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Peggy Coe, Managing Editor

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Notices of Rulemaking Intent

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

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

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

TITLE 40. BOARD OF TESTS FOR ALCOHOL AND DRUG INFLUENCE CHAPTER 25. DEVICES, EQUIPMENT, AND MATERIALS

[OAR Docket #06-1310]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

40:25-1-2. Approved evidential breath-alcohol analyzers
[AMENDED]

40:25-1-3. Alcoholic breath simulators [AMENDED]

SUMMARY:

The rule change would approve The CMI 8000 as an additional breath testing device and approve nitrogen-ethanol gas, manufactured by CMI and Scott Gas, as an additional alcohol breath testing control method. The rule change is intended to allow the Board to remain abreast of changing technology and allow or require the replacement of nonfunctioning devices with those using current technology. The newer testing devices and controls have no moving parts and, therefore, will be more reliable and more economical to operate. Further, the nitrogen/ethanol controls are impervious to vibration and changes in temperature.

AUTHORITY:

Board of Tests for Alcohol and Drug Influence; 47 O.S. §759 and OAC 40:1-1-4

COMMENT PERIOD:

Persons may submit written and oral comments to J. Robert Blakeburn at 3600 N. Martin Luther King Blvd., Oklahoma City, OK 73111 during the period from November 1, 2006 to December 1, 2006

PUBLIC HEARING:

A Public hearing has not been scheduled; However pursuant to 75 O.S. sec. 303 (B) (9), persons may demand a hearing by contacting J. Robert Blakeburn at 405-425-2406 no later than December 1, 2006.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

The proposed changes will not affect business entities.

COPIES OF PROPOSED RULES:

Copies of the proposed rules may be obtained from the Board of Tests for Alcohol and Drug Influence's office located at 3600 N. Martin Luther King Blvd., Oklahoma City, OK 73111. Copies may also be obtained by written request mailed to the attention of J. Robert Blakeburn at 3600 N. Martin Luther King Blvd., Oklahoma City, OK 73111.

RULE IMPACT STATEMENT:

Pursuant to 75 O.S., § 303 (D), a rule impact statement is being prepared and will be available for review after November 1, 2006 at the above address for the Board of Tests for Alcohol and Drug Influence's office.

CONTACT PERSON:

J. Robert Blakeburn, (405) 425-2460 (procedural and legal questions); Jeff Dean, (405) 425-2460 (technical questions).

[OAR Docket #06-1310; filed 9-25-06]

TITLE 40. BOARD OF TESTS FOR ALCOHOL AND DRUG INFLUENCE CHAPTER 30. ANALYSIS OF ALCOHOL IN BREATH

[OAR Docket #06-1312]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

40:30-1-3. Breath-alcohol analysis with the enhanced Intoxilyzer Model 5000-D [AMENDED]

SUMMARY:

The rule change will delete the word "regurgitate" from the actions proscribed during a deprivation period prior to testing and clarify that the observation must continue throughout the entire breath specimen collection process. It further establishes times and procedures for maintenance on breath instruments equipped with nitrogen/ethanol external controls.

AUTHORITY:

Board of Tests for Alcohol and Drug Influence; 47 O.S. §759 and OAC 40:1-1-4

COMMENT PERIOD:

Persons may submit written and oral comments to J. Robert Blakeburn at 3600 N. Martin Luther King Blvd., Oklahoma City, OK 73111 during the period from November 1, 2006 to December 1, 2006

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REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

The proposed changes will not affect business entities.

Notices of Rulemaking Intent

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CONTACT PERSON:

J. Robert Blakeburn, (405) 425-2460 (procedural and legal questions); Jeff Dean, (405) 425-2460 (technical questions).

[OAR Docket #06-1312; filed 9-25-06]

TITLE 40. BOARD OF TESTS FOR ALCOHOL AND DRUG INFLUENCE CHAPTER 50. IGNITION INTERLOCK DEVICES

[OAR Docket #06-1311]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

- 40:50-1-1. Explanation of terms and actions [AMENDED]
- 40:50-1-2. Procedure for device approval [AMENDED]
- 40:50-1-3. Technical requirements [AMENDED]
- 40:50-1-4. Miscellaneous requirements [AMENDED]
- 40:50-1-5. Maintenance and calibration requirements [AMENDED]
- 40:50-1-7. Certification and inspection of service centers [AMENDED]
- 40:50-1-8. Service representative [AMENDED]
- 40:50-1-9. Ignition interlock inspector [AMENDED]
- 40:50-1-11. Approved ignition interlock devices [AMENDED]

SUMMARY:

The rule change changes and clarifies the all aspects of the administrative code pertaining to ignition interlock devices, including requirements for installers and service centers, definitions, technical description of the approved devices, detailing reportable violations, and corrects grammatical errors.

AUTHORITY:

Board of Tests for Alcohol and Drug Influence; 47 O.S. §759 and OAC 40:1-1-4

COMMENT PERIOD:

Persons may submit written and oral comments to J. Robert Blakeburn at 3600 N. Martin Luther King Blvd., Oklahoma City, OK 73111 during the period from November 1, 2006 to December 1, 2006

PUBLIC HEARING:

A Public hearing has not been scheduled; However pursuant to 75 O.S. sec. 303 (B) (9), persons may demand a hearing by contacting J. Robert Blakeburn at 405-425-2406 no later than December 1, 2006.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

The proposed changes will not affect business entities.

COPIES OF PROPOSED RULES:

Copies of the proposed rules may be obtained from the Board of Tests for Alcohol and Drug Influence's office located at 3600 N. Martin Luther King Blvd., Oklahoma City, OK 73111. Copies may also be obtained by written request mailed to the attention of J. Robert Blakeburn at 3600 N. Martin Luther King Blvd., Oklahoma City, OK 73111. Further, the proposed permanent rules are identical to the emergency rules proposed regarding the same chapter.

RULE IMPACT STATEMENT:

Pursuant to 75 O.S., § 303 (D), a rule impact statement is being prepared and will be available for review after November 1, 2006 at the above address for the Board of Tests for Alcohol and Drug Influence's office.

CONTACT PERSON:

J. Robert Blakeburn, (405) 425-2460 (procedural and legal questions); Jeff Dean, (405) 425-2460 (technical questions).

[OAR Docket #06-1311; filed 9-25-06]

TITLE 585. PUBLIC EMPLOYEES RELATIONS BOARD CHAPTER 1. OPERATIONS

[OAR Docket #06-1328]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

- Subchapter 1. General Provisions [REVOKED]
- 585:1-1-1. through 585:1-1-5. [REVOKED]
- Subchapter 3. Program Administration and Description [REVOKED]
- 585:1-3-1. through 585:1-3-4. [REVOKED]
- 585:1-3-6. through 585:1-3-8. [REVOKED]
- Subchapter 5. Procedures [REVOKED]
- 585:1-5-1. through 585:1-5-8. [REVOKED]
- Subchapter 7. Certification cases:Representation petitions [REVOKED]
- 585:1-7-1. through 585:1-7-19. [REVOKED]

SUMMARY:

Revocation of these rules is necessary for the purpose of adoption of new permanent rules that will combine procedures and requirements for the administration of both the Fire and Police Arbitration Act and the Municipal Employee Collective Bargaining Act by the Public Employees Relations Board.

The proposed new rules will ensure consistent and efficient administration of both Acts by the Board.

AUTHORITY:

Public Employees Relations Board; 11 O.S., Section 51-101, *et seq.*; 75 O.S. § 302 *et seq.*

COMMENT PERIOD:

Persons wishing to present their views orally or in writing may do so before 5:00 p.m. on December 1st, 2006, at the following address: Debbie Tiehen, Public Employees Relations Board, Administration, 2401 N. Lincoln Boulevard, Suite 206, Oklahoma City, OK 73105.

PUBLIC HEARING:

A public hearing will be held at the Public Employees Relations Board, Will Rogers Office Building, Suite 214/216, 2401 N. Lincoln Boulevard, Oklahoma City, OK, on Friday, December 1st, 2006 at 10:00 a.m. Anyone who wishes to speak must sign in by 9:45 a.m. on that day.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

N/A

COPIES OF PROPOSED RULES:

Copies of proposed rules may be obtained for 25 cents copy charges from the Public Employees Relations Board, Administration, 2401 N. Lincoln Boulevard, Suite 206, Oklahoma City, OK 73105.

RULE IMPACT STATEMENT:

Pursuant to 75 O.S., Section 303(D), a rule impact statement will be available for review on and after November 16, 2006 at the Public Employees Relations Board, Administration, 2401 N. Lincoln Boulevard, Suite 206, Oklahoma City, OK.

CONTACT PERSON:

Debbie Tiehen, Administrative Rules Liaison, (405) 522-6723

[OAR Docket #06-1328; filed 10-6-06]

**TITLE 585. PUBLIC EMPLOYEES RELATIONS BOARD
CHAPTER 2. OPERATIONS UNDER THE FPAA AND THE MECBA**

[OAR Docket #06-1327]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

- Subchapter 1. General Provisions [NEW]
- 585:2-1-1. through 585:2-1-5. [NEW]
- Subchapter 3. Program Administration and Description [NEW]
- 585:2-3-1. through 585:2-3-9. [NEW]
- Subchapter 5. Procedures [NEW]
- 585:2-5-1. through 585:2-5-11. [NEW]
- Subchapter 7. Hearings [NEW]
- 585:2-7-1. through 2-7-16. [NEW]

SUMMARY:

The proposed rules are intended as aids to the efficient operation of the Public Employees relations Board and to the orderly administration of the Fire and Police Arbitration Act and the Municipal Employees Collective Bargaining Act. They are also intended to provide meaningful avenues for realizing and enforcing statutory rights and obligation s of certain public employees, public employee organizations, and the municipal employers of this state. The rules address information and procedures in one chapter to ensure consistent administration of both Acts.

AUTHORITY:

Public Employees Relations Board; 11 O.S., Section 51-101, *et seq.* and 11 O.S. Section 51-200, *et seq.*

COMMENT PERIOD:

Persons wishing to present their views orally or in writing may do so before 5:00 p.m. on December 1st, 2006, at the following address: Debbie Tiehen, Public Employees Relations Board, Administration, 2401 N. Lincoln Boulevard, Suite 206, Oklahoma City, OK 73105.

PUBLIC HEARING:

A public hearing will be held at the Public Employees Relations Board, Will Rogers Office Building, Suite 214/216, 2401 N. Lincoln Boulevard, Oklahoma City, OK, on Friday, December 1st, 2006 at 10:00 a.m. Anyone who wishes to speak must sign in by 9:45 a.m. on that day.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

N/A

COPIES OF PROPOSED RULES:

Copies of proposed rules may be obtained for 25 cents copy charges from the Public Employees Relations Board, Administration, 2401 N. Lincoln Boulevard, Suite 206, Oklahoma City, OK 73105.

RULE IMPACT STATEMENT:

Pursuant to 75 O.S., Section 303(D), a rule impact statement will be available for review on and after November 16, 2006 at the Public Employees Relations Board, Administration, 2401 N. Lincoln Boulevard, Suite 206, Oklahoma City, OK.

CONTACT PERSON:

Debbie Tiehen, Administrative Rules Liaison, (405) 522-6723

[OAR Docket #06-1327; filed 10-6-06]

**TITLE 585. PUBLIC EMPLOYEES RELATIONS BOARD
CHAPTER 10. UNFAIR LABOR PRACTICE CHARGES**

[OAR Docket #06-1326]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

Notices of Rulemaking Intent

PROPOSED RULES:

585:10-1-1. through 585:10-1-10. [REVOKED]
585:10-1-12. [REVOKED]

SUMMARY:

Revocation of these rules is necessary for the purpose of adoption of new permanent rules that will combine procedures and requirements for the administration of both the Fire and Police Arbitration Act and the Municipal Employee Collective Bargaining Act by the Public Employees Relations Board. The proposed new rules will ensure consistent and efficient administration of both Acts by the Board.

AUTHORITY:

Public Employees Relations Board; 11 O.S., Section 51-101, *et seq.*

COMMENT PERIOD:

Persons wishing to present their views orally or in writing may do so before 5:00 p.m. on December 1st, 2006, at the following address: Debbie Tiehen, Public Employees Relations Board, Administration, 2401 N. Lincoln Boulevard, Suite 206, Oklahoma City, OK 73105.

PUBLIC HEARING:

A public hearing will be held at the Public Employees Relations Board, Will Rogers Office Building, Suite 214/216, 2401 N. Lincoln Boulevard, Oklahoma City, OK, on Friday, December 1st, 2006 at 10:00 a.m. Anyone who wishes to speak must sign in by 9:45 a.m. on that day.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

N/A

COPIES OF PROPOSED RULES:

Copies of proposed rules may be obtained for 25 cents copy charges from the Public Employees Relations Board, Administration, 2401 N. Lincoln Boulevard, Suite 206, Oklahoma City, OK 73105.

RULE IMPACT STATEMENT:

Pursuant to 75 O.S., Section 303(D), a rule impact statement will be available for review on and after November 16, 2006 at the Public Employees Relations Board, Administration, 2401 N. Lincoln Boulevard, Suite 206, Oklahoma City, OK.

CONTACT PERSON:

Debbie Tiehen, Administrative Rules Liaison, (405) 522-6723

[OAR Docket #06-1326; filed 10-6-06]

TITLE 585. PUBLIC EMPLOYEES RELATIONS BOARD CHAPTER 15. CERTIFICATION CASES

[OAR Docket #06-1329]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

Subchapter 1. General Provisions [REVOKED]
585:15-1-1. through 585:15-1-6. [REVOKED]
585:15-1-8. [REVOKED]
Subchapter 3. Representation Petitions [REVOKED]
585:15-3-1. through 585:15-3-9. [REVOKED]
Subchapter 5. Elections [REVOKED]
585:15-5-1. and 585:15-5-2. [REVOKED]

SUMMARY:

Revocation of these rules is necessary for the purpose of adoption of new permanent rules that will combine procedures and requirements for the administration of both the Fire and Police Arbitration Act and the Municipal Employee Collective Bargaining Act by the Public Employees Relations Board. The proposed new rules will ensure consistent and efficient administration of both Acts by the Board.

AUTHORITY:

Public Employees Relations Board; 11 O.S., Section 51-101, *et seq.*

COMMENT PERIOD:

Persons wishing to present their views orally or in writing may do so before 5:00 p.m. on December 1st, 2006, at the following address: Debbie Tiehen, Public Employees Relations Board, Administration, 2401 N. Lincoln Boulevard, Suite 206, Oklahoma City, OK 73105.

PUBLIC HEARING:

A public hearing will be held at the Public Employees Relations Board, Will Rogers Office Building, Suite 214/216, 2401 N. Lincoln Boulevard, Oklahoma City, OK, on Friday, December 1st, 2006 at 10:00 a.m. Anyone who wishes to speak must sign in by 9:45 a.m. on that day.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

N/A

COPIES OF PROPOSED RULES:

Copies of proposed rules may be obtained for 25 cents copy charges from the Public Employees Relations Board, Administration, 2401 N. Lincoln Boulevard, Suite 206, Oklahoma City, OK 73105.

RULE IMPACT STATEMENT:

Pursuant to 75 O.S., Section 303(D), a rule impact statement will be available for review on and after November 16, 2006 at the Public Employees Relations Board, Administration, 2401 N. Lincoln Boulevard, Suite 206, Oklahoma City, OK.

CONTACT PERSON:

Debbie Tiehen, Administrative Rules Liaison, (405) 522-6723

[OAR Docket #06-1329; filed 10-6-06]

**TITLE 585. PUBLIC EMPLOYEES
RELATIONS BOARD
CHAPTER 30. UNFAIR LABOR PRACTICE
CHARGES UNDER THE FPA AND
PROHIBITED PRACTICE CHARGES
UNDER THE MECBA**

[OAR Docket #06-1330]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

585:30-1-1. through 585:30-1-7. [NEW]

SUMMARY:

The proposed rules are intended as aids to the efficient operation of the Public Employees relations Board and to the orderly administration of the Fire and Police Arbitration Act and the Municipal Employees Collective Bargaining Act. They are also intended to provide meaningful avenues for realizing and enforcing statutory rights and obligations of certain public employees, public employee organizations, and the municipal employers of this state. The rules address information and procedures in one chapter to ensure consistent administration of both Acts.

AUTHORITY:

Public Employees Relations Board; 11 O.S., Section 51-101, *et seq.* and 11 O.S. Section 51-200, *et seq.*

COMMENT PERIOD:

Persons wishing to present their views orally or in writing may do so before 5:00 p.m. on December 1st, 2006, at the following address: Debbie Tiehen, Public Employees Relations Board, Administration, 2401 N. Lincoln Boulevard, Suite 206, Oklahoma City, OK 73105.

PUBLIC HEARING:

A public hearing will be held at the Public Employees Relations Board, Will Rogers Office Building, Suite 214/216, 2401 N. Lincoln Boulevard, Oklahoma City, OK, on Friday, December 1st, 2006 at 10:00 a.m. Anyone who wishes to speak must sign in by 9:45 a.m. on that day.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

N/A

COPIES OF PROPOSED RULES:

Copies of proposed rules may be obtained for 25 cents copy charges from the Public Employees Relations Board, Administration, 2401 N. Lincoln Boulevard, Suite 206, Oklahoma City, OK 73105.

RULE IMPACT STATEMENT:

Pursuant to 75 O.S., Section 303(D), a rule impact statement will be available for review on and after November 16, 2006 at the Public Employees Relations Board, Administration, 2401 N. Lincoln Boulevard, Suite 206, Oklahoma City, OK.

CONTACT PERSON:

Debbie Tiehen, Administrative Rules Liaison, (405) 522-6723

[OAR Docket #06-1330; filed 10-6-06]

**TITLE 585. PUBLIC EMPLOYEES
RELATIONS BOARD
CHAPTER 35. CERTIFICATION CASES
UNDER THE FPA AND THE MECBA**

[OAR Docket #06-1331]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

Subchapter 1. General Provisions [NEW]

585:35-1-1. through 585:35-1-4. [NEW]

Subchapter 3. Representation Petitions Under the FPA [NEW]

585:35-3-1. through 585:35-3-9. [NEW]

Subchapter 4. Representation Petitions Under the MECBA [NEW]

585:35-4-1. through 585:35-4-8. [NEW]

SUMMARY:

The proposed rules are intended as aids to the efficient operation of the Public Employees relations Board and to the orderly administration of the Fire and Police Arbitration Act and the Municipal Employees Collective Bargaining Act. They are also intended to provide meaningful avenues for realizing and enforcing statutory rights and obligations of certain public employees, public employee organizations, and the municipal employers of this state. The rules address information and procedures in one chapter to ensure consistent administration of both Acts.

AUTHORITY:

Public Employees Relations Board; 11 O.S., Section 51-101, *et seq.* and 11 O.S. Section 51-200, *et seq.*

COMMENT PERIOD:

Persons wishing to present their views orally or in writing may do so before 5:00 p.m. on December 1st, 2006, at the following address: Debbie Tiehen, Public Employees Relations Board, Administration, 2401 N. Lincoln Boulevard, Suite 206, Oklahoma City, OK 73105.

PUBLIC HEARING:

A public hearing will be held at the Public Employees Relations Board, Will Rogers Office Building, Suite 214/216, 2401 N. Lincoln Boulevard, Oklahoma City, OK, on Friday, December 1st, 2006 at 10:00 a.m. Anyone who wishes to speak must sign in by 9:45 a.m. on that day.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

N/A

Notices of Rulemaking Intent

COPIES OF PROPOSED RULES:

Copies of proposed rules may be obtained for 25 cents copy charges from the Public Employees Relations Board, Administration, 2401 N. Lincoln Boulevard, Suite 206, Oklahoma City, OK 73105.

RULE IMPACT STATEMENT:

Pursuant to 75 O.S., Section 303(D), a rule impact statement will be available for review on and after November 16, 2006 at

the Public Employees Relations Board, Administration, 2401 N. Lincoln Boulevard, Suite 206, Oklahoma City, OK.

CONTACT PERSON:

Debbie Tiehen, Administrative Rules Liaison, (405) 522-6723

[OAR Docket #06-1331; filed 10-6-06]

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 25. OKLAHOMA AERONAUTICS COMMISSION CHAPTER 20. AIRCRAFT EXCISE TAX ~~CREDIT DEDICATION PROGRAM~~

[OAR Docket #06-1325]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

25:20-1-1. through 25:20-1-5. [REVOKED]

25:20-1-6. through 25:20-1-10. [NEW]

AUTHORITY:

Oklahoma Aeronautics Commission powers and duties, 3 O.S., § 81 through 93.

DATES:

Adoption:

August 10, 2006

Approved by Governor:

August 24, 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

INCORPORATION BY REFERENCE:

N/A

FINDING OF EMERGENCY:

Title 25, Chapter 20 were submitted as permanent rules on 03/31/2006; however due to circumstances beyond the Commission's control, Title 25, Chapter 20 were never approved and promulgated under the permanent rulemaking process, therefore, they are being submitted as emergency rules. The emergency rules, Title 25, Chapter 20 were adopted on August 10, 2006 and have not changed from the rules submitted as permanent rules.

ANALYSIS:

The proposed rules will set forth the requirements for participation in the aircraft excise tax dedication program administered by the Oklahoma Aeronautics Commission and to establish the procedures to be followed by the Commission. Sections 1-1 through 1-5 have been revoked due to statutory change. New rules for Sections 1-6 through 1-10 will replace the revoked sections. The proposed rules will affect persons or businesses who intend to purchase an aircraft resulting in an excise tax and who request the excise tax paid be dedicated to a specific general aviation airport owned or controlled by an airport sponsor or municipality in this state.

