30 calendar days after services begin, the facility must submit the original of the Long Term Care Assessment form (LTC-300) to LOCEU. Required attachments include current (within 90 days of requested approval date) medical information signed by a physician, a current (within 12 months of requested approval date) psychological evaluation, a copy of the pertinent section of the

Individual Developmental Plan or other appropriate documentation relative to discharge planning and the need for ICF/MR level of care, and a statement that the client is not an imminent threat of harm to self or others (i.e., suicidal or homicidal). If pre-approval was determined by LOCEU and the above information is received, medical approval will be entered on MEDATS.

(3) **Categorical relationship.** Categorical relationship must be established for determination of eligibility for long-term medical care. If categorical relationship to disability has not already been established, the proper forms and medical information are submitted to LOCEU. (Refer to OAC 317:35-5-4). In such instances, LOCEU will render a decision on categorical relationship using the same definition as used by SSA. A follow-up is required by the OKDHS worker with the Social Security Administration to be sure that their disability decision agrees with the decision of LOCEU.

317:30-5-124. Facility licensure

(a) **Nursing home license required.** A nursing facility must meet state nursing home licensing standards to provide, on a regular basis, health related care and services to individuals who do not require hospital care.

(1) In order for long term care facilities to receive payment from the Authority for the provision of nursing care, they must be currently licensed under provisions of Title 63 O.S., Nursing Home Care Act, 1995, Section 1-1901, et seq.

(2) The State Department of Health is responsible for the issuance, renewal, suspension and revocation of a facility's license in addition to the enforcement of the standards. The denial, suspension or revocation of a facility's license is subject to appeal to the State Department of Health. All questions regarding a facility's license should be directed to the State Department of Health.

(b) **Certification survey.** The Oklahoma State Department of Health is designated as the State Survey Agency and is responsible for determining a long term care facility's compliance with Title XIX requirements. The results of the survey are forwarded to the OHCA by the State Survey Agency.

(c) **Certification period.** The certification period of a long term care facility is determined by the State Survey Agency. In the event the facility's deficiencies are found to be of such serious nature as to jeopardize the health and safety of the patient, the State Survey Agency may terminate (de-certify) the facility's certification period and notify the Authority. Upon notification by the State Survey Agency, the Authority will notify the facility by certified letter that the Agreement is being terminated. The letter will indicate the effective date and specify the time period (~~not more than 30 days~~) that payment may continue in order to allow orderly relocation of recipient/patients. The decision to terminate a facility's certification by the State Survey Agency is subject to appeal to the State Department of Health. The decision to terminate a facility's Agreement by the Authority (for a reason other than the facility decertification or suspension/revocation of the facility license) is subject to appeal to the Oklahoma Health Care Authority

(see OAC ~~317:2-1-2.3~~ 317:2-1-8 for grievance procedures and process).

(d) **Certification with deficiencies.**

(1) When an ICF/MR facility is certified to be in compliance with the Title XIX requirements but has deficiencies which must be corrected, an Agreement may be executed, subject to the facility's resolution of deficiencies according to the approved plan of correction. Following the visit by the State Survey Agency, one of two actions may occur:

(A) The State Survey Agency will notify the Authority that all deficiencies have been corrected or acceptable progress has been made toward correction. The Authority, by letter, will notify the facility of the action and the Agreement may run to the expiration date; or

(B) The State Survey Agency will notify the Authority that some or all of the deficiencies have not been corrected and circumstances require that the **automatic cancellation date** be invoked. The Authority, by certified letter, will notify the facility, owners of the facility and regulatory agencies when the automatic cancellation date is invoked.

(2) The Agreement will terminate as a result of the automatic cancellation date being invoked. In accordance with federal regulations, payment for current residents of the facility can continue for no more than thirty (30) days from the date the automatic cancellation date is invoked, to permit an orderly relocation of patients. Payment cannot be made for patients admitted after the automatic cancellation date is invoked. The decision to invoke a facility's automatic cancellation date is subject to appeal to the State Department of Health.

(e) **Agreement procedures.**

(1) A facility participating in the Medicaid program will be notified by letter from the Authority ~~sixty~~ (60) days prior to the expiration of the existing Agreement. New Agreement forms will be sent to be completed if the facility wishes to continue participation in the Medicaid Program.

(2) Two copies of the Agreement to Provide Long Term Care Services under the Medicaid Act (Agreement) will be sent to the facility for completion. Both signed copies of the Agreement (signed with original signature only of owner, operator or administrator and properly notarized) must be returned to the OHCA.

(3) When the Agreement is received, approved by the Authority, and the HCFA-1539 has been received from the State Department of Health indicating the facility's certification period, the Agreement will be completed. A copy of the executed Agreement will be returned to the facility where it must be maintained for a period of six years for inspection purposes.

(4) Intermediate care facilities for the mentally retarded wishing to participate in the ICF/MR program must be approved and certified by the State Survey Agency as being in compliance with the ICF/MR regulations (42

CFR 442 Subpart C). It is the responsibility of a facility to request the State Survey Agency perform a survey of compliance with ICF/MR regulations.

(A) When the Authority has received notification of a facility's approval as an ICF/MR and the Title XIX survey of compliance has begun, the Agreement will be sent to the facility for completion.

(B) A facility which has been certified as an ICF/MR and has an Agreement with the Authority will be paid only for recipient/patients who have been approved for ICF/MR level of care. When the facility is originally certified to provide ICF/MR services, payment for recipient/patients currently residing in the facility who are approved for a NF level of care will be made if such care is appropriate to the recipient/patient's needs.

(f) **New facilities.** Any new facility in Oklahoma must receive, from the State Department of Health, a Certificate of Need. When construction of a new facility is completed and licensure and certification is imminent, facilities wishing to participate in the Title XIX Medicaid Program should request, by letter, an Agreement form. When the Authority has received notification from the State Department of Health of the new facility's licensure, the Agreement will be sent to the facility for completion, if not previously sent.

(1) It is the responsibility of the new facility to request the State Survey Agency to perform a survey for Title XIX compliance.

(2) The effective date of the provider Agreement will be subsequent to completion of all requirements for participation in the Medicaid Program. In no case can payment be made for any period prior to the effective date of the facility's certification.

(g) **Change of ownership.** The acquisition of a facility operation, either whole or in part, by lease or purchase, or if a new FEIN is required, constitutes a change of ownership. When such change occurs, it is necessary that a new Agreement be completed between the new owner and the Authority in order that payment can continue for the provision of nursing care. If there is any doubt about whether a change of ownership has occurred, the facility owner should contact the State Department of Health for a final determination.

(1) **License changes due to change of ownership.** State Law prescribes specific requirements regarding the transfer of ownership of a nursing facility from one person to another. When a transfer of ownership is contemplated, the buyer/seller or lessee/lessor must notify the State Department of Health, in writing, of the forthcoming transfer at least thirty (30) days prior to the final transfer and apply for a new facility license.

(2) **Certificate of Need.** A change of ownership is subject to review by the Oklahoma State Department of Health. Any person contemplating the acquisition of a nursing facility should contact Certificate of Need Division of the State Department of Health for further information regarding Certificate of Need requirements.

Emergency Adoptions

(A) When a long term care facility changes ownership, federal regulations require automatic assignment of the Agreement to the new owner. An assigned Agreement is subject to all applicable statutes and regulations under which it was originally issued.

This includes but is not limited to:

- (i) any existing plan of correction,
- (ii) any expiration date,
- (iii) compliance with applicable health and safety regulations, and
- (iv) compliance with any additional requirements imposed by the Medicaid agency.

(B) The new owner must obtain a Certificate of Need as well as a new facility license from the State Department of Health. Pending notification of licensure of the new owner, no changes are made to the Authority's facility records (i.e., provider number) with the exception of change in administrator or change in name, if applicable.

(C) When notification and licensure from the State Department of Health is received, procedures for transmitting forms to the facility and completing the Agreement, as described in Agreement Procedures for New Facilities, will be followed.

(D) The effective date of a facility's change of ownership is the date specified on the new license issued by the State Department of Health to the new owner or lessee.

317:30-5-131.1. Wage enhancement

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

(1) **"Employee Benefits"** means the benefits an employer provides to an employee which include:

- (A) FICA taxes,
- (B) Unemployment Compensation Tax,
- (C) Worker's Compensation Insurance,
- (D) Group health and dental insurance,
- (E) Retirement and pensions, and
- (F) Other employee benefits (any other benefit that is provided by a majority of the industry).

(2) **"Enhanced"** means the upward adjusted rate as required by Title 63, Section 5022 of Oklahoma Statutes.

(3) **"Enhancement"** means the upward adjusted rate as required by Title 63, Section 5022 of Oklahoma Statute.

(4) **"Regular employee"** means an employee that is paid an hourly/salaried amount for services rendered, however, the facility is not excluded from paying employee benefits.

(5) **"Specified staff"** means the employee positions listed in the Oklahoma Statutes under Section 5022, Title 63 that meet the requirements listed in 42 CFR Section 483.75(e)(1)-(8).

(b) **Enhancement.** Effective May 1, 1997, the OHCA provides a wage and salary enhancement to nursing facilities serving adults and Intermediate Care Facilities for the Mentally Retarded as required by Title 63, Section 5022 of Oklahoma

Statutes. The purpose of the wage and salary enhancement is to provide an adjustment to the facility payment rate in order for facilities to reduce turnover and be able to attract and retain qualified personnel. The maximum wage enhancement rates that may be reimbursed to the facilities per diem include:

- (1) Three dollars and fifteen cents (\$3.15) per patient day for NFs,
- (2) Four dollars and twenty cents (\$4.20) per patient day for standard private ICFs/MR, and
- (3) Five dollars and fifteen cents (\$5.15) per patient day for specialized private ICFs/MR.

(c) **Reporting requirements.** Each NF and ICF/MR is required to submit a Nursing and Intermediate Care Facilities Quarterly Wage Enhancement Report (QER) which captures and calculates specified facility expenses. The report must be completed quarterly and returned to OHCA no later than 45 days following the end of each quarter. QERs must be filed for the State Fiscal Year (SFY) which runs from July 1 to June 30. The Oklahoma Health Care Authority reserves the right to recoup all dollars that cannot be accounted for in the absence of a report. The QER is designed to capture and calculate specified facility expenses for quarterly auditing by the OHCA. The report is used to determine whether wage enhancement payments are being distributed among salaries/wages, employee benefits, or both for the employee positions listed in (1) through (8) of this subsection. Furthermore, the OHCA reserves the right to recoup all dollars not spent on salaries, wages, employee benefits, or both for the employee positions. The specified employee positions included on the QER are:

- (1) Licensed Practical Nurse (LPN),
- (2) Nurse Aide (NA),
- (3) Certified Medication Aide (CMA),
- (4) Social Service Director (SSD),
- (5) Other Social Service Staff (OSSS),
- (6) Activities Director (AD),
- (7) Other Activities Staff (OAS), and
- (8) Therapy Aide Assistant (TAA).

(d) **Timely filing and extension of time.**

(1) **Quarterly reports.** Quarterly reports are required to be filed within 45 days following the end of each quarter. This requirement is rigidly enforced unless approved extensions of time for the filing of the quarterly report is granted by OHCA. Filing extensions not to exceed 15 calendar days may be granted for extraordinary cause only. A failure to present any of the items listed in (A)-(D) of this paragraph will result in a denial of the request for an extension. The extension request shall will be attached to the filing of the report after the request has been granted. For an extension to be granted, the following must occur.

(A) An extension request must be received at the Oklahoma Health Care Authority on or before the 30th day after the end of the quarter.

(B) The extension must be addressed on a form supplied by the Health Care Authority.

(C) The facility must demonstrate there is an extraordinary reason for the need to have an extension. An extraordinary reason is defined in the plain meaning of the word. Therefore, it does not include reasons

such as the employee who normally makes these requests was absent, someone at the facility made a mistake and forgot to send the form, the facility failed to get documents to some third party to evaluate the expenditures. An unusual and unforeseen event must be the reason for the extension request.

(D) The facility must not have any extension request granted for a period of two years prior to the current request.

(2) **Failure to file a quarterly report.** If the facility fails to file the quarterly report within the required (or extended) time, the facility is treated as out of compliance and payments made for the quarter in which no report was filed will be subject to a 100% recoupment. The overpayment is recouped in future payments to the facility immediately following the filing deadline for the reporting period. The full overpayment is recovered within a three month period. The Oklahoma Health Care Authority reserves the right to discontinue wage enhancement payments until an acceptable QER (quarterly enhancement report) is received. In addition to the recoupment of payments, the matter of noncompliance is referred to the Legal Division of the OHCA to be considered in connection with the renewal of the facility's contract.

(3) **Ownership changes and fractional quarter report.** Where the ownership or operation of a facility changes hands during the quarter, or where a new operation is commenced, a fractional quarter report is required, covering each period of time the facility was in operation during the quarter.

(A) Fractional quarter reports are linked to the legal requirement that all facility reports be properly filed in order that the overall cost of operation of the facility may be determined.

(B) Upon notice of any change in ownership or management, the OHCA withholds payments from the facility until a fractional quarter report is received and evaluation of payment for the wage enhancement is conducted. In this case the QER is due within 15 days of the ownership or management change.

(4) **Pay periods and employee benefits reflected in the QER.** Salaries and wages are determined by accruing the payroll to reflect the number of days reported for the month. Unpaid salaries and wages are accrued through the quarter. Any salaries and wages accrued in the previous quarter and paid in the current quarter are excluded. Employee benefits are determined by accruing any benefits paid to coincide with the reporting month. Unpaid employee benefits are accrued through the quarter. Any employee benefits accrued in the previous quarter and paid in the current quarter are excluded. To be included as an allowable wage enhancement expenditure, accrued salaries, wages and benefits must be paid within forty-five (45) days from the end of the reporting quarter.

(5) **Report accuracy.** Errors and/or omissions discovered by the provider after the initial filing/approved extension are not considered grounds for re-opening/revisions of previously filed reports. Furthermore, errors

and/or omission discovered by the provider after the initial filing/approved extension can not be carried forward and claimed for future quarterly reporting periods.

