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

[OAR Docket #07-329]

INTENDED RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

Subchapter 1. General Provisions
252:100-1-3. Definitions [AMENDED]
Subchapter 7. Permits for Minor Facilities
Part 1. General Provisions
252:100-7-2. Requirement for permits for minor facilities [AMENDED]
Part 3. Construction Permits
252:100-7-15. Construction permit [AMENDED]
Part 4. Operating Permits
252:100-7-18. Operating permit [AMENDED]
Subchapter 8. Permits for Part 70 Sources
Part 1. General Provisions
252:100-8-1.1. Definitions [AMENDED]
Subchapter 17. Incinerators
Part 5. Municipal Waste Combustors
252:100-17-14.1. Definitions [AMENDED]
252:100-17-16. Standards for particulate matter and opacity [AMENDED]
252:100-17-17. Standards for municipal waste combustor metals [AMENDED]
252:100-17-19. Standards for municipal waste combustor organics expressed as total mass dioxins/furans [AMENDED]
252:100-17-20. Standards for nitrogen oxides [AMENDED]
252:100-17-21. Standards for municipal waste combustor operating practices [AMENDED]
252:100-17-24. Standards for municipal waste combustor operator training and certification [AMENDED]
252:100-17-25. Compliance and performance testing [AMENDED]
252:100-17-26. Reporting and recordkeeping requirements [AMENDED]
Subchapter 37. Control of Emission of Volatile Organic Compounds (VOCs)
Part 1. General Provisions
252:100-37-2. Definitions [AMENDED]
Part 7. Control of Specific Processes
252:100-37-38. Pumps and compressors [REVOKED]

Subchapter 39. Emission of Volatile Organic Compounds (VOCs) in Nonattainment Areas and Former Nonattainment Areas

Part 1. General Provisions

252:100-39-2. Definitions [AMENDED]

Subchapter 44. Control of Mercury Emissions from Coal-Fired Electric Steam Generating Units [NEW]

252:100-44-1. Purpose [NEW]

252:100-44-2. [RESERVED]

252:100-44-3. Reference to 40 CFR [NEW]

Appendix E. Primary Ambient Air Quality Standards [REVOKED]

Appendix E. Primary Ambient Air Quality Standards [NEW]

Appendix F. Secondary Ambient Air Quality Standards [REVOKED]

Appendix F. Secondary Ambient Air Quality Standards [NEW]

SUMMARY:

The Department is proposing to amend OAC 252:100-1-3, 252:100-8-1.1, 252:100-37-2 and 252:100-39-2 to clarify definitions including particulate matter and volatile organic compounds.

The Department is proposing to amend OAC 252:100-7-2, 252:100-7-15 and 252:100-7-18. The proposed revision will provide consistency with State Statutes and other Air Pollution Control rules, remove reference to Subchapter 41 which has been revoked, correct the emissions calculation methods for determining if a permit is required, clarify when construction permits are required and provide for administrative amendments to operating permits for minor facilities.

The Department proposes to amend OAC 252:100-17, Part 5 to meet federal requirements for state plans under section 111(d) of the federal Clean Air Act applicable to existing sources. The proposed changes would incorporate standards (40 CFR 60, Subpart Cb) published on May 5, 2006 in the Federal Register that apply to Municipal Waste Combustor (MWC) units with the capacity to combust more than 250 tons per day of municipal solid waste. The proposed changes to Subchapter 17 are accompanied by a 111(d) plan. Staff intends that this council meeting serve as a public hearing for both the rule and the plan.

The Department proposes to revoke OAC 252:100-37-38, Pumps and compressors.

The Department is proposing a new Subchapter 44, Control of Mercury Emissions from Coal Fired Electric Steam Generating Units. The proposed new subchapter will

Notices of Rulemaking Intent

incorporate by reference the federal Clean Air Mercury Rule (CAMR) issued in March 2005 with proposed allocations and set-asides. Prior to and at the April 18, 2007 public hearing, the Department will accept public comments regarding the allocation of mercury credits for inclusion in Oklahoma's CAMR State Implementation Plan (SIP).

The Department is proposing to update Appendices E and F to be consistent with federal standards.

AUTHORITY:

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

COMMENT PERIOD:

Written comments on the proposed rulemakings will be accepted prior to and at the hearing on April 18, 2007. For comments received at least 5 business days prior to the Council meeting, staff will post written responses on the Department's web page at least 1 day prior to the Council meeting and provide hard copy written responses to these comments to the Council and the public at that Council meeting. Oral comments may be made at the April 18, 2007 hearing and at the appropriate Environmental Quality Board meeting.

PUBLIC HEARINGS:

Before the Air Quality Advisory Council at 9:00 a.m. on Wednesday, April 18, 2007, at the Tulsa campus of Oklahoma State University, Tulsa. Before the Environmental Quality Board on August 21, 2007 in Guthrie.

This hearing shall also serve as the public hearing to receive comments on the proposed revisions to the SIP under the requirements of 40 CFR§ 51.102 of the EPA regulations concerning the SIPs and 27A O.S. § 2-5-107(6)(c).

REQUEST FOR COMMENTS FROM BUSINESS ENTITIES:

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

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

COPIES OF PROPOSED RULES:

The proposed rules are available for review 30 days prior to the hearing at the Air Quality Division of the Department at http://www.deq.state.ok.us/AQDnew/council_mtgs/index.htm, or copies may be obtained from the Department by calling Cheryl Bradley, Environmental Programs Manager, at (405) 702-4100.

RULE IMPACT STATEMENT:

Copies of the rule impact statement may be obtained by contacting Cheryl Bradley at (405) 702-4100.

CONTACT PERSON:

Please send written comments on the proposed rule changes to Cheryl Bradley at cheryl.bradley@deq.state.ok.us. Mail should be addressed to Department of Environmental Quality, Air Quality Division, P.O. Box 1677, Oklahoma City, Oklahoma 73101-1677, ATTN: Cheryl Bradley. The Air Quality Division FAX is (405)702-4101.

PERSONS WITH DISABILITIES:

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

[OAR Docket #07-329; filed 2-23-07]

Submissions for Review

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

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

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

[OAR Docket #07-313]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

317:2-1-2. [AMENDED]

317:2-1-5. [AMENDED]

(Reference APA WF # 06-34)

SUBMITTED TO GOVERNOR:

February 9, 2007

SUBMITTED TO HOUSE:

February 9, 2007

SUBMITTED TO SENATE:

February 9, 2007

[OAR Docket #07-313; filed 2-14-07]

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

[OAR Docket #07-305]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

Subchapter 7. SoonerCare Choice

Part 3. Enrollment Criteria

317:25-7-13. [AMENDED]

(Reference APA WF # 06-19)

SUBMITTED TO GOVERNOR:

February 9, 2007

SUBMITTED TO HOUSE:

February 9, 2007

SUBMITTED TO SENATE:

February 9, 2007

[OAR Docket #07-305; filed 2-14-07]

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY CHAPTER 10. PURCHASING

[OAR Docket #07-294]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

317:10-1-1. through 317:10-1-5. [AMENDED]

317:10-1-7. [AMENDED]

317:10-1-9. through 317:10-1-12. [AMENDED]

317:10-1-15. through 317:10-1-20. [AMENDED]

(Reference APA WF # 06-04)

SUBMITTED TO GOVERNOR:

February 9, 2007

SUBMITTED TO HOUSE:

February 9, 2007

SUBMITTED TO SENATE:

February 9, 2007

[OAR Docket #07-294; filed 2-14-07]

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

[OAR Docket #07-296]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

Subchapter 5. Individual Providers and Specialties

Part 77. Speech and Hearing Services

317:30-5-676. [AMENDED]

(Reference APA WF # 06-06)

SUBMITTED TO GOVERNOR:

February 9, 2007

SUBMITTED TO HOUSE:

February 9, 2007

SUBMITTED TO SENATE:

February 9, 2007

[OAR Docket #07-296; filed 2-14-07]

Submissions for Review

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

[OAR Docket #07-297]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

Subchapter 3. General Provider Policies
Part 3. General Medical Program Information
317:30-3-40. [AMENDED]
Subchapter 5. Individual Providers and Specialties
Part 41. Family Support Services
317:30-5-410. through 317:30-5-412. [AMENDED]
Part 51. Habilitation Services
317:30-5-480. through 317:30-5-482. [AMENDED]
(Reference APA WF # 06-07 and 06-48A)

SUBMITTED TO GOVERNOR:

February 9, 2007

SUBMITTED TO HOUSE:

February 9, 2007

SUBMITTED TO SENATE:

February 9, 2007

[OAR Docket #07-297; filed 2-14-07]

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

[OAR Docket #07-299]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

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)

SUBMITTED TO GOVERNOR:

February 9, 2007

SUBMITTED TO HOUSE:

February 9, 2007

SUBMITTED TO SENATE:

February 9, 2007

[OAR Docket #07-299; filed 2-14-07]

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

[OAR Docket #07-301]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

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)

SUBMITTED TO GOVERNOR:

February 9, 2007

SUBMITTED TO HOUSE:

February 9, 2007

SUBMITTED TO SENATE:

February 9, 2007

[OAR Docket #07-301; filed 2-14-07]

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

[OAR Docket #07-302]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

Subchapter 5. Individual Providers and Specialties
Part 1. Physicians
317:30-5-13. [AMENDED]
Part 5. Pharmacists
317:30-5-70.2. [AMENDED]
(Reference APA WF # 06-16 and 06-03)

SUBMITTED TO GOVERNOR:

February 9, 2007

SUBMITTED TO HOUSE:

February 9, 2007

SUBMITTED TO SENATE:

February 9, 2007

[OAR Docket #07-302; filed 2-14-07]

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

[OAR Docket #07-303]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

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]
- Subchapter 5. Individual Providers and Specialties
- Part 1. Physicians
317:30-5-25. [AMENDED]
- (Reference APA WF # 06-17 and 06-09)

SUBMITTED TO GOVERNOR:

February 9, 2007

SUBMITTED TO HOUSE:

February 9, 2007

SUBMITTED TO SENATE:

February 9, 2007

[OAR Docket #07-303; filed 2-14-07]

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

[OAR Docket #07-307]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

- Subchapter 5. Individual Providers and Specialties
- Part 62. Private Duty Nursing
317:30-5-556. [AMENDED]
- 317:30-5-558. [AMENDED]
- 317:30-5-560. [AMENDED]
- 317:30-5-560.1. [AMENDED]
- 317:30-5-560.2. [AMENDED]
- (Reference APA WF# 06-25 and 06-26)

SUBMITTED TO GOVERNOR:

February 9, 2007

SUBMITTED TO HOUSE:

February 9, 2007

SUBMITTED TO SENATE:

February 9, 2007

[OAR Docket #07-307; filed 2-14-07]

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

[OAR Docket #07-308]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

- Subchapter 5. Individual Providers and Specialties
- Part 61. Home Health Agencies
317:30-5-545. [AMENDED]
- (Reference APA WF # 06-27)

SUBMITTED TO GOVERNOR:

February 9, 2007

SUBMITTED TO HOUSE:

February 9, 2007

SUBMITTED TO SENATE:

February 9, 2007

[OAR Docket #07-308; filed 2-14-07]

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

[OAR Docket #07-309]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

- Subchapter 5. Individual Providers and Specialties
- Part 1. Physicians
317:30-5-12. [AMENDED]
- 317:30-5-22. [AMENDED]
- 317:30-5-24. [AMENDED]
- Part 19. Nurse Midwives
317:30-5-226. [AMENDED]
- Part 35. Rural Health Clinics
317:30-5-355.1. [AMENDED]
- 317:30-5-361. [AMENDED]
- Part 49. Family Planning Centers
317:30-5-466. [AMENDED]
- 317:30-5-467. [AMENDED]
- Part 89. Radiological Mammographer
317:30-5-901. [AMENDED]
- (Reference APA WF # 06-28 and 06-22)

SUBMITTED TO GOVERNOR:

February 9, 2007

SUBMITTED TO HOUSE:

February 9, 2007

Submissions for Review

SUBMITTED TO SENATE:

February 9, 2007

[OAR Docket #07-309; filed 2-14-07]

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

[OAR Docket #07-310]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

Subchapter 3. General Provider Policies
Part 3. General Medical Program Information
317:30-3-59. [AMENDED]
Subchapter 5. Individual Providers and Specialties
Part 10. Bariatric Surgery [NEW]
317:30-5-137. through 317:30-5-141. [NEW]
(Reference APA WF # 06-29)

SUBMITTED TO GOVERNOR:

February 9, 2007

SUBMITTED TO HOUSE:

February 9, 2007

SUBMITTED TO SENATE:

February 9, 2007

[OAR Docket #07-310; filed 2-14-07]

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

[OAR Docket #07-311]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

Subchapter 5. Individual Providers and Specialties
Part 33. Transportation by Ambulance
317:30-5-335. [AMENDED]
317:30-5-335.1. [NEW]
317:30-5-336. [AMENDED]
317:30-5-336.1. through 317:30-5-336.13. [NEW]
317:30-5-337. [AMENDED]
317:30-5-339. [AMENDED]
(Reference APA WF # 06-32)

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February 9, 2007

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SUBMITTED TO SENATE:

February 9, 2007

[OAR Docket #07-311; filed 2-14-07]

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

[OAR Docket #07-312]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

Subchapter 5. Individual Providers and Specialties
Part 3. Hospitals
317:30-5-40. [AMENDED]
317:30-5-40.1. [NEW]
317:30-5-40.2. [NEW]
317:30-5-41. [AMENDED]
317:30-5-41.1. [NEW]
317:30-5-42. [REVOKED]
317:30-5-42.1. through 317:30-5-42.18. [NEW]
317:30-5-47. [AMENDED]
317:30-5-47.1. through 317:30-5-47.4. [AMENDED]
317:30-5-50. [AMENDED]
317:30-5-56. through OAC 317:30-5-57. [NEW]
Part 63 Ambulatory Surgical Centers
317:30-5-566. [AMENDED]
317:30-5-567. [AMENDED]
(Reference APA WF # 06-33)

SUBMITTED TO GOVERNOR:

February 9, 2007

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February 9, 2007

[OAR Docket #07-312; filed 2-14-07]

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

[OAR Docket #07-314]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

Subchapter 5. Individual Providers and Specialties
Part 1. Physicians
317:30-5-14. [AMENDED]
(Reference APA WF # 06-38)

SUBMITTED TO GOVERNOR:

February 9, 2007

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February 9, 2007

[OAR Docket #07-314; filed 2-14-07]

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

[OAR Docket #07-300]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

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

SUBMITTED TO GOVERNOR:

February 9, 2007

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February 9, 2007

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February 9, 2007

[OAR Docket #07-300; filed 2-14-07]

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

[OAR Docket #07-304]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

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

SUBMITTED TO GOVERNOR:

February 9, 2007

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February 9, 2007

SUBMITTED TO SENATE:

February 9, 2007

[OAR Docket #07-304; filed 2-14-07]

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

[OAR Docket #07-306]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

- Subchapter 21. Breast and Cervical Cancer Treatment Program
- 317:35-21-12. [AMENDED]
- (Reference APA WF # 06-21)

SUBMITTED TO GOVERNOR:

February 9, 2007

SUBMITTED TO HOUSE:

February 9, 2007

SUBMITTED TO SENATE:

February 9, 2007

[OAR Docket #07-306; filed 2-14-07]

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

[OAR Docket #07-295]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

- Subchapter 5. Client Services
- Part 5. Specialized Foster Care
- 317:40-5-55. [AMENDED]
- Part 9. Service Provisions
- 317:40-5-103. [AMENDED]
- (Reference APA WF # 06-05)

SUBMITTED TO GOVERNOR:

February 9, 2007

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February 9, 2007

[OAR Docket #07-295; filed 2-14-07]

Submissions for Review

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

[OAR Docket #07-315]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

RULES:

Subchapter 5. Client Services
Part 1. ~~Companion/Adult Foster Care Services by Agency~~
Companion Services
317:40-5-3. [AMENDED]
Part 11. Community Residential Supports
317:40-5-152. [AMENDED]
Subchapter 7. Waiver Employment Services
317:40-7-8. [AMENDED]
317:40-7-18. [AMENDED]

(Reference APA WF # 06-48B)

SUBMITTED TO GOVERNOR:

February 9, 2007

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February 9, 2007

[OAR Docket #07-315; filed 2-14-07]

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

[OAR Docket #07-298]

RULEMAKING ACTION:

Submission for gubernatorial/legislative review

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 9. O-EPIC PA Employee Eligibility
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 5. O-EPIC Individual Plan Member Eligibility [NEW]
317:45-11-21. through 317:45-11-28. [NEW]

(Reference APA WF # 06-08)

SUBMITTED TO GOVERNOR:

February 9, 2007

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February 9, 2007

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February 9, 2007

[OAR Docket #07-298; filed 2-14-07]

TITLE 375. OKLAHOMA STATE BUREAU OF INVESTIGATION CHAPTER 15. OKLAHOMA REWARD SYSTEM

[OAR Docket #07-331]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

375:15-1-2. through 375:15-1-4. [AMENDED]

SUBMITTED TO THE GOVERNOR:

February 16, 2007

SUBMITTED TO THE HOUSE:

February 16, 2007

SUBMITTED TO THE SENATE:

February 16, 2007

[OAR Docket #07-331; filed 2-23-07]

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

[OAR Docket #07-317]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

600:10-1-4. Examination [AMENDED]
600:10-1-6. Experience prerequisite [AMENDED]
600:10-1-8. Course approval requirements [AMENDED]
600:10-1-16. Supervision of trainee appraisers [AMENDED]

SUBMITTED TO GOVERNOR:

February 20, 2007

SUBMITTED TO HOUSE:

February 20, 2007

SUBMITTED TO SENATE:

February 20, 2007

[OAR Docket #07-317; filed 2-20-07]

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

[OAR Docket #07-318]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

600:15-1-14. Disciplinary alternatives [AMENDED]

SUBMITTED TO GOVERNOR:

February 20, 2007

SUBMITTED TO HOUSE:

February 20, 2007

SUBMITTED TO SENATE:

February 20, 2007

[OAR Docket #07-318; filed 2-20-07]

**TITLE 710. OKLAHOMA TAX COMMISSION
CHAPTER 75. TOURISM PROMOTION**

[OAR Docket #07-327]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

PROPOSED RULES:

710:75-1-1. Purpose [REVOKED]

710:75-1-2. Definitions [REVOKED]

710:75-1-3. General applicability of Tourism Promotion Tax [REVOKED]

710:75-1-4. Application of Tourism Tax [REVOKED]

710:75-1-5. Tourism and Recreation Department and Historical Society facilities [REVOKED]

710:75-1-6. Tax not applicable to campsites [REVOKED]

710:75-1-7. Nonprofit charitable organizations [REVOKED]

710:75-1-8. Filing requirements; interest; penalty [REVOKED]

710:75-1-9. Recordkeeping [REVOKED]

710:75-1-10. Examples and applications [REVOKED]

SUBMITTED TO GOVERNOR:

February 22, 2007

SUBMITTED TO HOUSE:

February 22, 2007

SUBMITTED TO SENATE:

February 22, 2007

[OAR Docket #07-327; filed 2-22-07]

**TITLE 710. OKLAHOMA TAX COMMISSION
CHAPTER 85. VARIOUS TAX INCENTIVES**

[OAR Docket #07-326]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

PROPOSED RULES:

Subchapter 1. Oklahoma Quality Jobs Program

710:85-1-2. Definitions [AMENDED]

710:85-1-3. Procedure upon qualification; reporting [REVOKED]

710:85-1-8. Procedure for filing claim, verification, payment, protest [AMENDED]

Subchapter 5. Small Employer Quality Jobs Program

710:85-5-3. Procedure upon qualification; reporting [REVOKED]

710:85-5-10. Payment of claim [AMENDED]

SUBMITTED TO GOVERNOR:

February 22, 2007

SUBMITTED TO HOUSE:

February 22, 2007

SUBMITTED TO SENATE:

February 22, 2007

[OAR Docket #07-326; filed 2-22-07]

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

[OAR Docket #07-325]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 6. Oklahoma Safe Playground Surfaces Program [REVOKED]

Section 710:95-6-1. Purpose [REVOKED]

Section 710:95-6-2. Definitions [REVOKED]

Section 710:95-6-3. Determination of the availability of matching funds [REVOKED]

Section 710:95-6-4. Procedure to be used by public schools or institutions and state parks or recreation areas to request compensation [REVOKED]

Section 710:95-6-5. Review and determination of requests for reimbursement or payment [REVOKED]

SUBMITTED TO GOVERNOR:

February 22, 2007

SUBMITTED TO HOUSE:

February 22, 2007

Submissions for Review

SUBMITTED TO SENATE:

February 22, 2007

[OAR Docket #07-325; filed 2-22-07]

**TITLE 720. STATE TEXTBOOK
COMMITTEE
CHAPTER 10. TEXTBOOK SELECTION**

[OAR Docket #07-328]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 3. Bidding Procedures

720:10-3-7. Free Materials [AMENDED]

SUBMITTED TO GOVERNOR:

February 16, 2007

SUBMITTED TO HOUSE:

February 16, 2007

SUBMITTED TO SENATE:

February 16, 2007

[OAR Docket #07-328; filed 2-23-07]

Gubernatorial Approvals

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

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

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

[OAR Docket #07-338]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 14. Equine Viral Arteritis [NEW]

35:15-14-1. Definitions [RESERVED]

35:15-14-2. Entry requirements [NEW]

GUBERNATORIAL APPROVAL:

February 7, 2007

[OAR Docket #07-338; filed 2-23-07]

TITLE 375. OKLAHOMA STATE BUREAU OF INVESTIGATION CHAPTER 8. RECORDS RETENTION AND DESTRUCTION

[OAR Docket #07-330]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 13. Criminalistic Records

375:8-13-1. [AMENDED]

GUBERNATORIAL APPROVAL:

February 7, 2007

[OAR Docket #07-330; filed 2-23-07]

Emergency Adoptions

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

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

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

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

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

[OAR Docket #07-323]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 3. General Provider Policies

Part 3. General Medical Program Information

317:30-3-57. [AMENDED]

Subchapter 5. Individual Providers and Specialties

Part 17. Medical Suppliers

317:30-5-211. [AMENDED]

(Reference APA WF# 06-39)

AUTHORITY:

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

DATES:

Adoption:

December 14, 2006

Approved by Governor:

January 30, 2007

Effective:

Immediately upon Governor's approval or February 1, 2007, whichever is later.

Expiration:

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

SUPERSEDED EMERGENCY ACTIONS:

Superseded Rules:

Subchapter 3. General Provider Policies

Part 3. General Medical Program Information

317:30-3-57. [AMENDED]

Docket Number:

06-1436

(Reference APA WF# 06-22)

GUBERNATORIAL APPROVAL:

November 1, 2006

REGISTER PUBLICATION:

24 Ok Reg 303

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 provide external prostheses and support accessories to member's who have had a mastectomy. Women who choose not to have the more costly reconstructive surgery after a mastectomy, need external breast prosthesis and support garments to balance their body and to anchor the bra on the side of the mastectomy from riding up, which helps prevent back and neck pain and a sagging shoulder. There are also psychological benefits to having an external breast prosthesis which can

restore a sense of attractiveness to a woman who might otherwise be severely depressed.

ANALYSIS:

SoonerCare coverage rules and rules for medical suppliers are revised to add external breast prosthesis and support garments as benefits to women who have had a mastectomy. Women who choose not to have the more costly reconstructive surgery after a mastectomy, need external breast prosthesis and support garments to balance their body and to anchor the bra on the side of the mastectomy from riding up, which helps prevent back and neck pain and a sagging shoulder. There are also psychological benefits to having an external breast prosthesis which can restore a sense of attractiveness to a woman who might otherwise be severely depressed. Rule revisions are needed to expand coverage benefits to include external breast prosthesis and support garments to women who have had mastectomies.

CONTACT PERSON:

Joanne Terlizzi at (405) 522-7272

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED UPON APPROVAL BY THE GOVERNOR AS SET FORTH IN 75 O.S., SECTION 253(D), AND EFFECTIVE UPON APPROVAL BY GOVERNOR OR FEBRUARY 1, 2007, WHICHEVER IS LATER:

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 3. GENERAL MEDICAL PROGRAM INFORMATION

317:30-3-57. General Medicaid SoonerCare coverage - categorically needy

The following are general Medicaid SoonerCare coverage coverages for the categorically needy:

(1) Inpatient hospital services other than those provided in an institution for mental diseases.

(A) Adult coverage ~~limited to the compensable for inpatient hospital days stays as~~ described at OAC 317:30-5-41.

(B) Coverage for ~~persons~~ members under 21 years of age is not limited. All admissions must be medically necessary. All psychiatric admissions require prior authorization for an approved length of stay.

(2) Emergency department services.

Emergency Adoptions

- (3) Dialysis in an outpatient hospital or free standing dialysis facility.
- (4) Outpatient therapeutic radiology or chemotherapy for proven malignancies or opportunistic infections.
- (5) Outpatient surgical services - facility payment for selected outpatient surgical procedures to hospitals which have a contract with ~~the Authority~~ OHCA.
- (6) Outpatient Mental Health Services for medical and remedial care including services provided on an outpatient basis by certified hospital based facilities that are also qualified mental health clinics.
- (7) Rural health clinic services and other ambulatory services furnished by rural health clinic.
- (8) Optometrists' services - only as listed in Subchapter 5, Part 45, Optometrist specific rules of this Chapter.
- (9) Maternity Clinic Services ~~through the Oklahoma State Health Department~~.
- (10) Outpatient diagnostic x-rays and lab services. Other outpatient services provided to adults, not specifically addressed, are covered only when prior authorized by the agency's Medical Authorization Unit.
- (11) ~~One~~ Medically necessary screening mammogram and ~~one follow up mammogram every year for women beginning at age 30~~ mammography. Additional follow-up mammograms are covered when medically necessary. ~~Additional follow up mammograms require a prior authorization from the agency's Medical Authorization Unit.~~
- (12) Nursing facility services (other than services in an institution for tuberculosis or mental diseases).
- (13) Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT) are available for ~~each eligible individual~~ members under 21 years of age to provide access to regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth. Federal regulations also require that diagnosis and treatment be provided for conditions identified during a screening whether or not they are covered under the State Plan, as long as federal funds are available for these services. These services must be necessary to ameliorate or correct defects and physical or mental illnesses or conditions and ~~will~~ require prior authorization. EPSDT/OHCA Child Health services are outlined in OAC 317:30-3-65.2 through 317:30-3-65.4.
 - (A) Child health screening examinations for eligible children by a medical or osteopathic physician, physician assistant, or advanced practice nurse practitioner.
 - (B) Diagnostic x-rays, lab, and/or injections when prescribed by a physician provider.
 - (C) Immunizations.
 - (D) Outpatient care.
 - (E) Dental services as outlined in OAC 317:30-3-65.8.
 - (F) Optometrists' services. The EPSDT periodicity schedule provides for at least one visual screening and glasses each 12 months. In addition, payment is made for glasses for children with congenital aphakia

or following cataract removal. Interperiodic screenings and glasses at intervals outside the periodicity schedule for optometrists are allowed when a visual condition is suspected.