CONTACT PERSON:

Contact Erin Wright at the Oklahoma Aeronautics Commission by calling (405) 604-6901, by facsimile at (405) 604-6919, or by e-mail at erin.wright@oac.state.ok.us.

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

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

25:20-1-1. Purpose [REVOKED]

(a) ~~The purpose of this chapter is to set forth the requirements for participation in the aircraft excise tax credit program administered by the Oklahoma Aeronautics Commission, and to establish the procedures to be followed by the Aeronautics Commission.~~

(b) ~~Title 68, Revenue and Taxation found in Section 6003-1 of the Oklahoma Statutes, allows a credit against the excise tax levied with respect to the sale of aircraft with a selling price in excess of \$2,500,000.~~

(c) ~~To be eligible to be claimed as a credit, the person/business owing the tax must:~~

(1) ~~Spend funds for the benefit of public airports in Oklahoma.~~

(2) ~~Be certified as such by the Aeronautics Commission.~~

25:20-1-2. Definitions [REVOKED]

~~"Aeronautics Commission" means the organizational unit responsible for administering the aviation grant program for the State of Oklahoma and the Federal Aviation Administration.~~

~~"Aircraft" means and includes every self-propelled plane, airplane, helicopter, or balloon or sailplane manufactured by mass production or individually constructed or assemble, use, or designated for navigation or flight in the air or airspace, and subject to registration with the Federal Aviation Administration;~~

~~"Airport" means any area of land or water which is used, or intended for use, for the landing and take off of aircraft, and any appurtenant areas which are used, or intended for use, for airport buildings and facilities located thereon.~~

~~"Beneficiary Airport" the airport that directly benefits from the expenditure of excise tax credit funds.~~

~~"Director" means the director of the Oklahoma Aeronautics Commission.~~

~~"Expenditures" means eligible project items that have been identified and approved by the Commission.~~

~~"Letter of intent" means a letter from the sponsor's chief administrative officer describing the project and providing an estimate of the project's cost.~~

Emergency Adoptions

"Purchase price" means the total amount paid for the aircraft whether paid in money or otherwise. **"Purchase price"** is further defined as the fair market value when no current purchase is involved.

"Use" means and includes the operation or basing of an aircraft on or from any airport in this state for a period of thirty (30) days or more.

25:20-1-3. Project Identification [REVOKED]

(a) The person/business who intends to purchase an eligible aircraft shall contact the Director and indicate their interest in participating in the program.

(b) The purchaser shall meet with the Director and/or Aeronautics Commission staff and outline the proposed project. The proposed project, in as much as possible, shall be consistent with the Aeronautics Commission's Aeronautical Improvement Program and/or the Airport Development Worksheet of the beneficiary airport. The proposed project shall benefit all the users of the airport and not just for the exclusive use and benefit of the purchaser or any entity or individual.

(c) The Director and Aeronautics Commission staff shall inform the purchaser as to the eligibility of the proposed project.

(d) The purchaser, Aeronautics Commission staff, and staff of the beneficiary airport shall determine the specific project.

(e) By way of Letter of Intent, the purchaser shall provide to the Aeronautics Commission and beneficiary airport a detailed plan, estimated costs, and time frame for completion of the project.

25:20-1-4. Project Certification [REVOKED]

(a) The Aeronautics Commission staff shall present the request of the purchaser for an excise tax credit to the Aeronautics Commission for its determination as to whether the expenditures and project should be certified as benefiting the beneficiary airport.

(b) The Director shall advise the purchaser in writing of the Aeronautics Commission's determination concerning the purchaser's request for an excise tax credit.

(c) Within twenty (20) days after legal ownership or possession of the aircraft the purchaser shall expend funds equal to the excise tax owed on a Aeronautics Commission certified project, deposit an equal amount in an escrow account governed by an escrow agreement provided by the Aeronautics Commission, or pay the excise tax due to the Oklahoma Tax Commission.

(d) If the purchaser expends the funds on the certified project or deposits them in an approved escrow account, the Director shall advise the Oklahoma Tax Commission of the following:

- (1) The Aeronautics Commission's prior certification of the expenditures and project;
- (2) The purchaser/taxpayer's name and federal identification number;
- (3) The aircraft selling price;
- (4) The amount of the expenditure or the amount deposited in an approved escrow account (both amounts must be equal to the excise tax which would be owed on the aircraft).

(5) Provide a copy of the Federal Aviation Administration registration.

25:20-1-5. Project Implementation [REVOKED]

(a) The purchaser shall commence the project in accordance with the Letter of Intent.

(b) The purchaser is responsible to assure that the project is in compliance with the design and construction standards of the Federal Aviation Administration and/or the Oklahoma Department of Transportation.

(c) Representatives of the Aeronautics Commission and beneficiary airport shall make periodic project inspections.

(d) Final acceptance of the project shall be by the purchaser, the Aeronautics Commission staff, and the beneficiary airport staff.

25:20-1-6. Purpose

(a) Title 68, Revenue and Taxation found in Section 6003.1 of the Oklahoma Statutes, allows a purchaser of an aircraft with a selling price in excess of \$5,000,000, to request that the excise tax paid due to the purchase of the aircraft be dedicated to a specific general aviation airport owned or controlled by a airport sponsor or municipality in this state.

(b) The purpose of this chapter is to set forth the requirements for participation in the aircraft excise tax dedication program administered by the Aeronautics Commission, and to establish the procedures to be followed by the Aeronautics Commission in the administration and enforcement of that program.

25:20-1-7. Definitions

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

"Aeronautics Commission" means the organizational unit responsible for administering the aviation grant program for the State of Oklahoma and the Federal Aviation Administration.

"Aircraft" means and includes every self-propelled plane, airplane, helicopter, or balloon or sailplane manufactured by mass production or individually constructed or assemble, use, or designated for navigation or flight in the air or airspace, and subject to registration with the Federal Aviation Administration.

"Airport" means any area of land or water which is used, or intended for use, for the landing and take off of aircraft, and any appurtenant areas which are used, or intended for use, for airport buildings and facilities located thereon.

"Airport Sponsor" or "Municipality" is used interchangeably throughout this chapter. Either term means any incorporated city, village, or town of this state, any public institution of higher education, and any county or political subdivision or district of this state, or any public trust thereof, which is, or may be, authorized by law to acquire, establish, construct, maintain, improve, and operate airports, airstrips, and aeronautical facilities. To be eligible for the state grant program, the airport sponsor must be one of the governmental entities referenced in the preceding sentence and included in

the Oklahoma Airport System Plan. Nothing herein precludes two or more of these entities from acting jointly as an airport sponsor. In the event a public trust is the airport sponsor, the beneficiary of that public trust must also be a record owner of the airport property.

"Airport Development Worksheet" means a listing of the capital projects needed at an airport over a ten-year planning horizon together with the estimated cost, construction type, objective code, and airport component for each project. Projects identified for a particular airport must be consistent with the service level, functional classification, design standard, and airport reference code identified for the airport in the Oklahoma Airport System Plan. An airport development worksheet is developed and maintained for each system plan airport cooperatively by the airport sponsor and the Aeronautics Commission staff.

"Capital Improvement Program" means a list of airport capital projects approved by the Commission for implementation within a three-year planning horizon showing a description of the project, the costs of each phase of the project, when the project is expected to occur, and the sources of funding.

"Director" means the Director of the Oklahoma Aeronautics Commission.

"Legal Representative" means a person authorized to act as an official delegate or agent.

"Purchase price" means the total amount paid for the aircraft whether paid in money or otherwise. **"Purchase price"** is further defined as the fair market value when no current purchase is involved.

"Transfer of Legal Ownership" means when the purchaser has the legal right to take possession of the aircraft and the legal responsibility for the aircraft (not when the excise tax is paid or date of registration).

"Use" means and includes the operation or basing of an aircraft on or from any airport in this state for a period of thirty (30) days or more.

25:20-1-8. Program participation request and consideration

(a) To be eligible to participate in the excise tax dedication program, a legal representative of the aircraft purchaser must submit a written request to the Aeronautics Commission within twenty (20) days of the transfer of legal ownership of the aircraft. The written request shall:

- (1) Identify the taxpayers name and federal identification number;
- (2) Identify the actual selling price and the amount of the excise tax;
- (3) Identify the date of transfer of legal ownership;
- (4) Identify the date the aircraft purchaser took possession of the aircraft;
- (5) Identify the specific general aviation airport(s) to which the aircraft purchaser wants the excise tax dedicated; and
- (6) Include a statement which confirms that the person submitting the request is a legal representative of the aircraft purchaser.

(b) The Director and/or Aeronautics Commission staff shall present the request of the aircraft purchaser to the Aeronautics Commission for its approval, disapproval, or deferral.

(1) If approved, the funds will be dedicated to the designated airport(s) by way of a State Grant as set forth in 25:15-1-4.

(2) The Commission may disapprove the request if the approval would jeopardize the ability of the Commission to fulfill its statutory duties.

(3) In the event approval of the request would jeopardize the ability of the Commission to fulfill its statutory duties, the Commission may also choose to defer its decision for up to six (6) months from the date of the request, and then reconsider the request.

(4) The Director and/or Aeronautics Commission staff shall advise the purchaser and the owner of the specific airport(s) in writing of the Aeronautics Commission's determination concerning the purchaser's request for participation in the excise tax dedication program.

25:20-1-9. Program administration

(a) Upon approval of the request by the Aeronautics Commission, the excise tax funds dedicated in the request will be transferred to the designated excise tax fund created by the Aeronautics Commission.

(b) If the airport sponsor has a project(s) in the Aeronautics Commission's current three (3) year Capital Improvement Program then the dedicated excise tax funds shall be used to meet the state funding portion of the project as set forth in 25:15-1-4(e).

(c) If the airport sponsor does not have a project(s) in the Aeronautics Commission's current three (3) year Capital Improvement Program, then the Aeronautics Commission will select the highest priority project(s) identified on the airport sponsor's Capital Improvement Program or their Airport Development Worksheet. Should the excise tax funds dedicated not be adequate to fund the highest priority project on the airport sponsor's Capital Improvement Program or their Airport Development Worksheet, then the funds may be held until such time adequate funding is available or another project is identified and initiated. These funds shall be used to meet the state funding portion of the identified project as set forth in 25:15-1-4(e).

25:20-1-10. Project implementation

(a) Once the request has been approved by the Aeronautics Commission and the dedicated excise tax funds have been segregated, then the project selected will be implemented as set forth in 25:15-1-4.

(b) Upon the final expenditure of funds dedicated by the purchaser, the Finance Officer for Aeronautics Commission shall provide a summary of disbursements to the beneficiary airport(s) and to the Aeronautics Commission.

[OAR Docket #06-1325; filed 9-28-06]

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TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY CHAPTER 25. SOONERCARE CHOICE

[OAR Docket #06-1319]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 7. SoonerCare Choice

Part 1. General Provisions

317:25-7-2. [AMENDED]

Part 3. Enrollment Criteria

317:25-7-10. [AMENDED]

(Reference APA WF # 06-10)

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 438.52

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SUPERSEDED EMERGENCY ACTIONS:

N/A

INCORPORATIONS BY REFERENCE:

N/A

FINDING OF EMERGENCY:

The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to bring rules in line with current program guidelines and practices. Without revisions, only children under 18 years of age would be allowed to self refer for family planning services while other agency rules allow all individuals, regardless of age, to self refer for family planning services.

ANALYSIS:

SoonerCare Choice rules are revised to allow all SoonerCare Choice members to self refer for family planning services. SoonerCare came under the Medicaid managed care regulations as a Prepaid Ambulatory Health Plan (PAHP) effective January 1, 2005. PAHPS are contractually required by OHCA to let members see any family planning provider. Currently policy limits the ability to self refer for family planning services to members under the age of 18. Revisions are needed to permit all SoonerCare Choice members this same choice. Other revisions clarify that vision for refraction services are only compensable for children.

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 AUGUST 1, 2006, WHICHEVER IS LATER:

SUBCHAPTER 7. SOONERCARE CHOICE

PART 1. GENERAL PROVISIONS

317:25-7-2. SoonerCare Choice: overview

(a) The Oklahoma Health Care Authority (OHCA) operates a Primary Care Case Management (PCCM) system for SoonerCare Choice eligible ~~individuals~~ members. The program enrolls ~~Medicaid SoonerCare Choice recipients~~ members with Primary Care Provider/Case Managers PCP/CMs who provide and/or authorize all primary care services and all necessary specialty services, with the exception of services described in subsection (c) of this Section for which authorization is not required.

(b) In exchange for a fixed, periodic rate, which is paid per member per month, the Primary Care Provider/Case Manager (PCP/CM) provides, or otherwise assures the delivery of medically-necessary primary care medical services, including referrals for specialty services for an enrolled group of eligible ~~individuals~~ members. The PCP/CM assists the ~~client~~ member in gaining access to the health care system and monitors the ~~client's~~ member's condition, health care needs and service delivery.

(c) Services which do not require a referral from the PCP/CM include behavioral health services, vision for refraction services for children, dental services, child abuse/sexual abuse examinations, prenatal and obstetrical services, family planning services ~~for clients under age 18~~, emergency physician and hospital services, and services delivered to Native Americans at IHS, tribal, or urban Indian clinics.

(d) Non-capitated ~~Medicaid SoonerCare Choice~~ covered services delivered by the PCP/CM are reimbursed at the ~~Medicaid SoonerCare Traditional~~ fee-for-service rate under the procedure code established for each individual service. To the extent services are provided or authorized by the Primary Care Provider/Case Manager, the OHCA does not make ~~Medicaid SoonerCare Choice~~ payments for services delivered outside the scope of coverage of the ~~Medicaid SoonerCare Choice~~ program, thus a referral by the Primary Care Provider/Case Manager does not guarantee payment.

PART 3. ENROLLMENT CRITERIA

317:25-7-10. Enrollment with a Primary Care Provider/Case Manager

(a) All ~~Medicaid SoonerCare Choice~~ clients members described in OAC 317:25-7-12 are enrolled with a PCP/CM. ~~Medicaid SoonerCare Choice~~ applicants have the opportunity to select a PCP/CM during the application process. Enrollment with a PCP/CM for clients members determined to be eligible on or before the fifteenth day of the month are effective on the first day of the following month. Enrollment with a PCP/CM for clients members determined to be eligible after the fifteenth day of the month are effective on the first day of the second month following determination.

(1) The OHCA offers all beneficiaries members the opportunity to choose a PCP/CM from a directory which lists available PCP/CMs.

(2) If a SoonerCare Choice member moves more than the authorized distance/driving time from their current PCP/CM, that member will be disenrolled and assigned

to an appropriate PCP/CM. When a notice of PCP/CM assignment is sent to a client member, the client member is advised of the right to change the PCP/CM, at any time, or after the effective date of enrollment with the PCP/CM pursuant to OAC 317:25-7-27.

(b) Clients Members are restricted to receive services from the PCP/CM or from a provider to which the client member has been referred by the PCP/CM. Notwithstanding this provision, subject to limitations which may be placed on services by the Medicaid agency OHCA, clients members may self refer for behavioral health services, vision for refraction services for children, dental services, child abuse/sexual abuse examinations, prenatal and obstetrical services, family planning services for clients under age 18, services delivered to Native Americans at IHS, tribal, or urban Indian clinics, and emergency physician and hospital services.

(c) New SoonerCare Choice members will receive a period of six months of continuous guaranteed Medicaid SoonerCare eligibility following completion of the eligibility and enrollment process. The guaranteed period of eligibility is retroactive to the first day of the month in which they were determined eligible for Medicaid SoonerCare. The guaranteed period of eligibility is linked to the member and not the PCP/CM. The guaranteed period of eligibility ends if any of the conditions listed in (1)-(15) of this subsection occur:

- (1) ~~An individual A member~~ receives services in a nursing facility, in an intermediate care facility for the mentally retarded (ICF-MR) or through a Home and Community Based Waiver.
- (2) ~~An individual A member~~ becomes privately enrolled in an HMO.
- (3) ~~An individual A member~~ would be required to travel more than 45 miles or an average of 45 minutes to obtain primary care services, or a greater or lesser distance/driving time as determined pursuant to OAC 317:25-7-10(a).
- (4) ~~An individual A member~~ is in custody.
- (5) A member child is in a subsidized adoption.
- (6) ~~An individual A member~~ is deceased.
- (7) The State is unable to locate ~~an individual a member~~.
- (8) A determination is made that ~~an individual a member~~ has committed fraud related to the SoonerCare program.
- (9) An error has been made in determining income or resources and the ~~person member~~ is not eligible for Medicaid SoonerCare services.
- (10) ~~An individual's A member's~~ categorical relationship changes and he or she is no longer in a group eligible for SoonerCare Choice.
- (11) A woman has gained Medicaid SoonerCare eligibility solely due to a period of presumptive eligibility;
- (12) ~~An individual A member~~ is an unqualified or ineligible alien.
- (13) ~~An individual's A member's Medicaid SoonerCare~~ case has been closed.
- (14) ~~An individual A member~~ is excluded or terminated from SoonerCare for any reason.

(15) ~~An individual A member~~ becomes dually-eligible for Medicare and Medicaid-SoonerCare.

[OAR Docket #06-1319; filed 9-28-06]

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 25. SOONERCARE CHOICE**

[OAR Docket #06-1317]

RULEMAKING ACTION:
EMERGENCY adoption

RULES:
Subchapter 7. SoonerCare Choice
317:25-7-13. [AMENDED]
(Reference APA WF # 06-19)

AUTHORITY:
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR 435.1008

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SUPERSEDED EMERGENCY ACTIONS:

N/A

INCORPORATIONS BY REFERENCE:

N/A

FINDING OF EMERGENCY:

The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to allow the agency to comply with Federal regulations.

ANALYSIS:

SoonerCare Choice rules are revised to exclude individuals residing in an Institution for Mental Disease (IMD) from the SoonerCare Choice program. Currently, children residing in out-of-state behavioral health facilities, due to the inability of state facilities meeting their special needs, are included in the SoonerCare program. Federal regulations state that Federal Financial Participation is unavailable for individuals in an IMD (42 CFR 435.1008). Therefore, to comply with federal regulations, SoonerCare Choice rules are revised to exclude individuals residing in Institutions for Mental Disease.

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 AUGUST 1, 2006, WHICHEVER IS LATER:

SUBCHAPTER 7. SOONERCARE CHOICE

PART 3. ENROLLMENT CRITERIA

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317:25-7-13. Enrollment ineligibility

~~Clients~~Members in certain categories are excluded from participation in the SoonerCare program. All other ~~clients~~ members are enrolled in the SoonerCare program and subject to the provisions of this Subchapter. ~~Clients~~ Members excluded from participation in SoonerCare include:

- (1) Individuals receiving services in a nursing facility, in an intermediate care facility for the mentally retarded (ICF-MR) or through a Home and Community Based Waiver.
- (2) Individuals privately enrolled in an HMO.
- (3) Individuals who would be traveling more than 45 miles or an average of 45 minutes to obtain primary care services, or a greater or lesser distance/driving time as determined pursuant to OAC 317:25-7-10(a).
- (4) Children who are known to the OHCA to be in custody, as reported by the Oklahoma Department of Human Services.
- (5) Individuals who are eligible for ~~Medicaid~~ SoonerCare solely due to presumptive eligibility.
- (6) Non-qualified or ineligible aliens.
- (7) Children in subsidized adoptions.
- (8) Individuals who are dually-eligible for Medicaid and Medicare.
- (9) Individuals who are in an Institution for Mental Disease (IMD).

[OAR Docket #06-1317; filed 9-28-06]

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

[OAR Docket #06-1314]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 3. General Provider Policies
Part 4. Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
Program/Child Health Services
317:30-3-65.4. [AMENDED]
(Reference APA WF # 06-17)

AUTHORITY:

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

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SUPERSEDED EMERGENCY ACTIONS:

N/A

INCORPORATIONS BY REFERENCE:

N/A

FINDING OF EMERGENCY:

The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to add an environmental inspection service for children with elevated blood lead levels. Without revisions, the source of blood lead poisoning may go undetected.

ANALYSIS:

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) rules are revised to add coverage of environmental inspection service for children with elevated blood lead levels. High blood levels can cause serious health effects, including seizures, coma and death. Elevated blood levels have been associated with adverse effects on cognitive development, growth, and behavior among children aged 1 to 5. Because children with elevated blood lead levels ranging from 10 to 25 ug/dL do not develop clinical symptoms, screening is necessary to identify children who need environmental or medical intervention to reduce their blood lead levels. The Oklahoma Childhood Lead Poison Prevention Program (OCLPPP), by and through the Oklahoma State Department of Health, provide educational assistance, case management services and environmental inspections to children who have elevated blood lead in accordance with rules set forth by the Oklahoma State Board of Health (OAC 310:512-3-5). Federal policy requires that all state Medicaid programs cover a one-time environmental investigation to determine the source of lead. Revisions provide Federal Financial Participation to this state funded program.

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 AUGUST 1, 2006, WHICHEVER IS LATER:

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 4. EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) PROGRAM/CHILD HEALTH SERVICES

317:30-3-65.4. Screening components

Comprehensive EPSDT screenings are performed by, or under the supervision of, a ~~certified~~ Medicaid SoonerCare physician, ~~dentist or other provider qualified under State law to furnish primary medical and health services.~~ SoonerCare physicians are defined as all licensed medical and osteopathic physicians, physician assistants and advanced practice nurses in accordance with the rules and regulations covering the OHCA's medical care program. At a minimum, screening examinations must include, but not be limited to, the following components:

- (1) **Comprehensive health and developmental history.** Health and developmental history information may be obtained from the parent or other responsible adult who is familiar with the child's history and include an assessment of both physical and mental health development. Coupled with the physical examination, this includes:

- (A) **Developmental assessment.** Developmental assessment includes a range of activities to determine whether an individual's developmental processes fall

within a normal range of achievement according to age group and cultural background. Screening for development assessment is a part of every routine, initial and periodic screening examination. Acquire information on the child's usual functioning as reported by the child, teacher, health professional or other familiar person. Review developmental progress as a component of overall health and well-being given the child's age and culture. As appropriate, assess the following elements:

- (i) Gross and fine motor development;
- (ii) Communication skills, language and speech development;
- (iii) Self-help, self-care skills;
- (iv) Social-emotional development;
- (v) Cognitive skills;
- (vi) Visual-motor skills;
- (vii) Learning disabilities;
- (viii) Psychological/psychiatric problems;
- (ix) Peer relations; and
- (x) Vocational skills.