(6) **False statements or misrepresentations.** Penalties for false statements or misrepresentations made by or on behalf of the provider are provided at 42 U.S.C. Section 1320a-7b which states, in part, "*(a) Whoever... (2) at any time knowingly and willfully makes or cause to be made any false statement of a material fact for use in determining rights to such benefit or payment... shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with furnishing (by that person) of items or services for which payment is or may be made under this title (42 U.S.C. §1320 et. seq.), be guilty of a felony and upon conviction thereof fined not more than \$25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than \$10,000 or imprisoned for not more than one year, or both.*"

(7) **Audits, desk and site reviews.**

(A) Upon receipt of each quarterly report a desk review is performed. During this process, the report is examined to insure it is complete. If any required information is deemed to have been omitted, the report may be returned for completion. Delays that are due to incomplete reports are counted toward the 45 day deadline outlined in (c) of this Section. At that time the mathematical accuracy of all totals and extensions is verified. Census information may be independently verified through other sources. After completion of the desk review, each report is entered into the OHCA's computerized data base. This facilitates the overall evaluation of the industry's costs.

(B) Announced and/or unannounced site reviews are conducted at a time designated by the OHCA. The purpose of site reviews is to verify the information reported on the QER(s) submitted by the facility to the OHCA. Errors and/or omissions discovered by the OHCA upon the completion of a site review is immediately reflected in future payment(s) to the facility. The OHCA makes deficiencies known to the facility within 30 calendar days. A deficiency notice in no way prevents the OHCA from additionally finding any overpayment and adjusting future payments to reflect these findings.

(8) **Appeals process.**

(A) If the desk or site review indicates that a facility has been improperly paid, the OHCA ~~shall~~ will notify the facility that the OHCA will rectify the improper payment in future payments to the facility. Improper payments consist of an overpayment to a facility. The facility may appeal the determination to recoup an alleged overpayment and/or the size of the alleged overpayment, within 20 days of receipt of notice of the improper payment from the OHCA. Such appeals ~~shall~~ will be Level I proceedings heard pursuant to

Emergency Adoptions

OAC ~~317:2-1-2.1~~ 317:2-1-2(c)(2). The issues on appeals ~~shall~~ will be limited to whether an improper payment occurred and the size of the alleged improper payment. The methodology for determining base period computations ~~shall~~ will not be an issue considered by the administrative law judge.

(B) Certain exceptional circumstances, such as material expenses due to the use of contract employees, overtime expenses paid to direct care staff, or changes within classes of staff may have an effect on the wage enhancement payment and expense results. Facilities may demonstrate and present documentation of the affects of such circumstances before the administrative law judge.

(e) **Methodology for the distribution of payments/adjustments.** The OHCA initiates a two-part process for the distribution and/or recoupment of the wage enhancement.

(1) **Distribution of wage enhancement revenue.** All wage enhancement rates are added to the current facility per diem rate. Facilities receive the maximum wage enhancement rate applicable to each facility type.

(2) **Payment/recoupment of adjustment process.** Initially, all overpayments resulting from the Fourth Quarter of SFY-1997 and the First Quarter of SFY-1998 audits will be deducted from the first month's payment of the Third Quarter of SFY-1998 (January-1998). The Fourth and First Quarter of SFY-1997 and SFY 1998 audit results will be averaged to determine the adjustment. All overpayments as a result of the Second Quarter of SFY-1998 audit will be deducted from the first month's payment of the Fourth Quarter of SFY-1998 (April-1998). Audit results will determine whether or not a facility is utilizing wage enhancement payments that are being added to the facility's per diem rate. When audit results for a given quarter after the Second Quarter of SFY-1998 (October, November, and December 1997) reflect an adjustment, recoupments will be deducted from the facility. Any adjustments calculated will not be recouped during the quarter in which the calculation is made, rather, they will be recouped during the following quarter. The recoupments, as a result of an adjustment, will not exceed the wage enhancement revenue received for the quarter in which the audit is conducted. Recoupments will be included in the facility's monthly payment and will not exceed the three month period of the quarter in which it is being recouped.

(f) **Methodology for determining base year cost.** The information used to calculate Base Year Cost is taken from actual SFY-1995 cost reports submitted, to the OHCA, by the NFs and ICFs/MR that will be receiving a wage enhancement. A Statewide Average Base Cost is calculated for facilities that did not submit a cost report for SFY-1995. Newly constructed facilities that submit a partial year report are assigned the lower of the Statewide Average Base Cost or actual cost. The process for calculating the Base Year Cost, the Statewide Average Base Cost, and the process for newly constructed facilities is determined as follows.

(1) **Methodology used for determining base year cost.** The methodology for determining the Base Year Cost is determined by the steps listed in (A) through (E) of this paragraph.

(A) Regular employee salaries are determined by adding the salaries of LPNs, NAs, CMAs, SSDs, OSSS, ADs, OAS, and TAAs.

(B) Percentage of benefits allowed are determined by dividing total facility benefits by total facility salaries and wages.

(C) Total expenditures are determined by multiplying the sum of regular employee salaries by a factor of one plus the percentage of benefits allowed in (B) of this subparagraph.

(D) Base Year PPD Costs are determined by dividing total expenditures, in (3) of this subparagraph by total facility patient days. This information is used to determine statewide average base year cost.

(E) Inflated Base Year Costs are determined by multiplying Base Year Cost, in (C) of this subparagraph by the appropriate inflation factors. Base Year Expenditures were adjusted from the midpoint of the base year to the midpoint of the rate year using the moving rate of change forecast in the Data Resources, Inc., (DRI) "HCFA Nursing Home without Capital Market Basket" Index as published for the fourth quarter of calendar year 1995. The OHCA uses this same index (DRI) for subsequent years as it becomes available and is appropriate.

(2) **Methodology used for determining Statewide Average Base Cost.** A Statewide Average Base Cost is calculated for all facilities that did not submit a cost report, to the OHCA, for SFY-1995. The steps listed in (A) through (C) of this paragraph are applied to determine the Base Cost in the absence of actual SFY-1995 cost report information.

(A) Statewide Average Base Year PPD Costs are determined by adding Base Year PPD Cost, calculated in (1)(D) of this subsection, for all facilities that submitted SFY-1995 cost reports, the sum of this calculation is then divided by the number of facilities that submitted cost reports.

(B) Inflated Base Year PPD Costs are determined by multiplying Statewide Base Year PPD Cost by the appropriate inflation factors. Statewide Base Year PPD Cost was adjusted from the midpoint of the base year to the midpoint of the rate year using the moving rate of change forecast in the Data Resources, Inc., (DRI) "HCFA Nursing Home without Capital Market Basket" Index as published for the fourth quarter of calendar year 1995. The OHCA uses this same index (DRI) for subsequent years as it becomes available and is appropriate.

(C) The facilities base cost is determined by multiplying the facilities' current quarter census by the inflated statewide average PPD costs calculated in (B) of this unit.

(g) **Methodology for determining wage enhancement revenue and expenditure results.** The methodology for determining the facilities' wage enhancement revenue and expenditures results are calculated in (1) through (3) of this paragraph.

(1) **Wage enhancement revenue.** Total wage enhancement revenue received by the facility for the current quarter is calculated by multiplying the facilities total paid Medicaid days for the current quarter by the facilities wage enhancement rate. The Oklahoma Health Care Authority adjusts the computations and results when actual paid Medicaid data for the reporting quarter becomes available.

(2) **Wage enhancement expenditures.** Total wage enhancement expenditures are determined in a four step process as described in (A) through (D) of this paragraph.

(A) Total current quarter allowable expenses are calculated. Salaries and wages of specified staff are totaled and added to the applicable percent of customary employee benefits and 100% of the new employee benefits.

(B) Base period expenditures are calculated. An occupancy adjustment factor is applied to the quarterly average base period cost to account for changes in census.

(C) Current quarter wage enhancement expenditures are calculated by subtracting allowable base period expenditures (see (B) of this subparagraph) from total current quarter allowable expenses (see (A) of this subparagraph).

(D) Total wage enhancement expenditures are calculated by adding current quarter wage enhancement expenditures (see (C) of this subparagraph) to prior period wage enhancement expenditures carried forward.

(3) **Wage enhancement revenue and expenditure results.** Wage enhancement revenue and expenditure results are determined by comparing total wage enhancement revenue (see (1) of this paragraph) to total wage enhancement expenditures (see (2)(D) of this paragraph). Revenue exceeding expenses is subject to recoupment. Expenses exceeding revenue are carried forward to the next reporting period as a prior period wage enhancement expenditure carry over.

317:30-5-131.2. Quality of care fund requirements and report

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

(1) **"Nursing Facility and Intermediate Care Facility for the mentally retarded"** means any home, establishment, or institution or any portion thereof, licensed by the State Department of Health as defined in Section 1-1902 of Title 63 of the Oklahoma Statutes.

(2) **"Quality of Care Fee"** means the fee assessment created for the purpose of quality care enhancements pursuant to Section 2002 of Title 56 of the Oklahoma Statutes

upon each nursing facility and intermediate care facility for the mentally retarded licensed in this State.

(3) **"Quality of Care Fund"** means a revolving fund established in the State Treasury pursuant to Section 2002 of Title 56 of the Oklahoma Statutes.

(4) **"Quality of Care Report"** means the monthly report developed by the Oklahoma Health Care Authority to document the staffing ratios, total patient gross receipts, total patient days, and minimum wage compliance for specified staff for each nursing facility and intermediate care facility for the mentally retarded licensed in the State.

(5) **"Staffing ratios"** means the minimum direct-care-staff-to-resident ratios pursuant to Section 1-1925.2 of Title 63 of the Oklahoma Statutes and pursuant to OAC 310:675-1 et seq.

(6) **"Peak In-House Resident Count"** means the maximum number of in-house residents at any point in time during the applicable shift.

(7) **"Staff Hours worked by Shift"** means the number of hours worked during the applicable shift by direct-care staff.

(8) **"Direct-Care Staff"** means any nursing or therapy staff who provides direct, hands-on care to residents in a nursing facility and intermediate care facility for the mentally retarded pursuant to Section 1-1925.2 of Title 63 of the Oklahoma Statutes, pursuant to OAC 310:675-1 et seq., and as defined in subsection (c) of this Section.

(9) **"Major Fraction Thereof"** is defined as an additional threshold for direct-care-staff-to-resident ratios at which another direct-care staff person(s) is required due to the peak in-house resident count exceeding one-half of the minimum direct-care-staff-to-resident ratio pursuant to Section 1-1925.2 of Title 63 of the Oklahoma Statutes.

(10) **"Minimum wage"** means the amount paid per hour to specified staff pursuant to Section 5022.1 of Title 63 of the Oklahoma Statutes.

(11) **"Specified staff"** means the employee positions listed in the Oklahoma Statutes under Section 5022.1 of Title 63 and as defined in subsection (d) of this Section.

(12) **"Total Patient Days"** means the monthly patient days that are compensable for the current monthly Quality of Care Report.

(13) **"Total Gross Receipts"** means all cash received in the current Quality of Care Report month for services rendered to all residents in the facility. Receipts should include all Medicaid, Medicare, Private Pay and Insurance including receipts for items not in the normal per diem rate. Charitable contributions received by the nursing facility are not included.

(14) **"Service rate"** means the minimum direct-care-staff-to-resident rate pursuant to Section 1-1925.2 of Title 63 of Oklahoma Statutes and pursuant to OAC 310:675-1 et seq.

(b) **Quality of care fund assessments.**

(1) The Oklahoma Health Care Authority (OHCA) was mandated by the Oklahoma Legislature to assess a monthly service fee to each Licensed Nursing Facility in the State. The fee is assessed on a per patient day basis.

Emergency Adoptions

The amount of the fee is uniform for each facility type. The fee is determined as six percent (6%) of the average total gross receipts divided by the total days for each facility type.

(2) In determination of the fee for the time period beginning October 1, 2000, a survey was mailed to each licensed nursing facility requesting calendar year 1999 Total Patient Days, Gross Revenues and Contractual Allowances and Discounts. This data is used to determine the amount of fee to be assessed for the period of 10-01-00 through 06-30-01. The fee is determined by totaling the "annualized" gross revenue and dividing by the "annualized" total days of service. "Annualized" means that the surveys received that do not cover the whole year of 1999 are divided by the total number of days that are covered and multiplied by 365.

(3) The fee for subsequent State Fiscal Years is determined by using the monthly gross receipts and census reports for the six month period October 1 through March 31 of the prior fiscal year, annualizing those figures, and then determining the fee as defined above.

(4) Monthly reports of Gross Receipts and Census are included in the monthly Quality of Care Report. The data required includes, but is not limited to, the Total Gross Receipts and Total Patient Days for the current monthly report.

(5) The method of collection is as follows:

(A) The Oklahoma Health Care Authority assesses each facility monthly based on the reported patient days from the Quality of Care Report filed two months prior to the month of the fee assessment billing. As defined in this subsection, the total assessment is the fee times the total days of service. The Oklahoma Health Care Authority notifies the facility of its assessment by the end of the month of the Quality of Care Report submission date.

(B) Payment is due to the Oklahoma Health Care Authority by the 10th of the following month. Failure to pay the amount by the 10th or failure to have the payment mailing postmarked by the 8th will result in a debt to the State of Oklahoma and is subject to penalties of 10% of the amount and interest of 1.25% per month. The Quality of Care Fee must be submitted no later than the 10th of the month. If the 10th falls upon a holiday or weekend (Saturday-Sunday), the fee is due by 5 p.m. (Central Standard Time) of the following business day (Monday-Friday).

(C) The monthly assessment including applicable penalties and interest must be paid regardless of any appeals action requested by the facility. If a provider fails to pay the Authority the assessment within the time frames noted on the second invoice to the provider, the assessment, applicable penalty, and interest will be deducted from the facility's payment. Any change in payment amount resulting from an appeals decision will be adjusted in future payments. Adjustments to prior months' reported amounts for

gross receipts or patient days may be made by filing an amended part C of the Quality of Care Report.

(D) The Quality of Care fee assessments excluding penalties and interest are an allowable cost for Oklahoma Health Care Authority Cost Reporting purposes.

(E) The Quality of Care fund contains assessments collected excluding penalties and interest as described in this subsection and any interest attributable to investment of any money in the fund must be deposited in a revolving fund established in the State Treasury. The funds will be used pursuant to Section 2002 of Title 56 of the Oklahoma Statutes.