- (G) Hearing services as outlined in OAC 317:30-3-65.9.
- (H) Prescribed drugs.
- (I) Outpatient Psychological services as outlined in OAC 317:30-5-275 through OAC 317:30-5-278. ~~for eligible individuals under 21 years of age must be prior authorized. Payment is made to eligible psychologists who are duly licensed to practice. Outpatient testing and diagnosis is limited to one hour per patient each 12 months. Additional hours may be prior authorized.~~
- (J) Inpatient Psychotherapy Services services and psychological testing as outlined in OAC 317:30-5-95 through OAC 317:30-5-97. ~~Payment is made to eligible psychologists and psychiatrists. Inpatient psychotherapy by a psychologist must be prior authorized.~~
- (~~L~~ K) Inpatient psychological testing for eligible individuals under 21 years of age. Services are limited to one hour per each 12 months. If medically necessary, additional hours must be prior authorized. Payment is made to eligible psychologists who are duly licensed to practice.
- (~~L~~ K) Transportation. Provided when necessary in connection with examination or treatment when not otherwise available.
- (~~M~~ L) Inpatient hospital services.
- (~~N~~ M) Medical supplies, equipment, appliances and prosthetic devices beyond the normal scope of ~~Medicaid~~ SoonerCare.
- (~~O~~ N) EPSDT services furnished in a qualified child health center.
- (14) Family planning services and supplies for ~~individuals~~ members of child-bearing age, including counseling, insertion of intrauterine device, implantation of subdermal contraceptive device, and sterilization for ~~persons~~ members 21 years of age and ~~over older~~ who are legally competent, not institutionalized and have signed the "Consent Form" at least 30 days prior to procedure. Reversal of sterilization procedures for the purposes of conception is not covered. Reversal of sterilization procedures ~~may be~~ are covered when medically indicated and substantiating documentation is attached to the claim. ~~The Norplant System for birth control is covered; however, removal of the Norplant System prior to five years is covered only when documented as medically necessary. Reinsertion of Norplant contraceptive will be is considered on a case by case basis.~~
- (15) Family planning centers.
- (16) Physicians' services whether furnished in the office, the ~~patient's~~ member's home, a hospital, a nursing facility, ICF/MR, or elsewhere. For adults, payment ~~will be~~ is made for up to the limited number of compensable hospital days described at OAC 317:30-5-41. These days will

be maintained on the recipient record. Physician claims for hospital visits will be paid until the last compensable hospital day is captured. After the limited number of hospital days have been captured, inpatient physician services will not be paid beyond the last compensable hospital day. Office visits for adults are limited to four per month except when in connection with ~~emergency medical conditions as specified in OAC 317:30-5-9(b).~~

(17) Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law. See applicable provider section for limitations to covered services for:

- (A) Podiatrists' services
- (B) Optometrists' services
- (C) Psychologists' services
- (D) Certified Registered Nurse Anesthetists
- (E) Certified Nurse Midwives
- (F) Advanced Practice Nurses

(18) Free-standing ambulatory surgery centers.

(19) Prescribed drugs not to exceed a total of six prescriptions with a limit of three brand name prescriptions per month. Exceptions to the six prescription limit are:

(A) unlimited medically necessary monthly prescriptions for:

- (i) ~~individuals members~~ under the age of 21 years; and
- (ii) residents of Nursing Facilities or Intermediate Care Facilities for the Mentally Retarded.

(B) seven ~~additional~~ medically necessary generic prescriptions ~~which are generic products~~ per month in addition to the six covered under the State Plan are allowed for adults receiving services under the §1915(c) Home and Community Based Services Waivers. These additional Medically medically necessary prescriptions beyond the three brand name or thirteen total prescriptions ~~will be~~ are covered with prior authorization.

(20) Rental and/or purchase of durable medical equipment.

(21) Adaptive equipment, when prior authorized, for ~~persons members~~ residing in private ICF/MR's.

(22) Dental services for ~~persons members~~ residing in private ICF/MR's in accordance with the scope of dental services for ~~persons members~~ under age 21.

(23) Prosthetic devices limited to catheters and catheter accessories, colostomy and urostomy bags and accessories, tracheostomy accessories, nerve stimulators, hyperalimentation and accessories, home dialysis equipment and supplies, external breast prostheses and support accessories, oxygen/oxygen concentrator equipment and supplies, respirator or ventilator equipment and supplies, and those devices inserted during the course of a surgical procedure.

(24) Standard medical supplies.

(25) Eyeglasses under EPSDT for ~~individuals mem-~~ bers under age 21. Payment is also made for glasses for

children with congenital aphakia or following cataract removal.

(26) Blood and blood fractions for ~~eligible persons~~ members when administered on an outpatient basis.

(27) Inpatient services for ~~individuals members~~ age 65 or older in institutions for mental diseases, limited to those ~~persons members~~ whose Medicare, Part A benefits are exhausted for this particular service and/or those ~~persons members~~ who are not eligible for Medicare services.

(28) Nursing facility services, limited to ~~individuals members~~ preauthorized and approved by OHCA for such care.

(29) Inpatient psychiatric facility admissions for ~~in-~~ dividuals members under 21 are limited to an approved length of stay effective July 1, 1992, with provision for requests for extensions.

(30) Transportation and subsistence (room and board) to and from providers of medical services to meet ~~patient's~~ member's needs (ambulance or bus, etc.), to obtain medical treatment.

(31) Extended services for pregnant women including all pregnancy-related and postpartum services to continue to be provided, as though the women were pregnant, for 60 days after the pregnancy ends, beginning on the last date of pregnancy.

(32) Nursing facility services for ~~patients members~~ under 21 years of age.

(33) Personal care in ~~recipient's a~~ member's home, prescribed in accordance with a plan of treatment and rendered by a qualified person under supervision of ~~an~~ a R.N.

(34) Part A deductible and Part B medicare Coinsurance and/or deductible.

(35) Home and Community Based Waiver Services for the mentally retarded.

(36) Home health services limited to 36 visits per year and standard supplies for 1 month in a 12-month period. The visits ~~may be~~ are limited to any combination of Registered Nurse and nurse aide visits, not to exceed 36 per year.

(37) Medically necessary Organ solid organ and tissue bone marrow/stem cell transplantation services for children and adults, ~~limited to bone marrow, stem cells, cornea, heart, kidney, liver, lung, SPK (simultaneous pancreas kidney), PAK (pancreas after kidney), and heart lung,~~ are covered services based upon the conditions listed in (A)-(D) of this paragraph:

(A) ~~All transplantation services~~ Transplant procedures, except kidney and cornea, must be prior authorized to be compensable.

(B) To be prior authorized all procedures are reviewed based on appropriate medical criteria.

(C) To be compensable under the Medicaid SoonerCare program, all ~~organ~~ transplants must be performed at a Medicare approved transplantation center facility which meets the requirements contained in Section 1138 of the Social Security Act.

Emergency Adoptions

- (D) Finally, procedures considered experimental or investigational are not covered.
- (38) Home and community-based waiver services for mentally retarded ~~individuals~~ members who were determined to be inappropriately placed in a NF (Alternative Disposition Plan - ADP).
- (39) Case Management services for the chronically and/or severely mentally ill.
- (40) Emergency medical services including emergency labor and delivery for illegal or ineligible aliens.
- (41) Services delivered in Federally Qualified Health Centers. Payment ~~will be~~ is made on an encounter basis.
- (42) Early Intervention services for children ages 0-3.
- (43) Residential Behavior Management in therapeutic foster care setting.
- (44) Birthing center services.
- (45) Case management services through the Oklahoma Department of Mental Health and Substance Abuse.
- (46) Home and Community-Based Waiver services for aged or physically disabled ~~individuals~~ members.
- (47) Outpatient ambulatory services for ~~persons~~ members infected with tuberculosis.
- (48) Smoking and Tobacco Use Cessation Counseling for children and adults.
- (49) Services delivered to American Indians/Alaskan Natives in I/T/Us. Payment ~~will be~~ is made on an encounter basis.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 17. MEDICAL SUPPLIERS

317:30-5-211. Coverage for adults

(a) **Durable medical equipment, adaptive equipment, medical supplies and prosthetic devices.** Durable medical equipment, adaptive equipment, medical supplies and prosthetic devices for adults are covered as set forth in this Section.

(1) **Durable medical equipment.** The Oklahoma Health Care Authority provides coverage for durable medical equipment that meets the definition below, is prescribed by the appropriate medical provider, is medically necessary and meets the special requirements noted below.

(A) **Definition of DME.** Durable medical equipment (DME) is equipment which can withstand repeated use, is used to serve a medical purpose, is not useful to a person in the absence of an illness or injury, and is used in the most appropriate setting including the home or workplace.

(B) **Purchase of DME.** All durable medical equipment purchased with Oklahoma Medicaid funds becomes the property of the Oklahoma Health Care Authority to be used by the recipient until no longer needed.

(C) **Provision of DME.**

(i) **Rental.** Rental is the preferred method of providing medical equipment if the anticipated length of usage is less than 10 months. Except for oxygen and other respiratory equipment, rental of durable medical equipment is limited to 10 consecutive months. After rental has been paid for 10 months, the equipment becomes the property of the Oklahoma Health Care Authority to be used by the recipient until no longer needed.

(ii) **Purchase.** The purchase of durable medical equipment, not otherwise addressed in the section, is covered when the anticipated length of usage exceeds 10 months.

(D) **Prior authorization.**

(i) **Rental.** Rental of hospital beds, support surfaces, wheelchairs, continuous positive airway pressure devices and lifts require prior authorization initially and again before extending beyond five months of rental.

(ii) **Purchase.** DME with a fee schedule price of \$500 or more requires prior authorization. DME with a fee schedule price less than \$500 does not require prior authorization. An invoice or manufacturers quote may be required for pricing.

(iii) **Bath and toilet aids.** Bath and toilet aids, including commode chairs, sitz baths, and handrails require prior authorization. For bath and toilet aids to be medically necessary, patients must be confined to the bed or room, without indoor bathroom facilities, or unable to climb or descend the stairs necessary to reach the bathrooms of their homes. For a sitz bath to be medically necessary, the patient must have an infection or injury of the perineal area.

(E) **Requirement for Certificate of Medical Necessity.** For certain items of DME, a Certificate of Medical Necessity is required and should be submitted along with the request for prior authorization. These items are:

- (i) hospital beds,
- (ii) support surfaces,
- (iii) wheelchairs,
- (iv) continuous positive airway pressure devices, (BIPAP & CPAP)
- (v) lift devices,
- (vi) lymphedema pumps,
- (vii) external infusion pumps, and
- (viii) osteogenesis stimulators.

(2) **Adaptive equipment for ICF/MR residents.** Payment is made for certain adaptive equipment, for persons residing in private Intermediate Care Facilities for the Mentally Retarded (ICF/MR). Adaptive equipment is defined as medically necessary equipment (equipment, appliances and prosthetic devices) required because of physical disabilities. To be covered, adaptive equipment must be unique, individualized or personalized to a specific individual resident. This would include modified equipment or devices to assist in ambulation. Standard

wheelchairs, walkers, eyeglasses, etc. would not be considered adaptive equipment. All adaptive equipment must be prescribed by a physician, and prior authorization is required.

(3) **Supplies.** The Oklahoma Health Care Authority provides coverage for supplies that meet the definition below, are prescribed by the appropriate medical provider, are medically necessary and meet the special requirements noted below. Coverage is excluded for the items listed below:

(A) **Definition of supplies.** Medical supplies are defined as those disposable items which are used for the care and treatment of a medical condition.

(B) **Items not covered.** Items not covered include but are not limited to:

- (i) diapers,
- (ii) underpads,
- (iii) medicine cups,
- (iv) eating utensils, and
- (v) personal comfort items.

(C) **Medical supplies for nursing facility patients.** For patients residing in nursing facilities, separate payment is not made for supplies which are normally considered to be furnished as part of nursing care. Payment can be made separately to a supplier, however, for the following items for patients who reside in nursing facilities:

- (i) oxygen
- (ii) catheters and catheter accessories
- (iii) intravenous feeding supplies (see prosthetic devices/hyperalimentation for coverage of food supplements)
- (iv) colostomy and urostomy bags and accessories
- (v) tracheotomy supplies-
- (vi) external breast prostheses and support accessories.

(D) **Special requirements.**

(i) **Intravenous therapy.** Supplies for intravenous therapy are covered. Drugs for IV therapy are covered only as specified on the Vendor Drug program.

(ii) **Diabetic supplies.** Payment is made for the purchase of one glucometer, one spring loaded lancet device, and three replacement batteries per year. In addition, payment will be made for a maximum of 100 glucose test strips and 100 lancets per month. Diabetic supplies in excess of these parameters must be prior authorized.

(4) **Prosthetic devices.** Coverage is provided for prosthetic devices prescribed by an appropriate medical provider as conditioned in this paragraph.

(A) **Catheters.** Payment is made for permanent indwelling catheters, male external catheters, drain bags and irrigation trays. Payment is also made for single use self catheters when the patient has a history of urinary tract infections. The prescription from the

attending physician indicates that such documentation is available in the patient's medical record.

(B) **Nerve stimulators.** Payment is made for rental, not to exceed the purchase price, for transcutaneous nerve stimulators, implanted peripheral nerve stimulators, and neuromuscular stimulators. After rental has been paid for 10 months, the equipment becomes the property of the Oklahoma Health Care Authority to be used by the recipient until no longer needed.

(C) **Tracheotomy supplies.** Tracheotomy supplies are covered.

(D) **Home dialysis.** Equipment and supplies are covered for patients receiving home dialysis treatments.

(E) **Colostomy and urostomy supplies.** Payment is made for colostomy and urostomy bags and accessories.

(F) **Prosthetic devices inserted during surgery.** Payment is made for prosthetic devices inserted during the course of surgery when the prosthetic devices are not covered as a part of the inpatient hospital level of care per diem payment.

(G) Breast Prosthesis, bras, and prosthetic garments.

(i) Payment is made for:

(I) one prosthetic garment with mastectomy form every 12 months for use in the post-operative period prior to a permanent breast prosthesis or as an alternative to a mastectomy bra and breast prosthesis;

(II) two mastectomy bras per year; and

(III) one silicone or equal breast prosthetic per side every 24 months; or

(IV) one foam prosthetic per side every six months.

(ii) Payment is not made for both a silicone and a foam prosthetic in the same 12 month period.

(iii) Breast prostheses, bras, and prosthetic garments must be purchased from a Board Certified Mastectomy Fitter.

(iv) A breast prosthesis can be replaced if:

(I) it is lost;

(II) it is irreparably damaged (other than ordinary wear and tear); or

(III) the member's medical condition necessitates a different type of item and the physician provides a new prescription explaining the need for a different type of prosthesis.

(v) External breast prostheses are not covered once breast reconstruction is performed.

(G)H) Parenteral therapy. Payment is made for hyperalimentation, including supplements, supplies and equipment rental, in behalf of persons having permanently inoperative internal body organ or function. Payment can also be made for the infusion pump in cases where a patient is on therapy for a paralyzed esophagus.

(H) **Oxygen.** Coverage is provided for oxygen and oxygen supplies. Medical necessity will be determined from the results of blood gas analysis tests or oximetry tests. The PO₂ level can not exceed 59mm Hg and the arterial blood saturation can not exceed 89% at rest on room air. The tests results to document medical necessity must be within 30 days of the date of the physician's prescription.

(i) **Oxygen rental.** A monthly rental payment will be made for rental of liquid oxygen systems, gaseous oxygen systems and oxygen concentrators. The rental payment includes all contents and supplies, i.e., regulators, tubing, masks, a back-up oxygen system, etc. An additional monthly payment may be made for a portable liquid or gaseous oxygen system for ambulatory patients only. When six or more liters are required, an additional amount will be paid up to 150% of the allowable.

(ii) **Oxygen concentrators in nursing facility.** Oxygen concentrators are covered for patients residing in their home or in a nursing facility. It is expected that patients in nursing facilities requiring oxygen PRN will be serviced by oxygen kept on hand.

(iii) **Prescription for oxygen.** Prescription for oxygen services must be updated annually or any time a change in prescription occurs. All DME suppliers will be responsible for maintaining the prescription(s) of oxygen services (HCFA-484, Certificate of Medical Necessity for Oxygen) in each Medicaid recipient file. If any change in prescription occurs, the physician must complete a new HCFA-484 and this must be maintained in the recipient files by the DME supplier. The Surveillance and Utilization Review System (SURS) will conduct on going monitoring of prescriptions for oxygen services to ensure Medicaid guidelines are followed. Recoupment will be made on any cases not meeting the requirements.

(iv) **Oxygen for Medicare eligible nursing home patients.** Oxygen supplied to Medicare eligible nursing home patients may be billed directly to the fiscal agent. It is not necessary to obtain a rejection from Medicare prior to filing.

(b) **Miscellaneous non covered items.** Miscellaneous non covered durable medical equipment, adaptive equipment, medical supplies and prosthetic devices for adults are:

- (1) Sales taxes,
- (2) Enteral therapy and nutritional supplies and other food supplements, and
- (3) Electro-spinal orthosis system (ESO).

(c) **Prior authorization.**

- (1) Prosthetic devices, except for cataract lenses, require prior authorization.
- (2) Total parenteral therapy is considered a prosthetic device and requires prior authorization. The request for prior authorization must include a fully completed Certificate of Medical Necessity, Form HCFA-852, including

information from the attending physician regarding the patient's medical condition that necessitates the hyperalimentation and the expected length of treatment.

(3) The purchase of any oxygen delivery system requires prior authorization.

(d) **Requirement for Certificate of Medical Necessity.**

(1) The medical supplier must have a fully completed Certificate of Medical Necessity, Form ~~HCFA-848~~ HCFA 484, on file for certain prosthetic items including Parenteral Therapy and Transcutaneous Electric Nerve Stimulators (TENS).

(2) The medical supplier must have a fully completed current Certificate of Medical Necessity, Form HCFA 484, on file to support the claims for oxygen or oxygen supplies to establish whether coverage criteria are met and to ensure that the oxygen services provided are consistent with the physician's prescription (refer to instructions from Palmetto Government Benefits Administration, the Oklahoma Medicare Carrier, for further requirements for completion of the HCFA-484).

(3) The HCFA-484 must be completed and signed by the physician prior to submitting the initial claim. When a physician prescription for oxygen expires, a HCFA-484, including retesting, must be completed by the physician prior to the submission of claims. The medical and prescription information on HCFA-484 can be completed only by the attending physician or entered on the form from information in this patient's records by an employee of the physician for the physician's review and signature. In situations where the physician has prescribed oxygen over the phone, it is acceptable to have a cover letter containing the same information as the HCFA-484, stating the physician's orders, as long as the HCFA-484 has been signed by the physician or as set out above.

[OAR Docket #07-323; filed 2-22-07]

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

[OAR Docket #07-337]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 5. Individual Providers and Specialties

Part 1. Physicians

317:30-5-2. [AMENDED]

Part 79. Dentists

317:30-5-695. [AMENDED]

317:30-5-696. [AMENDED]

317:30-5-696.1. [NEW]

317:30-5-698. [AMENDED]

(Reference APA WF # 06-42)

AUTHORITY:

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; and 42 CFR §440.50.

DATES:

Adoption:

December 14, 2006

Approved by Governor:

January 30, 2007

Effective:

Immediately upon Governor's approval or February 1, 2007, whichever is later

Expiration:

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

SUPERSEDED EMERGENCY ACTIONS:

Superseded rules:

Subchapter 5. Individual Providers and Specialties
317:30-5-2. [AMENDED]

Gubernatorial approval:

November 1, 2006

Register publication:

24 Ok Reg 311

Docket number:

06-1433

(Reference APA WF # 06-38)

INCORPORATIONS BY REFERENCE:

N/A

FINDING OF EMERGENCY:

The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to expand dental sealants for children up to 18 years of age, to correct language that will allow stainless steel crowns for children with 70 percent or more of the root structure regardless of the child's age, and to add language under Smoking Cessation to agree with changes being made in other policy sections. Revisions also address expanding dental rules to establish limited dental benefits for pregnant women. Revisions add a limited dental benefit package for pregnant women as studies have indicated that treating periodontal disease during pregnancy has a positive effect on birth outcomes. Research has confirmed that the timely application of sealants can eliminate the need for cutting into a tooth for restorative treatment. The fee for one surface restoration is more than double the fee for one surface sealant so in the long-term, the use of sealants should result in a cost savings.

ANALYSIS:

Dental rules are revised to: (1) to add a limited dental benefits for pregnant women; (2) expand coverage for dental sealants for children up to age 18 to guard against tooth decay; (3) eliminate the age restriction on stainless steel crowns for children with 70 percent or more of root structure; (4) to clarify language on Smoking Cessation in dental policy to agree with other sections of policy by adding dentists as providers of this benefit; (5) separate rules regarding conscious sedation into their own Section; and (6) clarify general language. Revisions add a limited dental benefit package for pregnant women as studies have indicated that treating periodontal disease during pregnancy has a positive effect on birth outcomes. Currently, the age limit for dental sealants is 14. The age limits on sealant applications is being removed as this population may not come into the program at an early age and the application of sealant is limited to teeth without any pathology. Research has confirmed that the timely application of sealants can eliminate the need for cutting into a tooth for restorative treatment. The fee for one surface restoration is more than double the fee for one surface sealant so in the long-term, the use of sealants should result in a cost savings. A sealant should last approximately 5 years which will last through most member's cavity prone years. Current policy regarding coverage for stainless steel crowns states that the child has to be age 5 and have 70 percent of the root structure. The revision will correct the language to read "the child has to be age 5 or have 70 percent of the root structure". Other revisions clarify language in dental policy regarding Smoking Cessation to comply with other areas of policy. Rules regarding conscious sedation are moved from general coverage to a unique section describing dentists requirements for providing the service. Further revisions incorporate superseded emergency rules approved by the Governor on November 1, 2006.

CONTACT PERSON:

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED UPON APPROVAL

BY THE GOVERNOR AS SET FORTH IN 75 O.S., SECTION 253(D), AND EFFECTIVE UPON APPROVAL BY GOVERNOR OR FEBRUARY 1, 2007, WHICHEVER IS LATER:

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 1. PHYSICIANS

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

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

(1) Coverages Coverage include includes the following medically necessary services:

- (A) ~~Medically appropriate inpatient~~ Inpatient hospital visits ~~are covered~~ for all Medicaid SoonerCare covered stays. All inpatient services are subject to post-payment review by the OHCA, or its designated agent.
- (B) Inpatient psychotherapy by a physician.
- (C) Inpatient psychological testing by a physician.
- (D) One inpatient visit per day, per physician.
- (E) Certain surgical procedures performed in a Medicare certified free-standing ambulatory surgical center or a Medicare certified hospital that offers outpatient surgical services. Refer to the List of Covered Surgical Procedures.
- (F) Therapeutic radiology or chemotherapy on an outpatient basis without limitation to the number of treatments per month for ~~persons~~ members with proven malignancies or opportunistic infections.
- (G) Direct ~~physicians'~~ physician services ~~are covered~~ on an outpatient basis. A maximum ~~payment~~ of four visits are ~~covered~~ allowed per month per ~~patient~~ member in office or home regardless of the number of physicians providing treatment. Additional visits per month are allowed for those services related to emergency medical conditions and for services in connection with Family Planning.
- (H) Direct ~~physicians'~~ physician services in a nursing facility for those ~~patients-members~~ approved for nursing care residing in a long-term care facility. ~~Payment is made for a~~ A maximum of two nursing facility visits per month are allowed. To receive payment for a second nursing facility visit in a month denied by Medicare for a ~~Medicare/Medicaid patient~~ Medicare/SoonerCare patient, attach the EOMB from Medicare showing denial and mark "carrier denied coverage".

Emergency Adoptions

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

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

(K) ~~Obstetrical care.~~

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

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

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

(O) Family planning ~~including~~ includes sterilization procedures for legally competent persons members 21 years of age and over who voluntarily request such a procedure and, ~~with their physician, execute~~ executes the ~~Federally~~ federally mandated consent form (ADM-71) with his/her physician. A copy of the consent form must be attached to the claim form. Separate payment is ~~made~~ allowed for ~~an~~ I.U.D. ~~inserted~~ insertion during an office visit. Certain family planning products may be obtained through the Vendor Drug Program. Reversal of sterilization procedures for the purposes of conception ~~are~~ is not covered ~~allowed~~. Reversal of sterilization procedures ~~may be~~ are covered allowed when medically indicated and substantiating documentation is attached to the claim. ~~The Norplant System for birth control is covered; however, removal of the Norplant System prior to five years is covered only when documented as medically necessary. Reinsertion of Norplant contraceptive will be considered on a case by case basis.~~

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

(Q) ~~Blood count weekly~~ Weekly blood counts for persons members receiving the drug Clozaril.

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

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

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

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

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

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

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

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

(v) Seeing patients members without supervision;

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

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

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

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

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

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

(iii) Documentation of written policy and applicable training of physicians in the training program regarding when to seek the consultation of the attending physician.

(W) Payment to the attending physician for the outpatient services of an unlicensed physician in a training program when the following conditions are met:

(i) The patient member must be at least minimally examined ~~and reviewed~~ by the attending physician or a licensed physician under the supervision of the attending physician;

(ii) ~~This~~ The contact must be documented in the medical record.

(X) Payment to a physician for supervision of CRNA services unless the CRNA bills directly.

(Y) One pap smear per year for women of child bearing age. Two follow-up pap smears are covered when medically indicated.

(Z) ~~Medically necessary Organ solid organ and tissue bone marrow/stem cell transplantation services for children and adults, limited to bone marrow, stem cells, cornea, heart, kidney, liver, lung, SPK (simultaneous pancreas kidney), PAK (pancreas after kidney), and heart lung,~~ are covered services based upon the conditions listed in (i)-(iv) of this subparagraph:

- (i) ~~All transplantation services~~ Transplant procedures, except kidney and cornea, must be prior authorized to be compensable.
 - (ii) To be prior authorized all procedures are reviewed based on appropriate medical criteria.
 - (iii) To be compensable under the Medicaid SoonerCare program, all organ transplants must be performed at a Medicare approved transplantation center facility which meets the requirements contained in Section 1138 of the Social Security Act.
 - (iv) ~~Finally, procedures~~ Procedures considered experimental or investigational are not covered.
- (AA) Total parenteral nutritional therapy (TPN) for ~~certain identified~~ diagnoses and when prior authorized.
- (BB) Ventilator equipment.
- (CC) Home dialysis equipment and supplies.
- (DD) Ambulatory services for treatment of ~~persons~~ members with tuberculosis (TB). This includes, but is not limited to, physician visits, outpatient hospital services, rural health clinic visits and prescriptions. Drugs prescribed for the treatment of TB not listed in OAC 317:30-3-46 require prior authorization by the ~~University of Oklahoma College of Pharmacy Help Desk~~ using form "Petition for TB Related Therapy". Ambulatory services to ~~persons~~ members infected with TB are not limited to the scope of the Medicaid SoonerCare program, but require prior authorization when the scope is exceeded.
- (EE) Smoking and Tobacco Use Cessation Counseling for treatment of individuals using tobacco.
- (i) Smoking and Tobacco Use Cessation Counseling consists of the 5As:
 - (I) Asking the ~~patient~~ member to describe their smoking use;
 - (II) Advising the ~~patient~~ member to quit;
 - (III) Assessing the willingness of the ~~patient~~ member to quit;
 - (IV) Assisting the ~~patient~~ member with referrals and plans to quit; and
 - (V) Arranging for follow-up.
 - (ii) Up to eight sessions are covered per year per individual.
 - (iii) Smoking and Tobacco Use Cessation Counseling is a covered service when performed by physicians, physician assistants, nurse practitioners, nurse midwives, dentists, and Oklahoma State Health Department and FQHC nursing staff. It is reimbursed in addition to any other appropriate global payments for obstetrical care, PCP capitation payments, evaluation and management codes,

or other appropriate services rendered. It must be a significant, separately identifiable service, unique from any other service provided on the same day.