(B) **Assessment of nutritional status.** Nutritional assessment may include preventive treatment and follow-up services including dietary counseling and nutrition education if appropriate. This is accomplished in the basic examination through:

- (i) Questions about dietary practices;
- (ii) Complete physical examination, including an oral dental examination;
- (iii) Height and weight measurements;
- (iv) Laboratory test for iron deficiency; and
- (v) Serum cholesterol screening, if feasible and appropriate.

(2) **Comprehensive unclothed physical examination.** Comprehensive unclothed physical examination includes the following:

(A) **Physical growth.** Record and compare height and weight with those considered normal for that age. Record head circumference for children under one year of age. Report height and weight over time on a graphic recording sheet.

(B) **Unclothed physical inspection.** Check the general appearance of the child to determine overall health status and detect obvious physical defects. Physical inspection includes an examination of all organ systems such as pulmonary, cardiac, and gastrointestinal.

(3) **Immunizations.** Legislation created the Vaccine for Children Program to be effective October 1, 1994. Vaccines will be provided free of charge to all enrolled providers for Medicaid eligible children. Participating providers may bill for an administration fee to be set by CMS, formerly known as HCFA on a regional basis. They may not refuse to immunize based on inability to pay the administration fee.

(4) **Appropriate laboratory tests.** A blood lead screening test (by either finger stick or venipuncture) must be performed between the ages of nine and 12 months and

at 24 months. A blood lead test is required for any child up to age 72 months who had not been previously screened. A blood lead test equal to or greater than ~~10 ug/dL~~ 10 micrograms per deciliter (ug/dL) obtained by capillary specimen (fingerstick) must be confirmed using a venous blood sample. If a child is found to have blood lead levels equal to or greater than 10 ug/dL, ~~providers are to use their professional judgment, with reference to Centers for Disease Control (CDC) guidelines covering patient management and treatment, including follow up blood tests and initiating investigations to the source of lead~~ the Oklahoma Childhood Lead Poison Prevention Program (OCLPPP) must be notified according to rules set forth by the Oklahoma State Board of Health (OAC 310:512-3-5).

(A) The OCLPPP schedules an environmental inspection to identify the source of the lead for children who have a persistent blood lead level 15 ug/dL or greater. Environmental inspections are provided through the Oklahoma State Department of Health (OSDH) upon notification from laboratories or providers and reimbursed through the OSDH cost allocation plan approved by OHCA.

(B) Medical judgment is used in determining the applicability of all other laboratory tests or analyses to be performed unless otherwise indicated on the periodicity schedule. If any laboratory tests or analyses are medically contraindicated at the time of the screening, they are provided when no longer medically contraindicated. Laboratory tests should only be given when medical judgment determines they are appropriate. However, laboratory tests should not be routinely administered. General procedures including immunizations and lab tests, such as blood lead, are outlined in the periodicity schedule found at OAC 317:30-3-65.2.

(5) **Health education.** Health education is a required component of screening services and includes anticipatory guidance. At the outset, the physical and dental assessment, or screening, gives the initial context for providing health education. Health education and counseling to parents, guardians or children is required. It is designed to assist in understanding expectations of the child's development and provide information about the benefits of healthy lifestyles and practices as well as accident and disease prevention.

(6) **Vision and hearing screens.** Vision and hearing services are subject to their own periodicity schedules. However, age-appropriate vision and hearing assessments may be performed as a part of the screening as outlined in the periodicity schedule found at OAC 317:30-3-65.7 and 317:30-3-65.9.

(7) **Dental screening services.** An oral dental examination may be included in the screening and as a part of the nutritional status assessment. Federal regulations require a direct dental referral for every child in accordance with the periodicity schedule and at other intervals as medically necessary. Therefore, when an oral examination is done at the time of the screening, the child may be referred directly

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to a dentist for further screening and/or treatment. Specific dental services are outlined in OAC 317:30-3-65.8.

(8) **Child abuse.** Instances of child abuse and/or neglect discovered through screenings and regular examinations are to be reported in accordance with State Law, Title 21, Oklahoma Statutes, Section 846, as amended, states in part: "Every physician or surgeon, including doctors of medicine and dentistry, licensed osteopathic physicians, residents, and interns, examining, attending, or treating a child under the age of 18 years and every registered nurse examining, attending or treating such a child in the absence of a physician or surgeon, and every other person having reason to believe that a child under the age of 18 years has had physical injury or injuries inflicted upon him or her by other than accidental means where the injury appears to have been caused as a result of physical abuse or neglect, shall report the matter promptly to the county office of the Department of Human Services in the county wherein the suspected injury occurred. Providing it shall be a misdemeanor for any person to knowingly and willfully fail to promptly report an incident as provided above". Persons reporting such incidents of abuse and/or neglect in accordance with the law are exempt from prosecution in civil or criminal suits that might be brought solely as a result of the filing of the report.

[OAR Docket #06-1314; filed 9-28-06]

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

[OAR Docket #06-1321]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 5. Individual Providers and Specialties

Part 1. Physicians

317:30-5-13. [AMENDED]

(Reference APA WF # 06-16)

AUTHORITY:

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

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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 correct an inconsistency in policy in order to reduce the Medicaid provider error rate.

ANALYSIS:

Physician rules are revised to clarify reimbursement guidelines for rape and abuse exams. Language is added to specify that medically necessary procedures as well as the exam are compensable. Revisions reflect the current form and terminology used when billing for these services. Rule revisions are needed to provide consistency in rules and to reduce the Medicaid provider error rate.

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 AUGUST 1, 2006, WHICHEVER IS LATER:

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 1. PHYSICIANS

317:30-5-13. Rape and abuse exams

When a rape/abuse exam is performed on a child with ~~an active medical assistance case number or included in an active AFDC grant~~ SoonerCare benefits, a claim ~~should be~~ is filed with the fiscal agent. Payment is made for the rape/abuse exam and medically necessary procedures as per recognized coding guidelines.

(1) Supplies used during an exam for rape or abuse may be billed. ~~Use appropriate~~ Appropriate HCPCS and diagnosis codes are used.

(2) If the child is in custody as reported by the Oklahoma Department of Human Services but does not have ~~an active case number~~ SoonerCare benefits, or the child is not in custody and the parents are unable or unwilling to assume payment responsibility, the ~~caseworker~~ social worker obtains from the physician a completed OKDHS form 10AD012, Claim Form ~~ADM 12~~. The ~~ADM 12~~ 10AD012 form is routed according to procedures established by the Oklahoma Department of Human Services, Division of Children, Youth and Family services ~~Services.~~

[OAR Docket #06-1321; filed 9-28-06]

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

[OAR Docket #06-1318]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 5. Individual Providers and Specialties
Part 1. Physicians
317:30-5-25. [AMENDED]
(Reference APA WF # 06-09)

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 476; Sections 1154, 1866(a)(1)(F) and 1866(f)(2) of the Social Security Act

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INCORPORATIONS BY REFERENCE:

N/A

FINDING OF EMERGENCY:

The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions that reduce the potential abuse of observation services, as documented by the Office of Inspector General.

ANALYSIS:

Physician rules are revised to add post-payment retrospective reviews of medical necessity for outpatient observation services. Currently, outpatient observation services are not a part of post payment review by the agency's Quality Improvement Organization. Revisions are needed to reduce potential abuses of observation services, as documented by the Office of Inspector General. The revised rules would reduce potential abuses and allow the agency to recoup erroneous payments.

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 AUGUST 1, 2006, WHICHEVER IS LATER:

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 1. PHYSICIANS

317:30-5-25. Oklahoma Health Care Authority's Designated Agent Quality Improvement Organization (QIO)

All inpatient stays and outpatient observation services are subject to post-payment utilization review by the OHCA's designated Quality Improvement Organization (QIO) agent.

These reviews ~~will be~~ are based on severity of illness and intensity of treatment.

(1) It is the policy and intent of OHCA to allow hospitals and physicians the opportunity to present any and all documentation available to support the medical necessity of an admission ~~and or~~ and/or extended stay or outpatient observation of a Medicaid SoonerCare recipient member. ~~If OHCA's designated agent the QIO,~~ upon their initial review determines the admission or outpatient observation services 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~~ within the specified time-frame on the notice and consistent with the Medicare time frame guidelines. Additional information submitted with the reconsideration request ~~will be~~ is reviewed by ~~OHCA's designated agent the QIO who that~~ 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 the QIO sends written notification of the denial decision to the hospital, attending physician and the OHCA. Once the OHCA has been notified, the overpayment is processed as per the final denial determination.~~

(2) If the hospital or attending physician did not request reconsideration ~~by OHCA's designated agent from the QIO,~~ the designated agent QIO 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~~ processes the overpayment as per the denial notice sent to the OHCA by the QIO.

(3) If the ~~designated agent's QIO's~~ review results in denial and the denial is upheld throughout the review process and refund from the hospital and physician is required, the Medicaid SoonerCare recipient member cannot be billed for the denied services.

(4) If a hospital or physician believes a hospital admission, ~~or~~ continued stay, or outpatient observation service is not medically necessary and thus not Medicaid SoonerCare compensable but the patient member insists on treatment, the patient member ~~should be~~ is informed that he/she will be personally responsible for all charges.

(A) If a Medicaid SoonerCare claim is filed and paid and the service is later denied after medical necessity review, the patient member is not responsible.

(B) If a Medicaid SoonerCare claim is not filed, the patient member can be billed.

[OAR Docket #06-1318; filed 9-28-06]

Emergency Adoptions

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

[OAR Docket #06-1320]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 5. Individual Providers and Specialties
Part 39. Skilled and Registered Nursing Services
317:30-5-391. through 317:30-5-393. [AMENDED]
(Reference APA WF # 06-14)

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SUPERSEDED EMERGENCY ACTIONS:

N/A

INCORPORATIONS BY REFERENCE:

N/A

FINDING OF EMERGENCY:

The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to ease a serious shortage of nursing services for persons with mental retardation receiving community services.

ANALYSIS:

Agency Skilled and Registered Nursing Services rules are revised to establish a three-tier system to provide skilled nursing services to individuals demonstrating targeted medical needs enrolled in the Developmental Disabilities Services Division (DDSD) Homeward Bound and Community Waivers. One of the growing challenges in meeting the support needs of waiver service recipients is to provide adequate nursing support. Individuals who require nursing services have experienced changes to their health status and require skilled nursing intervention to prevent institutionalization. In recent years, DDSD has experienced a significant loss in the number of skilled nursing services providers, and continues to experience great difficulty in recruitment. DDSD has attempted to contract with other nursing agencies that have declined to service this population based on current reimbursement rates. To assure adequate nursing support for DDSD Waiver service recipients, a revision of the DDSD reimbursement structure is necessary.

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 AUGUST 1, 2006, WHICHEVER IS LATER:

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 39. SKILLED AND REGISTERED NURSING SERVICES

317:30-5-391. Coverage for Skilled Nursing Services

(a) All Skilled Nursing Services must be ordered and prescribed by a physician, supported by a nursing plan of care, included in the ~~Individual Habilitation Plan (IHP)~~ individual plan as described in OAC 340:100-5-53 and reflected in the ~~approved plan of care~~ Plan of Care approved in accordance with OAC 340:100-3-33 and OAC 340:100-3-33.1. For purposes of this Section, a physician is defined as all licensed medical and osteopathic physicians, physician assistants and advanced practice nurses in accordance with the rules and regulations covering the OHCA's medical care program. Arrangements for ~~care under this program~~ waiver Skilled Nursing Services are made ~~with the individual client's case manager~~ through the personal support team with the specific involvement of the assigned Developmental Disabilities Services Division (DDSD) registered nurse (RN). The DDSD RN develops a nursing service support plan subject to review and authorization by the DDSD state nursing director or designee.

(b) ~~All Registered Nursing (RN) Services must be ordered and prescribed by a physician, justified at a given level by the Physical Status Review, included in the Individual Habilitation Plan (IHP), and reflected in the approved plan of care. Arrangements for the provision of these services are made with the individual's case manager. Skilled Nursing Services are rendered in such a manner as to provide the service recipient as much autonomy as possible.~~

(1) Skilled Nursing Services must be flexible and responsive to changes in the service recipient's needs.

(2) Providers are expected to participate in annual personal support team meetings and other team meetings as required.

(3) Appropriate supervision of Skilled Nursing Services including services provided by licensed practical nurses (LPNs) is provided pursuant to State law and regulatory board requirements.

(4) Individual service providers must be RNs or LPNs currently licensed to practice in the State of Oklahoma.

317:30-5-392. Description of Skilled Nursing services

(a) ~~Skilled nursing services include preventive and rehabilitative procedures which have been ordered and prescribed by a physician and documented in the client's Individual Habilitation Plan. Services are provided to eligible individuals age six and older. Services include ongoing assessment and documentation of any changes in the patient's physical or mental status; reports of all significant observations or changes in physical or mental status or needs of the individual and maintenance of the plan of care based on these reports; administering medications as ordered and specified by the attending physician; documenting administration of, responses to, adverse reactions to or explanations of medication; maintaining current and accurate medication records; maintaining documentation daily of the individual's status and duties as outlined in the nurse care~~

plan; following annual nursing assessments and any needed interim written nursing assessments; implementing written plans of care; and providing leadership, supervision, training and motivation to direct care providers, participating in interdisciplinary team meetings to develop and revise Individual Habilitation Plans. Services include travel and benefits. Services are intended to contribute to the maintenance of the individual's physical health and well being. Services are provided in any community setting in which the service recipient resides.

(b) Registered Nursing (RN) Services include assessment, supervisory oversight, preventative, and nursing care procedures which have been ordered and prescribed by a physician and documented in the consumer's plan. Services are provided to eligible individuals and include ongoing assessment and treatment, documentation of the patients' physical or mental status, administering medications as ordered, preparing and presenting nursing assessment information, developing and implementing plans of care, providing leadership, supervision and training. Services are intended to contribute to the maintenance of the consumer's physical health and well being. Services may include direct skilled nursing services and also the provision of on-site supervision of LPN's. Direct service provision and supervision, on-site, is required in order to bill for this service. Off site administration of clinical supervision is not included in this service. Types of Skilled Nursing Services in the waiver programs offered by the Oklahoma Department of Human Services' Developmental Disabilities Services Division (DDSD) are:

(1) **Extended Duty Skilled Nursing Care.** Extended Duty Skilled Nursing Care allows a licensed nurse to provide direct services in a community setting up to 24 hours per day.

(A) Extended Duty Skilled Nursing Care must be:

- (i) provided only to those service recipients who have health-related issues that require skilled treatment or other intervention by a licensed nurse more frequently than every two hours;
- (ii) ordered by a licensed medical physician, osteopathic physician, physician assistant, or advanced practice nurse;
- (iii) justified in amount by the review done in accordance with OAC 340:100-5-26; and
- (iv) documented in the service recipient's Plan of Care.

(B) When Extended Duty Skilled Nursing Care is medically indicated in accordance with subparagraph (A) of this paragraph, Extended Duty Skilled Nursing Care includes:

- (i) skilled nursing care and interventions rendered directly to the service recipient by the nurse;
- (ii) monitoring, evaluation, and documentation of the service recipient's physical or mental status;
- (iii) administration of medication or treatments or both as ordered by the licensed medical physician, osteopathic physician, physician assistant or advanced practice nurse;

(iv) documentation of medication or treatment administration, skilled nursing interventions, service recipients's responses to medication or treatment, and any adverse reactions, or other significant changes;

(v) implementation of all tasks and objectives of the written nursing plan of care; and

(vi) performance of training and general care to the service recipient during periods in which skilled nursing tasks and interventions are not being performed.

(2) **Intermittent Skilled Nursing Care.** Intermittent Skilled Nursing Care involves performance of intermittent skilled tasks or interventions that only a licensed nurse can perform according to Section 1020 of Title 57 of the Oklahoma Statutes and OAC 340:100-5-26.3.

(A) Intermittent Skilled Nursing Care must be:

- (i) ordered by a licensed medical physician, osteopathic physician, physician assistant or advanced practice nurse;
- (ii) justified in amount by the review done in accordance with OAC 340:100-5-26; and
- (iii) documented in the service recipient's Plan of Care.

(B) Intermittent Skilled Nursing Care includes:

- (i) skilled nursing care and interventions rendered directly to the service recipient, as ordered by the licensed medical physician, osteopathic physician, physician assistant, or advanced practice nurse;
- (ii) health-related assessments;
- (iii) administration of medication or treatments ordered by the licensed medical physician, osteopathic physician, physician assistant, or advanced practice nurse;
- (iv) documentation of medication or treatment administration, the service recipient's response to medication or treatment, and any adverse reaction or other significant changes; and
- (v) implementation of all tasks and objectives of the nursing plan of care.

(3) **Individualized Skilled Nurse Training and Evaluation.** Individualized Skilled Nurse Training and Evaluation provides individualized evaluation and oversight of health care needs by a licensed nurse and specific, individualized health training by a licensed nurse to the service recipient or the service recipient's family or paid caregivers in accordance with Section 1020 of Title 56 of the Oklahoma Statutes and OAC 340:100-5-26.3.

(A) The licensed nurse assesses the service recipient's training needs prior to initiating competency-based training and develops a nursing plan of care that outlines the methods, goals, and objectives of the training to be performed. The nurse exercises prudent judgment in making the final decision as to what may be trained and delegated to community service workers, as provided by Section 1020 of Title 56 of the Oklahoma Statutes.

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- (B) Services include:
- (i) individualized nurse training or evaluation or both provided directly to the service recipient, family or paid caregiver(s), as identified in the individual plan and the nursing plan of care;
 - (ii) evaluation and documentation of the competency of individuals trained through return demonstration, written test, verbalization of understanding, or other means suitable to the type of training performed;
 - (iii) professional monitoring and supervision to the community service worker in accordance with the applicable licensing requirements and evaluation of:
 - (I) the stability of the condition of the service recipient;
 - (II) the training and capability of the person receiving training;
 - (III) the nature of the task being trained; and
 - (IV) the proximity and availability of the licensed nurse to the person when the task is being performed; and
 - (iv) attendance at required meetings as specified in the individual plan.

317:30-5-393. Coverage limitations for Skilled Nursing Services

- (a) A unit of Skilled Nursing Services is 30 minutes. Limits are specified in the recipient's IHP but may not exceed 48 units per day. Extended Duty Skilled Nursing Care cannot exceed three eight-hour shifts in a 24-hour period.
- (b) A unit of Registered Nursing Service is a visit. Limits are specified in the consumer's Individual Habilitation Plan (IHP), but may not exceed one unit per day, 7 units per week, and 36 units per plan of care year. Intermittent Skilled Nursing Care is limited to no more than three skilled task site visits in a 24-hour period of time.
- (c) Individualized Skilled Nurse Training and Evaluation is reimbursed on the basis of a 15-minute unit of service. No more than 16 units of Individualized Skilled Nurse Training and Evaluation can be provided per month, unless the exception is:
- (1) justified in writing by the team in accordance with OAC 340:100-3-33.1;
 - (2) recommended by the DDSD area nurse manager; and
 - (3) meets the requirements of OAC 340:100-3-33.1.

[OAR Docket #06-1320; filed 9-28-06]

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

[OAR Docket #06-1322]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 5. Individual Providers and Specialties

Part 77. Speech and Hearing Services

317:30-5-676. [AMENDED]

(Reference APA WF # 06-06)

AUTHORITY:

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

DATES:

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Expiration:

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SUPERSEDED EMERGENCY ACTIONS:

N/A

INCORPORATIONS BY REFERENCE:

N/A

FINDING OF EMERGENCY:

The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to remove a barrier to the delivery of necessary speech and hearing services to children.

ANALYSIS:

Agency rules are revised to remove the prior authorization requirement for initial speech and hearing services for children. Currently, rules state that all speech and hearing services, including the initial evaluation, for children must be prior authorized by the agency's Medical Authorization Unit. All requests for an evaluation are routinely approved which creates a large volume of unnecessary work for the unit. Revisions allow reimbursement for the initial therapy evaluation and the first three speech and hearing visits without prior authorization. These revisions are needed to remove an unnecessary prior authorization to an evaluation that is always allowed through the Early Periodic Screening and Diagnostic Testing program for children. Additional visits continue to require prior authorization.

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 AUGUST 1, 2006, WHICHEVER IS LATER:

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 77. SPEECH AND HEARING SERVICES

317:30-5-676. Coverage by category

Payment is made for speech and hearing services as set forth in this Section.

- (1) Children. Coverage for children is as follows: (A) Preauthorization required. All speech and hearing services must be preauthorized. Initial therapy evaluations and the first three therapy visits do not require prior authorization. All therapy services following the initial evaluation and first three visits must be preauthorized prior to continuation of service. (B) Speech/Language Services. Speech/language therapy services may include speech/language evaluations, individual and group therapy services provided by a state licensed speech/language pathologist. (C) Hearing aids. Hearing and hearing aid evaluations include pure tone air, bone and speech audiometry by a state licensed audiologist. Payment is made for a hearing aid following a recommendation by a Medical or Osteopathic physician and a hearing aid evaluation by a state licensed audiologist. (2) Adults. There is no coverage for adults. (3) Individuals eligible for Part B of Medicare. Services provided to Medicare eligible recipients should be filed directly with the fiscal agent.