(c) **Quality of care direct-care-staff-to resident-ratios.**

(1) Effective September 1, 2000, all nursing facilities and intermediate care facilities for the mentally retarded (ICFs/MR) subject to the Nursing Home Care Act, in addition to other state and federal staffing requirements, must maintain the minimum direct-care-staff-to-resident ratios or direct-care service rates as cited in Section 1-1925.2 of Title 63 of the Oklahoma Statutes and pursuant to OAC 310:675-1 et seq.

(2) For purposes of staff-to-resident ratios, direct-care staff are limited to the following employee positions:

- (A) Registered Nurse
- (B) Licensed Practical Nurse
- (C) Nurse Aide
- (D) Certified Medication Aide
- (E) Qualified Mental Retardation Professional (ICFs/MR only)
- (F) Physical Therapist
- (G) Occupational Therapist
- (H) Respiratory Therapist
- (I) Speech Therapist
- (J) Therapy Aide/Assistant
- (K) Social Services Director/Social Worker
- (L) Other Social Services Staff
- (M) Activities Director
- (N) Other Activities Staff
- (O) Combined Social Services/Activities

(3) Prior to September 1, 2003, activity and social services staff who are not providing direct, hands-on care may be included in the direct-care-staff-to-resident ratio in any shift or direct-care service rates. On and after September 1, 2003, such persons are not included in the direct-care-staff-to-resident ratio or direct-care service rates.

(4) In any shift when the direct-care-staff-to-resident ratio computation results in a major fraction thereof, direct-care staff is rounded to the next higher whole number.

(5) To document and report compliance with the provisions of this subsection, nursing facilities and intermediate care facilities for the mentally retarded must submit the monthly Quality of Care Report pursuant to subsection (e) of this Section.

(d) **Quality of care minimum wage for specified staff.**

Effective November 1, 2000, all nursing facilities and private intermediate care facilities for the mentally retarded receiving

Medicaid payments, in addition to other federal and state regulations, must pay specified staff not less than in the amount of \$6.65 per hour. Employee positions included for purposes of minimum wage for specified staff are as follows:

- (1) Registered Nurse
- (2) Licensed Practical Nurse
- (3) Nurse Aide
- (4) Certified Medication Aide
- (5) Other Social Service Staff
- (6) Other Activities Staff
- (7) Combined Social Services/Activities
- (8) Other Dietary Staff
- (9) Housekeeping Supervisor and Staff
- (10) Maintenance Supervisor and Staff
- (11) Laundry Supervisor and Staff

(e) **Quality of care reports.** Effective September 1, 2000, all nursing facilities and intermediate care facilities for the mentally retarded must submit a monthly report developed by the Oklahoma Health Care Authority, the Quality of Care Report, for the purposes of documenting the extent to which such facilities are compliant with the minimum direct-care-staff-to-resident ratios or direct-care service rates.

(1) The monthly report must be signed by the preparer and by the Owner, authorized Corporate Officer or Administrator of the facility for verification and attestation that the reports were compiled in accordance with this section.

(2) The Owner or authorized Corporate Officer of the facility must retain full accountability for the report's accuracy and completeness regardless of report submission method.

(3) Penalties for false statements or misrepresentation made by or on behalf of the provider are provided at 42 U.S.C. Section 1320a-7b which states, in part, "*Whoever... (2) at any time knowingly and willfully makes or causes to be made any false statement of a material fact for use in determining rights to such benefit or payment... shall (i) in the case of such statement, representation, concealment, failure, or conversion by any person in connection with furnishing (by that person) of items or services for which payment is or may be made under this title (42 U.S.C. §1320 et seq.), be guilty of a felony and upon conviction thereof fined not more than \$25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than \$10,000 or imprisoned for not more than one year, or both.*"

(4) The Quality of Care Report must be submitted by 5 p.m. (CST) on the 15th of the following month. If the 15th falls upon a holiday or a weekend (Saturday-Sunday), the report is due by 5 p.m. (CST) of the following business day (Monday - Friday).

(5) The Quality of Care Report will be made available in an electronic version for uniform submission of the required data elements.

(6) Facilities must submit the monthly report either through electronic mail to the Provider Compliance Audits Unit or send the monthly report in disk or paper format by certified mail and pursuant to subsection (e)(14) of this section. The submission date is determined by the date and time recorded through electronic mail or the postmark date and the date recorded on the certified mail receipt.

(7) Should a facility discover an error in its submitted report for the previous month only, the facility must provide to the Provider Compliance Audits Unit written notification with adequate, objective and substantive documentation within five business days following the submission deadline. Any documentation received after the five business day period will not be considered in determining compliance and for reporting purposes by the Oklahoma Health Care Authority.

(8) An initial administrative penalty of \$150.00 is imposed upon the facility for incomplete, unauthorized, or non-timely filing of the Quality of Care Report. Additionally, a daily administrative penalty will begin upon the Authority notifying the facility in writing that the report was not complete or not timely submitted as required. The \$150.00 daily administrative penalty accrues for each calendar day after the date the notification is received. The penalties are deducted from the Medicaid facility's payment. For 100% private pay facilities, the penalty amount(s) is included and collected in the fee assessment billings process. Imposed penalties for incomplete reports or non-timely filing are not considered for Oklahoma Health Care Authority Cost Reporting purposes.

(9) The Quality of Care Report includes, but is not limited to, information pertaining to the necessary reporting requirements in order to determine the facility's compliance with subsections (b) and (c) of this Section. Such reported information includes, but is not limited to: staffing ratios; peak in-house resident count; staff hours worked by shift; total patient days; total gross receipts; and direct-care service rates.

(10) Audits may be performed to determine compliance pursuant to subsections (b), (c) and (d) of this Section. Announced/unannounced on-site audits of reported information may also be performed.

(11) Direct-care-staff-to-resident information and on-site audit findings pursuant to subsection (c), will be reported to the Oklahoma State Department of Health for their review in order to determine "willful" non-compliance and assess penalties accordingly pursuant to Title 63 Section 1-1912 through Section 1-1917 of the Oklahoma Statutes. The Oklahoma State Department of Health informs the Oklahoma Health Care Authority of all final penalties as required in order to deduct from the Medicaid facility's payment. Imposed penalties are not considered for Oklahoma Health Care Authority Cost Reporting purposes.

(12) If a Medicaid provider is found non-compliant pursuant to subsection (d) based upon a desk audit and/or an on-site audit, for each hour paid to specified staff that does not meet the regulatory minimum wage of \$6.65, the

Emergency Adoptions

facility must reimburse the employee(s) retroactively to meet the regulatory wage for hours worked. Additionally, an administrative penalty of \$25.00 is imposed for each non-compliant staff hour worked. For Medicaid facilities, a deduction is made to their payment. Imposed penalties for non-compliance with minimum wage requirements are not considered for Oklahoma Health Care Authority Cost Reporting purposes.

(13) Under OAC 317:2-1-2, Long Term Care facility providers may appeal the administrative penalty described in (b)(5)(B) and (e)(8) and (e)(12) of this section.

(14) Facilities that have been authorized by the Oklahoma State Department of Health (OSDH) to implement flexible staff scheduling must comply with OAC 310:675-1 et seq. The authorized facility are required to complete the flexible staff scheduling section of Part A of the Quality of Care Report. The Owner, authorized Corporate Officer or Administrator of the facility must complete the flexible staff scheduling signature block, acknowledging their OSDH authorization for Flexible Staff Scheduling.

PART 21. OUTPATIENT BEHAVIORAL HEALTH SERVICES

317:30-5-241. Coverage for adults and children

(a) **Service descriptions and conditions.** Outpatient behavioral health services are covered for adults and children as set forth in this Section, unless specified otherwise, and when provided in accordance with a documented individualized service plan, developed to treat the identified mental health and/or substance abuse disorder(s). All services are to be for the goal of improvement of functioning, independence, or well being of the client. The client must be able to actively participate in the treatment. Active participation means that the client must have sufficient cognitive abilities, communication skills, and short-term memory to derive a reasonable benefit from the treatment. The assessment must include a DSM multi axial diagnosis completed for all five axes from the most recent DSM version. All services will be subject to medical necessity criteria. For ODMHSAS Contracted and Private facilities, an agent designated by the Oklahoma Health Care Authority will apply the medical necessity criteria. For public facilities (regionally based CMHCs), the medical necessity criteria will be self-administered following the same required elements as the private and contracted (ODMHSAS) agencies under OAC 317:30-5-241(b)(4)(B)(i). Non prior authorized services will not be Medicaid compensable with the exception of Mental Health Assessment by a Non-Physician, Mental Health Service Plan Development, Crisis Intervention Services (by a MHP and Facility based), and Program of Assertive Community Treatment Services (PACT). Payment is not made for Outpatient Behavioral Health Services for children who are receiving Residential Behavioral Management Services in a Group Home or Therapeutic Foster Care with the exception of Psychotherapy services which must be authorized by the OHCA or its designated agent as medically necessary and

indicated, and Crisis Intervention Services (facility based). Residents of nursing facilities are not eligible for Outpatient Behavioral Health services.

(1) **Mental Health Assessment by a Non-Physician** includes a history of psychiatric symptoms, concerns and problems, an evaluation of mental status, a psychosocial and medical history, a full five axes diagnosis and evaluation of current functioning, and an evaluation and assessment of alcohol and other drug use (historic and present). The service must also include an evaluation of the client's strengths and information regarding the client's treatment preferences. For adults, it may include interviews or communications with family, caretakers, or other support persons as permitted by the client. For children under the age of 18, it must include an interview with a parent, or other adult caretaker. For children, the assessment must also include information on school performance and school based services. This service is performed by an MHP. The minimum face-to-face time spent in assessment with the client and others as identified previously in this paragraph for a low complexity Mental Health Assessment by a Non-Physician is one and one half hours. For a moderate complexity, it is two hours or more. This service is compensable on behalf of a client who is seeking services for the first time from the contracted agency. This service is not compensable if the client has previously received or is currently receiving services from the agency, unless there has been a gap in services of more than six months and it has been more than one year since the previous assessment. This service is not allowed for AOD providers.

(2) **Alcohol and Drug Assessment.** Alcohol and Drug Assessment includes an assessment of past and present alcohol and other drug use. The ASI is to be completed. This service includes an evaluation of current and past functioning in all major life areas and an evaluation of potential mental illnesses that may also impact treatment. It includes a full five axes diagnosis. The service must also include an evaluation of the client strengths and weaknesses and information regarding the client's treatment preferences. For adults, it may include interviews and/or communication with family, caretakers or other support persons as permitted by the client. For children under the age of 18, it must include an interview with a parent or other adult caretaker. For children, the assessment must also include information on school performance and school based services. This service is performed by an AODTP. The minimum face to face time spent in assessment with the client (and other family or caretakers as previously described in this paragraph) for a low complexity is one and one-half hours. For a moderate complexity it is two hours or more. This service is compensable on behalf of a client who is seeking services for the first time from the contracted agency. The service is not compensable if the client has previously received or is currently receiving services from the agency, unless there has been a gap in services of more than six months and it has been

more than one year since the previous assessment. This service is not allowed for Mental Health Providers.

(3) **Mental Health Services Plan Development by a Non-Physician (moderate complexity).** Mental Health Services Plan Development by a Non-Physician (moderate complexity) is to be performed by the practitioners and others who will comprise the treatment team. It is performed with the direct active participation of the client and a client support person or advocate if requested by the client. In the case of children under the age of 18, it is performed with the participation of the parent or guardian and the child as age and developmentally appropriate. The Mental Health Services Plan is developed based on information obtained in the mental health assessment and includes the evaluation of assessment by the practitioners and the client of all pertinent information. It includes a discharge plan. It is a process whereby an individualized rehabilitation plan is developed that addresses the client's strengths, functional assets, weaknesses or liabilities, treatment goals, objectives and methodologies that are specific and time limited. For adults, it must be focused on recovery and achieving maximum community interaction and involvement including goals for employment, independent living, volunteer work, or training. For children, the service plan must address school and educational concerns and assisting the family in caring for the child in the least restrictive level of care. Each type of service to be received must be delineated in the service plan and the practitioner who will be providing and responsible for each service must be identified. In addition, the anticipated frequency of each type of service must be included. This service is provided by the client treatment team. This includes all staff responsible for the treatment services delineated in the plan, the client (if over age 14), and the parent/guardian if under age 18. The service plan is not valid until it is signed and dated by the responsible MHP, the treating physician, the client, the guardian (if applicable), and any other direct service provider, and all requirements have been met. Each signature must have the date written by the signing party on the date of signing. One unit per Medicaid recipient per provider is allowed without prior authorization. If determined by OHCA or its designated agent, one additional unit per year may be authorized.

(4) **Mental Health Services Plan Development by a Non-Physician (low complexity).** Mental Health Services Plan Development by a Non-Physician (low complexity) is for the purpose of reviewing, revising and updating an established Mental Health Services Plan. All elements of the plan must be reviewed with the client and treatment progress assessed. When significant progress toward recovery and the treatment goals is not occurring, the service plan must be altered in order to support and maximize progress toward recovery. When significant progress has been made, the plan must be updated to reflect the improved client's abilities and strengths and services adjusted accordingly. Mental Health Services Plan Development by a Non-Physician (low complexity)

will be provided by the treatment team members. The review is not valid until signed and separately dated by the responsible MHP, the responsible physician (if client is receiving medication or otherwise under the care of the physician), the client, the guardian (if applicable), and any other direct service provider, and all requirements have been met.