(iv) Chart documentation must include a separate note and signature along with the member specific information addressed in the five steps and the time spent by the practitioner performing the counseling. Anything under three minutes is considered part of a routine visit.

(FF) Immunizations as specified by the Advisory Committee on Immunization Practices (ACIP) guidelines.

- (2) General coverage exclusions include the following:
 - (A) Inpatient diagnostic studies that could be performed on an outpatient basis.
 - (B) Services or any expense incurred for cosmetic surgery.
 - (C) Services of two physicians for the same type of service to the same ~~patient~~ member at the same time, except when warranted by the necessity of supplemental skills. When supplemental skills are warranted, the initial consultation is reported utilizing the appropriate CPT code for inpatient consultations. Follow-up consultations include monitoring progress, recommending management modifications or advising on a new plan of care in response to changes in the ~~patient's~~ member's status. If the consultant physician initiates treatment at the initial consultation and participates thereafter in the ~~patient's~~ member's care, the procedure codes for subsequent hospital care ~~should~~ must be used.
 - (D) Refractions and visual aids.
 - (E) Separate A separate payment for ~~pre pre-operative care, if provided on the day before or the day of surgery, or for typical post-operative follow-up care and post-operative care when payment is made for surgery.~~
 - (F) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.
 - (G) Sterilization of ~~persons~~ members who are under 21 years of age, mentally incompetent, or institutionalized, ~~or Reversal reversal~~ of sterilization procedures for the purposes of conception.
 - (H) Non-therapeutic hysterectomy.
 - (I) Medical services considered to be experimental or investigational.
 - (J) Payment for more than four outpatient visits per month (home or office) per ~~patient~~ member except those visits in connection with family planning, or related to emergency medical conditions.
 - (K) Payment for more than two nursing facility visits per month.
 - (L) More than one inpatient visit per day per physician.
 - (M) Physician supervision of hemodialysis or peritoneal dialysis.

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(N) Physician services which are administrative in nature and not a direct service to the patient member including such items as quality assurance, utilization review, treatment staffing, tumor board, dictation, and similar functions.

(O) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.

(P) Payment for the services of physicians' assistants, social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in OHCA rules.

(Q) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury, or illness, ~~including-related to~~ a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or ~~that~~ when the pregnancy is the result of an act of rape or incest. (See Refer to OAC 317:30-5-6 or 317:30-5-50.)

(R) Night calls or unusual hours.

(S) Speech and Hearing services.

~~(T) Treatment for obesity, including weight reduction surgery.~~

~~(U) Mileage.~~

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

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

~~(X) Inpatient chemical dependency treatment.~~

~~(Y) Fertility treatment.~~

~~(Z) Routine immunizations.~~

~~(AA) Y~~ Payment for removal of benign skin lesions unless medically necessary.

(b) **Children.** Payment is made to physicians for medical and surgical services for ~~persons-members~~ under the age of 21 within the scope of the Authority's medical programs, provided the services are medically necessary for the diagnosis and treatment of illness or injury, or to improve the functioning of a malformed body member. Medical and surgical services for children are comparable to those listed for adults. In addition to those services listed for adults, the following services are covered for children.

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

(A) Effective October 1, 1993, all residential and acute psychiatric services ~~will-be-are~~ authorized based on the medical necessity criteria as described in OAC ~~317:30-5-46 317:30-5-95.25,317:30-5-95.27 and 317:30-5-95.29.~~

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

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

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

~~(A)~~ Extension requests for psychiatric admissions must be submitted to the OHCA or its designated agent. Extension requests must contain the appropriate documentation ~~which—validates~~ validating the need for continued treatment in accordance with the medical necessity criteria described in OAC ~~317:30-5-46—317:30-5-95.26, 317:30-5-95.28 and 317:30-5-95.30.~~ Requests ~~shall~~ must be made prior to the expiration of the approved inpatient stay. All decisions of OHCA or its designated agent are final.

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

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

(5) **Early and periodic screening diagnosis and treatment program.** Payment is ~~also—~~ made to eligible providers for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of ~~individuals~~ members under age 21. These services include medical, dental, vision, hearing and other necessary health care. Refer to OAC 317:30-3-65.2 through 317:30-3-65.11 for specific guidelines.

(6) **Child abuse/neglect findings.** Instances of child abuse and/or neglect discovered through screenings and regular exams are to be reported in accordance with State Law. Title 21, Oklahoma Statutes, Section 846, as amended, states in part: *Every physician or surgeon, including doctors of medicine and dentistry, licensed*

osteopathic physicians, residents, and interns, examining, attending, or treating a child under the age of eighteen (18) years and every registered nurse examining, attending or treating such a child in the absence of a physician or surgeon, and every other person having reason to believe that a child under the age of eighteen (18) years has had physical injury or injuries inflicted upon him or her by other than accidental means where the injury appears to have been caused as a result of physical abuse or neglect, shall report the matter promptly to the county office of the Department of Human Services in the county wherein the suspected injury occurred. Providing it shall be a misdemeanor for any person to knowingly and willfully fail to promptly report an incident as provided above. Persons reporting such incidents of abuse and/or neglect in accordance with the law are exempt from prosecution in civil or criminal suits that might be brought as a result of the report.

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

(A) Inpatient diagnostic studies that could be performed on an outpatient basis.

(B) Services or any expense incurred for cosmetic surgery unless the physician certifies the procedure emotionally necessary.

(C) Services of two physicians for the same type of service to the same ~~patient~~ member at the same time, except when warranted by the necessity of supplemental skills. When supplemental skills are warranted, the initial consultation is reported utilizing the appropriate CPT code for inpatient consultations. Follow-up consultations include monitoring progress, recommending management modifications or advising on a new plan of care in response to changes in the ~~patient's~~ member's status. If the consultant physician initiates treatment at the initial consultation and participates thereafter in the ~~patient's~~ member's care, the codes for subsequent hospital care ~~should~~ must be used.

(D) ~~Separate A separate payment for pre pre-operative care, if provided on the day before or the day of surgery, or for typical post-operative follow-up care and post operative care when payment is made for surgery.~~

(E) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.

(F) Sterilization of persons who are under 21 years of age.

(G) Non-therapeutic hysterectomy.

(H) Medical Services considered to be experimental or investigational.

(I) More than one inpatient visit per day per physician.

(J) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or

arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or that the pregnancy is the result of an act of rape or incest. (~~See Refer~~ to OAC 317:30-5-6 or 317:30-5-50.)

(K) Physician supervision of hemodialysis or peritoneal dialysis.

(L) Physician services which are administrative in nature and not a direct service to the ~~patient~~ member including such items as quality assurance, utilization review, treatment staffing, tumor board, dictation, and similar functions.

(M) Payment for the services of physicians' assistants except as specifically set out in OHCA rules.

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

~~(O) Treatment of obesity including weight reduction surgery.~~

~~(P) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.~~

~~(Q) Night calls or unusual hours.~~

~~(R) Mileage.~~

~~(S) Other than A routine hospital visit on date of discharge unless~~ patient the member expired.

~~(T) Tympanometry.~~

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

(1) Out of state claims will not "cross over". Providers must file a claim for coinsurance and/or deductible within 90 days of the Medicare payment. The Medicare EOMB must be attached to the claim.

(2) Claims filed under ~~Medicaid~~ SoonerCare must be filed within one year from the date of service. For dually eligible ~~individuals~~ members, to be eligible for payment of coinsurance and/or deductible under ~~Medicaid~~ SoonerCare, a claim must be filed with Medicare within one year from the date of service.

PART 79. DENTISTS

317:30-5-695. Eligible dental providers

(a) Eligible dental providers in Oklahoma's ~~Medicaid~~ SoonerCare program are:

(1) individuals licensed as dentists under 59 Oklahoma Statutes §§ 328.21, 328.22, and 328.23 (licensed dentists, specialty dentists and out of state dentists);

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- (2) individuals issued permits as dental interns under 59 Oklahoma Statute § 328.26;
 - (3) individuals who are third and fourth year dental students at an accredited Oklahoma dental college; and
 - (4) any individual issued a license in another state as a dentist.
- (b) All eligible providers must be in good standing with regard to their license. Any revocation or suspension status of a provider referenced in subsection (a) above renders the provider ineligible for payment or subject to recoupment under Medicaid SoonerCare.
- (c) Eligible providers must document and sign records of services rendered in accordance with guidelines found at OAC 317:30-3-15.

317:30-5-696. Coverage by category

Payment is made for dental services as set forth in this Section.

(1) Adults.

(A) Dental coverage for adults is limited to:

- (i) emergency extractions; ~~and~~
- (ii) Smoking and Tobacco Use Cessation Counseling; ~~and~~

~~Payment is made for dental care for adults residing in private Intermediate Care Facilities for the Mentally Retarded (ICF/MR) and who have been approved for ICF/MR level of care, similar to the scope of services available to individuals under age 21.~~

(iii) ~~Payment is also made for medical and surgical services performed by a dentist, to the extent such services may be performed under State law either by a doctor of dental surgery or dental medicine, when those services would be covered if performed by a physician.~~

(B) Payment is made for dental care for adults residing in private Intermediate Care Facilities for the Mentally Retarded (ICF/MR) and who have been approved for ICF/MR level of care, similar to the scope of services available to individuals under age 21.

(C) Pregnant women are covered under a limited dental benefit plan (Refer to (a)(4) of this Section).

~~Payment is made to Dentists who have received appropriate formal education in conscious (moderate) sedation, deep sedation, and general anesthesia and are qualified to use these modalities in practice. Training to competency in conscious (moderate) sedation techniques may be acquired at the predoctoral, postgraduate, graduate, or continuing education level. Dentists who wish to utilize conscious (moderate) sedation are expected to successfully complete formal training which is structured in accordance with the American Dental Association's educational guidelines as well as the board of Dentistry for the State in which they practice. The knowledge and skills required for the administration of deep sedation and general anesthesia are beyond the scope of pre-doctoral and continuing education. Only dentists~~

~~who have successfully completed an accredited/approved residency program in anesthesiology, for the administration of anesthetic agents will be permitted to provide and bill for this service. All anesthesia services must be provided in accordance with OAC 317:30-5-7.~~

(2) **Home and community based waiver services for the mentally retarded (HCBWS).** All providers participating in the HCBWS must have a separate contract with the OHCA to provide services under the HCBWS. ~~All services~~ Dental services are defined in each waiver and must be prior authorized.

(3) **Children.** The OHCA Dental Program provides the basic medically necessary treatment. The services listed below are compensable for ~~eligible individuals~~ members under 21 years of age without prior authorization. ALL OTHER DENTAL SERVICES MUST BE PRIOR AUTHORIZED. Anesthesia services are covered for children in the same manner as adults.

(A) **Comprehensive oral evaluation.** Comprehensive oral evaluation must be performed and recorded for each new patient, or established patient not seen for more than 18 months. This procedure is allowed once each 18 month period.

(B) **Periodic oral evaluation.** This procedure may be provided for a client of record if she or he has not been seen for more than six months.

(C) **Emergency examination/limited oral evaluation.** This procedure is not compensable within two months of a periodic oral examination or if the ~~client~~ member is involved in active treatment unless trauma or acute infection is the presenting complaint.

(D) **Emergency extractions.** This procedure is only for the relief of pain or treatment of acute infection.

(E) **Oral hygiene instructions.** The dentist or designated qualified dental staff shall instruct the ~~client~~ member or the responsible adult, if the child is under five years of age, in proper tooth brushing and flossing by actual demonstration. Verbal and/or written proper diet information should be discussed. This service includes a new tooth brush, disclosing tablets if available, and a small container of six or more yards of dental floss dispensed to the patient when appropriate. This service is limited to once per 12 months.

(F) **Radiographs (x-rays).** To be Medicaid SoonerCare compensable, x-rays must be determined as medically necessary by the dentist, of diagnostic quality and taken within the allowable limits of the program. The referring dentist is responsible for providing properly identified x-rays of acceptable quality with a referral, if that provider chooses to expose and submit for reimbursement prior to referral.

(G) **Dental sealants.** Tooth numbers ~~2, through 5, 12 through 3, 14, 15, 18, 19, 30 and through 21, and 28 through 31~~ must be caries free on all surfaces to be eligible for this service. This service is available

through 18 and is compensable only once per lifetime. Replacement of lost sealants will be at no cost to the OHCA. ~~Tooth numbers 03, 14, 19, and 30 are eligible for sealants from eruptions through eight years of age. Tooth numbers 02, 15, 18 and 31 are eligible for sealants from eruptions through 13 years of age. Tooth numbers 04, 05, 12, 13, 20, 21, 28, and 29 from eruptions through 14 years of age.~~

(H) **Dental prophylaxis.** This procedure is provided once every 184 days including topical application of fluoride.

(I) **Composite restorations.**

(i) This procedure is compensable for primary incisors as follows:

- (I) tooth numbers O and P to age 4.0 years;
- (II) tooth numbers E and F to age 6.0 years;
- (III) tooth numbers N and Q to 5.0 years; and
- (IV) tooth numbers D and G to 6.0 years.

(ii) The procedure is also allowed for use in all vital and successfully treated non-vital permanent anterior teeth.

(iii) Class I and II composite restorations are allowed in posterior teeth; however, the OHCA has certain restrictions for the use of this restorative material. (See OAC 317:30-5-699).

(J) **Amalgam.** Amalgam restorations are allowed in:

- (i) posterior primary teeth when:
 - (I) 50 percent or more root structure is remaining;
 - (II) the teeth have no mobility; or
 - (III) the procedure is provided more than 12 months prior to normal exfoliation.
- (ii) any permanent tooth, determined as medically necessary by the treating dentist.

(K) **Stainless steel crowns.** The use of stainless steel crowns is allowed as follows:

- (i) Stainless steel crowns are allowed if; the child is five years of age or under and 70 percent or more of the root structure remains or when the tooth would not exfoliate within the next 12 months.
- (ii) Stainless steel crowns are treatment of choice for primary teeth with pulpotomies or pulpectomies, if the above conditions exist, and for primary teeth where three surfaces of extensive decay exist or where cuspal occlusion is lost due to decay or accident.
- (iii) Stainless steel crowns are the treatment of choice on posterior permanent teeth that have completed endodontic therapy, if more than three surfaces or cuspal occlusion are lost due to decay prior to age 16.0 years.
- (iv) Preoperative periapical x-rays must be available for review, if requested.

(L) **Pulpotomies and pulpectomies.** The use of stainless steel crowns is allowed as follows:

(i) Therapeutic pulpotomies are allowable for molars and teeth numbers listed below. Pre and post operative periapical x-rays must be available for review, if requested.

- (I) Primary molars having at least 70 percent or more of their root structure remaining or more than 12 months prior to normal exfoliation;
- (II) Tooth numbers O and P before age 5.0 years;
- (III) Tooth numbers E and F before 6.0 years;
- (IV) Tooth numbers N and Q before 5.0 years; and
- (V) Tooth numbers D and G before 6.0 years.

(ii) Pulpectomies are allowed for primary teeth if exfoliation of the teeth is not expected to occur for at least one year or if 70 percent or more of root structure is remaining.

(M) **Anterior root canals.** Payment is made for the services provided in accordance with the following:

- (i) This procedure is done for permanent teeth when there are not other missing anterior teeth in the same arch requiring replacement.
- (ii) Acceptable ADA filling materials must be used.
- (iii) Preauthorization is required if the patient's member's treatment plan involves more than four anterior root canals.
- (iv) Teeth with less than 50 percent of clinical crown should not be treatment-planned for root canal therapy.
- (v) Pre and post operative periapical x-rays must be available for review.
- (vi) Pulpotomy may be performed for the relief of pain while waiting for the decision from the OHCA.
- (vii) Providers are responsible for any follow-up treatment required due to a failed root canal therapy for 24 month post completion.
- (viii) Endodontic treated teeth should be restored to limited occlusal function and all contours should be replaced. These teeth are not automatically approved for any type of crown.
- (ix) If there are three or more missing teeth in the arch that requires replacement, root therapy will not be allowed.

(N) **Space maintainers.** Certain limitations apply with regard to this procedure. Providers are responsible for recementation of any maintainer placed by them for six months post insertion.

(i) **Band and loop type space maintenance.** This procedure must be provided in accordance with the following guidelines:

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- (I) **Procedure.** This procedure is compensable for all primary molars where permanent successor is missing or where succedaneous tooth is more than 5mm below the crest of the alveolar ridge or where the successor tooth would not normally erupt in the next 12 months.
- (II) First primary molars are not allowed space maintenance ~~after age eight years~~ if the second primary and first permanent molars are present and in cuspal interlocking occlusion regardless of the presence or absence of normal relationship.
- (III) If there are missing teeth bilaterally in the same arch, under the above guidelines, bilateral space maintainer is the treatment of choice.
- (IV) The teeth numbers shown on the claim should be those of the missing teeth.
- (V) Post operative bitewing x-rays must be available for review.
- (ii) **Lingual arch bar.** Payment is made for the services provided in accordance with the following:
- (I) Lingual arch bar is used where multiple missing teeth exist in the same arch.
- (II) The requirements are the same as for band and loop space maintainer.
- (III) Multiple missing upper anterior primary incisors may be replaced with the appliance to age 6.0 years to prevent abnormal swallowing habits.
- (IV) Pre and post operative x-rays must be available.
- (iii) **Interim partial dentures.** These dentures are used for ~~single or multiple an~~ anterior permanent tooth replacement or if the member is missing three or more posterior teeth to age 16.0 years.
- (O) **Analgesia.** Use of nitrous oxide is compensable for four occurrences per year.
- (P) **Pulp caps (direct).** ADA accepted CAOHC containing material must be used.
- (Q) **Sedative treatment.** ADA acceptable materials must be used for temporary restoration. This restoration is used for very deep cavities to allow the tooth an adequate chance to heal itself or an attempt to prevent the need for root canal therapy. This restoration, when properly used, is intended to relieve pain and may include a direct or indirect pulp cap. The combination of a pulp cap and sedative fill is the only restorative procedure allowed per tooth per day. Subsequent restoration of the tooth is allowed after a minimum of 30 days.
- (R) **History and physical.** Payment is made for services for the purpose of admitting a patient to a hospital for dental treatment.
- (S) **Local anesthesia.** This procedure is included in the fee for all services.
- (T) **Smoking and Tobacco Use Cessation Counseling.** Smoking and Tobacco Use Cessation Counseling is covered when performed utilizing the five intervention steps of asking the patient to describe his/her smoking, advising the patient to quit, assessing the willingness of the patient to quit, assisting with referrals and ~~plant plans~~ to quit, and arranging for follow-up. Up to eight sessions are covered per year per individual who has documented tobacco use. It is a covered service when provided by ~~a Dentist~~ physicians, physician assistants, nurse practitioners, nurse midwives, and Oklahoma State Health Department and FQHC nursing staff in addition to other appropriate services rendered. Chart documentation must include a separate note, separate signature, and the patient specific information addressed in the five steps and the time spent by the practitioner performing the counseling. Anything under three minutes is considered part of a routine visit.
- (4) **Pregnant Women.** Dental coverage for this special population is provided regardless of age.
- (A) Proof of pregnancy is required (Refer to OAC 317:35-5-6).
- (B) Coverage is limited to a time period beginning at the diagnosis of pregnancy and ending upon 60 days post partum.
- (C) In addition to dental services for adults, other services available include:
- (i) Comprehensive oral evaluation must be performed and recorded for each new client, or established client not seen for more than 24 months;
- (ii) Periodic oral evaluation as in 317:30-5-696 (a)(3)(B);
- (iii) Emergency examinations/limited oral evaluation. This procedure is not allowed within two months of an oral examination by the same provider for the same client, or if the client is under active treatment;
- (iv) Oral hygiene instructions as in 317:30-5-696 (a)(3)(E);
- (v) Radiographs as in 317:30-5-696 (a)(3)(F);
- (vi) Dental prophylaxis as in 317:30-5-696 (a)(3)(H);
- (vii) Composite restorations:
- (I) Any permanent tooth that has an opened lesion that is a food trap will be deemed medically necessary for this program and will be allowed for all anterior teeth.
- (II) Class I posterior composite resin restorations are allowed in posterior teeth that qualify;
- (viii) Amalgam. Any permanent tooth that has an opened lesion that is a food trap will be deemed as medically necessary and will be allowed; and
- (ix) Analgesia. Use of nitrous oxide is compensable for four occurrences.
- (D) Services requiring prior authorization (Refer to OAC 317:30-5-698).

(E) Periodontal scaling and root planing. Required that 50% or more of six point measurements be 4 millimeters or greater. This procedure is designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins and microorganism and requires anesthesia and some soft tissue removal.

(4) Individuals eligible for Part B of Medicare.

(A) Payment is made utilizing the Medicaid allowable for comparable services. This is an all inclusive payment on assigned claims.

(B) Services which have been denied by Medicare as noncompensable should be filed directly with this Authority with a copy of the Medicare EOB attached.

317:30-5-696.1. Conscious Sedation

Payment is made for medical and surgical services performed by a dentist to the extent such services may be performed under State law either by a doctor of dental surgery or dental medicine, when those services would be covered if performed by a physician. Payment is made to Dentists who have received appropriate formal education in conscious (moderate) sedation, deep sedation, and general anesthesia and are qualified to use these modalities in practice.

(1) Training to competency in conscious (moderate) sedation techniques may be acquired at the predoctoral, postgraduate, graduate, or continuing education level. Dentists who wish to utilize conscious (moderate) sedation are expected to successfully complete formal training which is structured in accordance with the American Dental Association's educational guidelines as well as the board of Dentistry for the State in which they practice.

(2) The knowledge and skills required for the administration of deep sedation and general anesthesia are beyond the scope of pre-doctoral and continuing education. Only dentists who have successfully completed an accredited/approved residency program in anesthesiology, for the administration of anesthetic agents will be permitted to provide and bill for this service.

(3) All anesthesia services must be provided in accordance with OAC 317:30-5-7.

317:30-5-698. Services requiring prior authorization

(a) Providers must have prior authorization for certain specified services before delivery of that service, unless the service is provided on an emergency basis. Emergency dental care is immediate service that must be provided to relieve the recipient from pain due to an acute infection, swelling, trismus or trauma. Requests for dental services requiring prior authorization must be accompanied by sufficient documentation. Study models (where indicated), x-rays, six point periodontal charting, comprehensive treatment plan and narrative may be requested. If the quality of the supporting material is such that a determination of authorization cannot be made, the material is returned to the provider. Any new documentation must be provided at the provider's expense.

(b) Requests for prior authorization are filed on the currently approved ADA form. OHCA notifies the provider on the determination of prior authorization using OHCA Prior Authorization Request Decision form. Prior authorized services must be billed exactly as they appear on the prior authorization. Payment is not made for any services provided prior to receiving authorization except for the relief of pain.

(c) Prosthetic services provided to ~~patients~~ members who have become ineligible mid-treatment are covered if the ~~client~~ member was eligible for ~~Medicaid~~ SoonerCare on the date the final impressions were made.

(d) Listed below are examples of services requiring prior authorization for ~~individuals~~ members under 21 and eligible ICF/MR residents. Minimum required records to be submitted with each request are right and left mounted bitewing x-rays and periapical films of tooth/teeth involved or the edentulous areas if not visible in the bitewings. X-rays must be mounted so that they are viewed from the front of the ~~patient~~ member. If required x-rays sent are copies, each film or print must be of good, readable quality and identified as to left and right sides. The film must clearly show the requested service area of interest. X-rays must be identified with ~~client~~ member name, date, recipient ID number, provider name, and provider number. X-rays must be placed together in an envelope and stapled to the submission form. If radiographs are not taken, provider must include in narrative sufficient information to confirm diagnosis and treatment plan.

(1) Endodontics. Pulpotomy may be performed for the relief of pain while waiting for the decision from the OHCA on request for endodontics.

(A) Anterior root canals. This procedure is for ~~patients~~ members whom, by the provider's documentation, have a treatment plan requiring more than four anterior root canals and/or posterior endodontics. Payment is made for services provided in accordance with the following:

(i) Permanent teeth numbered 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26 and 27 are eligible for therapy if there are not other missing teeth in the same arch requiring replacement, unless numbers 6, 11, 22, or 27 are abutments for prosthesis.

(ii) Accepted ADA filling must be used.

(iii) Pre and post operative periapical x-rays must be available for review.

(iv) Providers are responsible for any follow-up treatment required by a failed endodontically treated tooth within 24 months post completion.

(v) A tooth will not be approved if it appears there is not adequate natural tooth structure remaining to establish good tooth/restorative margins or if crown to root ratio is poor.

(vi) An endodontic procedure may not be approved if the tooth requires a post and core in order to present adequate structure to retain a crown.

(vii) If there are three or more missing teeth in the arch that requires replacement, root therapy will not be allowed.

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(B) Posterior endodontics. The guidelines for this procedure are as follows:

- (i) The provider should document that the client has improved oral hygiene and flossing ability in this ~~client's~~ member's records.
- (ii) Teeth that would require pre-fabricated post and cores to minimally retain a crown due to lack of natural tooth structure should not be treatment planned for root canal therapy.
- (iii) Pre and post operative periapical x-rays must be available for review.
- (iv) Providers are responsible for any follow-up treatment required by a failed endodontically treated tooth within 24 months post completion.
- (v) A tooth will not be approved if it appears there is not adequate natural tooth structure remaining to establish good tooth/restorative margins or if there is a poor crown to root ratio or weakened root furcation area.
- (vi) Only ADA accepted filling materials are acceptable under the OHCA policy.
- (vii) Posterior endodontic procedure is limited to a maximum of five teeth. A request may not be approved if the tooth requires a post and core in order to present adequate structure to retain a crown.
- (viii) Endodontics will not be considered if:
 - (I) there are missing teeth in the same arch requiring replacement;
 - (II) an opposing tooth has super erupted;
 - (III) loss of tooth space is one third or greater;
 - (IV) opposing second molars are involved; or
 - (V) ~~a tooth is the~~ the member has multiple teeth failing due to previous inadequate root canal therapy.
- (ix) Endodontically treated teeth must be restored to limited occlusal function and all contours must be replaced. These teeth will not be approved for a crown if it appears the apex is not adequately sealed.

(x) a single failing root canal is determined not medically necessary for re-treatment.

(2) Cast metal crowns or ceramic-based crowns. This procedure is compensable for ~~patients~~ members who are 16 years of age or older and adults residing in private Intermediate Care Facilities for the Mentally Retarded (IF/MR) and who have been approved for IF/MR level of care. Certain criteria and limitations apply.