[OAR Docket #06-1322; filed 9-28-06]

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

[OAR Docket #06-1324]

RULEMAKING ACTION: EMERGENCY adoption

RULES:

- Subchapter 5. Individual Providers and Specialties Part 85. ADvantage Program Waiver Services 317:30-5-763. through 317:30-5-764. [AMENDED] Part 95. Agency Personal Care Services 317:30-5-951. through 30-5-953. [AMENDED] (Reference APA WF # 06-13A)

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The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR 440.167

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SUPERSEDED EMERGENCY ACTIONS:

N/A

INCORPORATIONS BY REFERENCE:

N/A

FINDING OF EMERGENCY:

The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to better meet the needs of individuals receiving Personal Care Services.

ANALYSIS:

Personal Care Services rules are revised at the request of the Oklahoma Department of Human Services (OKDHS) to shift the responsibility for the completion of the skilled nursing assessment and service planning from state employed OKDHS registered nurses to provider agency nurses. Existing rules require the OKDHS Long Term Care registered nurse to make a home visit to assess the member's needs, and develop and monitor the care and service plans. Once eligibility is determined for Personal Care Services, the individual chooses an agency Personal Care service provider who is reimbursed to provide the needed services and also monitor the service recipient's care and service plans, duplicating the efforts of the OKDHS Long Term Care nurse. Most individuals receiving Medicaid State Plan Personal Care services require assistance with the instrumental activities of daily living such as meal preparation, cleaning and chore services and do not require hands on care. The Nurse Practice Act does not require a registered nurse to complete the tasks of service planning, monitoring and plan development. By transferring additional responsibility to the Personal Care service agencies, the OKDHS registered nurses will have more time to concentrate on their numerous other responsibilities that require the expertise of registered nurses. Revisions are needed in order for the Oklahoma Department of Human Services to transfer the responsibility of the care plan development and monitoring to home care provider agency nurses.

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 AUGUST 1, 2006, WHICHEVER IS LATER:

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 85. ADVANTAGE PROGRAM WAIVER SERVICES

317:30-5-763. Description of services

Services included in the ADvantage Program are as follows:

(1) Case Management.

(A) Case Management services are services that assist a client member in gaining access to medical, social educational or other services, regardless of payment source of services, that may benefit the client member in maintaining health and safety. Case managers initiate and oversee necessary assessments and reassessments to establish or reestablish waiver program eligibility. Case managers develop the client's member's comprehensive plan of care, listing only services which are necessary to prevent institutionalization of the client member, as determined through assessments. Case managers initiate the addition of necessary services or deletion of unnecessary services, as dictated by the client's member's condition

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and available support. Case managers monitor the client's member's condition to ensure delivery and appropriateness of services and initiate plan of care reviews. If a client member requires hospital or nursing facility services, the case manager assists the client member in accessing institutional care and, as appropriate, periodically monitors the client's member's progress during the institutional stay and helps the client member transition from institution to home by updating the service plan and preparing services to start on the date the client member is discharged from the institution. Case Managers must meet ADvantage Program minimum requirements for qualification and training prior to providing services to clients members. Prior to providing services to clients members receiving Consumer-Directed Personal Assistance Services and Supports (CD-PASS), Case Managers are required to receive training and demonstrate knowledge regarding CD-PASS service delivery model, "Independent Living Philosophy" and demonstrate competency in Person-centered planning.

(B) Providers may only claim time for billable Case Management activities described as follows:

(i) A billable case management activity is any task or function defined under OAC 317:30-5-763(1)(A) that only an ADvantage case manager because of skill, training or authority, can perform on behalf of a client member;

(ii) Ancillary activities such as clerical tasks like mailing, copying, filing, faxing, drive time or supervisory/administrative activities are not billable case management activities, although the administrative cost of these activities and other normal and customary business overhead costs have been included in the reimbursement rate for billable activities;

(C) Case Management services are prior authorized and billed per 15-minute unit of service using the rate associated with the location of residence of the client member served.

(i) Standard Rate: Case Management services are billed using a Standard rate for reimbursement for billable service activities provided to a client member who resides in a county with population density greater than 25 persons per square mile.

(ii) Very Rural/Difficult Service Area Rate: Case Management services are billed using a Very Rural/Difficult Service Area rate for billable service activities provided to a client member who resides in a county with population density equal to or less than 25 persons per square mile. An exception would be services to clients members that reside in AA identified zip codes in Osage County adjacent to metropolitan areas of Tulsa and Washington Counties. Services to these clients members are prior authorized and billed using the Standard rate.

(iii) The United States 2000 Census, Oklahoma Counties population data is the source for determination of whether a client member resides in a county with a population density equal to or less than 25 persons per square mile, or resides in a county with a population density greater than 25 persons per square mile.

(2) **Respite.**

(A) Respite services are provided to clients members who are unable to care for themselves. They are provided on a short-term basis because of the absence or need for relief of the primary caregiver. Payment for respite care does not include room and board costs unless more than seven hours are provided in a nursing facility. Respite care will only be utilized when other sources of care and support have been exhausted. Respite care will only be listed on the plan of care when it is necessary to prevent institutionalization of the client member. Units of services are limited to the number of units approved on the plan of care.

(B) In-Home Respite services are billed per 15-minute unit service. Within any one-day period, a minimum of eight units must be provided with a maximum of 28 units provided. The service is provided in the client's member's home.

(C) Facility-Based Extended Respite is filed for a per diem rate, if provided in Nursing Facility. Extended Respite must be at least eight hours in duration.

(D) In-Home Extended Respite is filed for a per diem rate. A minimum of eight hours must be provided in the client's member's home.

(3) **Adult Day Health Care.**

(A) Adult Day Health Care is furnished on a regularly scheduled basis for one or more days per week, at least four hours per day in an outpatient setting. It provides both health and social services which are necessary to ensure the optimal functioning of the client member. Physical, occupational, respiratory and/or speech therapies may only be provided as an enhancement to the basic Adult Day Health Care service when authorized by the plan of care and billed as a separate procedure. Meals provided as part of this service shall not constitute a full nutritional regimen. Transportation between the client's member's residence and the service setting is provided as a part of Adult Day Health Care. Personal Care service enhancement in Adult Day Health Care is assistance in bathing and/or hair washing authorized by the plan of care and billed as a separate procedure. Most assistance with activities of daily living, such as eating, mobility, toileting and nail care, are services that are integral to the Adult Day Health Care service and are covered by the Adult Day Health Care basic reimbursement rate. Assistance with bathing and/or hair care is not a usual and customary adult day health care service. Enhanced personal care in adult day health care for assistance with bathing and/or hair washing

will be authorized when an ADvantage waiver client member who uses adult day health care requires assistance with bathing and/or hair washing to maintain health and safety.

(B) Adult Day Health Care is a 15 minute unit. No more than 6 hours are authorized per day. The number of units of service a client member may receive is limited to the number of units approved on the client's member's approved plan of care.

(C) Adult Day Health Care Therapy Enhancement is a maximum one session per day unit of service.

(D) Adult Day Health Personal Care Enhancement is a maximum one per day unit of bathing and/or hair washing service.

(4) **Environmental Modifications.**

(A) Environmental Modifications are physical adaptations to the home, required by the client's member's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home and without which, the client member would require institutionalization. Adaptations or improvements to the home which are not of direct medical or remedial benefit to the waiver client member are excluded.

(B) All services require prior authorization.

(5) **Specialized Medical Equipment and Supplies.**

(A) Specialized Medical Equipment and Supplies are devices, controls, or appliances specified in the plan of care, which enable clients members to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. Also included are items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid state plan. This service shall exclude any equipment and/or supply items which are not of direct medical or remedial benefit to the waiver client member. This service is necessary to prevent institutionalization.

(B) Specialized Medical Equipment and Supplies are billed using the appropriate HCPC procedure code. All services must be prior authorized.

(6) **Comprehensive Home Care.** Comprehensive Home Care is an integrated service-delivery package which includes case management, personal care, skilled nursing, in-home respite and advanced supportive/restorative assistance.

(A) Comprehensive Home Care is provided by an agency which has been trained and certified by the Long Term Care Authority to provide an integrated service delivery system. Comprehensive Home Care is case management in combination with one or more of the following services:

- (i) personal care,
- (ii) in-home respite,

(iii) skilled nursing, and/or

(iv) advanced supportive/restorative services.

(B) All services must be provided in the home and must be sufficient to achieve, maintain or improve the client's member's ability to carry out daily living activities. However, with OKDHS area nurse approval, or for ADvantage waiver clients—members, 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 member in achieving vocational goals identified on the service plan. The sub-component services of Comprehensive Home Care are the same as described in (A) of this paragraph (see subparagraph (1)(A) of this section for Case Management services, OAC 317:35-15-2 for Personal Care service, subparagraph (8)(A) of this section for Skilled Nursing, subparagraph (2)(A) of this section for In-Home Respite, and subparagraph (7)(A) of this section for Advanced Supportive/Restorative Assistance).

(C) CHC services are billed using the appropriate HCPC procedure code along with the CHC provider location code on the claim.

(7) **Advanced Supportive/Restorative Assistance.**

(A) Advanced Supportive/Restorative Assistance services are maintenance services to assist a client member who has a chronic, yet stable, condition. The service assists with activities of daily living which require devices and procedures related to altered body functions. This service is for maintenance only and is not utilized as a treatment service.

(B) Advanced Supportive/Restorative Assistance service is billed per 15-minute unit of service. The number of units of this service a client member may receive is limited to the number of units approved on the plan of care.

(8) **Skilled Nursing.**

(A) Skilled Nursing services are services of a maintenance or preventive nature provided to clients members with stable, chronic conditions. These services are not intended to be treatment for an acute health condition and may not include services which would be reimbursable under either Medicaid or Medicare's Home Health Program. This service primarily provides nurse supervision to the Personal Care Assistant or to the Advanced Supportive/Restorative Assistance Aide, assessment of the client's member's health and assessment of services to meet the client's member's needs as specified in the plan of care. A skilled nursing assessment/evaluation on-site visit is made to each client member for whom Advanced Supportive/Restorative Assistance services are authorized to evaluate the condition of the client member. ~~A~~ monthly An assessment/evaluation visit report will be made to the ADvantage Program case manager in accordance with review schedule determined in consultation between the Case Manager and the

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Skilled Nurse, to report the ~~client's~~ member's condition or other significant information concerning each advanced supportive/restorative care ~~client~~ member.

(i) The ADvantage Program case manager may recommend authorization of Skilled Nursing services for participation in interdisciplinary team planning of service plan and/or assessment/evaluation of:

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

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

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

(I) filling a one-week supply of insulin syringes for a blind diabetic who can self-inject the medication but cannot fill his/her own syringe. This service would include monitoring the ~~client's~~ member's continued ability to self-administer the insulin;

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

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

(IV) providing nail care for the diabetic ~~client~~ member or ~~client~~ member with circulatory or neurological deficiency;

(V) providing consultation and education to the ~~client~~ member, ~~client's~~ member's family and/or other informal caregivers identified in the service plan, regarding the nature of the chronic condition. Provide skills training (including return skills demonstration to establish competency) for preventive and rehabilitative care procedures to the ~~client~~ member, family and/or other informal caregivers as specified in the service plan.

(B) Skilled Nursing service is billed for ~~an~~ service plan development and/or assessment/evaluation ~~services per assessment~~ or, for non-assessment services, ~~Skilled Nursing services are billed for the first hour unit of service and for each per~~ 15-minute unit

~~of service provided after the first hour. A specific procedure code is used to bill for assessment/evaluation/service plan development skilled nursing services and other procedure code is used to bill for all other authorized skilled nursing services. A minimum of three and a maximum of seven units per day of skilled nursing for assessment/evaluation and/or service plan development are allowed.~~ An agreement by a provider to produce a nurse evaluation is an agreement, as well, to provide the nurse assessment identified Medicaid in-home care services for which the provider is certified and contracted. Reimbursement for a nurse evaluation shall be denied if the provider that produced the nurse evaluation fails to provide the nurse assessment identified Medicaid in-home care services for which the provider is certified and contracted.

(9) **Home Delivered Meals.**

(A) Home Delivered Meals provide one meal per day brought to the ~~client's~~ member's home. Each meal has a nutritional content equal to one third of the Recommended Daily Allowance. Meals are only provided to ~~clients~~ members who are unable to prepare meals and lack an informal provider to do meal preparation.

(B) Home Delivered Meals are billed per meal/unit. The limit of the number of units a ~~client~~ member is allowed to receive is limited on the ~~client's~~ member's plan of care.

(10) **Occupational Therapy services.**

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

deletion of services, based on the ~~client's~~ member's condition and ongoing rehabilitation potential.

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

(11) Physical Therapy services.

(A) Physical Therapy services are those services that prevent physical disability through the evaluation and rehabilitation of ~~clients~~ members disabled by pain, disease or injury. Services are provided in the ~~client's~~ member's home and are intended to help the ~~client~~ member achieve greater independence to reside and participate in the community. Treatment involves use of physical therapeutic means such as massage, manipulation, therapeutic exercise, cold or heat therapy, hydrotherapy, electrical stimulation and light therapy. Under a physician's order, a licensed physical therapist evaluates the ~~client's~~ member's rehabilitation potential and develops an appropriate, written therapeutic regimen. The regimen utilizes paraprofessional physical therapy assistant services, within the limits of their practice, working under the supervision of the licensed physical therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the ~~client's~~ member's rehabilitative progress and will report to the ~~client's~~ member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the ~~client's~~ member's condition and ongoing rehabilitation potential.

(B) Physical Therapy services are billed per 15-minute units of service. Payment is not allowed solely for written reports or record documentation.

(12) Comprehensive Home Care (CHC) Personal Care.

(A) Comprehensive Home Care (CHC) Personal Care is assistance to a ~~client~~ member in carrying out activities of daily living such as bathing, grooming and toileting, or in carrying out instrumental activities of daily living, such as preparing meals and doing laundry, to assure personal health and safety of the ~~client~~ member or to prevent or minimize physical health regression or deterioration. Personal Care services do not include service provision of a technical nature, i.e. tracheal suctioning, bladder catheterization, colostomy irrigation, and operation/maintenance of equipment of a technical nature.

(B) CHC Case Manager and Skilled Nursing staff are responsible for development and monitoring of the ~~client's~~ member's CHC Personal Care plan.

(C) Comprehensive Home Care (CHC) Personal Care services are prior authorized and billed per 15-minute unit of service with units of service limited to the number of units on the ADvantage approved plan of care.

(13) Speech and Language Therapy Services.

(A) Speech/Language Therapy services are those that prevent speech and language communication disability through the evaluation and rehabilitation of ~~clients~~ members disabled by pain, disease or injury. Services are provided in the ~~client's~~ member's home and are intended to help the ~~client~~ member achieve greater independence to reside and participate in the community. Services involve use of therapeutic means such as evaluation, specialized treatment, and/or development and oversight of a therapeutic maintenance program. Under a physician's order, a licensed Speech/Language therapist evaluates the ~~client's~~ member's rehabilitation potential and develops an appropriate, written therapeutic regimen. The regimen utilizes paraprofessional therapy assistant services within the limits of their practice, working under the supervision of the licensed speech/language therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the ~~client's~~ member's rehabilitative progress and will report to the ~~client's~~ member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the ~~client's~~ member's condition and ongoing rehabilitation potential.

(B) Speech/Language Therapy services are billed per 15-minute unit of service. Payment is not allowed solely for written reports or record documentation.

(14) Respiratory Therapy Services.

(A) Respiratory therapy services are provided for a ~~client~~ member who, but for the availability of in-home respiratory services, would require respiratory care as an inpatient in a hospital or nursing facility. Services are provided in the ~~client's~~ member's home under the care of a physician who is familiar with the technical and medical components of home ventilator support and the physician must determine medically that in-home respiratory care is safe and feasible for the ~~client~~ member. Treatment involved use of therapeutic means such as: evaluation, respiratory treatments, chest physiotherapy, and/or development and oversight of a therapeutic maintenance program. Under a physician's order, a registered respiratory therapist evaluates the ~~client~~ member and develops an appropriate, written therapeutic regimen. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the ~~client's~~ member's progress and will report to the ~~client's~~ member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the ~~client's~~ member's condition and ongoing rehabilitation potential.

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

(15) Hospice Services.

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(A) Hospice is palliative and/or comfort care provided to the client member and his/her family when a physician certifies that the client member has a terminal illness and has six months or less to live and orders Hospice Care. A hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional and spiritual stresses which are experienced during the final stages of illness and during dying and bereavement. The client member signs a statement choosing hospice care instead of routine medical care that has the objective to treat and cure the client's member's illness. Once the client member has elected hospice care, the hospice medical team assumes responsibility for the client's member's medical care for the terminal illness in the home environment. Hospice care services include nursing care, physician services, medical equipment and supplies, drugs for symptom control and pain relief, home health aide and personal care services, physical, occupational and/or speech therapy, medical social services, dietary counseling and grief and bereavement counseling to the client member and/or family. A Hospice plan of care must be developed by the hospice team in conjunction with the client's member's ADvantage case manager before hospice services are provided. The hospice services must be related to the palliation or management of the client's member's terminal illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills. ADvantage Hospice may be provided to the client member in a Nursing Facility (NF) only when the client member is placed in the NF for ADvantage Facility Based Extended Respite. Hospice provided as part of Facility Based Extended Respite may not be reimbursed for more than five days during any 30 day period. A client member that is eligible for Medicare Hospice provided as a Medicare Part A benefit, is not eligible to receive ADvantage Hospice services.

(B) Hospice services are billed per diem of service for days covered by a Hospice plan of care and during which the Hospice provider is responsible for providing Hospice services as needed by the client member or client's member's family.

(16) ADvantage Personal Care.

(A) ADvantage Personal Care is assistance to ~~an individual~~ a member in carrying out activities of daily living such as bathing, grooming and toileting, or in carrying out instrumental activities of daily living, such as preparing meals and doing laundry, to assure personal health and safety of the individual or to prevent or minimize physical health regression or deterioration. Personal Care services do not include service provision of a technical nature, i.e. tracheal suctioning, bladder catheterization, colostomy irrigation, and operation/maintenance of equipment of a technical nature.

(B) ADvantage Home Care Agency Skilled Nursing staff working in coordination with an ADvantage Case Manager are responsible for development and monitoring of the client's member's Personal Care plan.

(C) ADvantage Personal Care services are prior authorized and billed per 15-minute unit of service with units of service limited to the number of units on the ADvantage approved plan of care.

(17) Personal Emergency Response System.

(A) Personal Emergency Response System (PERS) is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal, in accordance with client member preference, a friend, a relative or a response center once a "help" button is activated. The response center is staffed by trained professionals. For an ADvantage Program client member to be eligible to receive PERS service, the client member must meet all of the following service criteria:

- (i) a recent history of falls as a result of an existing medical condition that prevents the individual from getting up from a fall unassisted;
- (ii) lives alone and has no regular caregiver, paid or unpaid, and therefore is left alone for long periods of time;
- (iii) demonstrates capability to comprehend the purpose of and activate the PERS;
- (iv) has a health and safety plan detailing the interventions beyond the PERS to assure the client's member's health and safety in his/her home;
- (v) has a disease management plan to implement medical and health interventions that reduce the possibility of falls by managing the client's member's underlying medical condition causing the falls; and,
- (vi) the service avoids premature or unnecessary institutionalization of the client member.

(B) PERS services are billed using the appropriate HCPC procedure code for installation, monthly service or purchase of PERS. All services are prior authorized in accordance with the ADvantage approved plan of care.

(18) Consumer-Directed Personal Assistance Services and Support (CD-PASS).

(A) Consumer-Directed Personal Assistance Services and Supports are Personal Services Assistance, Advanced Personal Services Assistance and Employer Support Services that enable an individual in need of assistance to reside in their home and in the community of their choosing rather than in an institution and to carry out functions of daily living, self care, and mobility. CD-PASS services are delivered as authorized on the service plan. The client member employs the Personal Services Assistant (PSA) and/or

the Advanced Personal Services Assistant (APSA) and is responsible, with assistance from the Employer Support Services provider, for ensuring that the employment complies with State and Federal Labor Law requirements. The client member may designate an adult family member or friend, an individual who is not a PSA or APSA to the client member, as an "authorized representative" to assist in executing these employer functions. The client member:

- (i) recruits, hires and, as necessary, discharges the PSA or APSA;
- (ii) provides instruction and training to the PSA or APSA on tasks to be done and works with the Consumer Directed Agent/Case Manager to obtain Advantage ADvantage skilled nursing services assistance with training when necessary. Prior to performing an Advanced Personal Services Assistance task for the first time, the SPSA must demonstrate competency in the tasks in an on-the-job training session conducted by the client member and the client member must document the attendant's competency in performing each task in the ASPA's personnel file;
- (iii) determines where and how the PSA or APSA works, hours of work, what is to be accomplished and, within Individual Budget Allocation limits, wages to be paid for the work;
- (iv) supervises and documents employee work time; and,
- (v) provides tools and materials for work to be accomplished.