(5) **Alcohol and/or Substance Abuse Services, Treatment Plan Development (moderate complexity).** Alcohol and Substance Abuse Treatment Plan Development (moderate complexity) is to be performed by the AODTP practitioners and others who will comprise the treatment team. The current edition of the ASAM criteria is to be utilized and followed. The service is performed with the direct active participation of the client and a client support person or advocate if requested by the client. In the case of children under the age of 18, it is performed with the participation of the parent or guardian and the child as age and developmentally appropriate. The Plan is developed based on information obtained in the assessment and includes the evaluation of all pertinent information by the practitioners and the client. The service includes a discharge plan. The service is a process whereby an individualized rehabilitation plan is developed that addresses the client's strengths, functional assets, weaknesses or liabilities, treatment goals, objectives and methodologies that are specific and time limited. For adults, it must be focused on recovery and achieving maximum community interaction and involvement including goals for employment, independent living, volunteer work, or training. For children, the service plan must address school and educational concerns and assisting the family in caring for the child in the least restrictive level of care. Each type of service to be received must be delineated in the service plan and the practitioner who will be providing and responsible for each service must be identified. In addition, the anticipated frequency of each type of service must be included. This service is provided by the client treatment team. This includes all staff responsible for the treatment services delineated in the plan, the client (if over age 14), and the parent/guardian if under age 18. The service plan is not valid until it is signed and dated by the responsible AODTP, the treating physician, the client, the guardian (if applicable), and any other direct service provider, and all requirements have been met. Each signature must have the date written by the signing party on the date of signing. One unit per Medicaid recipient per provider is allowed without prior authorization. If determined by OHCA or its designated agent, one additional unit per year may be authorized.

(6) **Alcohol and/or Substance Abuse Treatment Plan Development (low complexity).** Alcohol and/or Substance Abuse Treatment Plan Development (low complexity) is for the purpose of reviewing, revising and updating an established Mental Health Services Plan. The ASAM criteria will be utilized in the development of the Plan. All elements of the plan must be reviewed with the client and treatment progress assessed. When significant

progress toward recovery and the treatment goals is not occurring, the service plan must be altered in order to support and maximize progress toward recovery. When significant progress has been made, the plan must be updated to reflect the improved client's abilities and strengths and services adjusted accordingly. Alcohol and/or Substance Abuse Treatment Plan Development (low complexity) will be provided by the treatment team members. The review is not valid until signed and separately dated by the responsible AODTP, the responsible physician (if client is receiving medication or otherwise under the care of the physician), the client, the guardian (if applicable), and any other direct service provider, and all requirements have been met.

(7) Individual/Interactive Psychotherapy.

(A) Individual Psychotherapy is a face-to-face treatment for mental illnesses and behavioral disturbances, in which the clinician, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior and encourage growth and development. Insight oriented, behavior modifying and/or supportive psychotherapy refers to the development of insight of affective understanding, the use of behavior modification techniques, the use of supportive interactions, the use of cognitive discussion of reality, or any combination of these items to provide therapeutic change.

(B) Interactive Psychotherapy is generally furnished to children and involves the use of physical aids and nonverbal communication to overcome barriers to the therapeutic interaction between the clinician and the client who has not yet developed or who has lost either the expressive language communication skills to explain his/her symptoms and response to treatment, or the receptive communication skills to understand the clinician. The service may be used for adults who are hearing impaired and require the use of a language interpreter due to language barriers.

(C) There are a total of six different compensable units of individual/interactive psychotherapy, three each for interactive and individual psychotherapy. They are Individual Insight Oriented, Behavior Modifying and/or Supportive Psychotherapy in an Outpatient Setting (20 - 30 minutes, 45 - 50 minutes, and 75 - 80 minutes), and Interactive Psychotherapy in an office or Outpatient Setting (20 - 30 minutes, 45 - 50 minutes, and 75 - 80 minutes). There is a maximum of one unit of either Individual or Interactive Psychotherapy per day. With the exception of a qualified interpreter if needed, only the client and the MHP or AODTP should be present and the setting must protect and assure confidentiality. Ongoing assessment of the client's status and response to treatment as well as psycho-educational intervention are appropriate components of individual counseling.

The counseling must be goal directed, utilizing techniques appropriate to the service plan and the client's developmental and cognitive abilities.

(D) Individual/Interactive counseling must be provided by a MHP when treatment is for a mental illness and by an AODTP when treatment is for an alcohol or other drug disorder.

(8) Group Psychotherapy.

(A) Group psychotherapy is a method of treating behavioral disorders using the interaction between the MHP when treating mental illness or the AODTP when treating alcohol and other drug disorders, and two or more individuals to promote positive emotional or behavioral change. The focus of the group must be directly related to the goals and objectives in the individual client's current service plan. This service does not include social or daily living skills development as described under Individual and Group Psychosocial Rehabilitation Services, or Alcohol and/or Substance Abuse Services Skills Development.

(B) Group Psychotherapy must take place in a confidential setting limited to the MHP or the AODTP conducting the service, an assistant or co-therapist, if desired, and the group psychotherapy participants. Group Psychotherapy is limited to a total of eight adult individuals except when the individuals are residents of an ICF/MR where the maximum group size is six. For all children under the age of 18, the total group size is limited to six. The typical length of time for a group psychotherapy session is one hour. A maximum of two Group Psychotherapy units per day are allowed. Partial units are acceptable. The individual client's behavior, the size of the group, and the focus of the group must be included in each client's medical record. A group may not consist solely of related individuals.

(C) Group psychotherapy will be provided by a MHP when treatment is for a mental illness and by an AODTP when treatment is for an alcohol or other drug disorder.

(9) Family Psychotherapy.

(A) Family Psychotherapy is a face-to-face psychotherapeutic interaction between a MHP or an AOD and the client's family, guardian, and/or support system. It is typically inclusive of the identified client, but may be performed if indicated without the client's presence. When the client is an adult, his/her permission must be obtained. Family psychotherapy must be provided for the direct benefit of the Medicaid recipient to assist him/her in achieving his/her established treatment goals and objectives and it must take place in a confidential setting.

(B) The length of a Family Psychotherapy session is one hour. No more than two hours of Family Psychotherapy are allowed per day. Partial units are acceptable. Family Psychotherapy must be provided by a MHP when treatment is for a mental illness and

by an AODTP when treatment is for an alcohol or other drug disorder.

(10) Psychosocial Rehabilitation Services (group).

(A) Psychosocial Rehabilitation Services (PSR) are behavioral health remedial services which are necessary to improve the client's ability to function in the community. They are performed to improve the skills and abilities of clients to live interdependently in the community, improve self-care and social skills, and promote lifestyle change and recovery practices. This service may take the form of a work units component in a General PSR program certified through the ODMHSAS. Each day of PSR must be reflected by documentation in the client records, and must include the following:

- (i) date;
- (ii) start and stop time(s) for each day of service;
- (iii) signature of the rehabilitation clinician;
- (iv) credentials of the rehabilitation clinician;
- (v) specific goal(s) and/or objectives addressed (these must be identified on recovery plan);
- (vi) type of skills training provided;
- (vii) progress made toward goals and objectives;
- (viii) client satisfaction with staff intervention; and
- (ix) any new needed supports identified during service.

(B) Compensable Psychosocial Rehabilitation Services are provided to clients who have the ability to benefit from the service. The services performed must have a purpose that directly relates to the goals and objectives of the client's current service plan. A client who at the time of service is not able to cognitively benefit from the treatment due to active hallucinations, substance use, or other impairments is not suitable for this service.

(C) Travel time to and from PSR treatment is not compensable. Breaks, lunchtime and times when the client is unable or unwilling to participate are not compensable. The minimum staffing ratio is fourteen clients for each BHRS or MHP for adults and eight to one for children under the age of eighteen. Countable professional staff must be appropriately trained in a recognized behavioral/management intervention program such as MANDT or CAPE. In order to develop and improve the client's community and interpersonal functioning and self care abilities, rehabilitation may take place in settings away from the Outpatient Behavioral Health agency site. When this occurs, the BHRS or MHP must be present and interacting, teaching, or supporting the defined learning objectives of the client for the entire claimed time. The service is a fifteen minute time frame and may be billed up to a maximum of 24 units per day for adults and 16 units per day for children. The rate of compensation for this service includes the cost of providing

transportation for recipients who receive this service, but do not have their own transportation or do not have other support persons able to provide or who are responsible for the transportation needs. The OHCA transportation program will arrange for transportation for those who require specialized transportation equipment. Residents of ICF/MR facilities and children receiving RBMS in a group home or therapeutic Foster Home are not eligible for this service.

(D) A BHRS, AODTP (when treatment is for an alcohol or other drug disorder), or MHP may perform group psychosocial rehabilitation services, using a treatment curriculum approved by a MHP.

(11) Psychosocial Rehabilitation Services (individual).

(A) Psychosocial Rehabilitation (PSR) Services (individual) is performed for the same purposes and under the same description and requirements as Psychosocial Rehabilitation Services (group) [Refer to paragraph (10) of this subsection]. The service is generally performed with only the client present, but may include the client's family or support system in order to educate them about the rehabilitative activities, interventions, goals and objectives.

(B) A BHRS, AODTP (when treatment is for an alcohol or other drug disorder, or MHP must provide this service. Residents of ICF/MR facilities and children receiving RBMS in a group home or therapeutic Foster Home are not eligible for this service. This billing unit is fifteen minutes and no more than six units per day are compensable. Children under an ODMHSAS Systems of Care program may be prior authorized additional units as part of an intensive transition period.

(12) Psychological testing.

(A) Psychological testing is provided by a psychologist utilizing tests selected from currently accepted psychological test batteries. Test results must be reflected in the Mental Health Services plan. The medical record must clearly document the need for the testing and what the testing is expected to achieve.

(B) Psychological testing will be provided by a psychologist, certified psychometrist, or a psychological technician of a psychologist.

(13) Alcohol and/or Substance Abuse Services, Skills Development (group).

(A) Alcohol and/or Substance Abuse Services, Skills Development (group) consists of the therapeutic education of clients regarding their AOD addiction or disorder. The service may also involve teaching skills to assist the individual in how to live independently in the community, improve self care and social skills and promote and support recovery. The services performed must have a purpose that directly relates to the goals and objectives of the client's current service plan. A client who at the time of service is not able to cognitively benefit from the treatment due to active

Emergency Adoptions

hallucinations, substance use, or other impairments is not suitable for this service.

(B) Travel time to and from Alcohol and/or Substance Abuse Services, Skills Development is not compensable. Breaks, lunchtime and times when the client is unable or unwilling to participate are not compensable. The minimum staffing ratio is fourteen clients for each AODTP for adults and eight to one for children under the age of eighteen. This service may be performed by an AODTP or a BHRS. In order to develop and improve the client's community and interpersonal functioning and self care abilities, services may take place in settings away from the Outpatient Behavioral Health agency site. When this occurs, the AODTP or BHRS must be present and interacting, teaching, or supporting the defined learning objectives of the client for the entire claimed time. The service is a fifteen minute time frame and may be billed up to a maximum of 24 units per day for adults and 16 units per day for children. The rate of compensation for this service includes the cost of providing transportation for recipients who receive this service, but do not have their own transportation or do not have other support persons able to provide or who are responsible for the transportation needs. The OHCA transportation program will arrange for transportation for those who require specialized transportation equipment. Residents of ICF/MR facilities and children receiving RBMS in a group home or therapeutic Foster Home are not eligible for this service.

(C) Alcohol and/or Substance Abuse Services, Skills Development are provided utilizing a treatment curriculum approved by an AODTP.

(14) Alcohol and/or Substance Abuse Services, Skills Development (individual).

(A) Alcohol and/or Substance Abuse Services, Skills Development (individual) is performed for the same purposes and under the same description and requirements as Alcohol and/or Substance Abuse Services, Skills Development (group) [Refer to paragraph (13) of this subsection]. It is generally performed with only the client present, but may include the client's family or support system in order to educate them about the rehabilitative activities, interventions, goals and objectives.

(B) An AODTP or BHRS must provide this service. Residents of ICF/MR facilities and children receiving RBMS in a group home or therapeutic Foster Home are not eligible for this service. This billing unit is fifteen minutes and no more than six units per day are compensable.

(15) Medication Training and Support.

(A) Medication Training and Support is a documented review and educational session by a registered nurse, or physician assistant focusing on a client's response to medication and compliance with the medication regimen. The review must include an

assessment of medication compliance and medication side effects. Vital signs must be taken including pulse, blood pressure and respiration and documented within the progress notes. A physician is not required to be present, but must be available for consult. Medication Training and Support is designed to maintain the client on the appropriate level of the least intrusive medications, encourage normalization and prevent hospitalization. Medication Training and Support may not be billed for Medicaid recipients who reside in ICF/MR facilities.

(B) Medication Training and Support must be provided by a licensed registered nurse, or a physician assistant as a direct service under the supervision of a physician.

(16) Crisis Intervention Services.

(A) Crisis Intervention Services are for the purpose of responding to acute behavioral or emotional dysfunction as evidenced by psychotic, suicidal, homicidal or severe psychiatric distress. The crisis situation including the symptoms exhibited and the resulting intervention or recommendations must be clearly documented. Crisis Intervention Services are not compensable for Medicaid recipients who reside in ICF/MR facilities, or who receive RBMS in a group home or Therapeutic Foster home, or recipients who, while in attendance for other behavioral health services, experience acute behavioral or emotional dysfunction. The unit is a fifteen minute unit with a maximum of eight units per month and 40 units each 12 months per recipient.

(B) Crisis Intervention Services must be provided by a MHP.

(17) Crisis Intervention Services (facility based stabilization). Crisis Intervention Services (facility based stabilization) are emergency psychiatric and substance abuse services to resolve crisis situations. The services provided are emergency stabilization, which includes a protected environment, chemotherapy, detoxification, individual and group treatment, and medical assessment. Crisis Intervention Services (facility based stabilization) will be under the supervision of a physician aided by a licensed nurse, and will also include MHPs for the provision of group and individual treatments. A physician must be available. This service is limited to providers who contract with or are operated by the ODMHSAS to provide this service within the overall behavioral health service delivery system. Crisis Intervention Services (facility based stabilization) are compensable for child and adult Medicaid recipients. The unit of service is per hour. Providers of this service must meet the requirements delineated in the Oklahoma Administrative Code.

(18) Program of Assertive Community Treatment (PACT) Services.

(A) Program of Assertive Community Treatment (PACT) Services are those delivered within an assertive community based approach to provide treatment, rehabilitation, and essential behavioral health

supports on a continuous basis to individuals 18 years of age or older with serious mental illness with a self contained multi-disciplinary team. The team must use an integrated service approach to merge essential clinical and rehabilitative functions and staff expertise. This level of service is to be provided only for persons most clearly in need of intensive ongoing services. Services must satisfy all statutory required program elements as articulated in the Oklahoma Administrative Code 450:55. At a minimum, the services must include:

- (i) Assessment and evaluation;
- (ii) Treatment planning;
- (iii) Crisis intervention to cover psychiatric crisis and drug and alcohol crisis intervention;
- (iv) Symptom assessment, management, and individual supportive psychotherapy;
- (v) Medication evaluation and management, administration, monitoring and documentation;
- (vi) Rehabilitation services;
- (vii) Substance abuse treatment services;
- (viii) Activities of daily living training and supports;
- (ix) Social, interpersonal relationship, and related skills training; and,
- (x) Case management services.