(A) The following conditions must exist for approval of this procedure.

- (i) The tooth must be fractured or decayed to such an extent to prevent proper cuspal or incisa function.
- (ii) The clinical crown is destroyed by the above elements by one-half or more.

(iii) Endodontically treated teeth must have three or more surfaces restored or lost due to carious activity to be considered.

(B) The conditions listed in (A)(I) through (A)(iii) of this paragraph should be clearly visible on the submitted x-rays when a request is made for any type of crown.

(C) Routine build-up(s) for authorized crowns are included in the fee for the crown.

(D) A crown will not be approved if adequate tooth structure does not remain to establish cleansable margins, poor crown to root ratio, or the tooth appears to retain insufficient amounts of natural tooth structure. Cast ~~down~~ dowel cores are not allowed.

(E) Preformed post(s) and core build-up(s) are not routinely provided with crowns for endodontically treated teeth.

(F) Ceramic-metal based crowns will be considered only for tooth numbers 4 through 13 and 21 through 28.

(G) Full cast metal crowns are treatment of choice for all posterior teeth.

(H) Provider is responsible for replacement or repair of cast crowns for 48 months post insertion.

(3) Cast frame partial dentures. This appliance is the treatment of choice for replacement of three or more missing permanent teeth in the same arch for ~~individuals~~ members 16 through 20 years of age. Provider must indicate tooth number to be replaced and teeth to be clasped.

(4) Acrylic partial. This appliance is the treatment of choice for replacement of missing anterior permanent teeth or three or more missing teeth in the same arch for ~~children~~ members 12 through 16 years of age and adults residing in private Intermediate Care Facilities for the Mentally Retarded (ICF/MR) and who have been approved for ICF/MR level of care. Provider must indicate tooth numbers to be replaced and teeth to be clasped. This appliance includes all necessary clasps and rests.

(5) Fixed cast non-precious metal or porcelain/metal bridges. Only ~~patients~~ members 17 through 20 years of age where the bite relationship precludes the use of an acrylic or cast frame partial denture are considered. Study models with narrative are required to substantiate need for fixed bridge(s). ~~Client~~ Members must have excellent oral hygiene documented in the requesting provider's records.

(6) Periodontal scaling and root planing. This procedure requires that 50% or more of six point measurements be four millimeters or greater. This procedure is allowed on ~~patients~~ members 12 to 20 and requires anesthesia and some soft tissue removal occurs. Tooth planing is designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins and microorganism.

(7) Additional prophylaxis. The OHCA recognizes that certain physical conditions require more than two prophylaxes. The following conditions may qualify a ~~patient~~ member for one additional prophylaxis per year:

- (A) dilantin hyperplasia;

- (B) cerebral palsy;
- (C) mental retardation;
- (D) juvenile periodontitis.

[OAR Docket #07-337; filed 2-23-07]

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

[OAR Docket #07-324]

RULEMAKING ACTION:
EMERGENCY adoption

RULES:
Subchapter 5. Individual Providers and Specialties
Part 1. Physicians
317:30-5-8. [AMENDED]
(Reference APA WF# 06-40)

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

DATES:

Adoption:
December 14, 2006

Approved by Governor:
January 30, 2007

Effective:
Immediately upon Governor's approval or February 1, 2007, whichever is later.

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

SUPERSEDED EMERGENCY ACTIONS:

Superseded Rules:
Subchapter 5. Individual Providers and Specialties
Part 1. Physicians
317:30-5-8. [AMENDED]

Gubernatorial Approval:
October 8, 2006

Register Publication:
24 Ok Reg 143

Docket Number:
06-1349
(Reference APA WF# 06-12)

INCORPORATIONS BY REFERENCE:
N/A

FINDING OF EMERGENCY:
The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to comply with agency protocol for required documentation of medical necessity for prior approval of reduction mammoplasty. Failure to comply with current Agency rules could result in Performance Error Rate Measurement (PERM) findings and jeopardize federal funding. Additionally, current rules could result in denial of prior authorization for mammoplasty reduction surgery and increase member appeals.

ANALYSIS:
Surgery rules are revised to allow OHCA to comply with current protocol for required documentation of medical necessity for prior authorization of reduction mammoplasty. Existing rules outline the prior authorization procedures used by managed care plans which are now obsolete under SoonerCare. Failure to revise surgery rules could result in denial of mammoplasty reduction surgery authorization and increase member appeals.

CONTACT PERSON:
Joanne Terlizzi at (405)522-7272

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED UPON APPROVAL BY THE GOVERNOR AS SET FORTH IN 75 O.S., SECTION 253(D), AND EFFECTIVE UPON APPROVAL BY GOVERNOR OR FEBRUARY 1, 2007, WHICHEVER IS LATER:

**SUBCHAPTER 5. INDIVIDUAL PROVIDERS
AND SPECIALTIES**

PART 1. PHYSICIANS

317:30-5-8. Surgery

(a) **Use of surgical modifiers.** The Physicians' Current Procedural Terminology (CPT) provides for 2-digit surgical modifiers to further describe surgical services. All of these modifiers must be used on OHCA claims when applicable. The CPT also provides an alternate method of using a special 5-digit code beginning with 099-. These codes will not be accepted by OHCA. This method cannot be used to record modifications to the procedure code. Use the appropriate 2-digit modifier placed just to the right of the 5-digit surgical procedure code.

(b) **Description of modifiers and how they are paid.**

(1) -20 Microsurgery - OHCA does not make an additional payment for this modifier. The procedure will be paid at the regular OHCA allowable.

(2) -22 Unusual services - OHCA does not make an additional payment for this modifier. The procedure will be paid at the regular OHCA allowable.

(3) -26 Professional component - This modifier is used to identify a professional component. It is used when the physician provides an interpretation rather than a full-service procedure. Modifier -26 will also be used by the hospital-based radiologist or pathologist on radiology, surgical pathology and echocardiography done in the hospital. The allowables for modifier -26 are listed in the Authority's listing of the procedure-based maximum allowable payments.

(4) -47 Anesthesia by surgeon - OHCA does not make an additional payment for this modifier. OHCA does not make an additional payment for local anesthesia. OHCA will pay additional for surgical procedure codes 62274 through 62279 and nerve block, codes 64400 through 64530. These codes are used by surgeons or obstetricians when applicable without modifier -47. The procedure will be paid at the regular OHCA allowable. Anesthesia coding and methodology is described at the front of the CPT for the practicing anesthesiologist.

(5) -50 Bilateral procedure and - 51 Multiple surgery - There has been some misunderstanding about the use of modifier -50 (bilateral surgery) and -51 (multiple surgery). These modifiers are not interchangeable. They have very different meanings and result in very different payments.

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- (A) **Bilateral Procedure.** This modifier is to be used when there is no specific code in the CPT for a bilateral procedure. List the bilateral procedure on one line followed by modifier -50. The payment will be 150 percent of the base allowable for the procedure so it is no longer necessary to list the procedure twice on a claim when it is bilateral. The units of service are shown as "1".
- (B) **Multiple surgery.** When a surgeon or assistant surgeon performs multiple surgery, modifier -51 is applied to the secondary procedures. The multiple surgery rule provides that the second and subsequent surgeries are paid at a lesser amount. The major procedure is listed without a -51 modifier. This procedure will be whole or full allowable. All other procedures done at the same session are identified by modifier -51. If the secondary procedure(s) require modifier -51 and modifier -51 is not used, the claim will be denied with the message, "756 - must add modifier to CPT/HCPC." Modifier -51 prices the claim at fifty percent of the allowable.
- (6) **-52 Reduced services -** This modifier will be handled like modifier -51. The claim will be paid at 50 percent of the allowable.
- (7) **-54 Surgical care only -** This is applied to the procedure code when the physician performs itinerant surgery or another physician provides the post-operative care. OHCA will pay this at eighty percent of the allowable for the full procedure.
- (8) **-55 Postoperative management only -** When one physician performs the postoperative management and another physician has performed the surgical procedure, the postoperative component is identified by adding the modifier -55 to the usual procedure number. When the surgery is performed by an "itinerant surgeon", and post-operative care is provided by another physician, payment is made for postoperative care under modifier -55 at the rate of 20% of the surgical allowable. When the surgery is cataract surgery performed by an ophthalmologist as an "itinerant surgeon", the postoperative care is paid to the optometrist providing the postoperative care under modifier -55. Payment in this instance will also be made at 20% of the surgical allowable.
- (9) **-56 Preoperative management only -** OHCA will deny payment for this modifier. The physician who provides the preoperative care files under the appropriate medicine codes. A preoperative exam is considered part of the global fee for surgery.
- (10) **-62 Two surgeons -** This modifier is used when two surgeons work as co-surgeons. The code is used when the skills of two surgeons (usually of different specialties) are required in the management of a specific surgical procedure. OHCA will pay this at sixty percent of the allowable for the full procedure. The claims from both surgeons must reflect this modifier.
- (11) **-66 Surgical team -** OHCA will deny payment for this modifier. Each physician must file individually using appropriate modifiers.
- (12) **-75 Concurrent care -** This modifier is used when the patient member requires the services of two or more physicians. All claims for payment of concurrent care are suspended for medical review. This -75 modifier shows that a specialist is seeing the patient in consultation and rendering a special service or procedure in addition to the services of the admitting physician or primary physician.
- (13) **-76 Repeat procedure by same physician -** This is not to be used for bilateral surgery. When the same physician performs the same procedure two or more times on the same day, the claim is billed showing the procedure code and the number of times it was performed on one line unless the code itself signifies that multiple services were provided. This is particularly important for radiologists, as repeat procedures on the same day may otherwise deny as duplicates. However, if a repeat procedure on same day was omitted on the first filing, a claim is filed with modifier -76. If the claim is for professional component, modifier -26 must be entered as the first modifier and -76 as the second modifier. Alternately, the physician files an adjusted claim showing the correct number of procedures.
- (14) **-77 Repeat procedure by another physician -** This is not to be used for bilateral surgery. This modifier is used when appropriate as it identifies that the claim is not a duplicate of another physician's services. This is especially important for radiologists. If the claim is for professional component, modifier -26 is entered as the first modifier and -77 as the second modifier.
- (15) **-78 Return to the operating room for a related procedure during the postoperative period -** A procedure with this modifier suspends for physician review to determine appropriate payment.
- (16) **-79 Unrelated procedure or service by the same physician during the postoperative period -** A procedure with this modifier suspends for physician review to determine appropriate payment.
- (17) **-80 Assistant surgeon:**
- (A) The assistant surgeon identifies his service by the use of modifier -80 or -82 as appropriate. This modifier is applied to each and every surgical procedure code listed on his claim.
- (B) Where there is multiple surgery, the major procedure is followed by -80 and all secondary procedures will have two modifiers: -51, -80. These will follow the procedure code and be on the same line. OHCA will pay modifier -80 at twenty percent of the allowable for the full procedure. All secondary procedures require two modifiers, -51 and -80, and pay ten percent of the allowable for full procedure.
- (18) **-81 Minimum assistant surgeon -** OHCA will deny payment for this modifier.
- (19) **-82 Assistant surgeon (when qualified resident surgeon not available) -** This modifier is used when the claiming physician is the assistant surgeon in a teaching hospital; otherwise, the claim will be denied. OHCA will recognize modifier -82 and pay the modifier at twenty percent of the allowable for the procedure. See modifier -80 for multiple surgery.

(20) -90 Reference (outside) laboratory - OHCA denies payment for this modifier, since the provider performing the procedure must file the claim.

(21) -99 Multiple modifiers - Do not use modifier -99 on the claim. Where two modifiers are required, list the two modifiers on the claim and not the -99 modifier. If modifier -99 is used, OHCA will deny the claim.

(c) **Bilateral surgery.** When a bilateral procedure is performed, the physician lists the procedure only once on a single line and identifies it as bilateral by modifier -50. Additionally, the narrative description identifies it as bilateral so that the procedure code modifier and the description are compatible. This is true even when one physician does one side and another does the other side. In such instances the appropriate modifiers would be -50, -62. Both follow the procedure code and are on the same line.

(1) Modifier -50 has been developed so that CPT manual may eventually eliminate the use of special procedure codes to identify bilateral procedures and to provide for uniform coding of all bilateral procedures. The CPT manual states: "Use of this modifier will eventually eliminate many of the bilateral procedure numbers now listed separately by five digit codes."

(2) However, if the procedure code states bilateral, do not use the -50 modifier as the allowable has already been calculated as a bilateral procedure. It is extremely important that modifier -50 be applied only to bilateral procedures and not to other multiple surgery procedures. OHCA will suspend all modifier -50 claims for medical review to assure proper payment.

(d) **Multiple surgery.** When a surgeon or assistant surgeon performs multiple surgeries, modifier -51 is applied to secondary procedures. The major procedure must not have modifier -51 applied.

(1) When modifier -51 is used OHCA applies the multiple surgery rule. The multiple surgery rule provides that under certain circumstances the second and subsequent surgeries are paid at a lesser amount. OHCA currently pays procedure codes with modifier -51 at 50 percent of the full allowable for the procedure.

(2) One other issue is, given two or more procedures performed on the same person, on the same day, when does the multiple surgery rule apply? It is important to distinguish between multiple surgery and the multiple surgery rule. Multiple surgery refers to more than one surgical procedure done on the same person on the same day. The multiple surgery rule provides that under certain circumstances the second and subsequent surgeries are paid at a lesser amount.

(A) Some surgeries are never paid under the multiple surgery rule. In other words, they are never compensable when done in conjunction with other surgeries; payment is made only for the major procedure. Examples are exploratory laparotomy, lysis of adhesions or appendectomy for staging done in conjunction with other abdominal surgery. These procedures are always incidental to the major procedure.

(B) There are many surgeries which always include lesser surgeries. For example, a TUR always includes a cystoscopy; bronchoscopy always includes laryngoscopy. Payment for vaginal delivery always includes payment for any cervical block, episiotomy or episiotomy repair or pudendal block.

(C) Some surgeries do not contribute significantly to the difficulty of a major surgical procedure. These surgeries are denied because they do not represent any significant additional time or effort. An example is liver biopsy during other abdominal surgery.

(D) Some procedures, although multiple, have single codes which combine the procedures. For example, a skin graft to an area may include obtaining the graft from a different area and an arthrodesis code may specify that it includes obtaining the bone graft.

(E) Bilateral multiple surgery using modifier -50 is usually subject to the multiple surgery rule so that modifier -50, followed by -51 may be necessary for a bilateral secondary procedure. The result will be that an allowable of 150 percent is cut in half, or 75 percent of the basic allowable.

(F) Some multiple surgeries are properly treated as co-surgery under a single procedure code. For instance, a neurosurgeon and orthopedist may work together on a laminectomy with arthrodesis (single procedure code) or a neurosurgeon and ENT surgeon may work together on a transnasal surgery on the pituitary gland. Co-surgery is billed using modifier -62.

(3) There are two special procedure codes which may be used when microdissection is involved:

(A) 64830. Microdissection and/or repair of nerve. This code is listed on the next claim line immediately below the nerve repair and the allowable is 50 percent of the allowable for the repair itself.

(B) 61712. Microdissection, intracranial or spinal procedure. This code is listed on the next claim line immediately below the major procedure and the allowable is 25 percent of the major procedure code allowable.

(e) **Surgical codes not treated as multiple surgery.** There are some surgical procedures which OHCA does not recognize as requiring a multiple surgery modifier. When these procedures are performed in conjunction with another surgical procedure, these procedures will be paid at the full allowable after review.

(f) **Incidental procedures.** Some procedures are rarely compensable when done in conjunction with another surgical procedure. These are procedures which are incidental to the major procedure, such as an incidental appendectomy or a routine intra-abdominal biopsy. These procedures are identified in the CPT manual by the notation "Separate procedure" when they can also be performed as an independent procedure. Following are some of the most common:

(1) Appendectomy with hysterectomy.

(2) Exploratory laparotomy with any abdominal or pelvic surgical procedures.

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- (3) Ovarian cystectomy with hysterectomy or other ovarian surgery such as wedge-resection of ovaries.
 - (4) Diagnostic arthroscopy of the knee with any other arthroscopic surgery of the knee.
 - (5) Diagnostic laryngoscopy with any bronchoscopy procedure.
 - (6) Only one laparoscopic procedure allowed.
 - (7) Umbilica hernia repair when done at the same time as a ventral hernia repair.
- (g) **Assistant surgeons.** If two surgeons claim as co-surgeons rather than as a primary and assistant surgeon, both use modifier -62 (Two Surgeons) on their claims.
- (1) The Authority will not make payment for two assistant surgeons.
 - (2) Federal rules provide that ~~Medicaid~~ SoonerCare must not make payment for an assistant surgeon in a teaching setting when a resident is available to provide the service. An assistant surgeon who claims for services provided in a teaching setting uses modifier -82 to identify that a resident was not available. These claims are subject to audit and review of the records. If a physician claims for assistant surgeon when a qualified resident was available, penalties may be levied.
 - (3) Many procedures do not require an assistant surgeon. OHCA will not pay for an assistant surgeon or co-surgeon when unnecessary.
- (h) **Non-compensable surgery.** Procedures which are cosmetic are not covered for adults. Intradermal introduction of pigments or tattooing is considered cosmetic surgery and non-compensable for adults except when related to breast reconstruction after surgery for breast cancer and considered medically necessary. Intradermal introduction of pigments or tattooing require medical review prior to payment for children.
- (i) **General surgery information.**
- (1) When a D & C is performed in conjunction with abdominal hysterectomy, the full allowable is paid for the hysterectomy and 50% of the allowable is paid for the D & C (51 modifier required).
 - (2) When a D & C is performed in conjunction with a vaginal hysterectomy, only the hysterectomy can be paid.
 - (3) When multiple surgery involves tubal ligation, removal of tubes and ovaries, or other procedures for which specific codes exist, the regular procedure code is to be used. The proper consent form must also accompany these claims. If the multiple surgery on a person member under 21 years of age involves tubal ligation; removal of the tubes and ovaries, or other procedures for which specific codes exist, the sterilization procedure is not compensable. No consent form is necessary since sterilization may not be paid for patient member under 21 years of age. A post-partum tubal ligation (Procedure Code 58605) is paid at one hundred percent of the allowable charge if the member is over 21 years of age and the claim is accompanied by an acceptable consent form.
 - (4) Vasectomy requires sterilization consent form. Considered incidental in conjunction with any urological operative procedure.
 - (5) A cochlear implant device is not covered for ~~persons~~ members between the ages of 21 and 65. Cochlear implant is covered for ~~persons~~ members between the ages of two through 17 who meet all of the guidelines listed below.
 - (A) No contraindications to the implant, including those described in the product's FDA-approved package insert.
 - (B) Diagnosis of bilateral profound sensorineural deafness with little or no benefit from a hearing (or vibrotactile) aid, as demonstrated by the inability to improve on age appropriate closed-set word identification tasks.
 - (C) Freedom from middle ear infection, an accessible cochlear lumen that is structurally suited to implantation, and freedom from lesions in the auditory nerve and acoustic areas of the central nervous system.
 - (D) The device must be used in accordance with the FDA approved labeling.
 - (E) Claims are suspended for medical review to determine if the guidelines are met.
 - (6) All aspects of Electrophysiologic Study of the heart are done at one session (sinus node, A-V node, Bundle of HIS and arrhythmia itself). If more than one area is done at the same session, multiple surgery rules apply.
 - (7) Additional payment is allowed for use of marlex mesh or graft. Use code 99070.
 - (8) Gravlee jet washer - procedure is compensable only when the patient exhibits clinical symptoms suggestive of endometrial disease, such as irregular or heavy bleeding.
 - (9) ~~Payment A separate payment~~ is not made for pre and post operative care billed in conjunction with surgery. This does not apply to those specific surgical procedures where the fee is considered to be for the surgical procedure only or to the initial consultation or evaluation of the problem by the surgeon to determine the need for surgery. ~~Under most circumstances, payment~~ Payment for the immediate pre-operative visit within 24 hours, on the date immediately prior to or on the date of the procedure, either in the hospital, or elsewhere to examine the patient, complete the hospital records and initiate the treatment program, is included in the listed value for the surgery. All surgical procedures are considered to include ~~normal~~ typical, uncomplicated follow-up care unless otherwise indicated. ~~The Combined Procedures Terminology manual identifies most of these procedures with a star.~~
 - (10) Additional payment is not allowed for suprapubic cystotomy performed in conjunction with abdominal bladder or urethral surgery (Marshall-Marchetti). When suprapubic cystotomy is performed in conjunction with genito-urinary surgery from the vaginal approach, it would be allowed as multiple surgery.
 - (11) Balloon valvuloplasty of heart valves other than pulmonic valve, is not covered.
 - (12) In cataract participatory surgery, payment can be made to the Ophthalmologist for cataract surgery and separate payment to the Optometrist for postoperative

care. The surgery by the Ophthalmologist is billed under the appropriate CPT surgical code with modifier 54 and the payment is made at 80% of the surgical allowable. The postoperative care is billed by the Optometrist under the same CPT surgical code with modifier 55 and the payment is made at 20% of the surgical allowable. Cataract participatory surgery is appropriate for surgical procedure codes 66830 through 66986. The Ophthalmologist shows the name of the Optometrist providing postoperative care on the claim in the block requiring the referring physician's name. If this required information is not on the claim, the claim is denied.

(13) Reduction mammoplasty is covered only when the procedure has been determined medically necessary. ~~Prior approval by the Medical Concurrent Review team; prior authorization is required and prior authorization (PA) must be issued by OHCA. The procedure must be performed within the client's Medicaid certification period. The processes and required documentation for prior approval of reduction mammoplasty are provided in subparagraphs (A) and (B) of this paragraph.~~

(A) ~~Logarithm of body surface area will be applied.~~

(B) ~~If the data plots above the 22nd percentile, the procedure is considered medically necessary. If the data plots between the 5th and 22nd percentiles, medical necessity would be questioned and referred to the Agency's Medical Director for review. If below the 5th percentile, the procedure is considered cosmetic and not eligible for coverage.~~

~~(i) Prior approval is determined based on documentation provided.~~

~~(ii) Office progress notes from referring physician with detailed symptomatology must be submitted and includes:~~

~~(I) Office progress notes covering one year from current date;~~

~~(II) Chronic back and/or neck pain;~~

~~(III) Breast pain;~~

~~(IV) Intertrigo;~~

~~(V) Documented weight loss program if applicable.~~

~~(iii) Office progress notes and evaluation from surgeon must be submitted and includes:~~

~~(I) Patient's height and weight;~~

~~(II) Front and side view photographs;~~

~~(III) Projected number of grams of breast tissue to be removed;~~

~~(IV) Diagnosis; and~~

~~(V) CPT Code.~~

[OAR Docket #07-324; filed 2-22-07]

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

[OAR Docket #07-321]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 5. Individual Providers and Specialties

Part 9. Long Term Care Facilities

317:30-5-134. [AMENDED]

(Reference APA WF # 06-46)

AUTHORITY:

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; House Bill 1071XX (Appropriations Bill) of the 50th Oklahoma State Legislature.

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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 nurse aide training expenses to be paid as an administrative claim rather than being included in the nursing facility per diem rate. Federal law indicates that nursing costs for training and competency evaluation of its nurse aides must be identified separately from other nursing facility costs incurred in furnishing services to Medicaid members. This revision allows OHCA to remain in compliance with federal law and obtain federal matching funds.

ANALYSIS:

Long term care facility rules are revised to allow OHCA to make payments to nursing facilities for nurse aide training as an administrative claim instead of including the cost of nurse aide training in the nursing facility rate. Current rules indicate that this payment will only be made in the daily per diem rate. This process allows OHCA to comply with all State and Federal regulations to obtain federal matching funds for nurse aide training.

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED UPON APPROVAL BY THE GOVERNOR AS SET FORTH IN 75 O.S., SECTION 253(D), AND EFFECTIVE UPON APPROVAL BY GOVERNOR OR FEBRUARY 1, 2007, WHICHEVER IS LATER:

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 9. LONG TERM CARE FACILITIES

Emergency Adoptions

317:30-5-134. Nurse Aide Training Reimbursement

(a) Nurse Aide training programs and competency evaluation programs occur in two settings, a nursing facility setting and private training courses. Private training includes, but is not limited to, certified training offered at vocational technical institutions. This rule outlines payment for training in either setting.

~~(b) In the case of nurse aides trained and tested in a Medicaid contracted nursing facility training program, payment is made by the Oklahoma Health Care Authority in the daily per diem rate paid the nursing facility.~~ In the case a nursing facility provides training and competency evaluation in a program that is not properly certified under federal law, the Oklahoma Health Care Authority may offset the nursing facility's payment for monies paid to the facility for these programs. Such action shall occur after notification to the facility of the period of non-certification and the amount of the payment by the Oklahoma Health Care Authority.

(c) In the case of nurse aide training provided in private training courses, reimbursement is made to nurse aides who have paid a reasonable fee for training in a certified training program at the time training was received. The federal regulations prescribe applicable rules regarding certification of the program and certification occurs as a result of certification by the State Survey Agency. For nurse aides to receive reimbursement for private training courses, all of the following requirements must be met:

- (1) the training and competency evaluation program must be certified at the time the training occurred;
- (2) the nurse aide has paid for training;
- (3) a reasonable fee was paid for training (however, reimbursement will not exceed the maximum amount set by the Oklahoma Health Care Authority);
- (4) the Oklahoma Health Care Authority is billed by the nurse aide receiving the training within 12 months of the completion of the training;
- (5) the nurse aide has passed her or his competency evaluation; and
- (6) the nurse aide is employed at a ~~Medicaid~~ SoonerCare contracted nursing facility as a nurse aide during all or part of the year after completion of the training and competency evaluation.

(d) If all the conditions in subsection (c) are met, then the Authority will compensate the nurse aide based upon the following pro-rata formula:

- (1) For every month employed in a nursing facility, OHCA will pay 1/12 of the sum of eligible expenses incurred by the nurse aide. The term "every month" is defined as a period of 16 days or more within one month.
- (2) The maximum amount paid by the Oklahoma Health Care Authority may be set by the Rates and Standards Committee. The rate paid by the nurse aide, up to the maximum set by the Oklahoma Health Care Authority, will be paid in the event a nurse aide was employed all 12 months after completion of the training program.

(e) The claimant must submit a completed Nurse Aide Training Reimbursement Program Form and ~~FIN-12~~ ADM-12 claim voucher. Documentation of eligible expenses must also

be provided. Eligible expenses include course training fees, textbooks and exam fees.

(f) No nurse aide trained in a nursing facility program that has an offer of employment or is employed by the nursing facility in any capacity at the inception of the training program may be charged for the costs associated with the nurse aide training or competency evaluation program.

(g) The SoonerCare share of Nurse Aide training and testing costs incurred by a nursing facility will be reimbursed in the following manner:

(1) Annually, the facilities will complete and file a "Nurse Aide Training and Testing Costs" report as prescribed by the OHCA. These reports will be due by October 31 of the year and cover the preceding State Fiscal Year (July 1 to June 30).