(B) The service Personal Services Assistance may include:

- (i) assistance with mobility and with transfer in and out of bed, wheelchair or motor vehicle, or both;
- (ii) assistance with routine bodily functions that may include:
 - (I) bathing and personal hygiene;
 - (II) dressing and grooming;
 - (III) eating including meal preparation and cleanup;
- (iii) assistance with homemaker type services that may include shopping, laundry, cleaning and seasonal chores;
- (iv) companion type assistance that may include letter writing, reading mail and providing escort or transportation to participate in approved activities or events. "Approved activities or events" means community civic participation guaranteed to all citizens including but not limited to, exercise of religion, voting or participation in daily life activities in which exercise of choice and decision making is important to the client member that may include shopping for food, clothing or other necessities, or for participation in other activities or events that are specifically approved on the service plan.

(C) Advanced Personal Services Assistance are maintenance services provided to assist a client member with a stable, chronic condition with activities of daily living when such assistance requires devices and procedures related to altered body function if such activities, in the opinion of the attending physician or licensed nurse, may be performed if the individual were physically capable, and the procedure may be safely performed in the home. Advanced Personal Services Assistance is a maintenance service and should never be used as a therapeutic treatment. Clients Members who develop medical complications requiring skilled nursing services while receiving Advanced Personal Services Assistance should be referred to their attending physician who may, if appropriate, order home health services. The service of Advanced Personal Services Assistance includes assistance with health maintenance activities that may include:

- (i) routine personal care for persons with ostomies (including tracheotomies, gastrostomies and colostomies with well-healed stoma) and external, in dwelling, and suprapubic catheters which includes changing bags and soap and water hygiene around ostomy or catheter site;
- (ii) remove external catheters, inspect skin and reapplication of same;
- (iii) administer prescribed bowel program including use of suppositories and sphincter stimulation, and enemas (Pre-packaged only) with clients members without contraindicating rectal or intestinal conditions;
- (iv) apply medicated (prescription) lotions or ointments, and dry, non-sterile dressings to unbroken skin;
- (v) use lift for transfers;
- (vi) manually assist with oral medications;
- (vii) provide passive range of motion (non-resistant flexion of joint) delivered in accordance with the plan of care, unless contraindicated by underlying joint pathology;
- (viii) apply non-sterile dressings to superficial skin breaks or abrasions; and
- (ix) use Universal precautions as defined by the Center for Disease Control.

(D) The service Employer Support Services is assistance with employer related cognitive tasks, decision-making and specialized skills that may include:

- (i) assistance with Individual Budget Allocation planning and support for making decisions, including training, reference material and consultation, regarding employee management tasks such as recruiting, hiring, training and supervising the Personal Service Assistant or Advanced Personal Service Assistant;
- (ii) responsibility for obtaining criminal and abuse registry background checks, on behalf of the

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~~client member~~, on prospective hires for PSAs or APSAs;

(iii) for making available Hepatitis B vaccine and vaccination series to PSA and APSA employees in compliance with OSHA standards;

(iv) for performing Internal Revenue Service (IRS) fiscal reporting agent and other financial management tasks and functions including, but not limited to:

(I) employer payroll, at a minimum of semi monthly, and associated mandatory withholding for taxes, Unemployment Insurance and Workers' Compensation Insurance performed on behalf of the ~~client~~ member as employer of the PSA or APSA; and

(II) other employer related payment disbursements as agreed to with the ~~client member~~ and in accordance with the ~~client's~~ member's Individual Budget Allocation.

(E) The service of Personal Services Assistance is billed per 15-minute unit of service. The number of units of PSA a ~~client member~~ may receive is limited to the number of units approved on the Service Plan.

(F) The service of Advanced Personal Services Assistance is billed per 15-minute unit of service. The number of units of APSA a ~~client member~~ may receive is limited to the number of units approved on the Service Plan.

(G) The service of Employer Support Services is billed per month unit of service. The Level of service and number of units of Employer Support Services a ~~client member~~ may receive is limited to the Level and number of units approved on the Service Plan.

(19) **Institution Transition Services.**

(A) Institution Transition Services are those services that are necessary to enable an individual to leave the institution and receive necessary support through ADvantage waiver services in their home and/or in the community. Institution Transition Services may include, as necessary, any one or a combination of the following:

(i) Case Management;

(ii) Nursing Assessment and Evaluation for in-home service planning;

(iii) Environmental Modifications including Assessment for Transition Environmental Modification Services; and/or,

(iv) Medical Equipment and Supplies.

(B) Institution Transition Case Management Services are services as described in OAC 317:30-5-763(1) required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or to enable the individual to function with greater independence in the home, and without which, the individual would continue to require institutionalization. ADvantage Transition Case Management Services assist institutionalized individuals that are eligible to receive ADvantage

services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services to assist in the transition, regardless of the funding source for the services to which access is gained. Transition Case Management Services may be authorized for periodic monitoring of an ADvantage ~~client's~~ member's progress during an institutional stay, and for assisting the ~~client member~~ transition from institution to home by updating the service plan, including necessary Institution Transition Services to prepare services and supports to be in place or to start on the date the ~~client member~~ is discharged from the institution. Transition Case Management Services may be authorized to assist individuals that have not previously received Advantage services but have been referred by the AA or OKDHS to the Case Management Provider for assistance in transitioning from the institution to the community with Advantage services support.

(i) Institution Transition Case Management services are prior authorized and billed per 15 minute unit of service using the appropriate HCPC and modifier associated with the location of residence of the ~~client member~~ served as described in OAC 317:30-5-763(1)(C).

(ii) A unique modifier code is used to distinguish Institution Transition Case Management services from regular Case Management services.

(C) Institution Transition Skilled Nursing Services are nursing services, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or to enable the individual to function with greater independence in the home, and without which, the individual would continue to require institutionalization. Institutional Transition Skilled Nursing services are solely for assessment/evaluation and service planning for in-home assistance services.

(i) Institution Transition Skilled Nursing services are prior authorized and billed per assessment/evaluation visit using the appropriate HCPC.

(ii) A unique modifier code is used to distinguish Institution Transition Skilled Nursing Services from regular Skilled Nursing Services.

(D) Institution Transition Environmental Modifications are those physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would continue to require institutionalization. Such adaptations are the same as described under OAC 317:30-5-763(4)(A) and may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which

are necessary for the welfare of the individual. Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable state or local building codes. Services may include accessibility evaluation of the ~~client's~~ member's home and follow-up evaluation of the adequacy of installed environmental modifications to meet the ~~client's~~ member's accessibility and environmental adaptive needs. Accessibility evaluation services must be performed by an Accessibility Specialist who is trained and certified through a Federal or State agency approved program for Americans with Disabilities Act (ADA) Accessibility Guidelines - Title III (Public Accommodations) or by a physical or occupational therapist. Accessibility evaluation services do not include evaluations of the need for modifications or equipment that serve a therapeutic or rehabilitative function for which a therapist evaluation is necessary.

(i) Institution Transition Environmental Modification services are prior authorized and billed using the appropriate HCPC.

(ii) A unique modifier code is used to distinguish Institution Transition Environmental Modification Services and Assessments from regular Environmental Modification Services and Assessments.

(E) Institution Transition Specialized medical equipment and supplies are those devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would continue to require institutionalization. This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan. Item reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation.

(i) Institution Transition Medical Equipment and Supply services are prior authorized and billed using the appropriate HCPC.

(ii) A unique modifier code is used to distinguish Institution Transition Medical Equipment

and Supply Services from regular Medical Equipment and Supply services.

(F) Institutional Transition Services may be authorized and reimbursed under the following conditions:

(i) The service is necessary to enable the individual to move from the institution to their home;

(ii) The individual is eligible to receive Advantage services outside the institutional setting;

(iii) Institutional Transition Services are provided to the individual within 120 days of discharge from the institution;

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

(G) If the ~~client~~ member has received Institution Transition Services but fails to enter the waiver, any Institution Transition Services authorized and provided are reimbursed as "Medicaid administrative" costs and providers follow special procedures specified by the AA to bill for services provided.

317:30-5-764. Reimbursement

(a) Rates for waiver services are set in accordance with the rate setting process by the Committee for Rates and Standards and approved by the Oklahoma Health Care Authority Board.

(1) The rate for NF Respite is set equivalent to the rate for enhanced nursing facility services that require providers having equivalent qualifications;

(2) The rate for daily units for Adult Day Health Care are set equivalent to the rate established by the Oklahoma Department of Human Services for the equivalent services provided for the OKDHS Adult Day Service Program that require providers having equivalent qualifications;

(3) The rate for units of Home-Delivered Meals are set equivalent to the rate established by the Oklahoma Department of Human Services for the equivalent services provided for the OKDHS Home-Delivered Meals Program that require providers having equivalent qualifications;

(4) The rates for units of In-Home Respite, CHC Personal Care, and CHC In-Home Respite are set equivalent to State Plan Agency Personal Care unit rate which require providers having equivalent qualifications;

(5) The rates for a unit of Skilled Nursing and CHC Skilled Nursing are set equivalent to ~~State Plan Home Health Benefit Skilled Nursing unit that require providers having equivalent qualifications~~ the Advantage Case Management Standard rate.

(6) CD-PASS rates are determined using the Individual Budget Allocation (IBA) Expenditure Accounts Determination process for each ~~client~~ member. The IBA Expenditure Accounts Determination process includes consideration and decisions about the following:

(A) Authorized PSA and APSA units (determined from CDA/CM and ~~client~~ member planning);

(B) Total CD-PASS IBA (annualized authorized units X the rate for comparable agency personal assistance services). The Total CD-PASS IBA (TIBA)

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is the annualized budget amount calculated to cover reimbursement for all CD-PASS services - Personal Services Assistance (PSA), Advanced Personal Services Assistance (APSA) and Employer Support Services (ESS). The TIBA is equal to that portion of the annualized cost for Personal Care services and Advanced Supportive/Restorative assistance under the client's member's existing service plan that CD-PASS services replace;

(C) Authorized Employer Support Service level (based on AA assessment of client's member's level of need for Employer Supportive Services from review of Consumer Readiness assessment for those new to CD-PASS or performance if existing CD-PASS participant);

(D) Total Annual ESS budget allocation (annualized ESS authorized units X the ESS level rate) and

(E) Client IBA (CIBA) which is equal to the Total CD-PASS IBA minus Total ESS allocation (E=B-D).

(F) The Individual Budget Allocation (IBA) Expenditure Accounts Determination constrains total Medicaid reimbursement for CD-PASS to be equal to or less than expenditures for equivalent services using agency providers. The TIBA and service unit rates are calculated by the AA during the CD-PASS service eligibility determination process. Based upon the client member record review, client member "Self-assessment of Readiness" to assume employer role and responsibilities and other available information, the AA authorizes a level of support to cover Employer Support Service needs. This process establishes the monthly rate for Employer Support Services. Thereafter, as part of the service planning authorization process at a minimum of annually, the AA, in consultation with the client member reviews and updates the authorized level of Employer Support Services.

(G) The PSA rate is determined as follows. The monthly ESS rate amount is subtracted from an amount equivalent to the total monthly unit authorization reimbursement for agency Personal Care (PC) services under the client's member's existing service plan and the result is divided by the total number of PC units authorized per month.

(i) The allocation of portions of PSA rate to cover salary, mandatory taxes, Worker's Compensation insurance and optional benefits is determined individually for each client member using the CD-PASS Individualized Budget Allocation Expenditure Accounts Determination Process;

(ii) If both APSA and PSA units are being authorized the ESS monthly rate amount employed in the PSA rate determination is in proportion to the units of PSA to combined PSA plus APSA units;

(H) The APSA rate is determined as follows. The monthly ESS rate amount is subtracted from an amount equivalent to the total monthly unit authorization reimbursement for agency Advanced Supportive/Restorative (ASR) assistance services

under the client's member's existing service plan and the result divided by the total number of ASR units authorized per month.

(i) The allocation of portions of APSA rate to cover salary, mandatory taxes, Worker's Compensation insurance and optional benefits is determined individually for each client member using the CD-PASS Individualized Budget Allocation Expenditure Accounts Determination Process;

(ii) If both APSA and PSA units are being authorized, the ESS monthly rate amount employed in the APSA rate determination is in proportion to the units of APSA to combined PSA plus APSA units.

(I) The IBA Expenditure Accounts Determination process defines the level of program financial resources required to meet the consumer's member's need for CD-PASS services. If the client's member's need for services changes due to a change in health/disability status and/or a change in the level of support available from other sources to meet needs, the Case Manager, based upon an updated assessment, amends the service plan to increase CD-PASS service units appropriate to meet additional client member need. The AA, upon favorable review, authorizes the amended plan and updates the client's member's IBA. Service amendments based on changes in client member need for services do not change an existing PSA or APSA rate. The client member, with assistance from the ESSP, reviews and revises the IBA Expenditure Accounts calculation annually or more often to the extent appropriate and necessary.

(b) The AA approved ADvantage service plan is the basis for the MMIS service prior authorization, specifying:

- (1) service;
- (2) service provider;
- (3) units authorized; and
- (4) begin and end dates of service authorization.

(c) As part of ADvantage quality assurance, provider audits evaluate whether paid claims are consistent with service plan authorizations and documentation of service provision. Evidence of paid claims that are not supported by service plan authorization and/or documentation of service provision will be turned over to SURS for follow-up investigation.

PART 95. AGENCY PERSONAL CARE SERVICES

317:30-5-951. Coverage by category

Medicaid SoonerCare payment is made to agencies, on behalf of Medicaid recipients-SoonerCare members, for personal care services (PC services) provided in the recipient's member's home. Personal Care services may be provided in an educational or employment setting to assist the client member in achieving vocational goals identified on ~~the service plan with the approval of the DHS area nurse~~ an approved care plan. Personal care services prevent, or minimize, a member's physical health regression and deterioration. Tasks performed

during the provision of ~~personal care~~ PC services include, but are not limited to, assisting an individual in performing tasks of personal hygiene, dressing and medication. Tasks may also include meal preparation, light housekeeping, errands, and laundry directly related to the recipient's personal care needs. Personal care does not include the provision of care of a technical nature. For example, tracheal suctioning, bladder catheterization, colostomy irrigation and operation/maintenance of technical machinery is not performed as part of ~~personal care~~ PC services. PC skilled nursing service is an assessment of the member's needs to determine the frequency of PC services and tasks performed, development of a PC service care plan to meet identified personal care needs, service delivery oversight and annual re-assessment and updating of care plan. It may also include more frequent re-assessment and updating of the care plan if changes in the member's needs require.

(1) **Adults.** Payment for ~~agency personal care~~ services provided by a PC services agency is made on behalf of ~~aged or disabled~~ eligible individuals who have ~~been assessed using needs requiring the service in accordance with OAC 317:35-15-4 as determined through an assessment utilizing the Uniform Comprehensive Assessment Tool (UCAT) and whose needs, as determined through the assessment, require the provision of this service, in accordance with OAC 317:35 15 4. To be eligible for personal care~~ Before PC services can begin the individual must:

- (A) require a ~~treatment care~~ plan involving the planning and administration of services delivered under the supervision of professional personnel ~~and are prescribed by the physician;~~
- (B) have a physical impairment or combination of physical and mental impairments;
- (C) lack the ability to meet personal care needs without additional supervision or assistance, or to communicate needs to others; and
- (D) require assistance, not of a technical nature, to prevent or minimize physical health regression and deterioration.

(2) **Children.** Coverage for persons under 21 years of age is the same as for adults.

317:30-5-952. Prior authorization

~~Each client~~ Eligible members receiving personal care services must have a ~~treatment an approved care plan developed by a Department of Human Services (DHS) Long Term Care (LTC) PC services skilled nurse. For persons receiving ADvantage Program services, the nurse works with the member's or by an ADvantage Program Case Manager to develop the care plan. The amount and frequency of the service, to be provided to the client member, is listed on the treatment care plan. The amount and frequency of PC services is also prior authorized approved by the LTC OKDHS nurse or by the Administrative Agent's (AA) certification authorization of the ADvantage Program Service Plan. At the time of a PC services member's initial referral to a PC services agency, OKDHS or AA authorizes PC services, skilled nursing for PC~~

~~services, needs assessment and care plan development. The number of units of service PC services or PC skilled nursing the client member is eligible to receive is limited to the service time amounts approved on the nurse's prior authorization or on the AA certified ADvantage Program Service Plan converted to 15 minute units care plan as authorized by OKDHS or AA. Care plans are authorized for no more than one year from the date of care plan authorization. Services provided without prior authorization are not compensable.~~

317:30-5-953. Billing

~~Agency personal care unit of service is one hour. A billing unit of service for personal care skilled nursing service equals a visit. A billing unit of service for personal care services provided by a PC service agency is 15 minutes of PC services delivery. Billing procedures for Personal Care services are contained in the OKMMIS Billing and Procedure Manual.~~

[OAR Docket #06-1324; filed 9-28-06]

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

[OAR Docket #06-1315]

RULEMAKING ACTION:
EMERGENCY adoption

RULES:
Subchapter 3. Coverage and Exclusions
317:35-3-2. [AMENDED]
(Reference APA WF # 06-18)

AUTHORITY:
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR 435.1008

DATES:

Adoption:
June 8, 2006

Approved by Governor:
August 2, 2006

Effective:
Immediately upon Governor's approval or August 1, 2006, whichever is later

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 Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions that allow the agency to comply with Federal regulations.

ANALYSIS:
Non-emergency transportation (NET) rules are revised to exclude the capitated payment and transportation services for individuals who reside in an Institution for Mental Disease (IMD). Federal regulations state that Federal Financial Participation is unavailable for individuals in an IMD (42 CFR 435.1008). Therefore, to comply with federal regulations, NET rules

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are revised to exclude the capitated payment and transportation services for individuals residing in Institutions for Mental Disease.

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 AUGUST 1, 2006, WHICHEVER IS LATER:

SUBCHAPTER 3. COVERAGE AND EXCLUSIONS

317:35-3-2. Medicaid SoonerCare transportation and subsistence

The Oklahoma Health Care Authority (OHCA) is responsible for assuring that necessary transportation is available to all eligible ~~Medicaid recipients~~ SoonerCare members who are not otherwise covered through their Managed Care Plan and who are in need of SoonerCare medical services in accordance with 42 CFR 431.53. The agency contracts with a broker to provide statewide curb to curb coverage for non-emergency transportation under the SoonerRide program. The broker provides the most appropriate and least costly mode of transportation necessary to meet the individual needs of SoonerCare members. Payment for covered services to the broker is reimbursed under a capitated methodology based on per member per month. The agency contracts directly with ambulance and air providers for all other transportation needs for eligible members not provided by SoonerRide. Ambulance and air providers are reimbursed at a rate published statewide based on the Medicare established rates for covered services. Transportation must be for medically necessary treatment in accordance with 42 CFR 440.170 Reimbursement for transportation costs must be prior authorized by the local Department of Human Services' (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~~ excludes individuals who are enrolled in a Managed Care Organization (MCO) through OHCA, those individuals who are categorized as institutionalized, Home and Community

Based Waiver members with the exception of the In-home Supports Waiver for Children and the ADvantage Waiver, and those individuals who are categorized as Qualified Medicare Beneficiaries Plus (QMBP), Specified Low Income Medicare Beneficiaries (SLMB), and Qualifying Individuals-1 and individuals who are in an institution for mental disease (IMD). Clients Members 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~~ is answered Monday through Saturday, 8 a.m. to 6 p.m. Whenever possible, the ~~client~~ member is required to notify SoonerRide at least 72 hours prior to the appointment. The ~~client~~ member ~~will be~~ is asked to furnish the SoonerRide reservation center ~~the case their~~ SoonerCare member 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~~ makes arrangements for the most appropriate, least costly transportation. SoonerRide ~~will verify~~ verifies appointments when appropriate. The SoonerRide contractor ~~will be~~ is 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~~ are include, but ~~is~~ are not limited to, verification of liability insurance and drug testing. All non-emergency transportation will be arranged by SoonerRide. If the ~~client~~ member disagrees with the transportation arranged or denied by SoonerRide, an appeal ~~should be~~ is filed with 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~~ member. Dissatisfaction with the use of public transportation, shared rides, type of vehicle, etc., is not appropriate grounds for appeal. The Oklahoma Health Care Authority's decision ~~will be~~ is final. ~~As provider networks are developed, SoonerRide will be expanded to include additional counties. Before a county is phased into SoonerRide, county officials 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 or bus.**

~~(A) Transportation by private vehicle or bus is administered through the broker when it is necessary for an eligible member to receive medical services. 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 OKDHS or OHCA employee or the spouse of a 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 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).

~~(2B) 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 at the discretion of the broker. 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 SoonerCare 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 SoonerCare.

(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 SoonerCare funds. If the individual needs assistance with necessary expenses of lodging and meals, the member must first pay for the lodging and meals and then submit a travel reimbursement form for reimbursement does not have the funds for the necessary subsistence, authorization is made by the local office on ~~Room and Board Order form.~~ The travel reimbursement form may be obtained by contacting OHCA or the local OKDHS office. 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 OHCA 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.

[OAR Docket #06-1315; filed 9-28-06]

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

[OAR Docket #06-1323]

RULEMAKING ACTION:
EMERGENCY adoption

RULES:
Subchapter 15. Personal Care Services
317:35-15-2. [AMENDED]

Emergency Adoptions

317:35-15-8, through 317:35-15-8.1. [AMENDED]

317:35-15-10. [AMENDED]

317:35-15-13.1. [AMENDED]

(Reference APA WF # 06-13B)

AUTHORITY:

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR 440.167

DATES:

Adoption:

June 8, 2006

Approved by Governor:

August 2, 2006

Effective:

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

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 Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to better meet the needs of individuals receiving Personal Care Services.