(B) Providers of PACT services are specific teams within an established organization and must be operated by or contracted with and must be certified by the ODMHSAS in accordance with 43A O.S. 319 and Oklahoma Administrative Code 450:55. The unit is a per diem inclusive of all services provided by the PACT team. No more than 12 days of service per month may be claimed. Medicaid recipients who are enrolled in this service may not receive other Outpatient Behavioral Health Services except for Crisis Intervention Services (facility based stabilization).

(19) **Behavioral Health Aide.** This service is limited to children with serious emotional disturbance who are in an ODMHSAS contracted systems of care community based treatment program who need intervention and support in their living environment to achieve or maintain stable successful treatment outcomes. Behavioral Health Aides provide behavior management and redirection and behavioral and life skills remedial training. The behavioral aide also provides monitoring and observation of the child's emotional/behavioral status and responses, providing interventions, support and redirection when needed. Training is generally focused on behavioral, interpersonal, communication, self help, safety and daily living skills.

(A) Behavioral Health Aides must have completed 60 hours or equivalent of college credit to meet the requirement as a BHRS or may substitute one year of relevant employment and/or responsibility in the care of emotionally disturbed children for up to two years of college experience, and:

- (i) must have successfully completed the specialized training and education curriculum provided by the ODMHSAS; and
- (ii) must be directly and closely supervised by a licensed Mental Health Professional; and
- (iii) function under the general direction of the established systems of care team and the current treatment plan.

(B) These services must be prior authorized by OHCA (or its designated agent).

(b) **Prior authorization and review of services requirements.**

(1) **General requirement.**

(A) All Medicaid providers who provide outpatient behavioral health services are required to have the services they provide either prior authorized or retroactively reviewed by a contractor of OHCA. Private behavioral health providers and providers identified by the ODMHSAS as contracted providers are required to have all services prior authorized with the exception of the three services listed in paragraph (2)(A) of this subsection.

(B) CMHC's, as identified by the ODMHSAS, are required to have all services retroactively reviewed by a contractor of OHCA.

(2) **Prior authorization and review of services.**

(A) All Medicaid services identified in subsection (a) of this Section must be prior authorized or reviewed as set forth in paragraph (1) of this subsection except for the following services:

- (i) Mental Health Assessment by a Non-Physician [see subsection (a)(1) of this Section];
- (ii) Mental Health Services Plan Development by a Non-Physician (moderate complexity) [see subsection (a)(2) of this Section]; and
- (iii) Crisis Intervention Services and Adult Facility Based Crisis Intervention [see subsection (a)(17) and (18) of this Section]. Children's Facility Based Stabilization requires prior authorization.

(B) Prior authorization means the authorization of services prior to services being rendered. Should a provider perform services prior to the authorization, those services are performed at the risk of nonpayment by OHCA.

(3) **Contractor for prior authorization and review of services.** The contractor who performs the services identified in paragraph (1) of this subsection uses its independent medical judgment to perform both the review of services and the prior authorization of services. OHCA does retain final administrative review over both prior authorization and review of services as required by 42 CFR 431.10.

(4) **Prior authorization process.**

(A) **Definitions.** The following definitions apply to the process of applying for an outpatient behavioral health prior authorization.

Emergency Adoptions

- (i) **"Outpatient Request for Prior Authorization"** means the form used to request the OHCA contractor to approve services.
 - (ii) **"Authorization Number"** means the number that is assigned per recipient and per provider that authorizes payment after services are rendered.
 - (iii) **"Initial Request for Treatment"** means a request to authorize treatment for a recipient that has not received outpatient treatment in the last six months.
 - (iv) **"Extension Request"** means a request to authorize treatment for a recipient who has received outpatient treatment in the last six months.
 - (v) **"Modification of Current Authorization Request"** means a request to modify the current array or amount of services a recipient is receiving.
 - (vi) **"Correction Request"** means a request to change a prior authorization error made by OHCA's contractor.
 - (vii) **"Provider change in demographic information notification"** means a request to change a provider's name, address, phone, and/or fax numbers, or provider identification numbers. Change in demographics will require contractual changes with OHCA. Providers should contact OHCA's Contracts Services Division for more information.
 - (viii) **"Status request"** means a request to ask the OHCA contractor the status of a request.
 - (ix) **"Important notice"** means a notice that informs the provider that information is lacking regarding the approval of any prior authorization request.
 - (x) **"Letter of collaboration"** means an agreement between the recipient and two providers when a recipient chooses more than one provider during a course of treatment.
- (B) **Process.** A provider must submit an Initial Request for Treatment, an Extension Request, a Modification of Current Authorization Request, or a Correction Request on a form provided by the OHCA contractor, prior to rendering the initial services or any additional array of services, with the exception of the three services noted in paragraph (2) of this subsection.
- (i) These request forms must be fully completed including the following:
 - (I) pertinent demographic and identifying information;
 - (II) complete and current Client Assessment Record (CAR) unless another appropriate assessment tool is authorized by contractor;
 - (III) complete multi axial, Diagnostic and Statistical Manual (DSM) diagnosis using the most current edition;
 - (IV) psychiatric and treatment history;
 - (V) service plan with goals, objectives, treatment duration;
 - (VI) services requested;
 - (VII) signature of client on service plan; and
 - (VIII) appropriate provider signature on all forms.
 - (ii) The OHCA contractor may also require supporting documentation for any data submitted by the provider. The request may be denied if such information is not provided within ten calendar days of notification of the Important Notice.
 - (iii) Failure to provide a complete request form may result in a delay in the start date of the prior authorization.
- (C) **Authorization for services.**
- (i) Services are authorized by the contractor exercising independent medical judgment based upon the medical data provided by the provider. The medical data provided, including the functional assessment (including frequency, duration and severity of behaviors), diagnosis and other medical history, is of paramount importance. If services are authorized, a treatment course of one to six months will be authorized. The authorization of services is based upon six levels of care for children and five levels of care for adults. The numerically based levels of care are designed to reflect the client's acuity as each level of care, in ascending order, provides for more services for the recipient's care. For example, a Level I (adult) designation provides for 1-12 RVU's while a Level II provides for 1-20 RVU's per month. The range of RVU's between the Level I and Level IV for both children and adults is 1 RVU per month to 62 RVU's per month. Other levels of care are known as Exceptional Case, 0-36 months, ICF/MR, and RBMS.
 - (ii) If the provider requests services beyond the initial prior authorization period, additional documentation is required in the Extension Request.
- (D) **Appeals process.**
- (i) After the contractor issues a decision regarding an Initial Prior Authorization request, an Extension Request, a Modification Request or a Correction Request, the provider has five business days of receipt of the decision to request the contractor to reconsider its decision. The issues which a provider may ask for reconsideration are the number and type of services designated by the contractor and the length of treatment approved by the contractor. The reasoning or propriety of an Important Notice or a denial based upon insufficient data may not be reconsidered.
 - (ii) ~~If a reconsideration request is made, the contractor's decision is a final decision and notice is sent to the client as required by 42 CFR 431.211. Notice is also sent to the provider. If a reconsideration request is not made, the initial decision of the contractor constitutes the final decision regarding~~

the authorization and notice is sent to the recipient as required by 42 CFR 431.211.

~~(iii) In the event a recipient disagrees with the decision by OHCA's contractor, it may appeal the decision regarding the prior authorization under OAC 317:2-1-2. An appeal must commence within 20 calendar days of the prior authorization reconsideration decision (in the event the provider asks for reconsideration) or within 20 days of the initial decision (in the event no reconsideration request is filed).~~

PART 32. SOONERRIDE NON-EMERGENCY TRANSPORTATION

317:30-5-327. SoonerRide non-emergency non-ambulance transportation services for eligible medicaid recipients residing in nursing facilities

(a) Access to non-emergency non-ambulance transportation through SoonerRide.

(1) Non-emergency, non-ambulance transportation services are available through the State's SoonerRide Non-Emergency Transportation (NET) program. SoonerRide NET is available on a statewide basis to all eligible Medicaid recipients who reside in nursing facilities.

(2) SoonerRide NET includes non-emergency, non-ambulance transportation for eligible Medicaid recipients residing in nursing facilities to and from eligible Medicaid providers of health care services. Eligible Medicaid providers are providers who have valid Oklahoma Medicaid contracts. The NET must be necessary to access medically necessary Medicaid covered services for which a recipient has available benefits. Additionally, SoonerRide NET may also be provided for eligible Medicaid recipients to providers other than Medicaid providers if the transportation is to access medically necessary services which are Medicaid coverable services.

(3) The use of Medicaid funded transportation for any other purpose is fraudulent activity and subject to criminal prosecution and civil and administrative sanctions.

(4) The SoonerRide broker assures that NET transportation services are provided:

- (A) in a manner consistent with the best interest of the Medicaid recipient;
- (B) similar in scope and duration state-wide, although there will be some variation based on available resources in a particular geographical area of the state;
- (C) appropriate to available services; and
- (D) appropriate for the limitations of the recipient.

(b) Service availability.

(1) SoonerRide NET is available for covered inpatient hospital care, outpatient hospital care, services from physicians, diagnostic devices, clinic services, eye care and dental care.

(2) SoonerRide NET is available if an eligible Medicaid recipient is being discharged from a hospital to a

nursing facility. The nursing facility that the recipient is moving to will be responsible for scheduling the transportation and providing an Attendant for the recipient.

(3) In the event that an eligible Medicaid recipient is voluntarily moving from one nursing facility to another, SoonerRide will provide NET to the new facility. The nursing facility that the recipient is moving from will be responsible for scheduling the transportation and providing an Attendant for the recipient.

(4) In the event that a nursing facility's license is terminated, SoonerRide will provide NET to a new nursing facility. The nursing facility that the recipient is moving from will be responsible for scheduling the NET through SoonerRide and providing an Attendant to accompany the eligible Medicaid recipient.

(c) Exclusions from SoonerRide NET. SoonerRide NET excludes:

- (1) Transportation of eligible Medicaid recipients residing in nursing facilities to access emergency services.
- (2) Transportation of eligible Medicaid recipients residing in nursing facilities by ambulance for any reason.
- (3) Transportation of eligible Medicaid recipients residing in nursing facilities whose medical condition requires transport by stretcher.
- (4) Transportation of eligible Medicaid recipients residing in nursing facilities to services that are not Medicaid covered or coverable services.
- (5) Transportation of eligible Medicaid recipients residing in nursing facilities to services that are not medically necessary.

(d) Denial of SoonerRide NET services by the SoonerRide broker.

(1) In addition to the exclusions listed subsection (d) of this Section, the SoonerRide broker may deny NET services if:

- (A) The nursing facility refuses to cooperate in determining the recipient's Medicaid eligibility.
- (B) The nursing facility refuses to provide the documentation required to determine the medical necessity for NET services.
- (C) The recipient or Attendant exhibits uncooperative behavior or misuses/abuses NET services.
- (D) The recipient is not ready to board NET transport at the scheduled time or within 10 minutes after the scheduled pick up time.
- (E) The nursing facility fails to request a reservation at least three days in advance of a health care appointment without good cause. Good cause is created by factors such as, but not limit to any of the following:
 - (i) Urgent care.
 - (ii) Post-surgical and/or medical follow up care specified by a health care provider to occur in fewer than three days.
 - (iii) Imminent availability of an appointment with a specialist when the next available appointment would require a delay of two weeks or more.

Emergency Adoptions

- (iv) The result of administrative or technical delay caused by SoonerRide and requiring that an appointment be rescheduled.
- (2) ~~Pursuant to Federal law, The SoonerRide Broker must will~~ provide notification in writing to nursing facilities whose recipients have been denied services ~~within two business days of the request~~. This notification must include the specific reason for the denial and the recipient's right to appeal.
- (e) **SoonerRide provider network.**
- (1) The SoonerRide broker will maintain an adequate number of appropriate network providers to provide non-emergency, non-ambulance transportation services for eligible Medicaid recipients residing in nursing facilities.
- (2) If a nursing facility has the capability to provide non-emergency, non-ambulance transportation, the SoonerRide broker may contract with the nursing facility as a NET network provider. The nursing facility must meet the same standards as any other SoonerRide contracted provider for vehicle and driver licensing, safety, training, liability, and ADA regulations. Additionally, when a nursing facility is contracted as a NET provider, the nursing facility cannot limit transportation services to recipients of a specific nursing facility, but must have the same availability as any other contracted network provider except for the transportation of recipients for dialysis services.
- (3) SoonerRide may contract with a nursing facility or other transportation provider solely for the non-emergency, non-ambulance transportation of recipients for dialysis services.
- (f) **Type of services provided and duties of the SoonerRide driver.**
- (1) The SoonerRide NET program is limited to curb-to-curb services. Curb-to-curb services are defined as services for which the vehicle picks up and discharges the passengers at the curb or driveway in front of their place of residence or destination. The SoonerRide NET driver does not provide assistance to passengers along walkways or steps to the door or the residence or other destination or assistance getting into or out of the vehicle. The SoonerRide NET driver will open and close the vehicle doors, load or provide assistance with loading adaptive equipment. Additionally, the SoonerRide NET driver may fasten and unfasten safety restraints when that service is requested by the rider or on behalf of the rider.
- (2) If the recipient is traveling by lift van, the SoonerRide NET driver will load and unload the recipient according to established protocols for such procedures that have been approved by the Oklahoma Health Care Authority.
- (3) The SoonerRide NET driver will deliver the recipient to the scheduled destination, and is not required to remain with the recipient.
- (g) **Scheduling NET services through SoonerRide.**
- (1) The nursing facility will schedule SoonerRide NET services for transportation to covered services for nursing facility eligible residents. SoonerRide NET services may be scheduled by calling the toll free SoonerRide number or by faxing a request to SoonerRide.
- (2) All NET routine services must be scheduled by advance appointment. Appointments must be made at least three business days in advance of the health care appointment, but may be scheduled up to fourteen business days in advance. Scheduling for recipients with standing appointments may be scheduled for those appointments beyond the 14 days.
- (3) NET services for eligible recipients residing in nursing facilities will be scheduled and obtained through the SoonerRide NET program. The nursing facilities will be financially responsible for NET services which are not scheduled for eligible recipients residing in nursing facilities through the SoonerRide program. The nursing facility may not charge the recipient or recipient's family for NET services which were not paid for by SoonerRide because they were not scheduled through SoonerRide in the appropriate manner.
- (4) Whenever possible SoonerRide will give consideration for recipients who request NET for routine care and the request is made less than three business days in advance of the appointment. However, such requests for service are not guaranteed and will depend on the available space and resources.
- (5) If SoonerRide cannot provide NET for urgent care, the nursing facility may provide the NET transportation and submit proper documentation to SoonerRide for reimbursement. In such cases the nursing facility must attempt to schedule the service through SoonerRide first, or the service must have become necessary during a time that SoonerRide scheduling was unavailable, such as after hours or weekends. For NET for urgent services provided after hours or on weekends, the nursing facility must notify SoonerRide within two business days of the date of service.
- (6) Requests for NET Exceptional Transportation must be made through SoonerRide. Exceptional transportation service is denied as non-emergency transportation which is necessary under extraordinary medical circumstances that requires traveling out-of-state for health care treatment not normally provided through in-state health care providers. Exceptional travel does not include direct service providers within 50 miles of the State's border counties who are utilized for routine care.
- (h) **Requirement for an attendant to accompany Medicaid eligible recipients who reside in nursing facilities during SoonerRide NET.**
- (1) When Medicaid eligible recipients residing in nursing facilities utilize SoonerRide for NET services, the nursing facility must provide an Attendant who will accompany the recipient. For purposes of SoonerRide, an Attendant is defined as an employee of a nursing facility who is provided by and trained by the nursing facility at the nursing facility's expense.
- (2) An Attendant must be at least at the level of a Nurses Aide, and must have the appropriate training necessary to provide any and all assistance to the recipient,