(2) From the "Nurse Aide Training and Testing Costs" reports the OHCA will determine a cost per day for each facility for the upcoming rate period (State Fiscal Year). New facilities will be paid at the statewide average rate until their first report establishes a specific rate. Facilities that do not file or are late in filing will be paid at 90% of their previously established rate or at the 40th percentile of the established rate, whichever is less.

(3) Each month the OHCA will pay each facility based on the prior months' actual SoonerCare paid days regardless of service date.

[OAR Docket #07-321; filed 2-22-07]

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

[OAR Docket #07-319]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 5. Individual Providers and Specialties
Part 12. The Oklahoma Prescription Drug Discount Program [NEW]
317:30-5-180. through 317:30-5-180.5. [NEW]

(Reference APA WF # 06-41)

AUTHORITY:

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Title 59 O.S., Section 353.5 et seq

DATES:

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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 comply with Title 59, O.S., Section 353.5. Revisions will extend access to prescription drugs for low income Oklahomans through the Oklahoma Prescription Drug Discount Program (OPDDP). Oklahomans needing prescription drugs for which they have no coverage will be able to obtain prescription drugs at a discount or in some cases free of charge, in order to prevent or treat illness.

ANALYSIS:

Agency rules are issued to establish the Oklahoma Prescription Discount Drug Program under Title 59, O.S., Section 353.5, which enables Oklahomans needing medicines for which they have no coverage, to purchase prescription drugs at the lowest possible out-of-pocket cost through the OPDDP's pharmacy network. The agency has contracted with a provider to administer the program by: (1) establishing agreements with prescription drug manufacturers; (2) providing the means testing for their programs; (3) negotiating prescription drug discounts with manufacturers; (4) assisting program members in accessing appropriate manufacturer-sponsored prescription drugs; (4) utilizing Medicaid reimbursement for pharmacy networks; and (5) implementing a "one-stop" Oklahoma Prescription Drug Discount Program for uninsured Oklahomans and their families.

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED UPON APPROVAL BY THE GOVERNOR AS SET FORTH IN 75 O.S., SECTION 253(D), AND EFFECTIVE UPON APPROVAL BY GOVERNOR OR FEBRUARY 1, 2007, WHICHEVER IS LATER:

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 12. THE OKLAHOMA PRESCRIPTION DRUG DISCOUNT PROGRAM

317:30-5-180. Purpose and general provisions

The purpose of this Part is to establish guidelines for the Oklahoma Prescription Drug Discount Program (OPDDP) under Title 59, O.S., Section 353.5 et seq. The Oklahoma Prescription Drug Discount Program (OPDDP) enables Oklahomans without prescription drug coverage to purchase prescription drugs at the lowest possible out-of-pocket cost through the OPDDP's pharmacy network. The Oklahoma Health Care Authority (OHCA) contracts with a Pharmacy Benefit Manager (PBM) to administer the program. The OPDDP does not purchase drugs.

317:30-5-180.1. Definitions

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

"Enrollment Fee" means the amount charged per individual to enroll in the OPDDP.

"Network" means a group of individual retail pharmacies that contract with the designated Pharmacy Benefit Manager

to participate in the OPDDP and honor the discount offered through this program.

"Patient Assistance Programs (PAP)" means a program that some pharmaceutical companies use to offer medication assistance to low-income individuals and families. These programs typically require a doctor's consent and proof of financial status. They may also require the individual applying for their program either have no health insurance, or no prescription drug benefit through their health insurance. Each pharmaceutical company has specific eligibility requirements and application information. Neither OHCA nor the contracted PBM have any authority or responsibility for the structure of these private programs.

"Pharmacy Benefit Manager (PBM)" means the company contracted by OHCA to manage pharmacy networks, formularies, drug utilization reviews, pharmacotherapeutic outcomes, claims and/or other features of a pharmacy benefit.

"Prescription Drug" means a drug which can be dispensed only upon prescription by a health care professional authorized by his or her licensing authority and which is approved for safety and effectiveness as a prescription drug under Section 505 or 507 of the Federal Food, Drug and Cosmetic Act (52 Stat. 1040 (1938), 21 U.S.C.A., Section 301).

"Prescription Drug Coverage" means a payment or discount applied toward prescription drugs purchased by or for a consumer as part of a health insurance benefit.

317:30-5-180.2. Eligibility

In order to be eligible for the OPDDP, an individual must:

- (1) be an Oklahoma resident;
- (2) apply with the Pharmacy Benefit Manager (PBM);
- (3) not have insurance to cover all or part of prescriptions;
- (4) pay an enrollment fee when income is above 150% Federal Poverty Level (FPL); and
- (5) provide verification of income to determine enrollment fee, co-pay, and eligibility for the manufacturer's PAP.

317:30-5-180.3. Services

(a) Services provided through the OPDDP include a discount negotiated by the PBM for prescription drugs. The member purchases these discounted drugs with their OPDDP drug card at a Network pharmacy.

(b) The Patient Assistance Program (PAP) Application Assistance service provides a point of contact and applications to assist qualified members in applying for free or substantially reduced prices on prescription drugs through the manufacturer's Patient Assistance Programs.

317:30-5-180.4. Fraud

Applicants should be advised that the knowing misrepresentation of income or other information constitutes fraud and could lead to prosecution and recoupment of funds expended on their behalf.

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317:30-5-180.5. Pharmacy Benefit Manager

(a) The Oklahoma Health Care Authority (OHCA) will designate a PBM utilizing a competitive bidding process under state law.

(b) The designated PBM administers the OPDDP subject to administrative rules regulating the program and contract requirements placed upon the PBM.

(c) Per state law, all discounts must be passed through 100% to the member. No portion of any negotiated discount, rebate, or any other discount may be retained by the PBM to fund the OPDDP or for any other use.

[OAR Docket #07-319; filed 2-22-07]

PURSUANT TO ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED UPON APPROVAL BY GOVERNOR AS SET FORTH IN 75 O.S., § 253(D), AND EFFECTIVE UPON APPROVAL BY GOVERNOR OR FEBRUARY 1, 2007, WHICHEVER IS LATER:

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 108. NUTRITION SERVICES

317:30-5-1076. Coverage by category

Payment is made for Nutritional Services as set forth in this section.

(1) **Adults.** Payment is made for ~~two~~ six hours of medically necessary nutritional counseling per year by a licensed registered dietician. All services must be prescribed by a physician, physician assistant, nurse practitioner or nurse midwife and be face to face encounters between the a licensed registered dietitian and the client member. Services must be expressly for diagnosing, treating or preventing, or minimizing the effects of illness. ~~Nutritional services for the treatment of obesity is not covered unless there is documentation that the obesity is a contributing factor in another illness.~~

(2) **Children.** Coverage for children is the same as adults.

(3) **Home and Community Based Waiver Services for the Mentally Retarded.** All providers participating in the Home and Community Based Waiver Services for the Mentally Retarded program must have a separate contract with OHCA to provide Nutrition Services under this program. All services are specified in the individual's plan of care.

(4) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services. Services which are not covered under Medicare should be billed directly to ~~the Medicaid Agency~~ OHCA.

[OAR Docket #07-336; filed 2-23-07]

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

[OAR Docket #07-336]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 5. Individual Providers and Specialties

Part 108. Nutrition Services

317:30-5-1076. [AMENDED] (Reference APA WF # 06-54)

AUTHORITY:

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; House Bill 2842 of the 2nd Session of the 50th Oklahoma Legislature

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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 option of providing additional nutrition counseling services for individuals in an effort to improve the quality of the member's health as well as their care and reduce the cost of future care.

ANALYSIS:

Nutrition Services rules are revised to increase the maximum hours of medically necessary nutritional counseling by a licensed registered dietician to six hours per year. Current rules provide up to two hours of nutritional counseling to individuals needing the services expressly for diagnosing, treating, preventing, or minimizing the effects of illness. However, in some circumstances such as diabetes, hyperlipidemia, atherosclerotic vascular disease, or obesity, two hours of nutritional counseling may not provide a sufficient amount of counseling and follow-up. Increasing the maximum number of hours to six hours will allow more adequate dietary follow-up that is vital to treatment.

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

[OAR Docket #07-320]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 5. Individual Providers and Specialties

Part 6. Inpatient Psychiatric Hospitals

317:30-5-96.2. [AMENDED] (Reference APA WF # 06-35)

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 that will require inpatient psychiatric treatment centers to provide transportation for a patient's family members to attend required family therapy at the facility. The Oklahoma Medicaid State Plan states that the per diem rate for freestanding and hospital based facilities includes all non-physician services. The intent of this language is that the facility is responsible for all services except physician services, which are separately billable. The Department of Health and Human Services (DHHS), Office of Inspector General (OIG), has conducted audits that conclude clinic, pharmacy, case management, laboratory, dental, outpatient hospital and transportation should not be billed separately. Rule revisions are required to maintain compliance with Federal Law to obtain Federal Financial Participation (FFP).

ANALYSIS:

Rules are revised to reflect transportation of family members to participate in family counseling with SoonerCare member who resides in a psychiatric residential treatment center is the responsibility of the facility. Family therapy is a face-to-face interaction between a therapist and the patient/family to facilitate emotional, psychological or behavioral changes and promote communication and understanding. Family therapy must be provided for the benefit of a SoonerCare eligible child as a specifically identified component of an individual treatment plan. OHCA recently increased the per diem rate to facilities to cover this expense. Currently policy states that the facility is responsible for transportation but until recently, SoonerRide has been providing the transportation for family members. Rules are revised to specifically state that the facility has to provide transportation for the member's necessary patient care and the member's family to attend family therapy sessions at the facility.

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED UPON APPROVAL BY THE GOVERNOR AS SET FORTH IN 75 O.S., SECTION 253(D), AND EFFECTIVE UPON APPROVAL BY GOVERNOR OR FEBRUARY 1, 2007, WHICHEVER IS LATER:

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 6. INPATIENT PSYCHIATRIC HOSPITALS

317:30-5-96.2. Payments definitions

The following words and terms, when used in Sections OAC 317:30-5-96.3 through 317:30-5-96.7, shall have the following meaning, unless the context clearly indicates otherwise:

"Allowable costs" means costs necessary for the efficient delivery of patient care.

"Ancillary Services" means the services for which charges are customarily made in addition to routine services. Ancillary services include, but are not limited to, physical therapy, speech therapy, laboratory, radiology and prescription drugs.

"Border Status" means a placement in a state that does not border Oklahoma but agrees to the same terms and conditions of instate or border facilities.

"Community-Based extended" means a PRTF that provides an extended environment for individuals who have completed a more intense treatment program and are preparing for full transition into the community, but who are not yet ready for independent living due to unresolved clinical issues, or unmet needs for personal, social, or vocational skills, that is furnished in a large campus residential setting.

"Community-Based, transitional" means a PRTF that furnishes structured, therapeutic treatment services in the context of a family-like, small multiple resident home environments of 16 beds or less.

"Developmentally disabled child" means a child with deficits in adaptive behavior originating during the developmental period. This condition may exist concurrently with a significantly sub-average general intellectual functioning.

"Eating Disorders Programs" means acute or intensive residential behavioral, psychiatric and medical services provided in a discreet unit to individuals experiencing an eating disorder.

"Free-standing" means an entity that is not integrated with any other entity as a main provider, a department of a provider, remote location of a hospital, satellite facility, or a provider-based entity.

"Professional services" means services of a physician, psychologist or dentist legally authorized to practice medicine and/or surgery by the state in which the function is performed.

"Provider-Based PRTF" means a PRTF that is part of a larger general medical surgical main hospital, and the PRTF is treated as "provider based" under 42 CFR 413.65 and operates under the same license as the main hospital.

"Public" means a hospital or PRTF owned or operated by the state.

"Routine Services" means services that are considered routine in the freestanding PRTF setting. Routine services include, but are not limited to:

- (A) room and board;
- (B) treatment program components;
- (C) psychiatric treatment;
- (D) professional consultation;
- (E) medical management;
- (F) crisis intervention;
- (G) transportation;
- (H) rehabilitative services;
- (I) case management;

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- (J) interpreter services (if applicable);
- (K) routine health care for individuals in good physical health; and
- (L) laboratory services for a substance abuse/detoxification program.

"Specialty treatment program/specialty unit" means acute or intensive residential behavioral, psychiatric and medical services that provide care to a population with a special need or issues such as developmentally disabled, mentally retarded, autistic/Asperger's, eating disorders, sexual offenders, or reactive attachment disorders. These patients require a higher level of care and staffing ratio than a standard PRTF and typically have multiple problems.

"Sub-Acute Services" means a planned regimen of 24-hour professionally directed evaluation, care, and treatment for individuals. Care is delivered by an interdisciplinary team to individuals whose sub-acute neurological and emotional/behavioral problems are sufficiently severe to require 24-hour care. However, the full resources of an acute care general hospital or medically managed inpatient treatment is not necessary. An example of subacute care is services to children with pervasive developmental disabilities including autism, hearing impaired and dually diagnosed individuals with mental retardation and behavioral problems.

"Transportation" means the service, provided by the PRTF, of transporting a member for necessary patient care and furnishing transportation for the member's family to attend required family therapy at the facility.

"Treatment Program Components" means therapies, activities of daily living and rehabilitative services furnished by physician/psychologist or other licensed mental health professionals.

"Usual and customary charges" refers to the uniform charges listed in a provider's established charge schedule which is in effect and applied consistently to most patients and recognized for program reimbursement. To be considered "customary" for Medicaid reimbursement, a provider's charges for like services must be imposed on most patients regardless of the type of patient treated or the party responsible for payment of such services.

[OAR Docket #07-320; filed 2-22-07]

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

[OAR Docket #07-322]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 5. Eligibility and Countable Income
Part 5. Countable Income and Resources
317:35-5-41. [AMENDED]
(Reference APA WF # 06-47)

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 that will allow an individual with a monthly income which does not exceed \$3,000 who meets all eligibility conditions of long-term care to qualify for Long Term Care. For example, these persons include former long-term care SoonerCare members who became financially ineligible due to an across the board increase in Social Security benefits; however, their incomes are insufficient to pay for even the basic nursing home monthly rate.

ANALYSIS:

Resource eligibility rules for individuals related to aged, blind and disabled are revised to increase the maximum monthly income for a Medicaid Income Pension Trust, also known as a Miller Trust, from \$2,500 to \$3,000. A Medicaid Income Pension Trust is a trust account established for individuals in need of long-term care who have countable income above the categorically needy standard for long-term care but the income is insufficient to meet the cost of long-term care. The Trust consists of all of the individual's monthly income. A monthly income that is equal to the categorically needy standard for long-term care is disbursed from the trust to the individual thus qualifying the individual for Long Term Care. The State receives all amounts remaining in the trust upon the death of the individual up to an amount equal to the total benefits paid on behalf of the individual subsequent to the date of the establishment of the trust. The Medicaid Income Pension Trust rules were originally established in 1992 with a maximum monthly income amount for the Trust set at \$2,000. In 1998, the monthly maximum income was increased to \$2,500. This current maximum no longer meets the rising costs of minimum nursing home care nor the other necessary expenses such as prescribed medications, Medicare and health insurance premiums, and other personal need items. Therefore, rules are needed to increase the monthly income maximum for a Medicaid Income Pension Trust from \$2,500 to \$3,000.

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED UPON APPROVAL BY THE GOVERNOR AS SET FORTH IN 75 O.S., SECTION 253(D), AND EFFECTIVE UPON APPROVAL BY GOVERNOR OR FEBRUARY 1, 2007, WHICHEVER IS LATER:

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME

PART 5. COUNTABLE INCOME AND RESOURCES

317:35-5-41. Determination of capital resources for individuals categorically related to aged, blind and disabled

(a) **General.** The term capital resources is a general term representing any form of real and/or personal property which has an available money value. All available capital resources, except those required to be disregarded by law or by policies of the OHCA or OKDHS are considered in determining need. Available resources are those resources which are in hand or under the control of the individual.

(1) In defining need, OHCA and OKDHS recognize the importance of a recipient member retaining a small reserve for emergencies or special need and has established a maximum reserve a client member or family may hold and be considered in need.

(2) Capital resources are evaluated on a monthly basis in determining eligibility for an applicant for medical services. An applicant is determined ineligible for any month resources exceed the resource standard at any time during that month. When a recipient member has resources which exceed the resource standard, case closure action is taken for the next possible effective date.

(3) State law is specific on the mutual responsibility of spouses for each other. Therefore, if husband and wife are living together, a capital resource and/or income available to one spouse constitutes a resource and/or income to the other. When there is a break in the family relationship and the husband and wife are separated, but not divorced or legally separated, they constitute a possible resource to each other and this possible resource is explored to determine what, if any, resource can be made available. When spouse is in a nursing facility, see Subchapter 9 and 19 of this Chapter.

(4) Only the resources of the child determined eligible for TEFRA are considered in determining eligibility.

(5) Household equipment used for daily living is not considered a resource.

(6) Each time that need is determined, gross income and the equity of each capital resource are established. Equity equals current market value minus indebtedness. The recipient member may change the form of capital resources from time to time without affecting eligibility so long as the equity is not decreased in doing so or increased in excess of the allowable maximum reserve. In the event the equity is decreased as the result of a sale or transfer, the reduction in the equity is evaluated in relation to policy applicable to resources disposed of while receiving assistance.

(b) **Eligibility.** In determining eligibility based on resources, only those resources available for current use or those which the client member can convert for current use (no legal impediment involved) are considered as countable resources. Examples of legal impediments include, but are not limited to, clearing an estate, probate, petition to sell or appointment of legal guardian.

(1) Generally, a resource is considered unavailable if there is a legal impediment to overcome. However, the client member must agree to pursue all reasonable steps to

initiate legal action within 30 days. While the legal action is in process, the resource is considered unavailable.

(2) If a determination is made and documented that the cost of making a resource available exceeds the gain, the client member will not be required to pursue action to make it available.

(3) Determination of available and unavailable resources must be well documented in the case record.

(4) The major types of capital resources are listed in (c) and (d) of this Section. The list is not intended to be all inclusive and consideration must be given to all resources.

(c) **Home/real property.** Home property is excluded from resources regardless of value. For purposes of the home property resource exclusion, a home is defined as any shelter in which the individual has an ownership interest and which is used by the individual as his/her principal place of residence. The home may be either real or personal property, fixed or mobile. Home property includes all property which is adjacent to the home. Home property in a revocable trust under the direct control of the individual, spouse, or legal representative retains the exemption as outlined in OAC 317:35-5-41(c)(6). Property has a value regardless of whether there is an actual offer to purchase. Verification of home/real property value is established by collateral contacts with specialized individuals knowledgeable in the type and location of property being considered.

(1) The home may be retained without affecting eligibility during periods when it is necessary to be absent for illness or other necessity. The OHCA has not set a definite time limit to the client's member's absence from the home. When it is determined that the client member does not have a feasible plan for and cannot be expected to return to his/her home, the market value of the property is considered in relation to the reserve. The client member is responsible for taking all steps necessary to convert the resource for use in meeting current needs. If the client member is making an effort to make the resource available, a reasonable period of time is given (not to exceed 90 days) to convert the resource. He/she is advised in writing that the 90-day period begins with the determination that the property be considered in relation to the reserve. The 90-day period is given only if efforts are in progress to make the resource available. Any extension beyond the initial 90-day period is justified only after interviewing the client member, determining that a good faith effort to sell is still being made and failure to sell is due to circumstances beyond the control of the client member. A written notification is also provided to the client member at any time an extension is allowed. Detailed documentation in the case record is required.

(2) If the client member fails or is unwilling to take steps necessary to convert the resource for use in meeting current needs, continuing eligibility cannot be established and the client member is advised as to the effective date of closure and of the right to receive assistance when the resources are within the maximum reserve provided other conditions of eligibility continue to be met.

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(3) When a recipient member sells his/her home with the intention of purchasing another home or when an insurance payment for damage to the home is received, a reasonable period of time is given to reinvest the money in another home. A reasonable period of time is considered to be not in excess of a 90-day period. Extensions beyond the 90 days may be justified only after interviewing the client member, determining that a good faith effort is still being made and that completion of the transaction is beyond his/her control. This must be documented in the case record.

(4) At the point a recipient member decides not to reinvest the proceeds from the sale of his/her home in another home, the recipient's member's plan for use of the proceeds is evaluated in relation to rules on resources disposed of while receiving assistance.

(5) A home traded for another home of equal value does not affect the recipient's-member's eligibility status. If the home is traded for a home of lesser value, the difference may be invested in improvement of the new home.

(6) Absences from home for up to 90 days for trips or visits of six months for medical care (other than nursing facilities) do not affect receipt of assistance or the home exclusion as long as the individual intends to return home. Such absences, if they extend beyond those limits, may indicate the home no longer serves as the principal place of residence. Absence from home due to nursing facility care does not affect the home exclusion as long as the individual intends to return home within 12 months from the time he/she entered the facility. The Acknowledgment of Temporary Absence/Home Property Policy form is completed at the time of application for nursing facility care when the applicant has home property. After explanation of temporary absence, the client member, guardian or responsible person indicates whether there is or is not intent to return to the home and signs the form.

(A) If at the time of application the applicant states he/she does not have plans to return to the home, the home property is considered a countable resource. For recipients members in nursing facilities, a lien may be filed in accordance with OAC 317:35-9-15 and OAC 317:35-19-4 on any real property owned by the recipient member when it has been determined, after notice and opportunity for a hearing, that the recipient member cannot reasonably be expected to be discharged and return home. However, a lien shall not be filed on the home property of the recipient member while any of the persons described in OAC 317:35-9-15(b)(1) and OAC 317:35-19-4(b)(1) are lawfully residing in the home:

(B) If the individual intends to return home, he/she is advised that:

- (i) the 12 months of home exemption begins effective with the date of entry into the nursing home regardless of when application is made for Medicaid SoonerCare benefits, and
- (ii) after 12 months of nursing care, it is assumed there is no reasonable expectation the

recipient member will be discharged from the facility and return home and a lien may be filed against real property owned by the client member for the cost of medical services received.

(C) "Intent" in regard to absence from the home is defined as a clear statement of plans in addition to other evidence and/or corroborative statements of others.

(D) At the end of the 12-month period the home property becomes a countable resource unless medical evidence is provided to support the feasibility of the client member to return to the home within a reasonable period of time (90 days). This 90-day period is allowed only if sufficient medical evidence is presented with an actual date for return to the home.

(E) A client member who leaves the nursing facility must remain in the home at least three months for the home exemption to apply if he/she has to re-enter the facility.

(F) However, if the spouse, minor child(ren) under 18, or relative who is aged, blind or disabled or a recipient of TANF resides in the home during the individual's absence, the home continues to be exempt as a resource so long as the spouse or relative lives there (regardless of whether the absence is temporary).

(G) For purpose of this reference a relative is defined as: son, daughter, grandson, granddaughter, stepson, stepdaughter, in-laws, mother, father, stepmother, stepfather, ~~half-sister~~ half-sister, ~~half-brother~~ half-brother, niece, nephew, grandmother, grandfather, aunt, uncle, sister, brother, stepbrother, or stepsister.

(H) Once a lien has been filed against the property of an NF resident, the property is no longer considered as a countable resource.

(7) Mineral rights associated with the home property are considered along with the surface rights and are excluded as a resource. However, mineral rights which are not associated with the home property are considered as a resource. Since evaluation and scalability of mineral rights fluctuate, the establishment of the value of mineral rights are established based on the opinion of collateral sources. Actual offers of purchase are used when established as a legitimate offer through a collateral source. Mineral rights not associated with home property which are income producing are considered in the same way as income producing property.

(8) The market value of real estate other than home property owned by the client member or legal dependent and encumbrances against such property are ascertained in determining the equity (including the cost to the client member of a merchantable title to be determined when the reserve approaches the maximum). The market value of real estate other than the home owned by the applicant is established on the basis of oral and/or written information which the applicant has on hand **and** counsel with persons who have specialized knowledge about this kind of

resource. Refer to (12) of this subsection for exclusion of real estate that produces income.

(9) Land which is held by an enrolled member of an Indian tribe is excluded from resources as it cannot be sold or transferred without the permission of other individuals, the tribe, or a federal agency. If permission is needed, the land is excluded as a resource.

(10) A life estate conveys upon an individual or individuals for his/her lifetime, certain rights in property. Its duration is measured by the lifetime of the tenant or of another person; or by the occurrence of some specific event, such as remarriage of the tenant. The owner of a life estate has the right of possession, the right to use the property, the right to obtain profits from the property and the right to sell his/her life estate interest. However, the contract establishing the life estate may restrain one or more rights of the individual. The individual does not have title to all interest in the property and does not have the right to sell the property other than the interest owned during his/her lifetime. He/she may not usually pass it on to heirs in the form of an inheritance.

(A) When a life estate in property is not used as the client's member's home, it is necessary to establish the value. A computer procedure is available to compute the value of a life estate by input of the current market value of the property and the age of the life estate owner.

(B) The value of a life estate on mortgaged property is based on equity rather than market value and the age of the individual.

(C) In the event the client member does not accept as valid the value of the life estate as established through this method, the client member will secure written appraisal by two persons who are familiar with current values. If there is substantial unexplained divergence between these appraisals, the worker and the client member will jointly arrange for the market value to be established by an appraisal made by a third person who is familiar with current market values and who is acceptable to both the client member and the worker.

(11) Homestead rights held by a client member in real estate provide the client member with shelter (or shelter and income) so long as he/she resides on the property. Payment for care in a nursing facility provided to the recipient member through Medicaid-SoonerCare constitutes a waiver of the homestead rights of the recipient member. If the client member moves from the property, a lien is filed, or the client member otherwise abandons his/her homestead rights, the property becomes subject to administration. Since a homestead right cannot be sold, it does not have any value.

(12) Real and/or personal property which produces income is excluded if it meets the following conditions.

(A) **Trade or business property.** The existence of a trade or business may be established through business tax returns that would be used to compute self-employment earnings. If the current business

tax return is unavailable, the existence of the business may be determined through other business forms, records, partnership, a detailed description of the business and its activities, etc. Once it is established that a trade or business exists, any property (real or personal) connected to it and in current use is excluded. This exclusion includes liquid assets, such as a bank account(s) necessary for the business operation. All property used by a trade or business and all property used by an employee in connection with employment is excluded as property essential to self support. The income from the trade or business is determined as any other self-employment income.

(B) **Non-trade or non-business property.** Property which produces income but is not used in a trade or business is excluded if the total equity value does not exceed \$6000, and the net return equals at least 6% of the equity annually. An equity value in excess of \$6000 is a countable resource. If the equity exceeds \$6000 and 6% return is received on the total equity, only the amount in excess of \$6000 is a countable resource. An annual return of less than 6% is acceptable if it is beyond the individual's control, and there is a reasonable expectation of a future 6% return. Liquid resources cannot be excluded as income producing property or meeting the \$6000/6% rule (mortgages, including contract for deed, and notes which are income producing are considered as liquid resources). The \$6000/6% rule applies to all resources in total, and not separately. Examples of non-business income producing property are rental property, timber rights, mineral rights, etc.