ANALYSIS:

Personal Care Services rules are revised at the request of the Oklahoma Department of Human Services (OKDHS) to shift the responsibility for the completion of the skilled nursing assessment and service planning from state employed OKDHS registered nurses to provider agency nurses. Existing rules require the OKDHS Long Term Care registered nurse to make a home visit to assess the member's needs, and develop and monitor the care and service plans. Once eligibility is determined for Personal Care Services, the individual chooses an agency Personal Care service provider who is reimbursed to provide the needed services and also monitor the service recipient's care and service plans, duplicating the efforts of the OKDHS Long Term Care nurse. Most individuals receiving Medicaid State Plan Personal Care services require assistance with the instrumental activities of daily living such as meal preparation, cleaning and chore services and do not require hands on care. The Nurse Practice Act does not require a registered nurse to complete the tasks of service planning, monitoring and plan development. By transferring additional responsibility to the Personal Care service agencies, the OKDHS registered nurses will have more time to concentrate on their numerous other responsibilities that require the expertise of registered nurses. Revisions are needed in order for the Oklahoma Department of Human Services to transfer the responsibility of the care plan development and monitoring to home care provider agency nurses.

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 AUGUST 1, 2006, WHICHEVER IS LATER:

SUBCHAPTER 15. PERSONAL CARE SERVICES

317:35-15-2. Personal Care services

(a) Personal Care is defined as assistance to an individual in carrying out activities of daily living, such as bathing, grooming and toileting, or in carrying out instrumental activities

of daily living, such as preparing meals and doing laundry or errands directly related to the member's personal care needs, to assure personal health and safety of the individual or to prevent or minimize physical health regression or deterioration. The Personal Care service requires a skilled nursing assessment of need, development of a care plan to meet identified personal care needs, care plan oversight and periodic re-assessment and updating, if necessary, of the care plan. Personal Care services do not include technical service services provision of a technical nature, i.e. such as, tracheal suctioning, bladder catheterization, colostomy irrigation, and operation/maintenance operation of equipment of a technical nature.

(b) ~~Personal Care is a level of care for individuals who do not require care in a nursing facility (NF) or intermediate care facility for the mentally retarded (ICF/MR). Personal Care services are initiated to support the informal care that is being provided in the client's member's home. A rented apartment, room or shelter shared with others is considered "the client's member's home". A facility which meets the definition of a nursing facility, room and board, licensed residential care facility, group home, rest home or a specialized home as set forth in O.S. Title 63, Section 1-819 et seq., Section 1-899.1 et seq., and Section 1-1902 et seq., and/or in any other typed of settings prohibited under applicable federal or state statutes, rules, regulations, or other written instruments that have the effect of law is not a setting that qualifies as considered the "the client's member's home" for delivery of Medicaid SoonerCare Personal Care Program services. Personal Care shall not be approved if the client lives in the PCA's home except with agreement of the interdisciplinary service planning team that this is consistent with plan goals and outcomes for the client and has Personal Care Program administrative approval, or, if an ADvantage client, AA administrative approval. These services are not intended to take the place of regular care by family and significant others. When there is an informal (not paid) system of care available in the home, Personal Care service provision will supplement the system within the limitations of policy.~~

(c) Personal Care services may be provided ~~either~~ by an individual employed by the member DHS qualified contractor who is referred to as a Personal Care Assistant (PCA) employed by the client or by an a qualified employee of a home care agency holding a valid certification and contract to provide Medicaid Personal Care service that is certified to provide PC services and contracted with the OHCA to provide PC services. OKDHS must determine a PCA to be qualified to provide PC services before they can provide services.

317:35-15-8. Agency Personal Care service management

(a) ~~The LTC~~ At the time of assessment, the OKDHS nurse informs the client member of the Agency Personal Care service contractors qualified agencies in the their local area who are contracted available to deliver provide Personal Care services and obtains the client's informed member's primary and secondary choice of agencies. The client chooses a primary and secondary agency contractor from a list of qualified agencies. If the client and/or member or family declines to make a choice

choose a primary PC service agency, the OKDHS nurse uses a rotating system to select selects an agency contractor from a list of all local certified provider available agencies, using a round-robin system. The LTC OKDHS nurse documents the name of the selected PC service agency.

(b) After medical and financial eligibility have been are established, the LTC nurse reviews the care plan and service plan with the client and contractor and notifies the client and agency contractor to begin care plan and service plan implementation. The nurse maintains the original plans and forwards a copy of the UCAT, the Personal Care Planning Schedule, the approved Personal Care plan and the service plan to the chosen agency contractor and client within one working day of notice of approval OKDHS contacts the member's preferred PC service agency or, if necessary, the secondary agency or the agency selected by the rotation system. The OKDHS nurse forwards the referral to the PC services agency and establishes an initial PC skilled nursing service authorization for assessment and care plan development. Within one working day, OKDHS notifies the PC service agency and member of eligibility approval and also the authorization for PC skilled nursing for assessment and care plan development. The agency, prior to placing a PCA in the client's member's home, initiates an OSBI background check, checks the DHS OKDHS Community Services Worker Registry in accordance with Section 1025.2 of Title 56 of the Oklahoma Statutes, and, as appropriate, checks the Certified Nurse Aid Registry.

(c) The LTC nurse is the case manager and monitors the care plan and service plan for clients. The LTC nurse contacts the client within 30 calendar days of submitting the care plan and service plan to the agency in order to make sure that services have been implemented and the needs of the client are being met. The LTC nurse makes a home visit at a minimum of every 180 days beginning within 90 days of the date of service initiation for all individuals receiving Personal Care for the purpose of assessing the client's satisfaction with their care and for evaluating the plan of care for adequacy of goals and units allocated. Whenever a home visit is made, the LTC nurse communicates to the home health agency the results of the visit as documented on the Personal Care Services Progress Notes, DHS form AG 22. Requests by the agency for increases in the time allocated in the care plan and service plan are submitted to the LTC nurse and approved by the area nurse, or designee, prior to implementation. Within ten working days of receipt of the member's PC eligibility approval, the PC services agency skilled nurse completes an in-home assessment of the member's PC service needs, develops a care plan and submits the plan to the OKDHS nurse. The member's PC services care plan includes PC services goals and tasks, the number of authorized PC service units per month, frequency of PC service visits, the begin date for PC services, and the care plan end date which is no more than one year from the plan begin date. If more than one person in the household has been authorized to receive PC services, all household members' care plans are discussed and developed with the eligible members so service delivery can be coordinated to achieve the most efficient use of resources. The number of units of PC service authorized for each individual is

distributed between all eligible family members to assure that the absence of one family member does not adversely affect the family member(s) remaining in the home.

(d) When the service provider returns the service plan with a start date, the LTC nurse or the AA notifies the county social worker in writing of the number of units and the start date of PC services. Within three working days of receipt of the care plan from the PC services agency, the OKDHS nurse reviews and approves or denies the care plan and notifies the agency. The OKDHS nurse may also reduce the number of units requested by the PC services agency and then approve the care plan. When the OKDHS nurse denies a plan or approves a plan with fewer authorized units than the submitted plan, OKDHS consults with the PC services agency prior to denying the care plan or approving the care plan with reduced units.

(e) Personal Care is provided under the State Plan if a client requires Personal Care and is approved for the ADvantage waiver. It is the ADvantage case manager's responsibility to develop and monitor the care plan and service plan. The ADvantage case manager reviews the service plan with the client and forwards a copy of the service plan to the agency. All requests by the agency for increases in the time allocated in the service plan are submitted to the case manager and must be approved by the AA, or designee, prior to implementation. The ADvantage case manager contacts the client monthly and makes a home visit at a minimum of every 90 days and the home care agency nurse makes a home visit at a minimum of every 180 days to evaluate the client. Case manager and home care agency nurse visits are for the purpose of surveying the client's satisfaction with their care and for evaluating the plan of care for adequacy of goals and units allocated. The ADvantage case manager contacts the client within 5 calendar days of service plan certification by the AA in order to make sure that services have been implemented. The ADvantage case manager contacts the client within 30 calendar days of service plan certification by the AA in order to make sure that the needs of the client are being met. Any person approved under the ADvantage waiver is eligible to receive any Medicaid service including those in the State Plan (Refer to OAC 317:35-17). Prior to placing a PC attendant in the member's home or other service-delivery setting, an OSBI background check, OKDHS Community Service Worker Registry check in accordance with Section 1025.2 of Title 56 of the Oklahoma Statutes, and as appropriate, the Certified Nurse Aide Registry Check must be completed.

(f) With the exception of clients served by the ADvantage or any other Home and Community Based Services (HCBS) Waiver, the LTC nurse is the case manager for Personal Care (PC) clients. Clients served by the ADvantage or any other HCBS Waiver have case management services provided through these waivers. This function involves advocacy, service planning, coordination, monitoring and problem solving with service providers and with families in the provision of services. The PC service skilled nurse monitors their member's care plan. The PC service provider agency contacts the member within 5 calendar days of receipt of the approved care plan in order to make sure that services have been implemented and the needs of the member are being

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met. The PC services agency nurse makes a home visit at least every 180 days to assess the member's satisfaction with their care and to evaluate the care plan for adequacy of goals and units authorized. Whenever a home visit is made, the PC services agency nurse documents their findings in the personal care services progress notes. Requests by the PC service agency to change the number of units authorized in the care plan are submitted to OKDHS and are approved or denied by the OKDHS area nurse, or designee prior to implementation of the changed number of units. Annually, or more frequently if the member's needs change, the PC services agency nurse re-assesses member's need and develops a new care plan to meet personal care needs. If the member's need does not change, the agency nurse may re-authorize the member's existing plan.

(g) ~~Since PC services are intended to supplement and support existing informal care, use of informal supports as PCAs may jeopardize the informal support system [see OAC 317:35-15-2(a)]. The provider agency may only employ informal supports with the written agreement of the interdisciplinary team. When the PC services agency returns the member's care plan containing a service start date to OKDHS, the OKDHS nurse notifies the OKDHS county social worker in writing of the service and number of authorized PC service units and the start and end date of PC service authorization.~~

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

The Administrative Agent (AA) certifies qualified PC service agencies and facilitates the execution of the ~~agencies' SoonerCare~~ 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 PC services agency is not listed.~~

(1) **Payment for Personal Care.** Payment for ~~Personal Care~~ PC services is generally made for care in the ~~client's member's "own home". A~~ In addition to an owned or rented home, a rented apartment, room or shelter shared with others is considered ~~to be the member's "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 and/or in any other type of settings prohibited under applicable federal or state statutes, rules, regulations, or other written instruments that have the effect of law is not a setting that qualifies as the member's "own home" for delivery of PC services through SoonerCare. Personal Care may not be approved if the client lives in the PCA's home except with the interdisciplinary team's written approval. With OKDHS area nurse prior approval, or for ADvantage~~

~~waiver clients, with service plan authorization and ADvantage Program Manager approval, Personal Care PC services may be provided in an educational or employment setting to assist the ~~client-member~~ in achieving vocational goals identified on the ~~service care~~ plan.~~

(A) **Use of Personal Care service agency ~~contractors~~ for Personal Care.** To provide ~~Personal Care~~ PC services, an agency must be licensed by the Oklahoma State Department of Health, meet certification standards identified by OKDHS or the ~~Administrative Agent (AA), and possess a current Medicaid SoonerCare contract.~~

(B) **Reimbursement.** Personal Care services payment ~~for on behalf of a ~~client-member~~~~ is made according to the type of service and number of units of service ~~PC services identified authorized in the ~~service care~~ plan.~~

(i) ~~The unit amounts amount paid to agency contractors PC services providers for each unit of service is according to the established SoonerCare rates for the PC services. 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. Only authorized units contained on each eligible member's individual care plan are eligible for reimbursement. Providers serving more than one PC service member residing in the same residence will assure that the members' care plans combine units in the most efficient manner possible to meet the needs of all eligible persons in the residence.~~

(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 for PC services is for tasks performed in accordance with OAC 317:30-5-951 only when listed on an authorized care plan. 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 for PC skilled nursing service is made on behalf of the member for assessment/evaluation and associated service planning per assessment/service planning visit by the provider agency personal care skilled nurse.~~

(2) **Problem Issue resolution.** If the ~~client member~~ is dissatisfied with the PC services provider agency or the assigned PCA, and has exhausted attempts to work with the PC services agency's grievance process without resolution, the ~~client~~ ~~contacts the LTC member~~ may contact the OKDHS nurse for ~~problem resolution to attempt to resolve the issues. If the situation cannot be resolved, the~~ The ~~client member~~ has the right to appeal to the OHCA in accordance with OAC 317:2-1-2. (Refer to OAC 317:2-1-2). For ~~clients members~~ receiving ADvantage services, ~~the member or family should contact their case~~

manager should be contacted for the problem resolution. If the problem remains unresolved, the contact member or family should contact may be made with the Consumer Inquiry System (CIS) at the Long Term Care Authority. Providers are required to provide the CIS contact number to every member. The ADvantage Program member also has the right to appeal to the OHCA in accordance with OAC 317:2.

317:35-15-10. Redetermination for Personal Care services

(a) **Recertification.** The LTC OKDHS nurse re-assesses the PC services client member for medical re-certification based on the member's needs and level of caregiver support required, using the UCAT at least every 36 months. The LTC nurse, with the client's input, prepares a new care plan and service plan with any required adjustments in service. During this re-certification assessment, the OKDHS nurse informs the member of the state's other SoonerCare long-term care options. The LTC OKDHS nurse submits the re-assessment, new care plan, and new service plan to the OKDHS area nurse, or designee, for re-certification and authorization of services at a maximum of every 36 months. Recertification documents are sent to the area nurse, or designee, by no later than the tenth day of the month in which the certification expires. When the area nurse, or designee determines medical eligibility for Personal Care PC services, a service plan and care plan re-certification review date is entered on the system. The care plan and service plan re-certification depends on the client's needs and on the adequacy of the client's caregiver support.

(b) **Change in level of care.** If it comes to the attention of the LTC nurse that there is a marked change in an individual's condition that may affect medical eligibility or level of care, the nurse and social worker discuss the change to determine a plan of action. The LTC nurse discusses the plans with the client and contractor. If a client in a nursing facility is planning to return home, requests personal care and has a current medical evaluation review date, another medical decision is necessary. If there is not a current medical review date and the client requests a change in level of care, the UCAT, care plan and service plan are completed and sent to the area nurse, or designee, for a medical decision.

(c) **Change in service plan and care plan for State Plan PC members.** Upon notification by the PC service agency of the member's need for a change in the amount of PC service required, the OKDHS nurse initiates the process to increase or decrease the approved units of service on the member's care plan. Based on the documentation provided by the PC service agency to OKDHS, the area nurse or designee approves or denies the care plan changes within three working days of receipt of the request. A copy of the signed care plan is included in the case record. The social worker updates the service authorization system after they are notified of the increase or decrease.

(1) **Non-ADvantage clients.** The service contractor or the LTC nurse initiates the process for an increase or decrease in units of service to the client's service and care plans using a service provider communication form, DHS

form AG-7. Requested changes in service and justification for changes must be documented on the form. The area nurse, or designee, approves or denies the service plan and care plan change within three working days of receipt of the plan. A copy of the signed service plan is included in the case record. A significant change in the client's physical condition or caregiver support that requires an increase in service of 18 hours per month, either wholly or incrementally during the medical certification period, requires a UCAT re-assessment by the LTC nurse. Based on the re-assessment, the client may, as appropriate, be certified for a new care plan and service plan, certified for a different level of care or be eligible for a different service program. The LTC nurse notifies the social worker of an increase or decrease in services once approval is received in order that the authorization system can be updated.

(2) **ADvantage clients.** The service contractor or the ADvantage case manager initiates the process for an increase or decrease in units of service to the client's service plan using a service provider communication form. Requested changes in service and justification for changes must be documented on the form. The AA, or designee, approves or denies the service plan change within three working days of receipt of the plan. When the AA authorizes an increase in the number of units of service, the AA notifies the county social worker for entry into the authorization file effective the date the hours increased. When the AA authorizes a decrease in the number of units of service, the AA notifies the county social worker for entry into the authorization file effective the first of the next month. If received after the computer change deadline, the change will be effective the first of the following month. A copy of the certified service plan addendum is included in the case record by the AA. The AA notifies the social worker of an increase or decrease in services in order that the authorization system can be updated.

(d) **Voluntary closure of Personal Care State Plan PC services.** If the a client agrees member decides Personal Care services is are no longer needed to meet his/her needs, a medical decision from the area nurse, or designee, is not needed. The client member and the LTC OKDHS nurse or social worker completes and signs DHS OKDHS form AG-17, Voluntary Action of Personal Care Case Closure form.

(e) **Resuming Personal Care State Plan PC services.** If a client member approved for Personal Care services has been without PC services for less than 90 days and has a current medical and financial eligibility determination, services may be resumed using the previously approved care plan and service plan but still has a current PC services medical and SoonerCare financial eligibility approval, PC services may be resumed using the member's previously approved care plan. The PC service agency submits a PC services skilled nursing re-assessment of need within ten working days of the resumed plan start date. If the member's needs dictate, the PC services agency may submit a request for a change in authorized PC services units with the re-assessment for authorization review by OKDHS.

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(fe) **Financial ineligibility.** Anytime the ~~local office~~ OKDHS determines a PC services client member does not meet the SoonerCare financial eligibility criteria, the local OKDHS office notifies the client member, ~~contractor~~ PC service provider, and the LTC OKDHS nurse of financial ineligibility. ~~A medical eligibility redetermination is not required when the period of financial ineligibility does not exceed 90 days during the medical certification.~~

(gf) **Closure due to medical ineligibility.** ~~Any time~~ If the local OKDHS office is notified through the system of a ~~decision~~ decision that the client member is no longer medically eligible for Personal Care, the social worker notifies the client member of the decision. The OKDHS nurse is ~~responsible for notifying the contractor~~ notifies the PC service agency.

(hg) **Termination of State Plan Personal Care Services.** ~~The process for termination of Personal Care is provided in this subsection.~~

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

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

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

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

(D) the client's member's health, or safety, ~~and well-being~~ is at risk as documented on the UCAT; or

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

(2) ~~Personal Care services will be terminated when the~~ The client member refuses to select and/or accept the services of ~~an~~ a PC service agency or PCA for 90 consecutive days as supported by professional documentation.

(3) ~~The LTC nurse~~ For persons receiving State Plan PC services, the PC services agency submits documentation with the recommendation to ~~the area nurse~~ for a medical decision ~~discontinue services to OKDHS~~. The DHS Aging Services Division OKDHS notifies the client member and the Personal Care service agency or PCA, ~~area nurse, LTC nurse~~ and the local county social worker of the decision to terminate services. The social worker is ~~responsible for updating the computer system, closing~~ closes the authorization on the OKDHS system and ~~sending~~ which sends an official closure notice to the client ~~with the member~~ informing them of their appropriate client member rights to appeal the decision to discontinue services.

317:35-15-13.1. Individual Personal Care service management

(a) An individual PCA may be ~~authorized~~ utilized to provide PC services when it is documented to be in the best interest of the client member to have an individual personal care attendant (PCA) or when there are no ~~agency contractors~~ qualified PC service agencies available in the member's local area. When an individual PCA is ~~selected~~ utilized by the client, the DHS OKDHS nurse explains OHCA form HCA-66, Authorization for Withholding of FICA Tax in Personal Care, to the client member and obtains his/her signature. OHCA will check the list of providers that have been barred from Medicare/Medicaid participation to ensure that the individual provider is not listed.

(b) ~~After medical and financial eligibility have been~~ PC services eligibility is established and prior to implementation of PC services using an individual PAC, the LTC OKDHS nurse reviews the care plan and ~~service plan~~ with the client member and individual PCA and notifies the client member and PCA to begin ~~care plan and service plan implementation~~ PC services delivery. The OKDHS nurse maintains the original plans care plan and forwards a copy of the ~~approved Personal Care care plan and service plan~~ to the chosen PCA within one working day of notice of approval.

(c) ~~The LTC OKDHS nurse is the case manager and monitors the care plan and service plan for clients members with an individual PCA. The LTC nurse makes a home visit at a minimum of every 180 days beginning within 90 days of the date of service initiation for all individuals receiving Personal Care for the purpose of surveying the client's satisfaction with their care and for evaluating the plan of care for adequacy of goals and units allocated. Requests for increases in the time allocated in the care plan and service plan are submitted to the LTC nurse and approved by the area nurse, or designee, prior to implementation. For any member receiving PC services utilizing an individual PCA, the OKDHS nurse makes a home visit at least every 180 days beginning within 90 days of the date of PC service initiation. OKDHS assesses the member's satisfaction with their PC services and evaluates the care plan for adequacy of goals and units allocated. Requests for changes in the units authorized in the care plan must be approved by the OKDHS area nurse, or designee, prior to implementation of the changed number of units.~~

(d) ~~Personal Care is provided under the State Plan if a client requires Personal Care and is approved for the ADvantage waiver. It is the ADvantage case manager's responsibility to develop and monitor the care plan and service plan. If a member requires an individual PCA and is also approved for ADvantage waiver, the ADvantage case manager develops and monitors PC service delivery as part of the ADvantage service plan. The ADvantage case manager reviews the service care plan with the client member and forwards a copy of the service plan to the individual PCA. The ADvantage case manager contacts the member within five calendar days of service plan certification by the AA in order to make sure that services have been implemented. The ADvantage case manager contacts the member within 30 calendar days of service plan certification by the AA in order to make sure the needs of the member are being met. Requests for increases~~ changes in the time

allocated in the service plan authorized PC services units are submitted to the case manager and must be approved by the AA, or designee, prior to implementation by the ADvantage case manager for approval or denial by the AA or designee, prior to implementation of the changes in units. The ADvantage case manager contacts the client member monthly and makes a home visit at a minimum of least every 90 days and the LTC nurse makes a home visit at a minimum of every 180 days for supervision to evaluate the care plan for adequacy of goals and units allocated. Case manager and LTC nurse visits are for the purpose of assessing the client's satisfaction with their care and for evaluating the plan of care for adequacy of goals and units allocated. The ADvantage case manager contacts the client within 5 calendar days of service plan certification by the AA in order to make sure that services have been implemented. The ADvantage case manager contacts the client within 30 calendar days of service plan certification by the AA in order to make sure that the needs of the client are being met. Any person approved under the ADvantage waiver is eligible to receive any Medicaid service including those in the State Plan (Refer to OAC 317:35-17).

