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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 4. RULES OF PRACTICE AND PROCEDURE

[OAR Docket #07-1332]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

Subchapter 7. Environmental Permit Process

Part 7. Water Quality Division Tiers and Time Lines

252:4-7-73. Water quality applications - Tier I
[AMENDED]

252:4-7-74. Water quality applications - Tier II
[AMENDED]

SUMMARY:

The proposed changes to the Water Quality Application Tier rules cleans up language to make the classifications of Tier I permits consistent, clarifies that modifications to or the addition of impoundments to an existing permitted industrial wastewater system is a Tier I application, and adds language to clarify that a new industrial wastewater treatment system application is classified as a Tier II.

AUTHORITY:

Environmental Quality Board and Water Quality Management Advisory Council powers and duties, 27A O.S. §§ 2-2-101, 2-2-104, 2-2-201, 2-6-101 *et seq.*

COMMENT PERIOD:

Oral comments may be made at the meeting of the Water Quality Management Advisory Council to be held on October 2, 2007, and at the Environmental Quality Board on November 15, 2007. Written comments may be delivered or mailed to the contact person from August 15, 2007, through October 2, 2007.

PUBLIC HEARING:

Before the Water Quality Management Advisory Council at 1:00 p.m. on October 2, 2007, at the offices of the Oklahoma Department of Environmental Quality, 707 N. Robinson, Oklahoma City, Oklahoma.

Before the Environmental Quality Board at 9:30 a.m. on November 15, 2007, at Southwestern Oklahoma State University, Student Union Building, 800 North Custer, Weatherford, Oklahoma 73096.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

The DEQ requests that business entities affected by this rule provide the DEQ, within the comment period, in dollar

amounts if possible, the increase in the level of direct costs such as fees, and the indirect costs such as reporting, 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 rule.

COPIES OF PROPOSED RULE:

The proposed rule may be may be obtained from the contact person or reviewed at the Department of Environmental Quality, 707 N. Robinson, Oklahoma City, Oklahoma, 73102. Additionally, the proposed rules are available on-line at www.deq.state.ok.us/wqdnew/index.html under "what's new".

RULE IMPACT STATEMENT:

The rule impact statement for the proposed rule will be on file at the Department of Environmental Quality and may be requested from the contact person.

CONTACT PERSON:

Contact Donald D. Maisch at don.maisch@deq.state.ok.us or (405) 702-7189 (phone) or 702-7199 (fax). The DEQ is located at 707 N. Robinson, Oklahoma City, Oklahoma 73102. The mailing address is P.O. Box 1677, Oklahoma City, Oklahoma 73101-1677.

ADDITIONAL INFORMATION:

Persons with disabilities who desire to attend the rulemaking hearing and need an accommodation should notify the contact person three (3) days in advance of the hearing, TDD Relay Number 1-800-522-8506.

[OAR Docket #07-1332; filed 7-26-07]

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

[OAR Docket #07-1333]

RULEMAKING ACTION:

Notice of proposed PERMANENT and EMERGENCY rulemaking

PROPOSED RULES:

Subchapter 19. Operational Requirements

Part 13. Wheel Washes

252:515-19-132. Eligibility deadlines [AMENDED]

252:515-19-133. Definitions [AMENDED]

252:515-19-134. Approved costs [AMENDED]

252:515-19-135. Disapproved costs [AMENDED]

Notices of Rulemaking Intent

252:515-19-136. ~~Recoupment~~—Reimbursement process
[AMENDED]

252:515-19-137. State fiscal limitation on funds
[AMENDED]

SUMMARY:

The proposed amendments to 252:515, Subchapter 19, arise from legislation enacted in 2007, effective July 1, 2007. Senate Bill 509 made significant changes to the wheel wash law by eliminating the provision for "recoupment" and providing instead for "reimbursement". Therefore, no facility will be allowed to retain monies from the solid waste fee for recoupment of wheel wash costs. The proposed rules mirror the current wheel wash rules relative to the requirements for installation, operation, proper invoicing and DEQ approvals. The proposed rule 19-133 eliminates the definition of recoupment. The word "recoupment" is replaced with the word "reimbursement" in proposed rules 19-132, 19-134, 19-135, 19-136(a)(2) and 19-137(b). Any phrases related to "retaining of fees or funds" is replaced with the word "reimbursed" in proposed rules 19-137(a)&(b). Rules pertaining to the "recoupment process" were replaced with rules pertaining to the "reimbursement process" in proposed rule 19-136.