(d) **Personal property.**

(1) **Property used to produce goods and services.** Personal property necessary to perform daily activities or to produce goods for home consumption is excluded if the equity value does not exceed \$6000. An equity value in excess of \$6000 is a countable resource. The property does not have to produce a 6% annual return. The \$6000 equity maximum includes all such resources in total and does not pertain to each item separately. Examples of property used to produce goods and services are tractors, wildcatting tools, mechanized equipment for gardening, livestock grown for home consumption, etc.

(2) **Cash savings and bank accounts.** Money on hand or in a savings account is considered as reserve. The client's member's statement that he/she does not have any money on hand or on deposit is sufficient unless there are indications to the contrary. When there is information to the contrary or when the client member does not have records to verify the amount on deposit, verification is obtained from bank records. Title 56, O.S., Section 1671 provides that financial records obtained for the purpose of establishing eligibility for assistance or services must be furnished without cost to the client member or the Agency.

(A) Checking accounts may or may not represent savings. Current bank statements are evaluated with the client member to establish what, if any, portion of

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the account represents savings. Any income which has been deposited during the current month is not considered unless it exceeds what is considered as ordinary maintenance expense for the month.

(B) Accounts which are owned jointly by the ~~client member~~ and a ~~non-recipient~~—person not receiving SoonerCare are considered available to the ~~client member~~ in their entirety unless it can be established what part of the account actually belongs to each of the owners and the money is actually separated and the joint account dissolved. When the ~~recipient member~~ is in a nursing facility and the spouse is in the home or if both are institutionalized, a joint bank account may be maintained with one-half of the account considered available to each.

(3) **Life insurance policies.** If the total face value of all life insurance policies owned by an individual is \$1500 or less, the policies (both face value and cash surrender value) are excluded as resources.

(A) If the total face value of all policies owned by an individual exceeds \$1500, the net cash surrender value of such policies must be counted as resources. Life insurance policies which do not provide a cash surrender value (e.g., term insurance) are not used in determining whether the total face value of all policies is over \$1,500.

(B) The face value of a life insurance policy which has been assigned to fund a prepaid burial contract must be evaluated and counted according to the policy on burial funds or, if applicable, the policy on the irrevocable burial contract.

(C) The net cash surrender value of insurance (i.e., cash surrender value less any loans or unpaid interest thereon) usually can be verified by inspection of the insurance policies and documents in the ~~client's member's~~ possession or by use of the Request to Insurance Company form.

(D) Dividends which accrue and which remain with the insurance company increase the amount of reserve. Dividends which are paid to the ~~client member~~ are considered as income.

(E) If an individual has a life insurance policy which allows death benefits to be received while living, and the individual meets the insurance company's requirements for receiving such proceeds, the individual is not required to file for such proceeds. However, if the individual does file for and receive the benefits, the payment will be considered as income in the month it is received and countable as a resource in the following months to the extent it is available. The payment of such benefits is not considered a conversion of a resource because the cash surrender value of the insurance policy is still available to the individual. The individual is in effect, receiving the death benefits and not the cash surrender value.

(4) **Burial spaces.** The value of burial spaces for an individual, the individual's spouse or any member of the

individual's immediate family will be excluded from resources. "Burial spaces" means conventional grave sites, crypts, mausoleums, urns, and other repositories which are customarily and traditionally used for the remains of deceased persons. "Immediate family" means individual's minor and adult children, including adopted children and step-children; and individual's brothers, sisters, parents, adoptive parents, and the spouse of these individuals. Neither dependency nor living in the same household will be a factor in determining whether a person is an immediate family member.

(5) **Burial funds.** Revocable burial funds not in excess of \$1500 are excluded as a resource if the funds are specifically set aside for the burial arrangements of the individual or the individual's spouse. Any amount in excess of \$1500 is considered as a resource. Burial policies which require premium payments and do not accumulate cash value are not considered to be prepaid burial policies.

(A) "Burial funds" means a prepaid funeral contract or burial trust with a funeral home or burial association which is for the individual's or spouse's burial expenses.

(B) The face value of a life insurance policy, when properly assigned by the owner to a funeral home or burial association, may be used for purchasing "burial funds" as described in (5)(A) of this subsection.

(C) The burial fund exclusion must be reduced by the face value of life insurance policies owned by the individual or spouse; and amounts in an irrevocable trust or other irrevocable arrangement.

(D) Interest earned or appreciation on the value of any excluded burial funds are excluded if left to accumulate and become a part of the burial fund.

(E) If the ~~client member~~ did not purchase his/her own prepaid burial, even if his/her money was used for the purchase, the ~~client member~~ is not the "owner" and the prepaid burial funds cannot be considered a resource to him/her. However, if the ~~client's member's~~ money was used by another to purchase the prepaid burial, the rules on transfer of property must be applied since the purchaser (owner) could withdraw the funds any time.

(6) **Irrevocable burial contract.** Oklahoma law provides that a purchaser (buyer) of a prepaid funeral contract may elect to make the contract irrevocable. The irrevocability cannot become effective until 30 days after purchase.

(A) If the irrevocable election was made prior to July 1, 1986 and the ~~client member~~ received assistance on July 1, 1986, the full amount of the irrevocable contract is not considered a countable resource. This exclusion applies only if the ~~client member~~ does not add to the amount of the contract. Interest accrued on the contract is not considered as added by the ~~client member~~. Any break in assistance will require that the contract be evaluated at the time of reapplication according to rules in (B) of this paragraph.

(B) If the effective date for the irrevocable election or application for assistance is July 1, 1986 or later:

(i) the face value amount in an irrevocable contract cannot exceed \$7,500, plus accrued interest.

(ii) a client member may exclude the face value, up to \$7,500, plus accrued interest in any combination of irrevocable contract, revocable prepaid account, designated account or cash value in life insurance policies not used to fund the burial policy, regardless of the face value, provided the cash value in policies and designated accounts does not exceed \$1500. When the amount exceeds \$7,500, the client member is ineligible for assistance. Accrued interest is not counted as a part of the \$7,500 limit regardless of when it is accrued.

(iii) the face value of life insurance policies used to fund burial contracts is counted towards the \$7,500 limit.

(C) For an irrevocable contract to be valid, the election to make it irrevocable must be made by the purchaser (owner) or the purchaser's guardian or an individual with power of attorney for the purchaser (owner).

(D) In instances where Management of Recipient's Funds form is on file in the nursing facility, the form serves as a power of attorney for the administrator to purchase and/or elect to make irrevocable the burial funds for the client member.

(7) **Medical insurance.** When a client member has medical insurance, the available benefits are applied toward the medical expense for which the benefits are paid. The type of insurance is clarified in the record. If an assignment of the insurance is not made to the provider and payment is made directly to the client member, the client member is expected to apply the payment to the cost of medical services. Any amount remaining after payment for medical services is considered in relation to the reserve.

(8) **Stocks, bonds, mortgages and notes.** The client member's equity in stocks and bonds (including U.S. Savings Bonds series A thru EE) is considered in relation to the reserve. The current market value less encumbrances is the equity. In general, determination of current market value can be obtained from daily newspaper quotations, brokerage houses, banks, etc.

(A) The current value of U.S. Savings bonds which have been held beyond the maturity date is the redemption value listed in the table on the back of the bond for the anniversary date most recently reached. If the bond has been held beyond maturity date, it has continued to draw interest. An acceptable determination of the value may be made by checking against a chart at the bank.

(B) The amount which can be realized from notes and mortgages and similar instruments, if offered for immediate sale, constitutes a reserve. Notes and

mortgages and similar instruments have value regardless of whether there is an actual offer. Appraisals obtained from bankers, realtors, loan companies and others qualified to make such estimates are obtained in determining current market value. When a total reserve approaches the maximum, it is desirable to get two or more estimates.

(C) Mortgages (including contracts for deed) and notes which are income producing are liquid countable resources.

(9) **Trust accounts.** Monies held in trust for an individual applying for or receiving Medicaid SoonerCare must have the availability of the funds determined. Funds held in trust are considered available when they are under the direct control of the individual or his/her spouse, and disbursement is at their sole discretion. Funds may also be held in trust and under the control of someone other than the individual or his/her spouse, such as the courts, agencies, other individuals, etc., or the Bureau of Indian Affairs (BIA).

(A) **Availability determinations.** The social worker should be able to determine the availability of a trust using the definitions and explanations listed in (B) of this subsection. However, in some cases, the worker may wish to submit a trust to the OKDHS State Office for determination of availability. In these instances, all pertinent data is submitted to Family Support Services Division, Attention: Health Related and Medical Services Section, for a decision.

(B) **Definition of terms.** The following words and terms, when used in this paragraph, shall have the following meaning, unless the context clearly indicates otherwise:

(i) **Beneficiary.** Beneficiary means the person(s) who is to receive distributions of either income or principal, or on behalf of whom the trustee is to make payments.

(ii) **Corpus/principal.** Corpus/principal means the body of the trust or the original asset used to establish the trust, such as a sum of money or real property.

(iii) **Discretionary powers.** Discretionary powers means the grantor gives the trustee the power to make an independent determination whether to distribute income and/or principal to the beneficiary(ies) or to retain the income and add it to the principal of the trust.

(iv) **Distributions.** Distributions means payments or allocations made from the trust from the principal or from the income produced by the principal (e.g., interest on a bank account).

(v) **Grantor (trustor/settlor).** Grantor (trustor/settlor) means the individual who establishes the trust by transferring certain assets.

(vi) **Irrevocable trust.** Irrevocable trust means a trust in which the grantor has expressly not retained the right to terminate or revoke the trust and reclaim the trust principal and income.

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- (vii) **Pour over or open trust.** Pour over or open trust means a trust which may be expanded from time to time by the addition to the trust principal (e.g., a trust established to receive the monthly payment of an annuity, a workers' compensation settlement, a disability benefit or other periodic receivable). The principal may accumulate or grow depending upon whether the trustee distributes the receivable or permits it to accumulate. Generally, the terms of the trust will determine the availability of the income in the month of receipt and the availability of the principal in subsequent months.
- (viii) **Primary beneficiary.** Primary beneficiary means the first person or class of persons to receive the benefits of the trust.
- (ix) **Revocable trust.** Revocable trust means a trust in which the grantor has retained the right to terminate or revoke the trust and reclaim the trust principal and income. Unless a trust is specifically made irrevocable, it is revocable. Even an irrevocable trust is revocable upon the written consent of all living persons with an interest in the trust.
- (x) **Secondary beneficiary.** Secondary beneficiary means the person or class of persons who will receive the benefits of the trust after the primary beneficiary has died or is otherwise no longer entitled to benefits.
- (xi) **Testamentary trust.** Testamentary trust means a trust created by a will and effective upon the death of the individual making the will.
- (xii) **Trustee.** Trustee means an individual, individuals, a corporation, court, bank or combination thereof with responsibility for carrying out the terms of the trust.
- (C) **Documents needed.** To determine the availability of a trust for an individual applying for or receiving Medicaid SoonerCare, copies of the following documents are obtained:
- (i) Trust document;
 - (ii) When applicable, all relevant court documents including the Order establishing the trust, Settlement Agreement, Journal Entry, etc.; and
 - (iii) Documentation reflecting prior disbursements (date, amount, purpose).
- (D) **Trust accounts established on or before August 10, 1993.** The rules found in (i) - (iii) of this subparagraph apply to trust accounts established on or before August 10, 1993.
- (i) **Support trust.** The purpose of a support trust is the provision of support or care of a beneficiary. A support trust will generally contain language such as "to provide for the care, support and maintenance of ...", "to provide as necessary for the support of ...", or "as my trustee may deem necessary for the support, maintenance, medical expenses, care, comfort and general welfare." Except as provided in (I)-(III) of this unit, the amount

from a support trust deemed available to the beneficiary is the maximum amount of payments that may be permitted under the terms of the trust to be distributed to the beneficiary, assuming the full exercise of discretion by the trustee(s) for distribution of the maximum amount to the beneficiary. The beneficiary of a support trust, under which the distribution of payments to the beneficiary is determined by one or more trustees who are permitted to exercise discretion with respect to distributions, may show that the amounts deemed available are not actually available by:

- (I) Commencing proceedings against the trustee(s) in a court of competent jurisdiction;
 - (II) Diligently and in good faith asserting in the proceedings that the trustee(s) is required to provide support out of the trust; and
 - (III) Showing that the court has made a determination, not reasonably subject to appeal, that the trustee must pay some amount less than the amount deemed available. If the beneficiary makes the showing, the amount deemed available from the trust is the amount determined by the court. Any action by a beneficiary or the beneficiary's representative, or by the trustee or the trustee's representative, in attempting a showing to make the Agency or the State of Oklahoma a party to the proceeding, or to show to the court that Medicaid SoonerCare benefits may be available if the court limits the amounts deemed available under the trust, precludes the showing of good faith required.
- (ii) **Medicaid Qualifying Trust (MQT).** A Medicaid Qualifying Trust is a trust, or similar legal device, established (other than by will) by an individual or an individual's spouse, under which the individual may be the beneficiary of all or part of the distributions from the trust and such distributions are determined by one or more trustees who are permitted to exercise any discretion with respect to distributions to the individual. A trust established by an individual or an individual's spouse includes trusts created or approved by a representative of the individual (parent, guardian or person holding power of attorney) or the court where the property placed in trust is intended to satisfy or settle a claim made by or on behalf of the individual or the individual's spouse. This includes trust accounts or similar devices established for a minor child pursuant to Title 12 Oklahoma Statute § 83. In addition, a trust established jointly by at least one of the individuals who can establish an MQT and another party or parties (who do not qualify as one of these individuals) is an MQT as long as it meets the other MQT criteria. The amount from an irrevocable MQT deemed available to the individual is the maximum amount of payments that may be permitted under the terms of

the trust to be distributed to the individual assuming the full exercise of discretion by the trustee(s). The provisions regarding MQT apply even though an MQT is irrevocable or is established for purposes other than enabling an individual to qualify for Medicaid SoonerCare; and, whether or not discretion is actually exercised.

(I) **Similar legal device.** MQT rules listed in of this subsection also apply to "similar legal devices" or arrangements having all the characteristics of an MQT except that there is no actual trust document. An example is the client member petitioning the court to irrevocably assign all or part of his/her income to another party (usually the spouse). The determination whether a given document or arrangement constitutes a "similar legal device" should be made by the OKDHS Office of General Counsel, Legal Unit.

(II) **MQT resource treatment.** For revocable MQTs, the entire principal is an available resource to the client member. Resources comprising the principal are subject to the individual resource exclusions (e.g., the home property exclusion) since the client member can access those resource items without the intervention of the trustee. For irrevocable MQTs, the countable amount of the principal is the maximum amount the trustee can disburse to (or for the benefit of) the client member, using his/her full discretionary powers under the terms of the trust. If the trustee has unrestricted access to the principal and has discretionary power to disburse the entire principal to the client member (or to use it for the client's member's benefit), the entire principal is an available resource to the client member. Resources transferred to such a trust lose individual resource consideration (e.g., home property transferred to such a trust is no longer home property and the home property exclusions do not apply). The value of the property is included in the value of the principal. If the MQT permits a specified amount of trust income to be distributed periodically to the client member (or to be used for his/her benefit), but those distributions are not made, the client's member's countable resources increase cumulatively by the undistributed amount.

(III) **Income treatment.** Amounts of MQT income distributed to the client member are countable income when distributed. Amounts of income distributed to third parties for the client's member's benefit are countable income when distributed.

(IV) **Transfer of resources.** If the MQT is irrevocable, a transfer of resources has occurred to the extent that the trustee's access to the principal (for purposes of distributing it to the client

member or using it for the client's member's benefit) is restricted (e.g., if the trust stipulates that the trustee cannot access the principal but must distribute the income produced by that principal to the client member, the principal is not an available resource and has, therefore, been transferred).

(iii) **Special needs trusts.** Some trusts may provide that trust benefits are intended only for a beneficiary's "special needs" and require the trustee to take into consideration the availability of public benefits and resources, including Medicaid SoonerCare benefits. Some trusts may provide that the trust is not to be used to supplant or replace public benefits, including Medicaid SoonerCare benefits. If a trust contains such terms and is not an MQT, the trust is not an available resource.

(E) **Trust accounts established on or after August 11, 1993.** The rules found in (i) - (iii) of this subparagraph apply to trust accounts established on or after August 11, 1993.

(i) For purposes of this subparagraph, the term "trust" includes any legal document or device that is similar to a trust. An individual is considered to have established a trust if assets of the individual were used to form all or part of the principal of the trust and if the trust was established other than by will and by any of the following individuals:

- (I) the individual;
- (II) the individual's spouse;
- (III) a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse; or
- (IV) a person, including a court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

(ii) Where trust principal includes assets of an individual described in this subparagraph and assets of any other person(s), the provisions of this subparagraph apply to the portion of the trust attributable to the assets of the individual. This subparagraph applies without regard to the purposes for which the trust is established, whether the trustees have or exercise any discretion under the trust, and restrictions on when or whether distributions may be made from the trust, or any restrictions on the use of the distribution from the trust.

(iii) There are two types of trusts, revocable trusts and irrevocable trusts.

(I) In the case of a revocable trust, the principal is considered an available resource to the individual. Home property in a revocable trust under the direct control of the individual, spouse or legal representative retains the exemption as outlined in OAC 317:35-5-41(c)(6).

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Payments from the trust to or for the benefit of the individual are considered income of the individual. Other payments from the trust are considered assets disposed of by the individual for purposes of the transfer of assets rule and are subject to the 60 months look back period.

(II) In the case of an irrevocable trust, if there are any circumstances under which payments from the trust could be made to or for the benefit of the individual, the portion of the principal of the trust, or the income on the principal, from which payment to the individual could be made shall be considered available resources. Payments from the principal or income of the trust shall be considered income of the individual. Payments for any other purpose are considered a transfer of assets by the individual and are subject to the 60 months look back period. Any portion of the trust from which, or any income on the principal from which no payment could under any circumstances be made to the individual is considered as of the date of establishment of the trust (or if later, the date on which payment to the individual was foreclosed) to be assets disposed of by the individual for purposes of the asset transfer rules and are subject to the 60 months look back period.

(F) **Exempt trusts.** Subparagraph (E) of this paragraph shall not apply to the following trusts:

(i) A trust containing the assets of a disabled individual under the age of 65 which was established for the benefit of such individual by the parent, grandparent, legal guardian of the individual or a court if the State receives all amounts remaining in the trust on the death of the individual up to an amount equal to the total medical assistance paid on behalf of the individual. This type of trust requires:

(I) The trust may only contain the assets of the disabled individual.

(II) The trust must be irrevocable and cannot be amended or dissolved without the written agreement of the Oklahoma Department of Human Services or the Oklahoma Health Care Authority.

(III) Trust records shall be open at all reasonable times to inspection by an authorized representative of the OHCA or OKDHS.

(IV) The exception for the trust continues after the disabled individual reaches age 65. However, any addition or augmentation after age 65 involves assets that were not the assets of an individual under age 65; therefore, those assets are not subject to the exemption.

(V) Establishment of this type of trust does not constitute a transfer of assets for less than fair market value if the transfer is made into a

trust established solely for the benefit of a disabled individual under the age of 65.

(VI) Payments from the trust are counted according to SSI rules. According to these rules, countable income is anything the individual receives in cash or in kind that can be used to meet the individual's needs for food, clothing and shelter. Accordingly, any payments made directly to the individual are counted as income to the individual because the payments could be used for food, clothing, or shelter for the individual. This rule applies whether or not the payments are actually used for these purposes, as long as there is no legal impediment which would prevent the individual from using the payments in this way. In addition, any payments made by the trustee to a third party to purchase food, clothing, or shelter for the individual can also count as income to the individual. For example, if the trustee makes a mortgage payment for the individual, that payment is a shelter expense and counts as income.

(VII) A corporate trustee may charge a reasonable fee for services in accordance with its published fee schedule.

(VIII) The OKDHS Supplemental Needs Trust form is an example of the trust. Social workers may give the sample form to the ~~client~~ member or his/her representative to use or for their attorney's use.

(IX) To terminate or dissolve a Supplemental Needs Trust, the social worker sends a copy of the trust instrument and a memorandum to OKDHS Family Support Services Division, Attention: HR&MS explaining the reason for the requested termination or dissolution of the Supplemental Needs Trust, and giving the name and address of the trustee. The name and address of the financial institution and current balance are also required. Health Related and Medical Services notifies OHCA/TPL to initiate the recovery process.

(ii) A trust (known as the Medicaid Income Pension Trust) established for the benefit of an individual if:

(I) The individual is in need of long-term care and has countable income above the categorically needy standard for long-term care (OKDHS Appendix C-1) but less than ~~\$2500~~ \$3000 per month.

(II) The Trust is composed only of pension, social security, or other income of the individual along with accumulated income in the trust. Resources can not be included in the trust.

(III) All income is paid into the trust and the applicant is not eligible until the trust is established and the monthly income has been paid into the trust.

(IV) The trust must retain an amount equal to the ~~client's~~ member's gross monthly income less the current categorically needy standard of OKDHS Appendix C-1. The Trustee shall distribute the remainder.

(V) The income disbursed from the trust is considered as the monthly income to determine the cost of their care, and can be used in the computations for spousal diversion.

(VI) The trust must be irrevocable and cannot be amended or dissolved without the written agreement of the OHCA. Trust records shall be open at all reasonable times to inspection by an authorized representative of the OHCA or OKDHS.

(VII) The State will receive all amounts remaining in the trust up to an amount equal to the total ~~Medicaid~~ SoonerCare benefits paid on behalf of the individual subsequent to the date of establishment of the trust.

(VIII) Accumulated funds in the trust may only be used for medically necessary items not covered by ~~Medicaid~~ SoonerCare, or other health programs or health insurance and a reasonable cost of administrating the trust. Reimbursements cannot be made for any medical items to be furnished by the nursing facility. Use of the accumulated funds in the trust for any other reason will be considered as a transfer of assets and would be subject to a penalty period.

(IX) The trustee may claim a fee of up to 3% of the funds added to the trust that month as compensation.

(X) An example trust is included on OKDHS form M-11. Social Workers may give this to the ~~client~~ member or his/her representative to use or for their attorney's use as a guide for the Medicaid Income Pension Trust.

(XI) To terminate or dissolve a Medicaid Income Pension Trust, the social worker sends a memorandum with a copy of the trust to OKDHS Family Support Services Division, Attention: HR&MS, explaining the reason for the requested termination or dissolution of the Medicaid Income Pension Trust, and giving the name and address of the trustee. The name and address of the financial institution, account number, and current balance are also required. Health Related and Medical Services notifies OHCA/TPL to initiate the recovery process.

(iii) A trust containing the assets of a disabled individual when all of the following are met:

(I) The trust is established and managed by a non-profit association;

(II) The trust must be made irrevocable;

(III) The trust must be approved by the Oklahoma Department of Human Services and

may not be amended without the permission of the Oklahoma Department of Human Services;

(IV) The disabled person has no ability to control the spending in the trust;

(V) A separate account is maintained for each beneficiary of the trust but for the purposes of investment and management of funds, the trust pools these accounts;

(VI) The separate account on behalf of the disabled person may not be liquidated without payment to OHCA for the medical expenses incurred by the ~~recipients~~ members;

(VII) Accounts in the trust are established by the parent, grandparent, legal guardian of the individual, the individual, or by a court;

(VIII) To the extent that amounts remaining in the beneficiary's account on the death of the beneficiary are not retained by the trust, the trust pays to the State from such remaining amounts an amount equal to the total medical assistance paid on behalf of the individual. A maximum of 30% of the amount remaining in the beneficiary's account at the time of the beneficiary's death may be retained by the trust.

(G) **Funds held in trust by Bureau of Indian Affairs (BIA).** Interests of individual Indians in trust or restricted lands shall not be considered a resource in determining eligibility for assistance under the Social Security Act or any other federal or federally assisted program.

(H) **Disbursement of trust.** At any point that disbursement occurs, the amount disbursed is counted as a non-recurring lump sum payment in the month received. Some trusts generate income on a regular basis and the income is sent to the beneficiary. In those instances, the income is treated as unearned income in the month received.

(10) **Retirement funds.** The rules regarding the countable value, if any, of retirement funds are found in subparagraph (A) - (B) of this paragraph:

(A) **Annuities.**

(i) Annuities purchased prior to February 1, 2005. An annuity gives the right to receive fixed, periodic payments either for life or a term of years. The annuity instrument itself must be examined to determine the provisions and requirements of the annuity. For example, it is determined whether the individual can access the principal of the annuity; e.g., can it be cashed in. If so, the annuity is treated as a revocable trust (OAC 317:35-5-41(d)(9)(E)(iii)(I). If the individual cannot access the principal, the annuity is treated as an irrevocable trust. In this instance, it must also be determined what part of the annuity can, under any circumstances, be paid to, or for the benefit of the individual. When making such a determination, the date of application is used or, if later, the date

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of institutionalization (for an institutionalized individual) or the date of creation of the annuity (for a non-institutionalized individual). Also, these dates are used in determining whether the transfer of asset provisions apply to a particular annuity. If the annuity provides for payments to be made to the individual, those payments would be considered income to the individual. Any portion of the principal of the annuity that could be paid to or on behalf of the individual would be treated as a resource to the individual and portions of the annuity that cannot be paid to or for the benefit of the individual are treated as transfers of assets. Annuities may also be a transfer of assets for less than fair market value. The worker determines, in accordance with the OKDHS life expectancy tables, whether the client member will receive fair market value from the annuity during his/her projected lifetime. Any funds used to purchase the annuity that will not be repaid to the client member during his/her projected lifetime, are a transfer of assets and the appropriate penalty period is imposed.

(ii) Annuities purchased after January 31, 2005.

(I) An annuity is presumed to be an available resource to the individual who will receive the payments because the annuity can be sold. The value of the annuity is the total of all remaining payments, discounted by the Applicable Federal Rate set by the IRS for the valuation of annuities for the month of application or review.

(II) The applicant or recipient member may rebut the presumption that the annuity can be sold by showing compelling evidence to the contrary, in which case the annuity is not considered available. The applicant or recipient member may also rebut the presumed annuity value by showing compelling evidence that the actual value of the annuity is less than the presumed value.

(B) **Other retirement investment instruments.** This subparagraph relates to individual retirement accounts (IRA), Keogh plans, profit sharing plans, and work related plans in which the employee and/or employer contribute to a retirement account.

(i) **Countability of asset.** In each case, the document governing the retirement instrument must be examined to determine the availability of the retirement benefit at the time of application. Retirement benefits are considered countable resources if the benefits are available to the applicant and/or spouse. Availability means that the applicant and/or spouse has an option to receive retirement benefits or is actually receiving benefits. For example, a retirement instrument may make a fund available at the time of termination of employment, at age 65, or at some other time.

A retirement fund is not a countable resource if the applicant is currently working and must terminate employment in order to receive benefits. An individual may have the choice of withdrawing the monies from the retirement fund in a single payment or periodic payments (i.e., monthly, quarterly, etc.). If the individual elects to receive a periodic payment, the payments are considered as income as provided in OAC 317:35-5-42(c)(3). If the monies are received as a lump sum, the rules at OAC 317:35-5-42(c)(3)(C)(i) apply.

(ii) **Asset valuation.** Valuation of retirement benefits is the amount of money that an individual can currently withdraw from the fund or is actually receiving. Valuation does not include the amount of any penalty for early withdrawal. Taxes due on the monies received by the applicant are not deducted from the valuation.