(e) With the exception of clients members served by the ADvantage or any other Home and Community Based Services (HCBS) Waiver, the LTC OKDHS nurse is the case manager for Personal Care (PC) clients responsible for assessing and monitoring the provision of personal care for Individual Personal Care members. Clients served by the ADvantage or any other HCBS Waiver have case management services provided through these waivers. This function involves advocacy, service planning, coordination, monitoring and problem solving with service providers and with families in the provision of services.

(f) ~~Since PC services are intended to supplement and support existing informal care, use of informal supports as PCAs may jeopardize the informal support system [see OAC 317:35-15-2(a)].~~ Under certain circumstances, the use of informal supports as individual PCAs may be the only available option for providing services to the client member. The ADvantage Program consumer's interdisciplinary team authorizes the use of informal supports for the PC program.

(1) ~~One or more of the following conditions as determined by the LTC nurse must exist in order for informal supports to be approved as PCA service providers:~~

- ~~(A) The informal support is the only person who has the special ability and willingness to provide care due to the complexity of care needed; or,~~
- ~~(B) The client lives in a remote, rural area that has no personal care providers; or~~
- ~~(C) No other persons are available to provide PCA services in the community where the client lives.~~

(2) ~~The interdisciplinary team provides written justification on the plan of care for use of a family member as the PCA.~~

(3) ~~Whenever informal supports provide PCA services, care plan and service plan development must include components to prevent failure/burnout of the informal supports and assurances that the client is receiving the care required.~~

~~(A1) Components built into the care plan to prevent failure/burnout of informal supports may include, but are not limited to, the following:~~

- ~~(iA) an utilization of additional informal support supports, other than the one providing PCA services; provides services; and~~
- ~~(iiB) provision of home-delivered meals, adult day care, or formal PCA PC services by an agency are provided.~~

~~(B2) The ADvantage Program case manager routinely reviews the care plan to evaluate whether ensure the services authorized meet the client's member's needs are being met in accordance with the plan and to assess the stability of the informal support system and to assess the stability of the informal support system. The For members who receive services from an individual PCA, the case manager may increase the frequency of care plan these reviews for clients receiving PCA services from an informal support.~~

[OAR Docket #06-1323; filed 9-28-06]

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

[OAR Docket #06-1316]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

- Subchapter 1. General Provisions
 - 317:45-1-2. through 317:45-1-3. [AMENDED]
 - 317:45-1-4. [NEW]
 - Subchapter 3. O-EPIC PA Carriers
 - Subchapter 5. O-EPIC PA Qualified Health Plans
 - 317:45-5-1. [AMENDED]
 - Subchapter 7. O-EPIC PA Employer Eligibility
 - 317:45-7-2. [AMENDED]
 - 317:45-7-8. [AMENDED]
 - Subchapter 9. O-EPIC PA Employee Eligibility
 - 317:45-9-1. [AMENDED]
 - 317:45-9-3. [AMENDED]
 - 317:45-9-5. [REVOKED]
 - 317:45-9-7. [AMENDED]
 - Subchapter 11. O-EPIC IP [NEW]
 - Part 1. Individual Plan Providers [NEW]
 - 317:45-11-1. through 317:45-11-2. [NEW]
 - Part 3. O-EPIC IP Member Health Care Benefits [NEW]
 - 317:45-11-10. through 317:45-11-11. [NEW]
 - Part 5. O-EPIC Individual Plan Member Eligibility [NEW]
 - 317:45-11-20. through 317:45-11-28. [NEW]
- (Reference APA WF # 06-08)**

AUTHORITY:

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; O.S.S. §68-302-5 et seq.

DATES:

Adoption:

July 13, 2006

Approved by Governor:

August 31, 2006

Emergency Adoptions

Effective:

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

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 Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions that provide low income, uninsured employees with an option to purchase affordable health insurance. Without revisions, low income adults remain at risk of not receiving medical care.

ANALYSIS:

Agency rules are issued to establish criteria that implements the Oklahoma Employer and Employee Partnership for Insurance Coverage (O-EPIC) Individual Plan. Last fall, the agency initiated the O-EPIC Premium Assistance program for small Oklahoma's business employers with 25 employees or less. The O-EPIC Individual Plan program extends affordable health coverage to low income employees who cannot afford to participate in their employer's health plan, employees of non-participating employers, self-employed, unemployed seeking work, and workers with a disability. The Program is funded through a portion of monthly proceeds from the Tobacco Tax that are collected and dispersed through the Health Employee and Economy Improvement Act (HEEIA) Revolving Fund. In addition, rules for the O-EPIC Premium Assistance program are revised to: (1) allow employees with multiple employers to qualify for inclusion in the O-EPIC PA program if their primary employer meets eligibility guidelines; (2) add several definitions to rules; and (3) remove unnecessary requirements that are not being used in the current program.

CONTACT PERSON:

Joanne Terlizzi at (405)522-7272

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED UPON APPROVAL BY THE GOVERNOR AS SET FORTH IN 75 O.S., SECTION 253(D), AND EFFECTIVE UPON APPROVAL BY GOVERNOR OR SEPTEMBER 1, 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 O.S.S. §68-302-5 et seq., that are collected and dispersed through the HEEIA revolving fund, pursuant to Title 68, Section 302-5 (B.1. and D.1.) and Section 402-3 (B.1 and C.1.) of the Oklahoma Statutes.

(d) The Program is limited in scope such that ~~budgetary limits are~~ available funding is not exceeded. Available funding includes the estimated annual deposits from tax collections, accrued interest, federal matching funds and any other revenue source deposited in the HEEIA Revolving Fund for the purpose of this program. If at any time it becomes apparent there is risk the ~~budgetary limits~~ available funding 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 Applicants,~~ 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. Applications are identified by region and O-EPIC program. Regions are established based on population density statistics as determined through local and national data and may be periodically adjusted to assure statewide availability. O-EPIC program size is determined by OHCA and may be periodically adjusted.

(B) The waiting list utilizes a "first in - first out" method of selecting eligible ~~employers applicants~~ by region and O-EPIC program.

(C) When an ~~employer-group applicant~~ is determined eligible and moves from the waiting list to active participation, the ~~employer applicant~~ 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 applicants~~ who are currently participating in the O-EPIC program are not subject to the waiting list.

~~(F) If For approved employers of O-EPIC, 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.

~~(#F) If For approved employers of O-EPIC, 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.

317:45-1-3. Definitions

The following words or terms, when used in this Chapter, will have the following meanings unless the context clearly indicates otherwise:

"Carrier" means:

- (A) an insurance company, group health service or Health Maintenance Organization (HMO) that provides health benefits pursuant to Title 36 O.S., Section 6512;
- (B) A Multiple Employer Welfare Arrangement (MEWA) licensed by the Oklahoma Insurance Department; or
- (C) A domestic MEWA exempt from licensing pursuant to Title 36 O.S., Section 634(B) that otherwise meets or exceeds all of the licensing and financial requirements of MEWAs as set out in Article 6A of Title 36.

"Child Care Center" means a facility licensed by OKDHS which provides care and supervision of children and meets all the requirements in OAC 340:110-3-1 through OAC 340:110-3-33.3.

"Eligibility period" means the period of eligibility extending from an approval date to an end date.

"EOB" means an Explanation of Benefits.

"Explanation of Benefit" means a statement issued by a Carrier that indicates services rendered and financial responsibilities for the Carrier and O-EPIC PA member.

"Individual Plan" means the O-EPIC program that provides services to those individuals who do not meet the criteria for O-EPIC PA.

"O-EPIC" means the Oklahoma Employer and Employee Partnership for Insurance Coverage program.

"O-EPIC IP" means the Individual Plan program.

"O-EPIC PA" means the Premium Assistance program.

"OESC" means the Oklahoma Employment Security Commission.

"OHCA" means the Oklahoma Health Care Authority.

"OKDHS" means the Oklahoma Department of Human Services.

"Oklahoma Employer and Employee Partnership for Insurance Coverage" means a health plan purchasing strategy in which a state uses public funds to pay for a portion of the premium costs of employer sponsored health plans plan coverage for eligible populations.

"PCP" means Primary Care Provider.

"PEO" or "Professional Employer Organization" means any person engaged in the business of providing professional employer services. A person engaged in the business of providing professional employer services shall be subject to registration under the Oklahoma Professional Employer Organization Recognition and Registration Act as provided in Title 40, Chapter 16 of Oklahoma Statutes, Section 600.1 et.seq.

"Premium Assistance" means the O-EPIC program that provides premium assistance to small business for certain employees.

"Primary Care Provider" means a provider under contract to the Oklahoma Health Care Authority to provide primary care services, including all medically-necessary referrals.

"Primary Employer" means the employer who employs an employee for 24 hours or more per week to perform work in exchange for wages or salary.

"Premium" means a monthly payment to a Carrier for health plan coverage.

"OHP" means Qualified Health Plan

"Qualified Health Plan" means a health plan that has been approved by the OHCA for participation in the O-EPIC program.

"Qualifying Event" means the occurrence of an event that permits individuals to join a group health plan outside of the "open enrollment period" and/or that allows individuals to modify the coverage they have had in effect. Qualifying Events are defined by the employer's health plan and meet federal requirements under Public Law 104-191 (HIPAA), and 42 U.S.C. 300bb-3.

"State" means the State of Oklahoma, acting by and through the Oklahoma Health Care Authority or its designee.

"TPA" means the Third Party Administrator.

"Third Party Administrator" means the entity contracted by the State to provide the administration of the Oklahoma Employer and Employee Partnership for Insurance Coverage program.

317:45-1-4. Reimbursement for out-of-pocket medical expenses

(a) O-EPIC members are responsible for all out-of-pocket expenses. Out-of-pocket expenses for services covered by the health plan, as defined by the health plan's benefit summary and policies, that exceed 5% of the employee's gross annual household income during the current eligibility period may be reimbursable.

(b) The O-EPIC member must submit a reimbursement claim form with appropriate documentation to the TPA. Information may be submitted at any time but no later than 90 days after the close of their eligibility period. Appropriate supporting documentation includes an original EOB or paid receipt if no EOB is issued. Both EOB and paid receipts must include required information listed in OAC 317:45-5-1(c)(1)-(6). Reimbursement for out-of-pocket medical expenses is made for the amount indicated as the member's responsibility on the EOB or receipt reflecting the amount paid for medical expenses. Appropriate supporting documentation for prescribed prescriptions must be an original receipt and include information about the pharmacy at which the drug was purchased, the name of the drug dispensed, the quantity dispensed, the prescription number, the name of the person the drug is for, the date the drug was dispensed and the total amount paid.

(c) Reimbursement for qualified medical expenses is subject to a fixed cap amount. The fixed cap for reimbursement is established annually and is calculated using local and national data concerning individual out-of-pocket health care expenses. The objective of the fixed cap is to set the amount high enough such that, in the great majority of households, all of the costs above the 5% threshold would be absorbed.

Emergency Adoptions

SUBCHAPTER 3. O-EPIC PA CARRIERS

SUBCHAPTER 5. O-EPIC PA QUALIFIED HEALTH PLANS

317:45-5-1. Qualified Health Plan requirements

(a) Qualified Health Plans participating in O-EPIC must offer, at a minimum, benefits that include:

- (1) hospital services;
- (2) physician services;
- (3) clinical laboratory and radiology;
- (4) pharmacy; and
- (5) office visits.

(b) The health plan, if required, must be approved by the Oklahoma Department of Insurance for participation in the Oklahoma market. All health plans must share in the cost of covered services and pharmacy products in addition to any negotiated discounts with network providers, pharmacies, or pharmaceutical manufacturers. If the health plan requires co-payments or deductibles, the co-payments or deductibles cannot exceed the limits described in this subsection.

- (1) An annual out-of-pocket maximum cannot exceed \$3,000 per individual. This amount includes any individual, annual deductible amount, except for pharmacy.
- (2) Office visits cannot require a co-payment exceeding \$50 per visit.
- (3) Annual pharmacy deductibles cannot exceed \$500 per individual.

(c) Qualified Health Plans may provide an Explanation of Benefits (EOB) for paid or denied claims subject to member co-insurance or member deductible calculations. If an EOB is provided it must contain, at a minimum, the:

- (1) provider's name;
- (2) patient's name;
- (3) date(s) of service;
- (4) code(s) and/or description(s) indicating the service(s) rendered, the amount(s) paid or the denied status of the claim(s);
- (5) reason code(s) and description(s) for any denied service(s); and
- (6) amount due and/or paid from the patient or responsible party.

SUBCHAPTER 7. O-EPIC PA EMPLOYER ELIGIBILITY

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.

317:45-7-8. Closure

Eligibility provided under the O-EPIC program ends during the eligibility period when:

- (1) the employer terminates its contract with all Qualified Health ~~Plan~~ Plans;
- (2) the employer fails to pay premiums to the Carrier;
- (3) the employer fails to provide an invoice verifying the monthly health plan premium has been paid;
- (4) an audit indicates a discrepancy that makes the employer ineligible;
- (5) the employer no longer has a business location in Oklahoma;
- (6) the Qualified Health Plan or Carrier no longer qualifies for O-EPIC; ~~or~~
- (7) the employer's eligibility period ends and is not renewed; or
- (8) the employer seeks to add a QHP.

SUBCHAPTER 9. O-EPIC PA 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 in their ~~Employer Sponsored Health Plan (ESHP)~~ Employer's QHP. Employees eligible for O-EPIC must:

- (1) have a household income at or below 185% of the Federal Poverty Level;
- (2) be a US citizen or alien as described in OAC ~~317:35-5-27~~ 317:35-5-25;
- (3) be Oklahoma residents;
- (4) provide his/her social security number;
- (5) be not currently enrolled in, or have ~~applied for an~~ open application 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 primary employers employer(s) (if multiple) who all meet the eligible employer guidelines listed in OAC 317:45-7-1(a)(1)-(2); and
- (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 primary employer employer(s) meets ~~O-EPIC~~ employer guidelines listed in OAC 317:45-7-1(a)(1)-(2); and
 - (4) the spouse is enrolled in the same health plan as the employee.
- (e) If an employee or spouse is eligible for multiple O-EPIC Qualified Health Plans, each may receive a subsidy under only one health plan.

317:45-9-3. Qualifying Event

- (a) Employees are allowed ~~30 calendar days~~ to apply for O-EPIC following a Qualifying Event.
- (b) An employee's spouse may become eligible for coverage and is allowed ~~30 calendar days~~ to apply for O-EPIC following a Qualifying Event of the employee or spouse.

317:45-9-5. Reimbursement for out-of-pocket medical expenses [REVOKED]

- ~~(a) Employees are responsible for all out of pocket expenses. Out of pocket expenses for services covered by the health plan, as defined by the health plan's benefit summary and policies, that exceed 5% of the employee's gross annual household income during the current eligibility period may be reimbursable.~~
- ~~(b) The employee must submit a reimbursement claim form with appropriate documentation to the TPA. Information may be submitted at any time but no later than 90 days after the close of their eligibility period. Appropriate supporting documentation includes an original EOB or paid receipt. Both EOB and paid receipts must include required information listed in OAC 317:45-5-1(c)(1)-(6). Reimbursement for out of pocket medical expenses is made for the amount indicated as the member's responsibility on the EOB or receipt reflecting the amount paid for medical expenses, including prescribed prescriptions.~~
- ~~(c) Reimbursement for qualified medical expenses are subject to a fixed cap amount. The fixed cap for reimbursement is established annually and is calculated using local and national data concerning individual out of pocket health care expenses. The objective of the fixed cap is to set the amount high enough such that, in the great majority of households, all of the costs above the 5% threshold would be absorbed.~~

317:45-9-7. Closure

- (a) Employer and ~~employees~~ employee eligibility are tied together. If the employer no longer meets the requirements for O-EPIC then eligibility for the associated employees enrolled

under that employer are also ineligible. Employees are mailed a written notice 10 days prior to closure of eligibility.

- (b) The employee's certification period may be terminated when:
 - (1) termination of employment, either voluntary or involuntary, occurs;
 - (2) the employee moves out-of-state;
 - (3) the covered employee dies;
 - (4) the employer ends its contract with the Qualified Health Plan;
 - (5) the employer's eligibility ends;
 - (6) an audit indicates a discrepancy that makes the employee or employer ineligible;
 - (7) the employer is terminated from O-EPIC;
 - (8) the employer fails to pay the premium;
 - (9) the Qualified Health Plan or Carrier is no longer qualified;
 - (10) the employee becomes eligible for Medicaid/Medicare;
 - (11) the employee or employer reports to the OHCA or the TPA any change affecting eligibility; ~~or~~
 - (12) the employee is no longer listed as a covered person on the employer's health plan invoice; or
 - (13) the employee requests closure.

SUBCHAPTER 11. O-EPIC IP

PART 1. INDIVIDUAL PLAN PROVIDERS

317:45-11-1. O-EPIC Individual Plan providers

O-EPIC Individual Plan (IP) providers must comply with existing SoonerCare rules found at OAC 317:25 and OAC 317:30. In order to receive SoonerCare reimbursement, the IP provider:

- (1) must enter into a SoonerCare contract;
- (2) may collect the member's co-pay in addition to the SoonerCare reimbursement;
- (3) may refuse to see members based on their inability to pay their co-pay; and
- (4) must complete O-EPIC IP addendum if provider wants to provide primary care services as a PCP.

317:45-11-2. O-EPIC IP provider payments

Payment for covered benefits, as shown in OAC 317:45-11-10, rendered to O-EPIC IP members is made to contracted O-EPIC IP healthcare providers for medical and surgical services within the scope of OHCA's medical programs, provided the services are medically necessary as defined in OAC 317:30-3-1(f). Coverage of certain services requires prior authorization as shown in OAC 317:45-11-10 and may be based on a determination made by a medical consultant in individual circumstances.

PART 3. O-EPIC IP MEMBER HEALTH CARE BENEFITS

Emergency Adoptions

317:45-11-10. O-EPIC IP benefits

(a) All O-EPIC IP benefits are subject to rules delineated in OAC 317:30 except as specifically set out in this Section.

(b) A PCP referral is required to see any other provider with the exception of the following services:

- (1) behavioral health services;
- (2) prenatal and obstetrical supplies and services, meaning prenatal care, delivery and 60 days of postpartum care;
- (3) family planning supplies and services, meaning an office visit for a comprehensive family planning evaluation, including obtaining a pap smear;
- (4) women's routine and preventive health care services;
- (5) emergency medical condition as defined in OAC 317:30-3-1.
- (6) specialty care for members with special health care needs as defined by OHCA; and
- (7) services delivered to American Indians at Indian Health Service, tribal, or urban Indian clinics.

(c) O-EPIC IP covered benefits, limits, and applicable co-payments are listed in this subsection. In addition to the benefit-specific limits, there is a maximum lifetime benefit of \$1,000,000. Coverage includes:

- (1) Anesthesia / Anesthesiologist Standby. Eligible services are covered for covered illness or surgery including services provided by a Certified Registered Nurse Anesthetist (CRNA). Prior authorization is required for outpatient services.
- (2) Blood and Blood Products. Processing, storage, and administration of blood and blood products in inpatient and outpatient settings.
- (3) Chelation Therapy. Covered for heavy metal poisoning only.
- (4) Diagnostic X-ray, including Ultrasound. PCP referral is required. Standard radiology (X-ray or Ultrasound): \$0 co-pay. Specialized scanning and imaging (MRI, MRA, PET, or CAT Scan): \$25 co-pay per scan.
- (5) Emergency Room Treatment, services and supplies for treatment in an emergency. Contracted provider services are subject to a \$30 co-pay per occurrence. The emergency room co-pay will be waived if the member is admitted to the hospital or death occurs before admission.
- (6) Inpatient Hospital Benefits, limited to 24 days per person per state fiscal year (July 1 through June 30). The 24 day limit applies to both hospital and physician services. There are no exceptions or extensions to the 24 day inpatient services limitation. PCP referral is required: \$50 co-pay per admission.
- (7) Preventive Office Visit. For services of evaluation and medical management (wellness exam); one visit per year with a \$10 co-pay.
- (8) Office Visits/Specialist Visits. For services of evaluation and medical management; up to four visits are covered per month; PCP referral required for specialist visits, \$10 co-pay per visit.
- (9) Outpatient Hospital/Facility Services.

(A) Includes hospital surgery services in an approved outpatient facility including outpatient services and diagnostic services; PCP referral required. Prior authorization required for certain procedures; \$25 co-pay per visit.

(B) Therapeutic radiology or chemotherapy on an outpatient basis without limitation to the number of treatments per month for persons with proven malignancies or opportunistic infections; \$10 co-pay per visit.

(10) Maternity (Obstetric). All routine care, laboratory, one ultrasound per maternity cycle (one additional ultrasound as medically necessary when referred to a maternal fetal specialist for a complete level II ultrasound), anesthesia, delivery, and postpartum care. Prenatal vitamins do not count against monthly prescription limits. Nursery care paid separately under eligible child. \$10 co-pay for initial visit once diagnosis of pregnancy is confirmed; \$50 inpatient hospital co-pay.

(11) Laboratory/Pathology. As medically necessary; \$0 co-pay.

(12) Mammogram (Radiological or Digital). 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; \$0 co-pay.