including physical assistance needed to seat the recipient in the vehicle. The Attendant must have the ability to interface with health care providers as appropriate. An attendant must be of an age of legal majority recognized under State law.

(3) The Attendant will be responsible for any care needed by the recipient during transport and any assistance needed by the recipient to assure the safety of all passengers and the driver of the vehicle. An attendant leaves the vehicle at its destination and remains with the recipient.

(4) When multiple eligible Medicaid recipients who reside in the same nursing facility are being transported to the same provider for health care services the nursing facility may provide one qualified Attendant for each three recipients unless other circumstances indicate the need for additional attendants. Such circumstances might include but are not limited to:

- (A) the physical and/or mental status of the recipient,
- (B) difficulty in getting the recipient in and out of the vehicle,
- (C) the amount of time that a recipient would have to wait unattended, etc.

(5) SoonerRide is not responsible for arranging for an Attendant. The services of the Attendant are not directly reimbursable by the SoonerRide program or the Medicaid program. The cost for the attendant is included in the Medicaid nursing facility per diem rate.

(i) Use of an escort to accompany Medicaid eligible recipients who reside in nursing facilities during SoonerRide NET.

(1) In certain instances a family member or legal guardian may wish to accompany the eligible Medicaid recipient who resides in a nursing facility for health care services. In such instances, the family member or legal guardian may accompany the recipient in place of the Attendant.

(2) An Escort is defined as a family member or legal guardian whose presence is required to assist a recipient during transport and while at the place of treatment. An escort replaces the Attendant who would normally be employed by the nursing facility. An Escort voluntarily accompanies the recipient during transport and leaves the vehicle at its destination and remains with the recipient. An escort must be of an age of legal majority recognized under State law. Only one Escort may accompany a recipient. The Escort must be able to provide any services and assistance necessary to assure the safety of all passengers in the vehicle.

(3) When an Escort wishes to accompany the recipient in place of an Attendant provided by the nursing facility the Escort and the nursing facility must sign a release form stating that an Escort will be traveling with the recipient and performing the services which would normally be performed by the Attendant. This release must be faxed to the SoonerRide business office prior to the date of the transport.

(4) If an Escort is used in place of an Attendant provided by the nursing facility, that Escort cannot be counted as an Escort for any other Medicaid recipients who are traveling in the same vehicle.

(5) SoonerRide is not required to transport any additional family members other than the one family member providing Escort services. In the event that additional family members request transportation, SoonerRide may charge those family members according to SoonerRide policies which have been approved by OHCA.

(6) An Escort is not eligible for direct compensation by the SoonerRide or Medicaid program.

(j) Transportation for dialysis Services.

(1) For eligible Medicaid recipients residing in nursing facilities who require NET for dialysis, SoonerRide shall allow one Attendant to accompany a group of up to three dialysis patients when they are being transported for dialysis services. The Attendant will remain with the patients unless the provider of the dialysis treatment and the nursing facility sign a release form stating that the presence of the Attendant is not necessary during the dialysis treatment. This release must be faxed to the SoonerRide business office prior to the date of the dialysis service.

(2) In instances when an Attendant does not remain with the eligible Medicaid recipient during dialysis treatment, SoonerRide is not responsible for transporting the Attendant back to the nursing facility.

(3) In instances when an Attendant does not remain with the eligible Medicaid recipient during dialysis treatment, the nursing facility is responsible for providing an Attendant to accompany the recipient on the return trip from the dialysis center. The nursing facility is also responsible for transporting that Attendant to the dialysis center in order to accompany the recipient on their return trip.

**PART 65. MANAGEMENT SERVICES FOR OVER
21**

317:30-5-586.1. Prior authorization

(a) Prior authorization of services and requirements to be authorized to provide case management services is mandatory. The provider must request prior authorization from the OHCA or its designated agent. In order for the services to be prior authorized, consumer information requested must be submitted. Consumer information includes but is not limited to the following:

- (1) Complete multi-axial DSM IV diagnosis with supportive documentation and mental status examination summary; and
- (2) Treatment history; and
- (3) Current psycho social information; and
- (4) Psychiatric history; and
- (5) Fully developed case management service plan, with goals, objectives, and time frames for services.

(b) Medicaid recipients will be considered for prior authorization after receipt of complete and appropriate information

Emergency Adoptions

submitted by the provider. Based on diagnosis, functional assessment, history and other Medicaid services being received, the Medicaid recipient may be approved to receive case management services. Medicaid recipients who reside in nursing facilities, residential behavior management services, group or foster homes, or ICF/MR's may not receive Medicaid compensable case management services. A Medicaid recipient may be approved for a time frame of one to six months. The OHCA (or its designated agent) will review the request for completeness and appropriateness. The provider will be notified within 24 hours (excluding weekends and holidays) if the request is incomplete, deficient, or inappropriate, and, if so, additional information will be requested. A completed request will be reviewed and processed within 72 working hours. Requests will be reviewed by licensed master's prepared therapists (Licensed Clinical Social Workers, Licensed Professional Counselors, Licensed Marriage and Family Therapists) with experience in behavioral health care, Licensed Registered Nurses with experience in behavioral health care, Psychiatrists (M.D. and D.O.), or Psychologists possessing current state licensure.

(c) A prior authorization decision may be appealed by the provider or consumer if filed within five working 20 days of receipt of the decision. ~~The first level of appeal is to~~ Until July 1, 2006, a provider may request a reconsideration from OHCA's designated agent within five working days of receipt of the decision. If the appeal is not satisfactorily resolved during reconsideration, the provider or consumer may submit an appeal to the OHCA through its standard grievance process (refer to OAC 317:2). The designated agent's decision regarding a reconsideration requests is final.

(d) Providers seeking prior authorization will follow OHCA's designated agent's Outpatient Behavioral Health Prior Authorization Manual guidelines for submitting requests on behalf of the Medicaid recipient.

PART 67. BEHAVIORAL HEALTH CASE MANAGEMENT SERVICES FOR INDIVIDUALS UNDER 21 YEARS OF AGE

317:30-5-596.1. Prior authorization

(a) Prior authorization of behavioral health case management services is mandatory. The provider must request prior authorization from the OHCA or its designated agent.

(b) Medicaid recipients who are eligible for services will be considered for prior authorization after receipt of complete and appropriate information submitted by the provider in accordance with the guidelines for behavioral health case management services developed by OHCA or its designated agent. A Medicaid recipient may be approved for a time frame of one to six months. The OHCA (or its designated agent) will review the initial request in accordance with the guidelines for prior authorization in the Behavioral Health Case Management Manual. An initial request for case management services requires the provider to submit specific documentation to OHCA or its designated agent. A fully developed service plan is not required at the time of initial request. The provider

will be given a time frame to develop the service plan while working with the child and his/her family and corresponding units of service will be approved prior to the completion of the service plan. The provider will be required to engage with the child/family within 72 hours of discharge from an inpatient psychiatric hospital and/or within 72 hours of receiving the request for services from the family or other community resource. The expectation is for the behavioral health case manager to immediately engage with the child/family to prevent hospital readmission and to refer to needed community resources. Extension requests will be reviewed by licensed master's prepared therapists (Licensed Clinical Social Workers, Licensed Professional Counselors, Licensed Marriage and Family Therapists, Licensed Behavioral Practitioners) with experience in behavioral health care, Licensed Registered Nurses with experience in behavioral health care, Psychiatrists (M.D. and D.O.), or Psychologists possessing current state licensure.

(c) ~~A prior authorization decision may be appealed by the provider or client if filed within five working days of receipt of the decision. The first level of appeal is to request a reconsideration from OHCA's designated agent. If the appeal is not satisfactorily resolved during reconsideration, the provider or client may submit an appeal to the OHCA through its standard grievance process (refer to OAC 317:2). In the event that a recipient disagrees with the decision by OHCA's contractor, it receives an evidentiary hearing under OAC 317:2-1-2(a). The recipient's request for such an appeal must commence within 20 calendar days of the initial decision. Providers may access a reconsideration process by OHCA's designated agent, whose decision is final. After the contractor issues a decision regarding an Initial Prior Authorization request, an Extension Request, a Modification Request or a Correction Request, the provider has five business days of receipt of the decision to request the contractor to reconsider its decision. The issues which a provider may ask for reconsideration are the number and type of services designated by the contractor and the length of treatment approved by the contractor. The reasoning or propriety of an Important Notice or a denial based upon insufficient data may not be reconsidered. The reconsideration process will end on July 1, 2006.~~

(d) Providers seeking prior authorization will follow OHCA's designated agent's prior authorization process guidelines for submitting behavioral health case management requests on behalf of the Medicaid recipient.

PART 83. RESIDENTIAL BEHAVIOR MANAGEMENT SERVICES IN FOSTER CARE SETTINGS

317:30-5-746. Appeal of Prior Authorization Decision

~~If~~ Until July 1, 2006, if a denial decision is made, a reconsideration request an appeal may be initiated by the resident or the residential foster care agency. ~~A reconsideration request must be made to the OHCA designated agent (the agent who denied the prior authorization) within 10 working days of the denial. The agent will return a decision within 10 working days from the date of receipt of the reconsideration. If the~~

~~denial decision is upheld, the~~ The denial can be appealed to the Oklahoma Health Care Authority within 20 calendar days of the receipt of the notification of the denial by the OHCA designated agent.

[OAR Docket #06-297; filed 3-15-06]

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

[OAR Docket #06-293]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 5. Individual Providers and Specialties
Part 3. Hospitals
317:30-5-47. [AMENDED]
(Reference APA WF # 05-21)

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 447.250; 42 CFR 447.298

DATES:

Adoption:

December 8, 2005

Approved by Governor:

December 27, 2005

Effective:

Immediately upon Governor's approval or February 1, 2006, whichever is later

Expiration:

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

SUPERSEDED EMERGENCY ACTIONS:

Superseded rules:

Subchapter 5. Individual Providers and Specialties
Part 3. Hospitals
317:30-5-47. [AMENDED]
(Reference APA WF # 05-15)

Gubernatorial approval:

October 3, 2005

Register publication:

23 Ok Reg 239

Docket number:

05-1310

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 reinstate language that was unintentionally removed from hospital rules by a previous emergency rule action.

ANALYSIS:

Agency hospital rules are being revised to reinstate language related to pre-admission procedures that were inadvertently deleted from rules. In October of this year, the agency adopted hospital reimbursement rules that used the Diagnosis Related Groups, or DRGs. When agency staff re-wrote those rules, language was inadvertently omitted that is now being reinstated. The language that is being added back into the rules includes reimbursement for pre-admission diagnostic testing performed within 72 hours of admission, organ transplants, Disproportionate Hospital adjustments and graduate medical education activities. Revisions are needed to reinstate language that was unintentionally removed from hospital rules by a previous emergency rule action. Other rules are incorporated due to superseding emergency rules previously approved by the Governor on October 3, 2005 in APA WF # 05-15.

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 FEBRUARY 1, 2006, WHICHEVER IS LATER:

**SUBCHAPTER 5. INDIVIDUAL PROVIDERS
AND SPECIALTIES**

PART 3. HOSPITALS

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;

Emergency Adoptions

- (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).

(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 Electrocochiliography
- (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
 (LIII) 27.22 Biopsy of uvula and soft palate
 (LIV) 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
 (IC) 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

Emergency Adoptions

(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
(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 Vaginoscopy
(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.

(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:

(I) 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.

(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.

Emergency Adoptions

(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.

(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].

Emergency Adoptions

(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 hospitals'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.

Reimbursement will be made for inpatient hospital services rendered on or after October 1, 2005, in the following manner:

(1) Covered inpatient services 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 DRG 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 during the inpatient stay. 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;
- (D) transportation, including ambulance, to and from another facility to receive specialized diagnostic and therapeutic services;
- (E) pre-admission diagnostic testing performed within 72 hours of admission; and
- (F) organ transplants.

(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.

(12) Payments will be made to hospitals qualifying for Disproportionate Hospital adjustments, and graduate medical education activities pursuant to the methodologies described in the Oklahoma Title XIX Inpatient Hospital Reimbursement Plan, effective date October 1, 2005, and incorporated herein by reference.