(iii) **Timing of valuation.** Retirement funds are a countable resource in the month that the funds are available to the applicant. For purposes of this subsection, the month that the funds are available means the month following the month of application for the funds. For example, the retirement instrument makes retirement funds available at age 65. The applicant turns 65 on January 1st. The applicant makes a request for the funds on February 1st and the monies are received on June 1st. The retirement fund would be considered as a countable resource in the month of March. The resource would not be counted in the month in which it is later received.

(11) **Automobiles, pickups, and trucks.** Automobiles, pickups, and trucks are considered in the eligibility determination for Medicaid SoonerCare benefits.

(A) **Exempt automobiles.** One automobile is excluded from counting as a resource to the extent its current market value (CMV) does not exceed \$4,500. The CMV in excess of \$4,500 is counted against the resource limit; or exempt one automobile, pickup or truck per family regardless of the value if it is verified that the car is used:

- (i) for medical services 4 times a year to obtain either medical treatment or prescription drugs; or
- (ii) for employment purposes; or
- (iii) especially equipped for operation by or transportation of a handicapped person.

(B) **Other automobiles.** The equity in other automobiles, pickups, and trucks is considered in relation to the reserve. The current market value, less encumbrances on the vehicle, is the equity. Only encumbrances that can be verified are considered in computing equity.

(i) The market value of each year's make and model is established on the basis of the "avg avg. Trade In" value as shown in the current publication of the National Automobile Dealers Association (NADA) on "Cars, Trucks, and Imports" which

is provided monthly to each county office by the OKDHS State Office.

(ii) If a vehicle's listing has been discontinued in the NADA book, the household's estimate of the value of the vehicle is accepted unless the worker has reason to believe the estimate is incorrect.

(iii) The market value of a vehicle no longer operable is the verified salvage value.

(iv) In the event the client member and worker cannot agree on the value of the vehicle, the client member secures written appraisal by two persons who are familiar with current values. If there is substantial unexplained divergence between these appraisals or between the book value and one or more of these appraisals, the worker and the client member jointly arrange for the market value to be established by an appraisal made by a third person who is familiar with current values and who is acceptable to both the client member and the worker.

(12) **Resource disregards.** In determining need, the following are not considered as resources:

(A) The coupon allotment under the Food Stamp Act of 1977;

(B) Any payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970;

(C) Education grants (excluding Work Study) scholarships, etc., that are contingent upon the student regularly attending school. The student's classification (graduate or undergraduate) is not a factor;

(D) Loans (regardless of use) if a bona fide debt or obligation to pay can be established. Criteria to establish a loan as bona fide includes:

(i) an acknowledgment of obligation to repay or evidence that the loan was from an individual or financial institution in the loan business. If the loan agreement is not written, OKDHS Form ADM-103, Loan Verification, should be completed by the borrower attesting that the loan is bona fide and signed by the lender verifying the date and amount of loan. When copies of written agreements or Form ADM-103 are not available, detailed case documentation must include information that the loan is bona fide and how the debt amount and date of receipt was verified.

(ii) If the loan was from a person(s) not in the loan business, the borrower's acknowledgment of obligation to repay (with or without interest) and the lender's verification of the loan are required to indicate that the loan is bona fide.

(iii) Proceeds of a loan secured by an exempt asset are not an asset.

(E) Indian payments or items purchased from Indian payments (including judgement funds or funds held in trust) distributed per capita by the Secretary of the Interior (BIA) or distributed per capita by the tribe subject to approval by the Secretary of the Interior. Also, any interest or investment income accrued on

such funds while held in trust or any purchases made with judgement funds, trust funds, interest or investment income accrued on such funds. Any income from mineral leases, from tribal business investments, etc., as long as the payments are paid per capita. For purposes of this Subchapter, per capita is defined as each tribal member receiving an equal amount. However, any interest or income derived from the principal or produced by purchases made with the funds after distribution is considered as any other income;

(F) Special allowance for school expenses made available upon petitions (in writing) from funds held in trust for the student;

(G) Benefits from State and Community Programs on Aging (Title III) are disregarded. Income from the Older American Community Service Employment Act (Title V), including AARP and Green Thumb organizations as well as employment positions allocated at the discretion of the Governor of Oklahoma, is counted as earned income. Both Title III and Title V are under the Older Americans Act of 1965 amended by PL 100-175 to become the Older Americans Act amendments of 1987;

(H) Payments for supportive services or reimbursement of out-of-pocket expenses made to individual volunteers serving as foster grandparents, senior health aides, or senior companions, and to persons serving in the Services Corps of Retired Executives (SCORE) and Active Corps of Executives (ACE);

(I) Payment to volunteers under the Domestic Volunteer Services Act of 1973 (VISTA), unless the gross amount of VISTA payments equals or exceeds the state or federal minimum wage, whichever is greater;

(J) The value of supplemental food assistance received under the Child Nutrition Act or the special food services program for children under the National School Lunch Act;

(K) Any portion of payments made under the Alaska Native Claims Settlement Act to an Alaska Native which are exempt from taxation under the Settlement Act;

(L) Experimental Housing Allowance Program (EHAP) payments made under Annual Contributions Contracts entered into prior to January 1, 1975, under Section 23 of the U.S. Housing Act of 1937, as amended;

(M) Payments made from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In Re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.);

(N) Payments made from the Radiation Exposure Compensation Trust Fund as compensation for injuries or deaths resulting from the exposure to radiation from nuclear testing and uranium mining;

(O) Federal major disaster and emergency assistance provided under the Disaster Relief Act of 1974, and comparable disaster assistance provided

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by States, local governments and disaster assistance organizations;

(P) Interests of individual Indians in trust or restricted lands. However, any disbursements from the trust or the restricted lands are considered as income;

(Q) Resources set aside under an approved Plan for Achieving Self-Support for Blind or Disabled People (PASS). The Social Security Administration approves the plan, the amount of resources excluded and the period of time approved. A plan can be approved for an initial period of 18 months. The plan may be extended for an additional 18 months if needed, and an additional 12 months (total 48 months) when the objective involves a lengthy educational or training program;

(R) Payments made to individuals because of their status as victims of Nazi persecution (PL 103-286);

(S) A migratory farm worker's out-of-state homestead is disregarded if the farm worker's intent is to return to the homestead after the temporary absence;

(T) Payments received under the Civil Liberties Act of 1988. These payments are to be made to individuals of Japanese ancestry who were detained in interment camps during World War II;

(U) Dedicated bank accounts established by representative payees to receive and maintain retroactive SSI benefits for disabled/blind children up to the legal age of 18. The dedicated bank account must be in a financial institution, the sole purpose of which is to receive and maintain SSI underpayments which are required or allowed to be deposited into such an account. The account must be set up and verification provided to SSA before the underpayment can be released; and

(V) Payments received as a result of participation in a class action lawsuit entitled "Factor VIII or IX Concentrate Blood Products Litigation". These payments are made to hemophilia patients who are infected with HIV. Payments are not considered as income or resources. A penalty cannot be assessed against the individual if he/she disposes of part or all of the payment. The rules at OAC:35-5-41(d)(9) regarding the availability of a trust do not apply if an individual establishes a trust using the settlement payment.

(e) **Changes in capital resources.** Rules on transfer or disposal of capital resources are not applicable. See OAC 317:35-9, OAC 317:35-17, and OAC 317:35-19 if the individual enters a nursing home or receives Home and Community Based Waiver Services, HCBWS/MR or ADvantage waiver services.

(1) **Resources of an applicant.** If the resource(s) of an applicant is in a form which is not available for immediate use, such as real estate, mineral rights, or one of many other forms, and the applicant is trying to make the resource available, the applicant may be certified and given a reasonable amount of time to make this available. A reasonable amount of time would normally not exceed

90 days. The client member is notified in writing that a period of time not to exceed 90 days will be given to make the resource available. Any extension beyond the initial 90-day period is justified only after interviewing the client member, determining that a good faith effort to sell is still being made and failure to sell is due to circumstances beyond the control of the client member.

(2) **Capital resources acquired while receiving assistance.** If the recipient member acquires resources which increase his/her available reserve above the maximum, he/she is ineligible for assistance unless there are specific plans for using the resources in compliance with rules on "resources disposed of while receiving assistance". The term "using the resource" is construed to mean that the resource has been encumbered or actually transferred. If the facts show a reasonable delay in executing the plan to use the required resource or if the resource is in a form which is not available for immediate use (such as real estate, mineral rights, or one of many other forms), and if efforts are in progress to make the resource available, the recipient member is given a reasonable amount of time to make this available. The client member is notified in writing that a period of time not to exceed 90 days will be given to make the resources available.

(A) Any extension beyond the initial 90 day period is justified only after interviewing the client member, determining that a good faith effort is still being made and that failure to make the resource available is due to circumstances beyond the control of the client member.

(B) Money borrowed on any of the client's member's resources, except the home, merely changes his/her resource from one form to another. Money borrowed on the home is evaluated in relation to the reserve.

(f) **Maximum reserve.** Maximum reserve is a term used to designate the largest amount which a recipient member can have in one or more nonexempt resources, and still be considered to be in need. A recipient's member's reserve may be held in any form or combination of forms. If the resources of the applicant or recipient member exceed the maximums listed on OKDHS Appendix C-1, he/she is not eligible.

(1) For each minor blind or disabled child up to the age of 18 living with parent(s) whose needs are not included in a TANF grant, or receiving SSI and/or SSP, the resource limit is the same as the individual limit as shown on OKDHS Appendix C-1. If the parent's resources exceed the maximum amount, the excess is deemed available to the child (resources of an ineligible child are not deemed to an eligible child). If there is more than one eligible child, the amount is prorated.

(2) If the minor blind or disabled child:

(A) is residing in a nursing facility, or a medical facility if the confinement lasts or is expected to last for 30 days, the parent(s)' resources are not deemed to the child; or

(B) under age 19 is eligible for TEFRA, the parent's(s)' resources are not deemed to the child.

(3) Premature infants (i.e., 37 weeks or less) whose birth weight is less than 1200 grams (approximately 2 pounds 10 ounces) will be considered disabled by SSA even if no other medical impairment(s) exist. In this event, the parents resources are not deemed to the child until the month following the month in which the child leaves the hospital and begins living with his/her parents.

(4) when both parents are in the home and one parent is included in an aged, blind or disabled case and the spouse is included in an TANF case with the children, the resources of both parents are evaluated in relation to eligibility for SSI and therefore not considered on the AFDC case. All resources of the parents would be shown on the aged, blind or disabled case.

[OAR Docket #07-322; filed 2-22-07]

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

[OAR Docket #07-334]

RULEMAKING ACTION:
EMERGENCY adoption

RULES:
Subchapter 7. Medical Services
Part 5. Determination of Eligibility for Medical Services
317:35-7-48. [AMENDED]
(Reference APA WF # 06-43)

AUTHORITY:
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; House Bill 1071XX (Appropriations Bill) of the 50th Oklahoma State Legislature.

DATES:
Adoption:
December 14, 2006
Approved by Governor:
January 30, 2007

Effective:
Immediately upon Governor's approval or February 1, 2007, 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 comply with CMS clarifications stating that individuals with creditable health insurance that includes family planning services are not eligible for SoonerPlan, regardless of whether a particular family planning service(s) is not covered by the other health insurance.

ANALYSIS:
SoonerPlan rules are revised to allow OHCA to comply with CMS clarifications that persons who have Medicare or other creditable health insurance coverage including family planning services are not eligible for SoonerPlan, the Family Planning Waiver program. Stand alone policies such as dental, vision or pharmacy are not considered creditable insurance coverage when determining eligibility for the SoonerPlan program. This revision also

addresses the \$240 deduction for work related expenses for individuals who qualify for SoonerPlan as addressed in Work Folder #06-53 submitted to the Governor this same date.

CONTACT PERSON:
Joanne Terlizzi at (405)522-7272

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED UPON APPROVAL BY THE GOVERNOR AS SET FORTH IN 75 O.S., SECTION 253(D), AND EFFECTIVE UPON APPROVAL BY GOVERNOR OR FEBRUARY 1, 2007, WHICHEVER IS LATER:

SUBCHAPTER 7. MEDICAL SERVICES

PART 5. DETERMINATION OF ELIGIBILITY FOR MEDICAL SERVICES

317:35-7-48. Eligibility for the Family Planning Waiver Program

(a) Women and men ages 19 and above are eligible to receive family planning services if they meet all of the conditions of eligibility in paragraphs (1), (2), and (3) of this Section. This is regardless of pregnancy or paternity history and includes women who gain eligibility for family planning services due to a pregnancy, but whose eligibility ends 60 days postpartum.

(1) The countable income is at or below 185% of the federal poverty level. The standard deduction for work related expenses such as income tax payments, Social Security taxes, and transportation to and from work, is \$240 per each full-time or part-time employed member of the benefit group. Deductions for work related expenses for self-employed individuals are found at OAC 317:35-10-26(b)(1).

(2) The individual is not otherwise eligible for Medicaid.

(3) The individual is uninsured, ~~or has health insurance coverage but this coverage excludes all coverage for family planning services.~~ Persons who have Medicare or creditable health insurance coverage are not eligible for the Family Planning Waiver program. A stand alone policy such as dental, vision or pharmacy is not considered creditable health insurance coverage.

(b) All health insurance is listed on the OKDHS computer system in order for OHCA Third Party Liability Unit to verify insurance coverage.

(c) Income for the Family Planning Waiver Program does not require verification, unless questionable. If the income is questionable the worker must verify the income.

(d) There is not an asset test for Family Planning Waiver Program.

[OAR Docket #07-334; filed 2-23-07]

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

[OAR Docket #07-332]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 10. Medical Aid to Families with Dependent Children

Part 5. Income

317:35-10-26. [AMENDED]

(Reference APA WF# 06-53A)

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 435.601

DATES:

Adoption:

December 14, 2006

Approved by Governor:

January 30, 2007

Effective:

Immediately upon Governor's approval or February 1, 2007, 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 will extend health coverage to more low income working individuals.

ANALYSIS:

Rules are revised to reflect a \$240 earned income disregard for work related expenses when determining SoonerCare eligibility for certain populations. Currently, individuals related to AFDC or Pregnancy receive a monthly \$120 deduction from earned income for work related expenses when calculating the benefit group's income for SoonerCare eligibility. Recently, the Oklahoma Department of Human Services increased the monthly earned income disregard for Temporary Assistance to Needy Families (TANF, formerly known as AFDC) recipients from \$120 to \$240. In order for SoonerCare to continue to be linked with TANF, OHCA must apply the financial methodologies and requirements of the cash assistance program that are most closely categorically related to the individual's status. In addition, individuals participating in the Oklahoma Employer and Employee Partnership for Insurance Coverage (O-EPIC) and those eligible for family planning services only (SoonerPlan), presently do not receive any deduction from earned income for work related expenses. These revisions will give all working individuals in these groups the same monthly work related expense deduction of \$240.

CONTACT PERSON:

Joanne Terlizzi at (405)522-7272

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED UPON APPROVAL BY THE GOVERNOR AS SET FORTH IN 75 O.S., SECTION 253(D), AND EFFECTIVE UPON APPROVAL BY GOVERNOR OR FEBRUARY 1, 2007, WHICHEVER IS LATER:

SUBCHAPTER 10. MEDICAL AID TO FAMILIES WITH DEPENDENT CHILDREN

PART 5. INCOME

317:35-10-26. Income

(a) General provisions regarding income.

(1) The income of categorically needy individuals who are related to AFDC or Pregnancy does not require verification, unless questionable. If the income is questionable the worker must verify the income. The worker views all data exchange screens on all individuals included in the household size. If the data exchange screen reveals conflicting information, the worker must resolve the conflicting information and if necessary, request verification.

(2) All available income, except that required to be disregarded by law or OHCA's policy, is taken into consideration in determining need. Income is considered available both when actually available and when the applicant or recipient member has a legal interest in a liquidated sum and has the legal ability to make such sum available for support and maintenance. When an individual's income is reduced due to recoupment of an overpayment or garnishment, the gross amount before the recoupment or garnishment is counted as income. The client member is responsible for reporting all income, the source, amount and how often received.

(A) Income received on behalf of a member of the benefit group by another individual such as, but not limited to, a guardian or conservator, is considered available to the benefit group.

(B) Money received and used for the care and maintenance of a third party who is not included in the benefit group is not counted as income if it can be identified and verified as intended for third party use.

(C) If it appears any member of the benefit group or an individual whose income is considered when determining eligibility is eligible for any type of income or benefits, the benefit group must be notified in writing by the Oklahoma Department of Human Services (OKDHS). The notice must contain the information that failure to apply for and take all appropriate steps to obtain such benefits within 30 days from the date of the notice will result in a determination of ineligibility. An application for Supplemental Security Income (SSI) is not required.

(D) If the recipient member and spouse are living together or they are living apart but there has not been a clear break in the family relationship, income received by either spouse and income received jointly is considered as family income. Income cannot be diverted to a household member who is not included in the household size for health benefits. Consideration is not given to a SSI recipient's income in computing eligibility for the AFDC related unit.

(E) Income which can reasonably be anticipated to be received is considered to be available for the month its receipt is anticipated.

(F) Income produced from resources must be considered as unearned income.

(3) Income that must be verified is verified by the best available information such as pay stubs presented by the ~~client~~ member or an interview with the employer. Pay stubs may only be used for verification if they have the ~~client's~~ member's name and/or social security number indicating that the pay stubs are in fact the ~~client's~~ member's wages. The stubs should also include the date(s) of the pay period and the amount of income before deductions. If this information is not included, employer verification is required. The worker verifies medical insurance which may be available at the same time that income is verified. When a member of the benefit group accepts employment and has not received any wages, verification (if necessary) of the amount of income to be considered and the anticipated date of receipt must be obtained from the employer. Income which is expected to be received during a month is considered available to the benefit group and is counted in determining eligibility for the month of receipt.

(4) Monies received in a lump sum from any source are considered income in the month received. Changing a resource from one form to another, such as converting personal property to cash, is not considered a lump sum payment. Exception: lump sum payments used to establish dedicated bank accounts by representative payees in order to receive and maintain retroactive SSI benefits for disabled/blind children under age 18 are excluded as income. The interest income generated from dedicated bank accounts is also excluded.

(A) A nonrecurring lump sum payment considered as income includes payments based on accumulation of income and payments which may be considered windfall in nature and may include but are not limited to TANF grant diversion, VA or Social Security lump sum payments, inheritance, gifts, worker's compensation payments, cash winnings, personal injury awards, etc. Retirement benefits received in a lump-sum are considered as unearned income. A non-recurring lump sum SSI retroactive payment, made to an AFDC or pregnancy related recipient who is not currently eligible for SSI, is not counted as income.

(B) The worker must ask applicants if they have received a lump sum payment during the month of application, any month during the application process or anticipate to receive a lump sum in the future. ~~Recipients~~ Members are asked at the time of periodic redetermination if the benefit group has received or is expecting to receive a lump sum. The worker provides an oral explanation, including examples of lump sum payments, how the rule affects other benefits and the importance of reporting anticipated receipt of a lump sum payment. The worker also offers counseling when there is indication of anticipated receipt,

including voluntary withdrawal of the application or case closure and availability of free legal advice.

(C) Lump sum payments (minus allowable deductions related to establishing the lump sum payment) which are received by AFDC/Pregnancy related individuals or applicants are considered as income. Allowable deductions are expenses earmarked in the settlement or award to be used for a specific purpose which may include, but are not limited to, attorney's fees and court costs that are identified in the lump sum settlement, medical or funeral expenses for the immediate family, etc. "Earmarked" means that such expense is specifically set forth in the settlement or award.

(D) When a lump sum is received by a stepparent not included in the household size, only the stepparent's contribution is considered in accordance with the stepparent's liability policy.

(E) When a third party reveals that a lump sum payment has been received or is expected to be received by the applicant or ~~recipient~~ member, adverse action notification is given or mailed to the ~~applicant/recipient~~ applicant/member and appropriate action taken.

(F) Recurring lump sum income received from any source for a period covering more than one month, that is received in a lump sum recurrently (such as annual rentals from surface or minerals, Windfall Profits tax refund, etc.) is prorated over a period of time it is intended to cover, beginning with the month of receipt of a lump sum payment.

(G) Net income from oil and gas production (gross minus production taxes withheld), received in varying amounts on a regular or irregular basis for the past six months, will be averaged and considered as income for the next six months. In instances where an applicant or a ~~recipient~~ member receives new income from oil and gas production and verification for the past six months is not available, the worker accepts the available verification and averages over the period of time intended to cover. Net income may be verified by seeing the individual's production check stub, or by contacting the oil and gas company.

(5) Income that is based on the number of hours worked, as opposed to income based on regular monthly wages, must be computed as irregular income. The income received irregularly or in varying amounts will be averaged using the past two months to establish the amount to be anticipated and considered for prospective budgeting.

(6) A caretaker relative can only be included in the benefit group when the biological or adoptive parent is not in the home. A stepparent can be included when the natural or biological parent is either incapacitated or not in the home.

(A) Consideration is not given to the income of the caretaker relative or the income of his or her spouse in determining the eligibility of the children regardless of whether the caretaker relative's needs are or are not

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included. However, if that person is the stepparent, the policy on stepparent liability is applicable.

(B) If a caretaker relative is married and living with the spouse who is an SSI or SSP recipient, the spouse or spouse's income is not considered in determining the eligibility of the relative caretaker. The income of the caretaker relative and the spouse who is not an SSI or SSP recipient must be considered. Only one caretaker relative is eligible to be included in any one month.

(7) A stepparent can be included when the natural or biological parent is either incapacitated or not in the home. The income of the stepparent is counted if the stepparent's needs are being included.

(8) When there is a stepparent or person living in the home with the natural or adoptive parent who is not a spouse by legal marriage to or common-law relationship with the own parent but who is acting in the role of a spouse, the worker determines the amount of income that will be made available to meet the needs of the child(ren) and the parent. Only contributions made in cash directly to the benefit group can be counted as income. In-kind contributions are disregarded as income. When the individual and the ~~client-member~~ state the individual does not make a cash contribution, further exploration is necessary. This statement can only be accepted after clarifying that the individual's contributions are only in-kind.

(b) **Earned income.** The term "earned income" refers to monies earned by an individual through the receipt of wages, salary, commission or profit from activities in which the individual is engaged as self-employed or as an employee. Payments made for accumulated annual leave/vacation leave, sick leave or as severance pay are considered as earned income whether paid during employment or at termination of employment. Temporary disability insurance payment(s) and temporary worker's compensation payments are considered as earned income if payments are employer funded and the individual remains employed. Income received as a one-time nonrecurring payment is considered as a lump sum payment. Earned income includes in-kind benefits received by an employee from an employer in lieu of wages or in conjunction with wages. An exchange of labor or services, e.g., barter, is considered as an in-kind benefit. Such benefits received in-kind are considered as earned income only when the employee/employer relationship has been established. Income from self-employment also includes in-kind benefits for a work activity or service for which the self-employed person ordinarily receives payment in the business enterprise. Medical insurance secured through the employer, whether purchased or as a benefit, is not considered in-kind income. Gross earned income is used to determine eligibility. Gross earned income is defined as the "true wage" prior to payroll deductions and/or withholdings.

(1) **Earned income from self-employment.** If the income results from the individual's activities primarily as a result of the individual's own labor from the operation of a business enterprise, the "earned income" is the total profit after deducting the business expenses (cost of the

production). Money from the sale of whole blood or blood plasma is also considered as self-employment income subject to necessary business expense and appropriate earned income exemptions.

(A) Allowable costs of producing self-employment income include, but are not limited to, the identifiable cost of labor, stock, raw material, seed and fertilizer, interest payments to purchase income-producing property, insurance premiums, and taxes paid on income-producing property.

(i) The federal or state income tax form for the most recent year is used for calculating the income, if necessary, only if it is representative of the individual's current situation. The individual's business records beginning the month income became representative of the individual's current situation is used if the income tax information does not represent the individual's current situation.

(ii) If the self-employment enterprise has been in existence for less than a year, the income is averaged over the period of time the business has been in operation to establish the monthly income amount.

(iii) Self-employment income which represents an annual support is prorated over a 12-month period, even if the income is received in a short period of time. For example, self-employment income received by crop farmers is averaged over a 12-month period if the income represents the farmer's annual support.

(B) **Items not considered.** The following items are not considered as a cost of producing self-employed income:

(i) The purchase price and/or payments on the principal of loans for capital assets, equipment, machinery, and other durable goods;

(ii) Net losses from previous periods;

(iii) Depreciation of capital assets, equipment, machinery, and other durable goods; and

(iv) Federal, state and local income taxes, FICA, money set aside for retirement purposes, and other work related personal expenses, such as meals and necessary transportation. These expenses are accounted for by the work related expense deduction.

(C) **Room and/or board.** Earned income from a room rented in the home is determined by considering 25% of the gross amount received as a business expense. If the earned income includes payment for room and board, 50% of the gross amount received is considered as a business expense.

(D) **Rental property.** Income from rental property is to be considered income from self employment if none of the activities associated with renting the property is conducted by an outside-person or agency.

(2) **Earned income from wages, salary or commission.** If the income is from wages, salary or commission, the "earned income" is the gross income prior to payroll

deductions and/or withholdings. Income from the Older American Community Service Employment Act (Title V), including AARP and Green Thumb organizations as well as employment positions allocated at the discretion of the Governor of Oklahoma, is counted as any other earned income.

(3) **Earned income from work and training programs.** Earned income from work and training programs such as the Job Training Partnership Act (JTPA) received by an adult as wages is considered as any other earned income. Also, JTPA earned income of a dependent child is considered when received in excess of six months in any calendar year.

(4) **Individual earned income exemptions.** Exemptions from each individual's earned income include a monthly standard work related expense and child care expenses the individual is responsible for paying. Expenses cannot be exempt if paid through state or federal funds or the care is not in a licensed facility or home. Exempt income is that income which by law may not be considered in determining need.

(A) **Work related expenses.** The standard deduction for work related expenses such as income tax payments, Social Security taxes, and transportation to and from work, is ~~\$120~~ \$240 per each full-time or part-time employed member of the benefit group.

(B) **Child care expenses.** Disregard of child care expense is applied after all other income disregards.

(i) Child care expense may be deducted when:

(I) suitable care for a child included in the benefit group is not available from responsible persons living in the home or through other alternate sources; and

(II) the employed member whose income is considered must purchase care.

(ii) Child care expenses must be verified and the actual amount per month, as paid, up to a maximum of \$200 for a child under the age of two or \$175 for a child age two or older may be deducted. In considering the care expense, only actual work hours and travel time between work and the child care facility or child care home will be allowed.

(iii) In explaining child care expenses, the worker informs the individual that payment for care is the responsibility of the client member and any changes in the plan for care must be reported immediately.