(13) Immunizations for Adults. Covered in accordance with the current Centers for Disease Control and Prevention guidelines, excluding vaccines for travelers. Member pays preventive office visit; \$10 co-pay per visit.

(14) Assistant Surgeon. Covered in accordance with Medicare guidelines.

(15) Dialysis, Kidney dialysis, and services and supplies, either at home or in a facility. PCP referral required, \$0 co-pay.

(16) Oral Surgery, removal of wisdom teeth is not a covered service. Service includes the removal of tumors or cysts, for emergency oral surgery, see Emergency Room Treatment. Prior authorization is required for certain outpatient services; Inpatient Hospital \$50 or Outpatient Hospital/Facility \$25 co-pay applies.

(17) Mental Health Treatment (Inpatient), limited to 24 days per person per state fiscal year (July 1 through June 30). The 24 day limit applies to both hospital and physician services. There are no exceptions or extensions to the 24 day inpatient services limitation. Prior authorization is required; \$50 co-pay per admission.

(18) Mental Health Treatment (Outpatient). Outpatient benefits, which exceed 12 visits per calendar year, require prior authorization. Outpatient benefits are limited to 26 visits per calendar year. Exceptions apply to diagnoses of schizophrenia, bipolar disorder/manic-depressive illnesses, major depressive disorder, panic disorder, obsessive-compulsive disorder, and schizo-affective disorder; these diagnoses are allowed up to 48 maximum visits; \$10 co-pay per visit.

- (19) Substance Abuse Treatment (Outpatient). Outpatient benefits, which exceed 12 visits per calendar year require prior authorization. Outpatient benefits are limited to 26 visits per calendar year; \$10 co-pay per visit.
- (20) Durable Medical Equipment and Supplies. A PCP referral and prior authorization is required. DME/Supplies are covered up to a \$15,000 lifetime maximum; \$5 co-pay for durable/non-durable supplies and \$25 co-pay for durable medical equipment.
- (21) Diabetic Supplies. A PCP referral is required. Prior authorization is only required beyond quantity limits; \$5 co-pay per prescription.
- (22) Oxygen. Documentation must meet medical necessity; \$5 co-pay per month.
- (23) Pharmacy. Six prescriptions per month with 3 brand name limit; Quantity limits, step therapy, tiered co-payment and prior authorization apply, see member handbook; \$5/\$10 co-pay.
- (24) Smoking Cessation Product Therapy. If prescribed by a physician, will reimburse for prescription medications used to treat nicotine addiction; One smoking cessation therapy (90 day session) per calendar year; prior authorization required beyond one session; \$0 co-pay.

317:45-11-11. O-EPIC IP non-covered services

Certain health care services are not covered in the O-EPIC IP benefit package listed in OAC 317:45-11-10. These services include, but are not limited to:

- (1) services that the member's PCP or O-EPIC does not consider medically necessary;
- (2) any medical service when the member refuses to authorize release of information needed to make a medical decision;
- (3) organ transplants;
- (4) treatment of obesity;
- (5) sterilization procedures for persons 21 years of age or older without proper consent forms;
- (6) procedures, services and supplies related to sex transformation;
- (7) supportive devices for the feet (orthotics) except for the diagnosis of diabetes;
- (8) cosmetic surgery;
- (9) over-the-counter drugs, medicines and supplies except contraceptive devices and products, and diabetic supplies;
- (10) experimental procedures, drugs or treatments;
- (11) dental services (preventive, basic, major, orthodontia, extractions or services related to dental accident);
- (12) vision care and services (including glasses), except services treating diseases or injuries to the eye;
- (13) physical medicine including speech, physical, occupational, chiropractic, acupuncture and osteopathic manipulation therapy;
- (14) hearing services;
- (15) transportation [emergent or non-emergent (air or ground)];
- (16) rehabilitation (inpatient);
- (17) cardiac rehabilitation;

- (18) allergy testing and treatment;
- (19) home health care including medications, intravenous (IV) therapy, supplies;
- (20) hospice regardless of location;
- (21) nurse midwife services;
- (22) Temporomandibular Joint Dysfunction (TMD) (TMJ);
- (23) ultraviolet treatment-actinotherapy;
- (24) genetic counseling;
- (25) fertility evaluation/treatment/and services;
- (26) sterilization reversal;
- (27) Christian Science Nurse;
- (28) Christian Science Practitioner;
- (29) fundus photography;
- (30) skilled nursing facility;
- (31) longterm care;
- (32) stand by services; and
- (33) thermograms.

PART 5. O-EPIC INDIVIDUAL PLAN MEMBER ELIGIBILITY

317:45-11-20. O-EPIC Individual Plan eligibility requirements

- (a) Employees not eligible for participating in an employer's Qualified Health Plan (QHP), employees of non-participating employers, self-employed, unemployed seeking work, and workers with a disability may apply for the O-EPIC Individual Plan. Applicants cannot obtain O-EPIC IP coverage if they are eligible for O-EPIC PA.
- (b) Applications may be found on the World Wide Web or may be requested by calling the O-EPIC helpline. Completed applications are submitted to the TPA.
- (c) 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 complete application is received by the TPA. The applicant is notified in writing of the eligibility decision.
- (d) In order to be eligible for the IP, the applicant must:
 - (1) choose a valid PCP according to the guidelines listed in OAC 317:45-11-22, at the time they make application;
 - (2) be a US citizen or alien as described in OAC 317:35-5-25;
 - (3) be an Oklahoma resident;
 - (4) provide his/her social security number;
 - (5) be not currently enrolled in, or have an open application for, Medicaid/Medicare;
 - (6) be age 19 through 64; and
 - (7) make premium payments by the due date on the invoice.
- (e) If employed and working for an approved O-EPIC employer who offers a QHP, the applicant must meet the requirements in subsection (d) of this Section and:
 - (1) have household income at or below 185% of the Federal Poverty Level.

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- (2) be ineligible for participation in their employer's QHP due to number of hours worked.
- (3) have received notification from O-EPIC indicating their employer has applied for O-EPIC and has been approved.
- (f) If employed and working for an employer who doesn't offer a QHP, the applicant must meet the requirements in subsection (d) of this Section and:
- (1) have household income at or below 185% of the Federal Poverty Level; and
 - (2) have received notification from O-EPIC indicating their employer has applied and has been approved with the attestation that they are not offering a QHP.
- (g) If self-employed, the applicant must meet the requirements in subsection (d) of this Section and:
- (1) must have household income at or below 185% of the Federal Poverty Level;
 - (2) verify self-employment by providing the most recent federal tax return with all supporting schedules and copies of all 1099 forms; and
 - (3) verify current income by providing appropriate supporting documentation.
- (h) If unemployed seeking work, the applicant must meet the requirements in subsection (d) of this Section and:
- (1) must have household income at or below 185% of the Federal Poverty Level; and
 - (2) verify eligibility by providing a most recent copy of their monetary OESC determination letter and a most recent copy of at least one of the following:
 - (A) OESC eligibility letter,
 - (B) OESC weekly unemployment payment statement, or
 - (C) bank statement showing state treasurer deposit.
- (i) If working with a disability, the applicant must meet the requirements in subsection (d) of this Section and:
- (1) must have household income at or below 200% of the Federal Poverty Level based on a family size of one; and
 - (2) verify eligibility by providing a copy of their:
 - (A) ticket to work, or
 - (B) ticket to work offer letter.

317:45-11-21. Spouse eligibility

- (a) If the spouse of an O-EPIC IP approved individual is eligible for O-EPIC PA, they must apply for O-EPIC PA. Spouses cannot obtain O-EPIC IP coverage if they are eligible for O-EPIC PA.
- (b) The spouse of an applicant approved according to the guidelines listed in OAC 317:45-11-20(a) through (h) is eligible for O-EPIC IP.
- (c) The spouse of an applicant approved according to the guidelines listed in OAC 317:45-11-20(i) does not become automatically eligible for O-EPIC IP. The spouse may choose to apply separately.
- (d) The applicant and the spouses' eligibility are tied together. If the applicant no longer meets the requirements for O-EPIC IP, then the associated spouse enrolled under that applicant is also ineligible.

317:45-11-22. PCP choices

- (a) The applicants (and spouse if also applying for O-EPIC IP) are required to select valid PCP choices as required on the application.
- (b) If a valid PCP is selected by the applicant or spouse and they are not enrolled with the first PCP choice, they are enrolled with the next available PCP choice. The applicant is notified in writing why their choice was not selected.
- (c) After initial enrollment in O-EPIC IP, the applicant or spouse can change their PCP selection by calling the O-EPIC helpline. Changes take effect the first day of the next month or the first day of the 2nd consecutive month. Applicant and spouse are only allowed to change their PCP a maximum of four times per calendar year.

317:45-11-23. Employee eligibility period

- (a) The rules in this subsection apply to applicants eligible according to OAC 317:45-11-20(a)-(f).
- (1) The employee's coverage period begins only after receipt of the premium payment.
 - (A) If the application is received and approved before the 15th of the month, eligibility begins the first day of the second consecutive month. If the application is not received or approved before the 15th of the month, eligibility begins the first day of the 3rd consecutive month. (Examples: An application is received and approved on 1-14-06 and the premium is received before 2-15-06, eligibility begins 3-1-06; or an application is received and approved 1-15-06 and the premium is received on 3-15-06, eligibility begins 4-1-06.)
 - (B) If premiums are paid early, eligibility still begins as scheduled.
 - (2) Employee eligibility is contingent upon the employer's program eligibility.
 - (3) The employee's eligibility is determined by the TPA using the eligibility requirements listed in OAC 317:45-9-1 or OAC 317:45-11-20(a)-(f).
 - (4) If the employee is determined eligible for O-EPIC IP, he/she is approved for a period not greater than 12 months. The length of the eligibility period is based on the remaining number of months the employer has left in its eligibility period as defined in OAC 317:45-7-1, 317:45-7-2 and 317:45-7-8.
- (b) The rules in this subsection apply to applicants eligible according to OAC 317:45-11-20(a)-(d) and 317:45-11-20(g)-(i).
- (1) The applicant's eligibility is determined by the TPA using the eligibility requirements listed in OAC 317:45-11-20(a)-(d) and 317:45-11-20(g)-(i).
 - (2) If the applicant is determined eligible for O-EPIC IP, he/she is approved for a period not greater than 12 months.
 - (3) The applicant's eligibility period begins only after receipt of the premium payment.
 - (A) If the application is received and approved before the 15th of the month, eligibility begins the first

day of the second consecutive month. If the application is not received or approved before the 15th of the month, eligibility begins the first day of the 3rd consecutive month. (Examples: An application is approved on 1-14-06 and the premium is received before 2-15-06, eligibility begins 3-1-06; or an application is approved 1-15-06 and the premium is received on 3-15-06, eligibility begins 4-1-06.)

(B) If premiums are paid early, eligibility still begins as scheduled.

317:45-11-24. Member cost sharing

(a) Members are given monthly invoices for health plan premiums. The premiums are due, and must be paid in full, no later than the 15th day of the month prior to the month of IP coverage.

(1) Members are responsible for their monthly premiums, in an amount not to exceed four percent of their gross monthly household income.

(2) Working disabled individuals are responsible for their monthly premiums in an amount not to exceed 4% of their gross monthly household income, based on a family size of one and capped at 151% of the Federal Poverty Level.

(b) IP coverage is not provided until the premium and any other amounts due are paid in full. Other amounts due may include but are not limited to any fees, charges, or other costs incurred as result of Insufficient/Non-sufficient funds.

317: 45-11-25. Premium payment

(a) O-EPIC IP premiums are based upon a percentage of the Federal Poverty Level (FPL) income guidelines. The FPL income guidelines are determined annually by the Federal Government.

(b) Monthly premiums in the IP program vary based on:

- (1) income reported on the member's application; and
- (2) a family size of one for single coverage or a family size of two for dual coverage.

317:45-11-26. Audits

Members participating in the O-EPIC program are subject to audits related to their eligibility, subsidy payments, premium payments and out-of-pocket reimbursements. Eligibility may be reversed at any time if inconsistencies are found. Any monies paid in error will be subject to recoupment.

317:45-11-27. Closure

(a) Members are mailed a written notice 10 days prior to closure of eligibility.

(b) Employer and employees eligibility are tied together. If the employer no longer meets the requirements for O-EPIC then eligibility for the associated employees enrolled under that employer are also ineligible.

(c) The employee's certification period may be terminated when:

- (1) the member requests closure;

- (2) the member moves out-of-state;
- (3) the covered member dies;
- (4) the employer's eligibility ends;
- (5) an audit indicates a discrepancy that makes the member or employer ineligible;
- (6) the employer is terminated from O-EPIC;
- (7) the member fails to pay the premium as well as any other amounts on or before the due date;
- (8) the Qualified Health Plan or Carrier is no longer qualified;
- (9) the member becomes eligible for Medicaid/Medicare; or
- (10) the member or employer reports to the OHCA or the TPA any change affecting eligibility.

(d) This subsection applies to applicants eligible according to OAC 317:45-11-20 (a)-(d) and 317:45-11-20(g)-(i). The member's certification period may be terminated when:

- (1) the member requests closure;
- (2) the member moves out-of-state;
- (3) the covered member dies;
- (4) the employer's eligibility ends;
- (5) an audit indicates a discrepancy that makes the member or employer ineligible;
- (6) the member fails to pay the premium;
- (7) the member becomes eligible for Medicaid/Medicare; or
- (8) the member or employer reports to the OHCA or the TPA any change affecting eligibility.

317:45-11-28. Appeals

(a) Member appeal procedures based on denial of eligibility due to income are described at OAC 317:2-1-2.

(b) Member appeals related to premium payments and/or out-of-pocket expenses are made to the TPA. If the member disagrees with the TPA's findings, reconsideration of the finding may be made to the OHCA. The decision of the OHCA is final.

(c) Employee appeals regarding out-of-pocket expenses are made to the TPA. If the employee disagrees with the TPA's findings, reconsideration of the finding may be made to the OHCA. The decision of the OHCA is final.

[OAR Docket #06-1316; filed 9-28-06]

**TITLE 800. DEPARTMENT OF WILDLIFE CONSERVATION
CHAPTER 15. COMMERCIAL HARVEST RULES; AQUATIC SPECIES**

[OAR Docket #06-1313]

RULEMAKING ACTION:

EMERGENCY adoption

RULE:

Subchapter 7. Commercial Mussel Harvest
800:15-7-3. General; operating provisions [AMENDED]

AUTHORITY:

Title 29 O.S., Section 3-103; 4-129(c) and Section 1 and 3 of the Constitution of Oklahoma; Department of Wildlife Conservation.

Emergency Adoptions

DATES:

Adoption:

July 10, 2006

Approved by Governor:

August 24, 2006

Effective:

Upon Governor Approval

Expiration:

Effective through July 14, 2007, unless superseded by another rule or disapproved by the Legislature.

SUPERSEDED EMERGENCY ACTION:

n/a

INCORPORATED BY REFERENCE:

n/a

FINDING OF EMERGENCY:

This emergency action is necessary to correct an inadvertent transcription error in the submitted language of the Commercial Mussel Harvest Rule adopted by the Oklahoma Wildlife Commission on February 6, 2006. The error occurred during transcription of the Permanent Final Adoption submitted to the Secretary of State. Subsequently, the incorrect language in the rule was published in the Oklahoma Register on May 15, 2006.

No changes are being proposed to the Commercial Mussel Harvest Rule in this emergency action other than those already discussed and adopted by the Commission on February 6, 2006. Emergency action is necessary in order to provide mussel buyers the correct explanation of how they must calculate the required statutory severance fee that is paid each month to the Oklahoma Department of Wildlife Conservation (ODWC).

ANALYSIS:

This emergency rule contains language that requires mussel shell harvesters to notify local game wardens of commercial mussel harvest operations and provides an explanation of how mussel dealers calculate their dollar value of purchased shells to determine severance fee payments to ODWC. It is identical to the amended rule adopted by the Oklahoma Wildlife Commission on February 6, 2006, but inadvertently transcribed in error and subsequently published (containing errors) in the Oklahoma Register.

CONTACT PERSON:

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

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 7. COMMERCIAL MUSSEL HARVEST

800:15-7-3. General; operating provisions

Operating provisions for commercial mussel harvesting shall be in accordance with 29 O. S., Section 4-129 and the following:

- (1) **Harvest methods.** It shall be unlawful to take any mussels except by hand only, with or without, the use of diving equipment. No power dredge, crowfeet, common dredge, scrapes or rakes may be used in the taking of mussels.
- (2) **Size limit.** It shall be unlawful for anyone to take or possess mussels or shells smaller than the size limits provided in 29 O.S., Section 4-129(D). All undersized mussels shall be immediately returned to the water from which they were taken.
- (3) **Season and time of day.** The season shall be open throughout the year from January 1 through December 31.

Commercial mussel pickers may harvest from daylight to dark on weekdays only. No mussels shall be harvested except during daylight hours, from sunrise until sunset, Monday through Friday. No mussels shall be harvested at any time on Saturdays or Sundays or the following state holidays: Memorial Day, Independence Day, or Labor Day.

(4) **Reporting.** Each Commercial Mussel Picker shall notify the local game warden ~~in each area~~ where he plans to harvest mussel shells at least one day prior to mussel harvest and ~~shall give inform~~ the game warden ~~the day and area where he plans to~~ when and where the mussel harvester plans to harvest mussel shells. Each Commercial Mussel Dealer must keep accurate records of all mussels purchased within and exported from the State of Oklahoma. These records shall be available for inspection by any agent of the Department at any time. A copy of each mussel purchase transaction must be given to the seller (picker) by the buyer (dealer) at the time of sale on forms provided by the Department. A copy of all mussel purchase transactions and mussel exports shall be submitted to the Department as follows:

(A) Each Commercial Mussel Dealer shall complete and submit to the Department a true and accurate purchase ~~record-report~~ for each mussel purchase transaction. Each purchase ~~record-report~~ must contain:

- (i) the buyer's (Dealer's) name and license number;
- (ii) seller's (picker's) name and license number;
- (iii) the ~~total-pound~~ pounds of mussels purchased by species;
- (iv) the total amount paid to pickers for these mussels by species; and
- (v) the price per pound by species for the transaction.

(B) ~~A copy of each transaction along with a monthly summary~~ Monthly Mussel Dealers Summary Report must be mailed to the Department by the 15th of ~~each~~ the following month by each Commercial Mussel Dealer and include copies of each purchase transaction and sales receipts from all sales transactions between the Mussel Dealer and the mussel exporter, wholesaler or mussel buying company during that month.

(C) Each Commercial Mussel Dealer must supply to the Department shipping bills of lading of all mussels exported from the state during the monthly reporting period. A copy of the shipping bill of lading must accompany all mussel shell shipments from the state.

(D) The shipping bill of lading must contain:

- (i) Person, firm or corporation's name transporting mussels out of Oklahoma;
- (ii) Person, firm or corporation's name(s) that sold or otherwise provided the mussels to be transported out of Oklahoma;

- (iii) Date of shipment;
 - (iv) Total pounds, live weight, of mussels in the shipment;
 - (v) Total pounds, dry weight, of mussels in the shipment;
 - (vi) The mussel harvest season, species legal for harvest and all mussel size restrictions in the state where the mussels were harvested;
 - (vii) Origin of shipment;
 - (viii) Destination of shipment; and
 - (ix) Total purchase price (amount paid to pickers), live weight, of mussels in shipment.
- (E) Each commercial mussel dealer must supply to the Department an annual Mussel Dealers summary report of all mussels purchased within and exported from the State of Oklahoma. This report shall contain:
- (i) total pounds of mussels purchased, by species;
 - (ii) total purchase value of mussels ~~purchased~~ paid to pickers, by species;

- (iii) total pounds of mussels exported from Oklahoma, by species;
 - (iv) total sale price of mussels exported from Oklahoma during the year.
- (5) **Severance fee.** Any person who purchases and ~~or~~ exports mussels from the State of Oklahoma shall pay the Department a severance fee amount of 1/8 (12.5%) of the dollar value of purchased shells. For the purpose of this rule, the "dollar value of purchased shells" shall be the value of the mussel shells purchased from the Mussel Dealer by a mussel exporter, wholesaler or mussel shell buying company. Payment shall be computed ~~from the monthly purchase records on the Monthly Mussel Dealer Summary form~~ (as described in ~~(A)~~ of paragraph ~~(4)~~ (4)(B) of this subsection) and paid by the 15th of the following month. ~~The purchase price of the mussel shells purchased by the Commercial Mussel buyer shall be based on fair market value at time of purchase.~~

[OAR Docket #06-1313; filed 9-26-06]

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

1:2006-19.

EXECUTIVE ORDER 2006-19

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, October 5, 2006, to honor Trooper William "Bill" L. McClendon, who died on Sunday, October 1, 2006, while in the line of duty.

Trooper Bill McClendon was born and raised in Oklahoma, graduating from Drumright High School. He was a member of the Oklahoma Highway Patrol since 1998. He received the Chiefs Award in 2000, the Troop Commanders Award in 2000, 2001, 2003 and 2005, Unit Commendations in 2001 and 2005 and the COHPS Award for Outstanding Service.

Law enforcement officers are true heroes, quietly risking their lives every day to protect our public and private safety. Trooper McClendon died while doing his duty, patrolling the highways of Oklahoma. The loss of any law enforcement officer is a tragedy and we must remember these men and women

who make the ultimate sacrifice by giving their lives. We must honor the memory by carrying on their crusade to make our nation a better and safer place.

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 2nd day of October, 2006.

BY THE GOVERNOR OF THE
STATE OF OKLAHOMA

Brad Henry

ATTEST:
M. Susan Savage
Secretary of State

[OAR Docket #06-1325A; filed 10-3-06]