[OAR Docket #06-293; filed 3-14-06]

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

[OAR Docket #06-295]

RULEMAKING ACTION:
EMERGENCY adoption

RULES:
Subchapter 5. Individual Providers and Specialties
Part 41. Family Support Services
317:30-5-412. [AMENDED]
(Reference APA WF # 05-22)

AUTHORITY:
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Section 1175.6b of Title 22 of the Oklahoma Statutes

DATES:

Adoption:
December 8, 2005

Approved by Governor:
December 27, 2005

Effective:
Immediately upon Governor's approval or February 1, 2006, 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 raise the coverage limitation maximum for Family Training Services in order to better meet the needs of some of the Developmental Disabilities Services Division clients.

ANALYSIS:
Developmental Disabilities Services Division Family Support Services rules are revised to increase the annual limits on expenditures for Individual and Group Family Training Services from \$5000 to \$5500 per service recipient. Since the implementation of Section 1175.6b of Title 22 of the Oklahoma Statutes, the Oklahoma Department of Human Services (OKDHS) has seen an increase in a challenging and dangerous population coming into the community program via the courts and the Oklahoma Department of Mental Health and Substance Abuse Services. These individuals have pending criminal charges but have been determined to be incompetent due to mental retardation. If the court finds that the individual is not dangerous, the court may suspend the criminal proceedings and refer the person to OKDHS for services. The Oklahoma Department of Human Services, who pays the state share for these services, has requested this rule change as residential staff who care for these individuals need additional training in order to meet the needs of

Emergency Adoptions

these clients. Revisions are needed to increase the annual expenditure limits for Individual and Group Family Training Services.

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 FEBRUARY 1, 2006, WHICHEVER IS LATER:

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 41. FAMILY SUPPORT SERVICES

317:30-5-412. Description of services

Family Support Services include the following:

(1) **Transportation services.** Transportation services are provided in accordance with OAC 317:40-5-103.

(2) **Adaptive equipment services.** Adaptive equipment (assistive technology) services are provided in accordance with OAC 317:40-5-100.

(3) **Architectural modification.** Architectural modification services are provided in accordance with OAC 317:40-5-101.

(4) **Family training.**

(A) **Minimum qualifications.** Training providers must hold current licensure as a clinical social worker, psychologist, professional counselor, psychiatrist, registered nurse, nutritionist/dietitian, physical therapist, occupational therapist or speech therapist. Training may also be provided by other local or state agencies whose programs have been approved by the Developmental Disabilities Services Division (DDSD) Director of Training.

(B) **Description of services.** Family Training Services include instruction in skills and knowledge pertaining to the support and assistance of persons with developmental disabilities provided to individuals and natural, adoptive or foster families of eligible individuals age six and older. Services are intended to allow families to become more proficient in meeting the needs of eligible individuals. Services are provided in any setting in which the individual/family resides and/or the provider conducts business and may be provided in either group (2-15 persons) or individual formats.

(C) **Coverage limitations.** Payment rates and coverage limitations for family training are as follows:

(i) Description: Individual Family Training; ~~Payment Rate: 95% of Billed Charges~~; Limitation: ~~\$5,000~~ \$5,500 each 12 months.

(ii) Description: Group Family Training; ~~Payment Rate: 95% of Billed Charges~~; Limitation: ~~\$5,000~~ \$5,500 each 12 months.

(5) **Family counseling.**

(A) **Minimum qualifications.** Counseling providers must hold current licensure as a clinical social worker, psychologist or professional counselor.

(B) **Description of services.** Family Counseling Services include counseling in emotional and social issues provided to eligible individuals age six and older and their natural, adoptive or foster families. Services are intended to maximize individual's/family's emotional/social adjustment and well-being. Services are rendered in any setting in which the individual/family resides or the provider's office and may be provided in either group (six person maximum) or individual formats.

(C) **Coverage limitations.** Payment rates and coverage limitations for family counseling are as follows:

(i) Description: Individual Family Counseling; Unit: 15 minutes; Limitation: 400 units each 12 months.

(ii) Description: Group Family Counseling; Unit: 30 minutes; Limitation: 225 units each 12 months.

(6) **Specialized medical supplies.**

(A) **Minimum qualifications.** Specialized medical equipment providers must meet all applicable state and local requirements for licensure and/or certification.

(B) **Description of services.** Specialized medical supplies include supplies specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living. This service also includes the purchase of ancillary supplies not available under Oklahoma's Title XIX State Plan and excludes those items which are not of direct medical and remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation. Supplies include, but are not limited to:

(i) prescriptions in excess of Medicaid limitations;

(ii) adult briefs;

(iii) nutritional supplements;

(iv) supplies needed for tracheotomy/respirator/ventilator care; and

(v) supplies for decubitus care.

(C) **Coverage limitations.** Specialized medical services are billed using the appropriate HCPC Code. Individual limits are specified in each recipient's IHP. All services require prior authorization.

[OAR Docket #06-295; filed 3-14-06]

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

[OAR Docket #06-296]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 3. Coverage and Exclusions
317:35-3-2. [AMENDED]
Subchapter 15. Personal Care Services
317:35-15-8.1. [AMENDED]
Subchapter 19. Nursing Facility Services
317:35-19-16. [AMENDED]

(Reference APA WF # 05-24E)

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:

January 12, 2006

Approved by Governor:

March 9, 2006

Effective:

Immediately upon Governor's approval or March 1, 2006 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 insure compliance with federal regulations, thereby avoiding any potential economic impact caused by noncompliance with federal regulations and rule inconsistencies.

ANALYSIS:

Agency appeal rules are being revised to accurately reflect the agency which will hear various employer and employee eligibility appeals for the Oklahoma Employer and Employee Partnership for Insurance Coverage (O-EPIC) Program. Rules regarding the various appeal processes are relocated to individual sections to help clarify the correct procedures to be followed. In addition, rules are amended to correct various rule citations. Revisions are needed to provide appeal guidelines for the O-EPIC program and clarify appeal procedures.

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 MARCH 1, 2006, WHICHEVER IS LATER:

SUBCHAPTER 3. COVERAGE AND EXCLUSIONS

317:35-3-2. Medicaid transportation and subsistence

The Oklahoma Health Care Authority (OHCA) is responsible for assuring that necessary transportation is available to

all eligible Medicaid recipients who are not otherwise covered through their Managed Care Plan and who are in need of Medicaid medical services. Reimbursement for transportation costs must be prior authorized by the local Department of Human Services' (~~DHS~~ OKDHS) county director. Transportation costs must be for a medically necessary examination or treatment and only when transportation is not otherwise available. Payment through Medicaid may be made for transportation by private vehicle, bus, taxi, ambulance or airplane. Payment is made for a private vehicle at the Medicaid fee schedule rate and for public carrier at the public carrier rate. Individuals transporting more than one authorized recipient, from and to one destination and back, at the same time are reimbursed for only one trip. When transporting more than one authorized recipient, from and to and back to different locations, at the same time, reimbursement is made for one round trip. Beginning June 1, 1999, the Oklahoma Health Care Authority (OHCA) will begin a pilot transportation broker project with the Metropolitan Tulsa Transit Authority (MTTA) known as SoonerRide. SoonerRide will exclude individuals who are enrolled in a Managed Care Organization (MCO) through OHCA, those individuals who are categorized as institutionalized, and those individuals who are categorized as Qualified Medicare Beneficiaries Plus (QMBP), Specified Low Income Medicare Beneficiaries (SLMB), and Qualifying Individuals-1 ~~and~~—2. Clients seeking medically necessary non-emergency transportation will be required to contact the SoonerRide reservation center. Contact will be made via a toll-free phone number which will be answered Monday through Saturday, 8 a.m. to 6 p.m. Whenever possible, the client is required to notify SoonerRide at least 72 hours prior to the appointment. The client will be asked to furnish the SoonerRide reservation center the case number, home address, the time and date of the medical appointment, the address of the medical provider, and any physical/mental limitations which will impact the type of transportation needed. SoonerRide will make arrangements for the most appropriate, least costly transportation. SoonerRide will verify appointments when appropriate. The SoonerRide contractor will be responsible for recruiting providers in each county and ensuring that all transportation providers meet all appropriate regulations for the provision of public transportation. Provider qualifications will include, but is not limited to, verification of liability insurance and drug testing. All non-emergency transportation will be arranged by SoonerRide. If the client disagrees with the transportation arranged or denied by SoonerRide, an appeal should be filed with ~~SoonerRide~~ OHCA within 48 hours of the notification. The appropriateness of transportation may be appealed only to the extent that the transportation does not meet the medical needs of the client. Dissatisfaction with the use of public transportation, shared rides, type of vehicle, etc., is not appropriate grounds for appeal. The Oklahoma Health Care Authority—~~Authority's~~ decision will ~~make the~~ be final ~~decision on any disputes which cannot be settled between the client and SoonerRide.~~ As provider networks are developed, SoonerRide will be expanded to include additional counties. Before a county is phased into SoonerRide, county officials

Emergency Adoptions

and clients will be notified. A public meeting will be held prior to inclusion of each new county.

(1) **Authorization for transportation by private vehicle.**

(A) Reimbursement for transportation by a private vehicle (privately owned, leased or rented) may be made directly to the client or to another person providing the private transportation for the client. Authorization cannot be made to a ~~DHS~~ OKDHS or OHCA employee or the spouse of a ~~DHS~~ OKDHS or OHCA employee, unless he/she is a certified volunteer, or any employee of another county, state or federal agency who is providing the transportation as a part of the regular duties within that agency. Private transportation is authorized at the Medicaid fee schedule rate from and to the transporter's point of origin. Claim for payment is filed on a travel reimbursement form, after it has been documented that the individual kept the appointment(s) for the medical services. Transportation by a private vehicle may be authorized when the recipient:

- (i) lives in a rural area where needed Medicaid medical examination or treatment is not available and the recipient must travel outside his/her local community to receive the needed medical services.
- (ii) receives Medicaid medical services within his/her own community, and it has been documented that the transportation cannot be made available through the individual's own efforts or through community volunteer resources.

(B) The distances for which reimbursement is claimed may not exceed the distances set forth in the latest Transportation Commission road map. Travel claimed between points not shown on the official map shall be based on actual odometer readings. Vicinity travel is entered on travel claims as a separate item from road map mileage, for city and rural traveling within a small area, and is computed using mileage on the basis of actual odometer readings.

(C) Travel is reimbursed on the basis of the actual number of miles traveled from the transporter's point of origin to the first official call, subsequent official calls, and return to the point of origin. Recipients or transporters returning to a destination other than the original starting point (with local ~~DHS~~ OKDHS County Director approval) must provide a brief explanation on the travel reimbursement form.

(D) Reimbursement for out-of-state transportation (not to exceed 100 map miles) that is medically necessary and would not require reimbursement for per diem may be authorized when the transportation is deemed in the best interest of the recipient and the OHCA.

(2) **Reimbursement for public transportation.**

(A) **Authorization for transportation by bus.** Transportation by bus is authorized when it is necessary for an eligible individual to receive treatment

in a medical facility. (If the services of an escort are necessary, see (6) of this Section).

(B) **Authorization for transportation by taxi.** Taxi service may be authorized only when transportation cannot be arranged through the individual's own efforts or through community resources. When taxi service is necessary to transport recipients to and from their home to the medical provider or to the nearest point of common carrier access or a common carrier to the medical provider, reimbursement is paid on the basis of actual expenses. A memo giving a detailed explanation of why the taxi service had to be used must be attached to the travel reimbursement form. Taxicab charges must be itemized on the travel reimbursement form and are reimbursed only upon justification as to the necessity of their use.

(3) **Transportation by ambulance (ground, air ambulance or helicopter).** Transportation by ambulance is compensable for individuals eligible for Medicaid benefits when other available transportation does not meet the medical needs of the individual. Payment is made for ambulance transportation to and/or from a medical facility (a physician's office or clinic is not considered a medical facility) for medical care compensable under Medicaid.

(4) **Transportation by airplane.** When an individual's medical condition is such that transportation out-of-state by a commercial airline is required, approval for airfare must be secured by telephoning the OHCA, Medical Authorization Unit, who will make the necessary flight arrangements.

(5) **Subsistence (sleeping accommodations and meals).** An individual who is eligible for transportation to or from a medical facility to obtain medical services may receive assistance with the necessary expenses of lodging and meals from Medicaid funds. If the individual does not have the funds for the necessary subsistence, authorization is made by the local office on Room and Board Order form. The individual may choose to pay for the lodging and meals and be reimbursed by filing a travel reimbursement form. Any subsistence expense claimed on the travel reimbursement form must be documented with receipts, and reimbursement cannot exceed state per diem amounts. Payment for meals is based on a daily per diem and may be used for breakfast, lunch or dinner, or all three meals, whichever is required.

(6) **Escort assistance required.** Payment for transportation and subsistence of one escort may be authorized if the service is required. Only one escort may be authorized. It is the responsibility of the Oklahoma Department of Human Services' social worker to determine this necessity. The decision should be based on the following circumstances:

- (A) when the individual's health does not permit traveling alone; and
- (B) when the individual seeking medical services is a minor child.

SUBCHAPTER 15. PERSONAL CARE SERVICE

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

The Administrative Agent (AA) certifies qualified agencies and facilitates the execution of contracts on behalf of OHCA with qualified agencies for provision of Personal Care services. At contract renewal, the AA re-evaluates provider qualifications and facilitates execution of renewal contracts on behalf of the OHCA. OHCA will check the list of providers that have been barred from Medicare/Medicaid participation to ensure that the provider agency is not listed.

(1) **Payment for Personal Care.** Payment for Personal Care is generally made for care in the client's own home. A rented apartment, room or shelter shared with others is considered "own home". A facility that meets the definition of a nursing facility, room and board, licensed residential care facility, licensed assisted living facility, group home, rest home or a specialized home as set forth in O.S. Title 63, Section 1-819 et seq., Section 1-890.1 et seq., and Section 1-1902 et seq., does not constitute a suitable substitute home. Personal Care may not be approved if the client lives in the PCA's home except with the interdisciplinary team's written approval. With ~~DHS~~ OKDHS area nurse approval, or for ADvantage waiver clients, with service plan authorization and ADvantage Program Manager approval, Personal Care services may be provided in an educational or employment setting to assist the client in achieving vocational goals identified on the service plan.

(A) **Use of agency contractors for Personal Care.** To provide Personal Care services, an agency must be licensed by the Oklahoma State Department of Health, meet certification standards identified by ~~DHS~~ OKDHS or the Administrative Agent (AA), and possess a current Medicaid contract.