(iv) Oklahoma law requires all child care centers and homes be properly approved or licensed; therefore, child care expenses can only be deducted if the child is in a properly licensed facility or receiving care from an approved in-home provider. However, in cases where licensed dependent care facilities and/or approved in-home providers are not available (e.g, night employment), and the client member arranges for care outside the home, an immediate referral is made by OKDHS Form K-13 to the licensing worker for

a licensing decision. The cost of child care can be considered until the worker receives notification from the licensing worker that the home does not meet licensing standards or registration. If licensing or registration is denied, the client member will be allowed 30 days after notification to make other child care arrangements, during which time the child care exemption will continue to be allowed.

(v) Child care provided by another person in the household who is not a member of the benefit group may be considered as child care expenses as long as the case meets applicable standards of State, local or Tribal law.

(vi) Documentation is made of the child care arrangement indicating the name of the child care facility or the name of the in-home provider, and the documentation used to verify the actual payment of child care per month.

(5) **Formula for determining the individual's net earned income.** Formulas used to determine net earned income to be considered are:

(A) **Net earned income from employment other than self-employment.** Gross Income minus work related expense minus child care expense equals net income.

(B) **Net earned income from self-employment.** Gross income minus allowable business expenses minus work related expense and child care expense equals net income.

(c) **Unearned income.**

(1) **Capital investments.** Proceeds, i.e., interest or dividends from capital investments, such as savings accounts, bonds (other than U.S. Savings Bonds, Series A through EE), notes, mortgages, etc., received constitute income.

(2) **Life estate and homestead rights.** Income from life estate or homestead rights, constitute income after deducting actual business expenses.

(3) **Minerals.** If the client member owns mineral rights, only actual income from minerals, delayed rentals, or production is considered. Evidence is obtained from documents which the client member has in hand. When the client member has no documentary evidence of the amount of income, the evidence, if necessary, is secured from the firm or person who is making the payment.

(4) **Contributions.** Monetary contributions are considered as income except in instances where the contribution is not made directly to the ~~recipient member~~.

(5) **Retirement and disability benefits.** Income received monthly from retirement and disability benefits are considered as unearned income. Information as to receipt and amount of OASDI benefits is obtained, if necessary, from BENDEX, the ~~client's~~ member's award letter, or verification from SSA. If the individual states that he/she does not receive OASDI, has a pending application or has been denied OASDI, this can be verified, if necessary, by use of TPQYC computer transaction. Retirement benefits

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received as a lump sum payment at termination of employment are considered as income. Supplemental Security Income (SSI) does not fall under these types of benefits.

(6) **Unemployment benefits.** Unemployment benefits are considered as unearned income.

(7) **Military benefits.** Life insurance, pensions, compensation, servicemen dependents' allowances and the like, are all sources of income which the recipient member and/or dependents may be eligible to receive. In each case under consideration, information is obtained as to whether the client's member's son, daughter, husband or parent, has been in any military service. Clearance is made with the proper veterans' agency, both state and federal, to determine whether the benefits are available.

(8) **Casual and inconsequential gifts.** Monetary gifts which do not realistically represent income to meet living expenses, e.g., Christmas, graduation and birthday gifts, not to exceed \$30 per calendar quarter for each individual, are disregarded as income. The amount of the gifts are disregarded as received during the quarter until the aggregate amount has reached \$30. At that time the portion exceeding \$30 is counted as lump sum income. If the amount of a single gift exceeds \$30, it is not inconsequential and the total amount is therefore counted. If the recipient member claims that the gift is intended for more than one person in the family unit, it is allowed to be divided. Gifts between members of the family unit are not counted.

(9) **Grants.** Grants which are not based on financial need are considered income.

(10) **Funds held in trust by Bureau of Indian Affairs (BIA).** The BIA frequently puts an individual's trust funds in an Individual Indian Money (IIM) account. To determine the availability of funds held in trust in an IIM account, the social worker must contact the BIA in writing and ascertain if the funds, in total or any portion, are available to the individual. If any portion of the funds is disbursed to the individual client member, guardian or conservator, such funds are considered as available income. If the BIA determines the funds are not available, they are not considered. Funds held in trust by the BIA and not disbursed are considered unavailable.

(A) In some instances, BIA may determine the account is unavailable; however, they release a certain amount of funds each month to the individual. In this instance the monthly disbursement is considered as income.

(B) When the BIA has stated the account is unavailable and the account does not have a monthly disbursement plan, but a review reveals a recent history of disbursements to the individual client member, guardian or conservator, these disbursements must be resolved with the BIA. These disbursements indicate all or a portion of the account may be available to the individual client member, guardian or conservator.

(C) When disbursements have been made, the worker verifies whether such disbursements were made to the client member or to a third party vendor in payment for goods or services. Payments made

directly from the BIA to vendors are not considered as income to the client member. Workers obtain documentation to verify services rendered and payment made by BIA.

(D) Amounts disbursed directly to the clients members are counted as non-recurring lump sum payments in the month received. Some trusts generate income on a regular basis and the income is sent to the beneficiary. In those instances, the income is counted in the month received.

(d) **Income disregards.** Income that is disregarded in determining eligibility includes:

(1) Food Stamp benefits;

(2) Any payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970;

(3) Education Grants (including work study), scholarships, etc., that are contingent upon the student regularly attending school. The student's classification (graduate or undergraduate) is not a factor;

(4) Loans (regardless of use) if a bona fide debt or obligation to pay can be established. Criteria to establish a loan as bona fide includes an acknowledgement acknowledgment of obligation to repay or evidence that the loan was from an individual or financial institution in the loan business. If the loan was from a person(s) not in the loan business, the borrower's acknowledgment of obligation to repay (with or without interest) is required to indicate that the loan is bona fide. If the loan agreement is not written, OKDHS Form Adm-103, Loan Verification, should be completed by the borrower attesting that the loan is bona fide and signed by the lender verifying the date and amount of loan. When copies of written agreements or OKDHS Form Adm-103 are not available, detailed case documentation must include information that the loan is bona fide and how the debt amount and date of receipt was verified;

(5) Indian payments (including judgement funds or funds held in trust) which are distributed per capita by the Secretary of the Interior (BIA) or distributed by the tribe subject to approval by the Secretary of the Interior. Also, any interest or investment income accrued on such funds while held in trust or any purchases made with judgement funds, trust funds, interest or investment income accrued on such funds. Any income from mineral leases, from tribal business investments, etc., as long as the payments are paid per capita. For purposes of this paragraph, per capita is defined as each tribal member receiving an equal amount. However, any interest or income derived from the principal or produced by purchases made with the funds after distribution is considered as any other income;

(6) Special allowance for school expenses made available upon petition in writing from trust funds of the student;

(7) Benefits from State and Community Programs on Aging under Title III of the Older Americans Act of 1965 amended by PL 100-175 to become the Older Americans Act amendments of 1987;

- (8) Unearned income received by a child, such as a needs based payment, cash assistance, compensation in lieu of wages, allowance, etc., from a program funded by the Job Training and Partnership Act (JTPA) including Job Corps income. Also, JTPA earned income received as wages, not to exceed six months in any calendar year;
 - (9) Payments for supportive services or reimbursement for out-of-pocket expenses made to individual volunteers serving as foster grandparents, senior health aids, or senior companions, and to persons serving in the Service Corps of Retired Executives (SCORE) and Active Corps of Executives (ACE);
 - (10) Payments to volunteers under the Domestic Volunteer Service Act of 1973 (VISTA), unless the gross amount of VISTA payments equals or exceeds the state or federal minimum wage, whichever is greater;
 - (11) The value of supplemental food assistance received under the Child Nutrition Act or the special food service program for children under the National School Lunch Act;
 - (12) Any portion of payments, made under the Alaska Native Claims Settlement Act to an Alaska Native, which are exempt from taxation under the Settlement Act;
 - (13) If an adult or child from the family group is living in the home and is receiving SSI, his/her individual income is considered by the Social Security Administration in determining eligibility for SSI. Therefore, that income cannot be considered as available to the benefit group;
 - (14) Experimental Housing Allowance Program (EHAP) payments made under Annual Contributions Contracts entered into prior to January 1, 1975, under Section 23 of the U.S. Housing Act of 1937, as amended;
 - (15) Earnings of a child who is a full-time student are disregarded;
 - (16) The first \$50 of the current monthly child support paid by an absent parent. Only one disregard is allowed regardless of the number of parents paying or amounts paid. An additional disregard is allowed if payments for previous months were paid when due but not received until the current month;
 - (17) Government rental or housing subsidies by governmental agencies, e.g., HUD (received in-kind or in cash) for rent, mortgage payments or utilities;
 - (18) Reimbursements from an employer for out-of-pocket expenditures and allowances for travel or training to the extent the funds are used for expenses directly related to such travel or training, and uniform allowances if the uniform is uniquely identified with company name or logo;
 - (19) Low Income Home and Energy Assistance Program (LIHEAP) and Energy Crisis Assistance Program (ECAP) payments;
 - (20) Advance payments of Earned Income Tax Credit (EITC) or refunds of EITC as a result of filing a federal income tax return;
 - (21) Payments made from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In Re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.);
 - (22) Payments made from the Radiation Exposure Compensation Trust Fund as compensation for injuries or deaths resulting from the exposure to radiation from nuclear testing and uranium mining;
 - (23) Federal major disaster and emergency assistance provided under the Disaster Relief Act of 1974, and comparable disaster assistance provided by states, local governments and disaster assistance organizations;
 - (24) Interests of individual Indians in trust or restricted lands;
 - (25) Income up to \$2,000 per year received by individual Indians, which is derived from leases or other uses of individually-owned trust or restricted lands;
 - (26) Any home produce from garden, livestock and poultry utilized by the ~~recipient~~—member and his/her household for their consumption (as distinguished from such produce sold or exchanged);
 - (27) Any payments made directly to a third party for the benefit of a member of the benefit group;
 - (28) Financial aid provided to individuals by agencies or organizations which base their payment on financial need;
 - (29) Assistance or services received from the Vocational Rehabilitation Program, such as transportation expenses to a rehabilitation center, extra clothing, lunches, grooming needed for a training program and an other such complimentary payments; and
 - (30) Payments made by a public or private non-profit child care agency for a child placed in foster care or subsidized adoption.
- (e) In computing monthly income, cents will be carried at all steps until the monthly amount is determined and then will be rounded to the nearest dollar. These rounding procedures apply to each individual and each type of income. Income which is received monthly but in irregular amounts is averaged using two month's income, if possible, to determine income eligibility. Less than two month's income may be used when circumstances (e.g., new employment, unpaid sick leave, etc.) would indicate that previous income amounts would not be appropriate to use in determining future income amounts. Income received more often than monthly is converted to monthly amounts as follows:
- (1) **Daily.** Income received on a daily basis is converted to a weekly amount then multiplies by 4.3.
 - (2) **Weekly.** Income received weekly is multiplied by 4.3.
 - (3) **Twice a month.** Income received twice a month is multiplied by 2.
 - (4) **Biweekly.** Income received every two weeks is multiplied by 2.15.

[OAR Docket #07-332; filed 2-23-07]

Emergency Adoptions

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

[OAR Docket #07-335]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 7. O-EPIC PA Employer Eligibility

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

317:45-7-8. [AMENDED]

Subchapter 11. O-EPIC IP [NEW]

Part 3. O-EPIC IP Member Health Care Benefits [NEW]

317:45-11-10. through 45-11-11. [NEW]

(Reference APA WF # 06-55)

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:

December 14, 2006

Approved by Governor:

January 30, 2007

Effective:

Immediately upon Governor's approval or February 1, 2007, whichever is later

Expiration:

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

SUPERSEDED EMERGENCY ACTIONS:

Superseded rules:

Subchapter 7. O-EPIC PA Employer Eligibility

317:45-7-1. [AMENDED]

Gubernatorial approval:

October 8, 2006

Register publication:

24 Ok Reg 153

Docket number:

06-1348

(Reference APA WF # 06-20)

Superseded rules:

Subchapter 7. O-EPIC PA Employer Eligibility

317:45-7-2. [AMENDED]

317:45-7-8. [AMENDED]

Subchapter 11. O-EPIC IP [NEW]

Part 3. O-EPIC IP Member Health Care Benefits [NEW]

317:45-11-10. through 45-11-11. [NEW]

Gubernatorial approval:

August 31, 2006

Register publication:

24 Ok Reg 101

Docket number:

06-1316

(Reference APA WF # 06-08)

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 adults with an option to purchase affordable health insurance.

ANALYSIS:

O-EPIC rules are revised to update and clarify the covered benefits, limits, and applicable co-payments for the Individual Plan benefit package. Last fall, the agency initiated the O-EPIC Premium Assistance program for small business employers. The O-EPIC Individual Plan 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. Additional revisions clarify employer eligibility procedures for the O-EPIC Premium Assistance (PA) program; in addition to the OES-3 form, employers will be able to provide documentation regarding terminated or part time employees to determine the number of company employees. O-EPIC 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. Rule revisions are needed to finalize the benefit package offered under the O-EPIC Individual Plan and clarify employer eligibility procedures for the O-EPIC PA program.

CONTACT PERSON:

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED UPON APPROVAL BY THE GOVERNOR AS SET FORTH IN 75 O.S., SECTION 253(D), AND EFFECTIVE UPON APPROVAL BY GOVERNOR OR FEBRUARY 1, 2007, WHICHEVER IS LATER:

SUBCHAPTER 7. O-EPIC PA EMPLOYER ELIGIBILITY

317:45-7-1. Employer application and eligibility requirements for O-EPIC

(a) In order for an employer to be eligible to participate in the O-EPIC program the employer must:

(1) have no more than a total of ~~25~~ 50 employees on its payroll. The number of employees is determined based on the third month employee count of the most recently filed OES-3 form with the Oklahoma Employment Security Commission (OESC) and that is in compliance with all requirements of the OESC. Employers may provide additional documentation confirming terminated or part time employees that will be excluded from the OESC employee count. If the employer is exempt from filing an OES-3 form or is contracted with a PEO or is a Child Care Center, in accordance with OHCA rules, this determination is based on appropriate supporting documentation, such as the W-2 Summary Wage and Tax form as required under OAC 365:10-5-156 to verify employee count;

(2) have a business that is physically located in Oklahoma;

(3) be currently offering or intending to offer within ~~60~~ 90 calendar days an O-EPIC Qualified Health Plan. The Qualified Health Plan coverage must begin on the first day of the month and continue through the last day of the month;

(4) offer Qualified Health Plan coverage to employees in accordance with Oklahoma Small Business Statutes, Oklahoma Department of Insurance, and all other regulatory agencies;

(5) contribute a minimum 25 percent of the eligible employee monthly health plan premium;

(b) An employer who meets all requirements listed in subsection (a) of this Section must complete and submit an employer enrollment packet to the TPA.

(c) The employer must provide its Federal Employee Identification Number (FEIN).

(d) The employer must notify the TPA, within 5 working days from occurrence, of any O-EPIC employee's termination or resignation. ~~Additionally, the employer must notify the TPA of new hires within 30 days of eligibility for the health plan.~~

317:45-7-2. Employer eligibility determination

Eligibility for employers is determined by the TPA using the eligibility requirements listed in OAC 317:45-7-1. An employer determined eligible for O-EPIC is approved for up to a 12 month period. The eligibility period begins on the first day of the month following the date of approval. The eligibility period ends the last day of the 12th month ~~or when coverage through a health plan requires renewal or an open enrollment period occurs.~~ The eligibility period will renew automatically unless the employer's eligibility has been closed (refer to OAC 317:45-7-8). 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; ~~or~~
- (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~~

SUBCHAPTER 11. O-EPIC IP

PART 3. O-EPIC IP MEMBER HEALTH CARE BENEFITS

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; and

(6) 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. Covered in accordance with OAC 317:30-5-7. Eligible services are covered for covered illness or surgery including services provided by a Certified Registered Nurse Anesthetist (CRNA).

(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. Covered in accordance with OAC 317:30-5-22(b)(2). 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. Covered in accordance with OAC 317:30-5-41, 317:30-5-47 and 317:30-5-95; \$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. This visit counts as an office visit.

(8) Office Visits/Specialist Visits. Covered in accordance with OAC 317:30-5-9, 317:30-5-10, and 317:30-5-11. 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. 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). Covered in accordance with OAC 317:30-5-22. Nursery care paid separately under eligible child; \$50 inpatient hospital co-pay.

(11) Laboratory/Pathology. Covered in accordance with OAC 317:30-5-20; \$0 co-pay.

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- (12) Mammogram (Radiological or Digital). Covered in accordance with OAC 317:30-5-901; \$0 co-pay.
- (13) Immunizations for Adults. Covered in accordance with OAC 317:30-5-2; \$10 co-pay per immunization.
- (14) Assistant Surgeon. Covered in accordance with OAC 317:30-5-8.
- (15) Dialysis, Kidney dialysis, and services and supplies, either at home or in a facility; \$0 co-pay.
- (16) Oral Surgery. Services are limited to the removal of tumors or cysts; Inpatient Hospital \$50 or Outpatient Hospital/Facility; \$25 co-pay applies.
- (17) Mental Health Treatment (Inpatient). Covered in accordance with OAC 317:30-5-95.1; \$50 co-pay per admission.
- (18) Mental Health Treatment (Outpatient). Covered in accordance with OAC 317:30-5-241; \$10 co-pay per visit.
- (19) Substance Abuse Treatment (Outpatient). Covered in accordance with OAC 317:30-5-241; \$10 co-pay per visit.
- (20) Durable Medical Equipment and Supplies. Covered in accordance with OAC 317:30-5, Part 17. A PCP referral and prior authorization is required for certain items. DME/Supplies are covered up to a \$15,000 annual maximum; exceptions from the annual DME limit are diabetic supplies, oxygen, home dialysis, and parenteral therapy; \$5 co-pay for durable/non-durable supplies and \$25 co-pay for durable medical equipment.
- (21) Diabetic Supplies. Covered in accordance with OAC 317:30-5, Part 17; not subject to \$15,000 annual DME limit; \$5 co-pay per prescription.
- (22) Oxygen. Covered in accordance with OAC 317:30-5, Part 17; not subject to \$15,000 annual DME limit; \$5 co-pay per month.
- (23) Pharmacy. Covered in accordance with OAC 317:30-5-72.1 and 317:30-5-72. Prenatal vitamins and smoking cessation products do not count against monthly prescription limits; \$5/\$10 co-pay per prescription.
- (24) Smoking Cessation Products. Products do not count against monthly prescription limits. Covered in accordance with OAC 317:30-5-77.2; \$5/\$10 co-pay per product.
- (25) Nutrition Services. Covered in accordance with OAC 317:30-5-1076; \$10 co-pay per visit.
- (26) External Breast Prosthesis, Bras and Prosthetic Garments. Covered in accordance with OAC 317:30-5, Part 17; \$25 co-pay per prosthesis.
- (27) Surgery. Covered in accordance with OAC 317:30-5-8; \$50 co-pay per inpatient admission and \$25 co-pay per outpatient visit.
- (28) Home Dialysis. Covered in accordance with OAC 317:30-5, Part 17; not subject to \$15,000 annual DME limit; \$0 co-pay.
- (29) Parenteral Therapy. Covered in accordance with OAC 317:30-5, Part 17; not subject to \$15,000 annual DME limit; \$25 co-pay per month.
- (30) Family Planning Services and Supplies, including Sterilizations. Covered in accordance with OAC 317:30-3-57; \$0 co-pay.

- (31) Home Health Medications, Intravenous (IV) Therapy and Supplies. Covered in accordance with OAC 317:30-5-211(a)(3)(D)(i) and 317:30-5-41(2)(J)(iii).
- (32) Ultraviolet Treatment-Actinotherapy.
- (33) Fundus photography.

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 and tissue transplant services;
- (4) treatment of obesity;
- (5) procedures, services and supplies related to sex transformation;
- (6) supportive devices for the feet (orthotics) except for the diagnosis of diabetes;
- (7) cosmetic surgery, except as medically necessary and as covered in OAC 317:30-3-59(19);
- (8) over-the-counter drugs, medicines and supplies except contraceptive devices and products, and diabetic supplies;
- (9) experimental procedures, drugs or treatments;
- (10) dental services (preventive, basic, major, orthodontia, extractions or services related to dental accident);
- (11) vision care and services (including glasses), except services treating diseases or injuries to the eye;
- (12) physical medicine including speech, physical, occupational, chiropractic, acupuncture and osteopathic manipulation therapy;
- (13) hearing services;
- (14) transportation [emergent or non-emergent (air or ground)];
- (15) rehabilitation (inpatient);
- (16) cardiac rehabilitation;
- (17) allergy testing and treatment;
- (18) home health care with the exception of medications, intravenous (IV) therapy, supplies;
- (19) hospice regardless of location;
- (20) Temporomandibular Joint Dysfunction (TMD) (TMJ);
- (21) genetic counseling;
- (22) fertility evaluation/treatment/and services;
- (23) sterilization reversal;
- (24) Christian Science Nurse;
- (25) Christian Science Practitioner;
- (26) skilled nursing facility;
- (27) longterm care;
- (28) stand by services;
- (29) thermograms; and

(30) abortions (for exceptions, refer to OAC 317:30-5-6).

[OAR Docket #07-335; filed 2-23-07]

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

[OAR Docket #07-333]

RULEMAKING ACTION:
EMERGENCY adoption

RULES:

- Subchapter 9. O-EPIC PA Employee Eligibility 317:45-9-1. [AMENDED]
 - Subchapter 11. O-EPIC IP [NEW]
 - Part 5. O-EPIC Individual Plan Member Eligibility [NEW] 317:45-11-20. [NEW]
- (Reference APA WF # 06-53B)

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 435.601

DATES:

Adoption:

December 14, 2006

Approved by Governor:

January 30, 2007

Effective:

Immediately upon Governor's approval or February 1, 2007, whichever is later

Expiration:

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

SUPERSEDED EMERGENCY ACTIONS:

Superseded rules:

- Subchapter 9. O-EPIC PA Employee Eligibility 317:45-9-1. [AMENDED]
- Subchapter 11. O-EPIC IP [NEW]
- Part 5. O-EPIC Individual Plan Member Eligibility [NEW] 317:45-11-20. [NEW]

Gubernatorial approval:

August 31, 2006

Register publication:

24 Ok Reg 101

Docket number:

06-1316

(Reference APA WF # 06-08)

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 will extend health coverage to more low income working individuals.

ANALYSIS:

Rules are revised to reflect a \$240 earned income disregard for work related expenses when determining Oklahoma Employer and Employee Partnership for Insurance Coverage (O-EPIC) eligibility. Currently, individuals related to AFDC or Pregnancy receive a monthly \$120 deduction from earned income for work related expenses when calculating the benefit group's income for SoonerCare eligibility. Recently, the Oklahoma Department of Human Services increased the monthly earned income disregard for Temporary Assistance to Needy Families (TANF, formerly known as AFDC) recipients from \$120 to \$240. In order for SoonerCare to continue to be linked with TANF, OHCA must apply the financial methodologies and requirements of the cash assistance program that are most closely categorically related to the

individual's status. In addition, individuals participating in the Oklahoma Employer and Employee Partnership for Insurance Coverage (O-EPIC) and those eligible for family planning services only (SoonerPlan), presently do not receive any deduction from earned income for work related expenses. These revisions will give all working individuals in these groups the same monthly work related expense deduction of \$240. Agency rules are revised to allow a monthly earned income disregard of \$240 for working individuals related to AFDC or Pregnancy, those eligible for family planning services only, and those participating in O-EPIC.

CONTACT PERSON:

Joanne Terlizzi at (405)522-7272

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED UPON APPROVAL BY THE GOVERNOR AS SET FORTH IN 75 O.S., SECTION 253(D), AND EFFECTIVE UPON APPROVAL BY GOVERNOR OR FEBRUARY 1, 2007, WHICHEVER IS LATER:

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 countable household income at or below 185% of the Federal Poverty Level. The standard deduction for work related expenses such as income tax payments, Social Security taxes, and transportation to and from work, is \$240 per each full-time or part-time employed member;
- (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;

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- (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.

SUBCHAPTER 11. O-EPIC IP

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.
 - (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 a countable household income at or below 185% of the Federal Poverty Level. The standard deduction for work related expenses such as income tax payments, Social Security taxes, and transportation to and from work, is \$240 per each full-time or part-time employed member; 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.

[OAR Docket #07-333; filed 2-23-07]

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

1:2007-8.

EXECUTIVE ORDER 2007-8

I, Brad Henry, Governor of the State of Oklahoma, by the authority vested in me pursuant to Sections 1 and 2 of Article VI of the Oklahoma Constitution, hereby establish the Governor's Elimination of Health Disparities Task Force.

The purpose shall be to help the Oklahoma Department of Health eliminate health access disparities in Oklahoma among multicultural, disadvantaged and regional populations. The task force shall focus on at least six (6) major areas of health including, but not limited to, cardiovascular disease, infant mortality, diabetes, cancer and adult and child immunizations.

The Elimination of Health Disparities Task Force will investigate and report on issues related to disparities in health and health access among multicultural, disadvantaged and regional populations. Such issues may include the definition of health disparities, insurance, transportation, geographic isolation and rural area availability of health care providers, cultural competency of providers, severity of poverty among multicultural groups, education as it relates to health, and behaviors that lead to poor health status. The Task Force shall recommend short-term and long-term strategies to eliminate health and health access disparities among multicultural, disadvantaged and regional populations. The task force will study and make recommendations to improve the lack of coverage for preventative measures by third party health insurance providers.

The Task force will make recommendations to implement a standardized statewide data collection system to track disparities. Such data collection system shall be in compliance with local and federal laws including, but not limited to, The Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Task Force shall develop partnerships between federal, state and local agencies and communities to minimize cultural and communication barriers that impact access to health care and health education. The Task Force will recommend training for health care providers to reduce health care disparities.

The Task Force shall consist of twelve (12) members to be appointed by, and to serve at the pleasure of, the Governor. Appointees may include persons who represent faith-based communities, the business community, the labor community,

the Legislature, charitable or community organizations, racial or ethnic groups affected by health disparities, community based health organizations, the government and health care organizations.

The Task Force shall meet at least quarterly at the call of the chair. Members shall serve without compensation. Task Force members employed by a state agency shall be reimbursed travel expenses related to their service on the Task Force as authorized by state law by their respective state agency. Legislative members of the Task Force shall be reimbursed as authorized by state law by their respective houses for necessary travel expenses incurred in the performance of their duties. Remaining Task Force members shall also be reimbursed travel expenses related to their service on the Task Force as authorized by state law by the Oklahoma Department of Health. Administrative support for the Task Force, including, but not limited to, personnel necessary to ensure the proper performance of the duties and responsibilities of the Task Force, shall be provided by the Oklahoma Department of Health. All participating state agencies and entities shall provide for any administrative support requested by the Task Force.

The Task Force shall elect a chair and vice chair from its membership. The Task Force shall annually submit a report on the progress of the Oklahoma Department of Health in achieving the goals outlined in this Order to the Governor, Speaker of the House of Representatives and President Pro Tempore of the Senate. The final report shall be completed within two (2) years of the date of this Order.

This Executive Order shall be distributed to the Oklahoma Department of Health which shall cause the provisions of this Order to be implemented.

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 23 day of February, 2007.

BY THE GOVERNOR OF THE
STATE OF OKLAHOMA

Brad Henry

ATTEST:

Kathy Jekel

Acting Assistant Secretary of State

[OAR Docket #07-339; filed 2-26-07]