(B) **Reimbursement.** Personal Care payment for a client is made according to the number of units of service identified in the service plan.

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

(ii) The contractor payment fee covers all Personal Care services included on the service and care plans developed by the LTC nurse or ADvantage case manager. Payment is made for direct services and care of the eligible client(s) only. The area nurse, or designee, authorizes the number of units of service the client receives each month.

(2) **Problem resolution.** If the client is dissatisfied with the agency or the assigned PCA, the client contacts the LTC nurse for problem resolution. If the situation cannot be resolved, the client has the right to appeal to

the OHCA. (Refer to OAC ~~317:2~~ 317:2-1-2). For clients receiving ADvantage services, their case manager should be contacted for the problem resolution. If the problem remains unresolved, the contact may be made with the Consumer Inquiry System (CIS) at the Long Term Care Authority.

SUBCHAPTER 19. NURSING FACILITY SERVICES

317:35-19-16. PASRR appeals process

(a) Any individual who has been adversely affected by any PASRR determination made by the State in the context of either a preadmission screening or resident review may appeal that determination by requesting a fair hearing. If the individual does not consider the PASRR decision a proper one, the individual or their authorized representative must contact the local county ~~DHS~~ OKDHS office to discuss a hearing. Forms for requesting a fair hearing (OAC 340:2, Appendix G), as well as assistance in completing the forms, can be obtained at the local county office. Any request for a hearing must be made no later than ~~30~~ 20 days following the date of written notice. There is no distinction between the Medicaid and non-Medicaid patient; therefore, all individuals seeking an appeal have the same rights, regardless of source of payment. Level I determinations are not subject to appeal.

(b) When the individual is found to experience MR or MI through the Level II screen, the PASRR determination made by the MR/MI authorities cannot be countermanded by the state Medicaid agency, either in the claims process or through other utilization control/review processes, or by the state survey and certification agency. Only appeals determinations made through the fair hearing process may overturn a PASRR determination made by the MR/MI authorities.

[OAR Docket #06-296; filed 3-15-06]

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

[OAR Docket #06-294]

RULEMAKING ACTION:
EMERGENCY adoption

- RULES:**
- Subchapter 1. General Provisions [NEW]
 - 317:45-1-2. [NEW]
 - Subchapter 3. Carriers [NEW]
 - 317:45-3-1. [NEW]
 - Subchapter 7. Employer Eligibility [NEW]
 - 317:45-7-1. through 317:45-7-2. [NEW]
 - 317:45-7-5. [NEW]
 - Subchapter 9. Employee Eligibility [NEW]
 - 317:45-9-1. [NEW]
- (Reference APA WF # 05-27)

Emergency Adoptions

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 2nd Session of the 49th Oklahoma Legislature

DATES:

Adoption:

December 8, 2005

Approved by Governor:

December 27, 2005

Effective:

Immediately upon Governor's approval or February 1, 2006, whichever is later

Expiration:

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

SUPERSEDED EMERGENCY ACTIONS:

Superseded rules:

Subchapter 1. General Provisions [NEW]

317:45-1-2. [NEW]

Subchapter 3. Carriers [NEW]

317:45-3-1. [NEW]

Subchapter 7. Employer Eligibility [NEW]

317:45-7-1. through 317:45-7-2. [NEW]

317:45-7-5. [NEW]

Subchapter 9. Employee Eligibility [NEW]

317:45-9-1. [NEW]

(Reference APA WF # 05-27)

Gubernatorial approval:

October 3, 2005

Register publication:

23 Ok Reg 278

Docket number:

05-1311

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 assure equal access to the O-EPIC program across the state and ease implementation.

ANALYSIS:

Oklahoma Employer and Employee Partnership for Insurance Coverage (O-EPIC) rules are revised to incorporate several changes which were requested by Oklahoma small business owners at the time of implementation of the program. In order to assure statewide availability of O-EPIC, regions are established based on population density and applications will be date and time stamped by region. If an employer is exempt from filing an OES-3 form with the Oklahoma Employment Security Commission, the employer may provide other supporting documentation to verify their number of employees. Revisions stipulate that the Qualified Health Plan offered by the employer must begin on the first day of the month and continue through the last day of the month and that the employer must notify the Third Party Administrator of new hires within 30 days of eligibility for the health plan. An employer may be determined to participate for a period up to 12 months and the eligibility period ends the last day of the 12th month or when coverage through a health plan requires renewal or an open enrollment period occurs. Revisions are needed to assure equal access to the O-EPIC program across the state and ease implementation. Other revisions are incorporated due to superseding emergency rules previously approved by the Governor in APA WF 05-16 on October 3, 2005.

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 FEBRUARY 1, 2006, WHICHEVER IS LATER:

SUBCHAPTER 1. GENERAL PROVISIONS

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 by region when received by the TPA. Regions are established based on population density statistics as determined through local and national data and may be periodically adjusted to assure statewide availability.

(B) The waiting list utilizes a "first in - first out" method of selecting eligible employers by region.

(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.

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. Carriers must also provide the name, address, telephone number, and, if available, email address of a contact individual who is able to verify O-EPIC employer enrollment status in a Qualified Health Plan.

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. If the employer is exempt from filing an OES-3 form, in accordance with OHCA rules, this determination is based on appropriate supporting documentation, such as the W-2 Summary Wage and Tax form as required under OAC 365:10-5-156 to verify employee count;

(2) have a business that is physically located in Oklahoma;

(3) be currently offering or intending to offer within 60 calendar days an O-EPIC Qualified Health Plan. The Qualified Health Plan coverage must begin on the first day of the month and continue through the last day of the month;

(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 O-EPIC employee's termination or resignation. Additionally, the employer must notify the TPA of new hires within 30 days of eligibility for the health plan.

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 up to a 12 month period. The eligibility period begins on the first day of the month following the date of approval. The eligibility period ends the last day of the 12th month or when coverage through a health plan requires renewal or an open enrollment period occurs. The TPA notifies the employer of the eligibility decision for employer and employees.

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 fax or mail.

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 and are eligible for enrollment in the health plan. 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 not currently enrolled in, or have applied for, Medicaid/Medicare;

(6) be employed with a qualified employer at a business location in Oklahoma;

(7) be age 19 through age 64;

(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;

Emergency Adoptions

- (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.

[OAR Docket #06-294; filed 3-14-06]

TITLE 435. STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION CHAPTER 45. RESPIRATORY CARE PRACTITIONER

[OAR Docket #06-388]

RULEMAKING ACTION:

EMERGENCY adoption.

RULES:

Subchapter 5. Regulation of Practice
435:45-5-1. Continuing education [AMENDED]

AUTHORITY:

Title 59 O.S., Section 2031, Board of Medical Licensure and Supervision

DATES:

Adoption:

January 26, 2006

Approved by Governor:

March 16, 2006

Effective:

Immediately upon Governor's approval

Expiration:

Effective through July 14, 2007 unless superseded by another rule or disapproved by the Legislature.

SUPERSEDED EMERGENCY ACTIONS:

n/a

INCORPORATIONS BY REFERENCE:

n/a

FINDING OF EMERGENCY:

The Board found a compelling public interest required an emergency amendment to the continuing education rule for respiratory care practitioners.

ANALYSIS:

With the advancement of internet courses as well as various other forms of learning experiences now offered, it is necessary to update the continuing education rule by noting what would be acceptable to meet the requirement and to require that at least half of the hours must be related to clinical practice.

CONTACT PERSON:

Jan Ewing, Deputy Director, 405-848-6841, ext. 104

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

SUBCHAPTER 5. REGULATION OF PRACTICE

435:45-5-1. Continuing education

(a) The purpose of continuing education is to aid in maintaining competency in the advancing art and science of respiratory care. Continuing education is a variety of forms of learning experiences including, but not limited to, lectures, conferences, academic studies, in-services education, institutes, seminars, home study, Internet courses, and workshops taken by Respiratory Care Practitioners for licensure renewal. These learning experiences are meant to enhance the knowledge of the Respiratory Care Practitioner in direct and indirect patient care. Continuing education does not include basic education or training needed to become a licensed RCP.

(b) All program objectives, curricular content, presenter qualifications, and outcomes shall be subject to review. Contact hours will be determined based on program content, outcomes, and participant involvement.

(~~c~~) Respiratory Care Practitioner licenses shall be renewed every two years on or before the last day of the month in which initial licensure was granted. The application and fee for renewal of licensure shall be postmarked or hand delivered to the Board office on or before the required date.

(~~d~~) Regardless of the source, continuing education hours must be in clinical respiratory care or related areas of health care. The Board may consult with the Committee to resolve questions as to appropriate continuing education hours. The Board of Medical Licensure and Supervision shall be the final authority on acceptance of any educational activity requirements submitted by a licensee to meet the continuing education requirements.

(~~e~~) Licensees shall be responsible for submitting documentation of their continuing education unit activities to the Board at the time of license renewal.

(~~f~~) Respiratory Care Practitioners must accrue twelve (12) CRCE (Continuing Respiratory Care Education) credits in each successive two year period (biennium) to maintain a license to practice in the state of Oklahoma. At least half of the required Continuing Respiratory Care Education hours must be directly related to clinical practice. Unless otherwise specified, one clock hour of direct instruction/training class time is equivalent to one continuing education unit.

(~~g~~) The Board shall accept American Medical Association (AMA) and America Osteopathic Association (AOA) credits. Other acceptable continuing education credits include all programs approved by, or where applicable the affiliates of, the American Association for Respiratory Care (AARC); the American Thoracic Society (ATS); the American College of Chest Physicians (ACCP); the American Society of Anesthesiology (ASA); the American Lung Association (ALA); the American College of Cardiology (ACC); the American Heart Association (AHA); the American Nursing Association (ANA), American Red Cross and the American Council for Continuing Medical Education (ACCME).

(~~h~~) Other agencies and professional organizations may be considered and approved for eligible continuing education credits upon review by the Chairman of the Committee with final approval by the Secretary of the Board. Those wishing

to sponsor a program/meeting/class and receive approval for awarding CRCE credits must contact the Board and receive approval in advance. To apply toward satisfaction of the continuing education requirements, the following shall be submitted:

- (1) The request shall be submitted in writing to the Board office at least thirty (30) days prior to the program. The Board shall give written notification of the approval or disapproval of the educational program or seminar.
- (2) A request to be an eligible continuing education seminar or course shall include:
 - (A) Name of the seminar or course;
 - (B) Sponsoring party;
 - (C) Objective of the seminar or format and subjects of seminar or course;
 - (D) Number of hours resulting in CRCEs;
 - (E) Method for certification of attendance;
 - (F) Name and qualifications of the faculty; and
 - (G) Evaluation mechanism.

(g) RCPs who submit proof of successful completion of the National Board for Respiratory Care (NBRC) entry or the advanced practitioner credentialing examination or recertification examination may be granted continuing education credit as awarded by the American Association for Respiratory Care.

(h) Credits may be awarded for completion of continuing education processes in accordance with the following guidelines:

- (1) Direct conference/lecture/classroom attendance - 1.0 CRCE per hour.
- (2) Teleconference (audio only) - 0.5 CRCE per hour.
- (3) Teleconference (audio with handouts or slides) - 1.0 CRCE per hour.
- (4) Videoconference (live video) - 1.0 CRCE per hour.
- (5) Video tape instruction/programs - 0.2 CRCE per hour.
- (6) Correspondence journal/workbooks with test - 0.2 CRCE per subject.
- (7) Interactive video instruction (computer) with test - 1.0 CRCE per subject.
- (8) NBRC recertification examination (passing) - 6.0 CRCE per biennium.
- (9) Resuscitation and life support courses - limit one of the following courses per compliance period:
 - (A) Advanced Cardiac Life Support - 6 CRCE;
 - (B) Neonatal Resuscitation Program - 6 CRCE;
 - (C) Pediatric Advanced Life Support - 6 CRCE;
 - (D) Advanced Trauma Life Support - 6 CRCE;
 - (E) Basic Life Support - 6 for initial certification; 3 for recertification.

[OAR Docket #06-388; filed 3-22-06]

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

1:2006-8.

EXECUTIVE ORDER 2006-8

I, Brad Henry, Governor of the State of Oklahoma, 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 Thursday, March 30, 2006, to honor Chickasha firefighter Destry Horton, who died on Friday, March 24, 2006.

Horton was critically injured on March 1, 2006, while fighting a grass fire near Duncan. The State of Oklahoma owes a great debt of gratitude to the men and women who work as firefighters. They work long, often thankless hours and risk their own safety to ensure the safety of their fellow Oklahomans. Destry Horton was such a man and the sacrifice he made will never be forgotten.

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 28th day of March, 2006.

BY THE GOVERNOR OF THE
STATE OF OKLAHOMA

Brad Henry

ATTEST:

Kathy Jekel

Acting Assistant Secretary of State

[OAR Docket #06-474; filed 3-28-06]

1:2006-9.

EXECUTIVE ORDER 2006-9

I, Brad Henry, Governor of the State of Oklahoma, by the authority vested in me pursuant to Sections 1 and 2 of Article VI of the Oklahoma Constitution, hereby order the Oklahoma Tax Commission to cease issuing pre-determination letters pursuant to the Small Business Capital Formation Incentive Act, 68 O.S. §§2357.60, *et seq.*, and the Rural Venture Capital Formation Incentive Act, 68 O.S. §§2357.71, *et seq.*, as further described herein.

The Oklahoma Tax Commission is hereby directed to cease issuing pre-determination letters pursuant to the Small Business Capital Formation Incentive Act, 68 O.S. §§2357.71, *et seq.* The Oklahoma Tax Commission is hereby directed to develop and implement procedures necessary to carry out the provisions of this Executive Order.

Copies of this Executive Order shall be distributed to the Oklahoma Tax Commission and the Secretary for Finance and Revenue for distribution and immediate implementation.

The provisions of this Executive Order shall be effective from March 30, 2006, and shall terminate September 1, 2006.

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 30 day of March, 2006.

BY THE GOVERNOR OF THE
STATE OF OKLAHOMA

Brad Henry

ATTEST:

M. Susan Savage
Secretary of State

[OAR Docket #06-506; filed 3-31-06]