AUTHORITY:

Environmental Quality Board; 27A O.S. §§ 2-2-101, 2-2-201 and 2-10-802.

COMMENT PERIOD:

Deliver or mail written comments on the proposed rule to the contact person from August 15 through September 20, 2007. Oral comments may be made at the Solid Waste Management Advisory Council meeting on September 20, 2007, or at the Environmental Quality Board meeting on November 15, 2007.

PUBLIC HEARING:

Before the Solid Waste Management Advisory Council at its meeting at 9:00 a.m. on September 20, 2007, in the Multi-Purpose Room, first floor of the Department of Environmental Quality, 707 N. Robinson, Oklahoma City, OK 73102.

Before the Environmental Quality Board on November 15, 2007, at 9:30 a.m. at Southwestern Oklahoma State University, 800 N. Custer, Student Union Bldg., Weatherford, Oklahoma 73096.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

The DEQ requests that business entities affected by the proposed rule provide the DEQ, within the comment period, in dollar amounts if possible, the increase in the level of direct costs such as fees, and the indirect costs such as reporting, 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 rule.

COPIES OF PROPOSED RULE:

A copy of the proposed rule may be obtained from the contact person, viewed on the DEQ website at www.deq.state.ok.us, or may be viewed at the Department

of Environmental Quality, 707 N. Robinson, Oklahoma City, Oklahoma, 73102.

RULE IMPACT STATEMENT:

The rule impact statement for the proposed rule may be obtained from the contact person, viewed on the DEQ website at www.deq.state.ok.us, or may be viewed at the Department of Environmental Quality, 707 N. Robinson, Oklahoma City, Oklahoma, 73102.

CONTACT PERSON:

Contact Dee Ready at d.ready@deq.state.ok.us or (405) 702-5218 (phone) or (405) 702-5101 (fax). The DEQ is located at 707 N. Robinson, Oklahoma City, Oklahoma 73102. The mailing address is P.O. Box 1677, Oklahoma City, Oklahoma 73101-1677.

ADDITIONAL INFORMATION:

Persons with disabilities who desire to attend the rulemaking hearing and need an accommodation should notify the contact person three (3) days in advance of the hearing, TDD Relay Number 1-800-522-8506.

[OAR Docket #07-1333; filed 7-26-07]

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

[OAR Docket #07-1334]

RULEMAKING ACTION:

Notice of proposed PERMANENT and EMERGENCY rulemaking

PROPOSED RULES:

Subchapter 21. Waste Tire Processing, Certification, Permits and Compensation

Part 1. General Provisions

252:515-21-1. [AMENDED]

252:515-21-3. [AMENDED]

252:515-21-5. [AMENDED]

Part 3. Waste Tire Facilities

252:515-21-32. [AMENDED]

Part 5. Waste Tire Transportation

252:515-21-51. [AMENDED]

Part 7. Compensation from the Waste Tire Indemnity Fund

252:515-21-71. [AMENDED]

252:515-21-73. [AMENDED]

Part 9. Erosion Control, River Bank Stabilization and other Conservation Projects

252:515-21-92. [AMENDED]

Part 13. Tire Dealer and Motor License Agent Audits
[NEW]

252:515-21-131. [NEW]

SUMMARY:

The purpose of the proposed new and amended language to 252:515, Subchapter 21 arises from Senate Bill 747. These

rules implement statutory changes effective July 2007. The statutory changes require waste tire facilities, tire derived fuel facilities and entities involved in erosion control projects (hereinafter referred to as "qualified applicants") to submit requests for reimbursement to the Oklahoma Department of Environmental Quality (DEQ). Proposed rule changes will require qualified applicants to demonstrate that at least two percent (2%) of the waste tires are collected from illegal dumps or landfills on the priority cleanup list (PCL) or community-wide cleanup events as opposed to the previous requirement of five percent (5%). Amendments to 252:515, Subchapter 21 require qualified applicants to receive DEQ approval upon completion of collection efforts from illegal tire dumps and community-wide cleanup events. The proposed new rules and amendments also clarify DEQ's authority with respect to manifest requirements, tire dealer audits, and motor license agent audits.

AUTHORITY:

Environmental Quality Board powers and duties, 27A O.S. § 2-2-101, Solid Waste Management Advisory Council powers and duties, 27A O.S. § 2-2-201 and § 2-10-201, and the Oklahoma Waste Tire Recycling Act, 27A O.S. § 2-11-401, et seq.

COMMENT PERIOD:

Deliver or mail written comments on the proposed rules to the contact person from August 15 through September 20, 2007. Oral comments may be made at the Solid Waste Management Advisory Council meeting at 9:00 a.m. on September 20, 2007, in the Multi-Purpose Room, first floor of the Department of Environmental Quality, 707 N. Robinson, Oklahoma City, OK 73102., and at the Environmental Quality Board meeting at 9:30 a.m. on November 15, 2007, at Southwestern Oklahoma State University, 800 N. Custer, Student Union Building, Weatherford, Oklahoma 73096.

PUBLIC HEARINGS:

Before the Solid Waste Management Advisory Council at 9:00 a.m. on September 20, 2007, in the Multi-Purpose Room, first floor of the Department of Environmental Quality, 707 N. Robinson, Oklahoma City, OK 73102.

Before the Environmental Quality Board at 9:30 a.m. on November 15, 2007, at Southwestern Oklahoma State University, 800 N. Custer, Student Union Building, Weatherford, Oklahoma 73096.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

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

COPIES OF PROPOSED RULES:

Copies of the proposed rules may be obtained from the contact person, may be viewed on the DEQ web site at

www.deq.state.ok.us/LPDnew/LPPproprules.htm, or may be reviewed at the Department of Environmental Quality, 707 N. Robinson, Oklahoma City, Oklahoma.

RULE IMPACT STATEMENT:

The Rule Impact Statement for the proposed rules will be on file at the Department of Environmental Quality and may be requested from the contact person, or may be viewed on the DEQ web site at www.deq.state.ok.us/LPDnew/LPPproprules.htm.

CONTACT PERSON:

Ferrella March, Land Protection Division, Solid Waste Management Section, P.O. Box 1677, Oklahoma City, OK 73101-1677, e-mail at ferrella.march@deq.state.ok.us, phone 405-702-5175, or fax 405-702-5101.

ADDITIONAL INFORMATION:

Persons with disabilities who desire to attend the public hearing to be held before the Solid Waste Management Advisory Council and need assistance should notify the contact person three days in advance of the meeting during business hours at 405-702-5100 or by using TDD relay number 1-800-522-8506.

[OAR Docket #07-1334; filed 7-26-07]

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

[OAR Docket #07-1335]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

Appendix C. List of Hazardous Inorganic and Organic Constituents [REVOKED]

Appendix C. List of Hazardous Inorganic and Organic Constituents [NEW]

SUMMARY:

The proposed amendment to OAC 252:515, Appendix C, deletes the suggested methods and PQL columns of Appendix C to update it to the current Federal Appendix II to 40 CFR 258. On October 30, 2002, EPA proposed to amend the testing and monitoring requirements under the hazardous and non-hazardous solid waste regulations. On June 14, 2005, EPA finalized those regulatory revisions as discussed in the Federal Register dated June 14, 2005 (Volume 70, Number 113), FR Doc 05-10197.

The "suggested methods" column in the current rules outlines SW-846 methods to be utilized by regulated entities to analyze for certain parameters. The column entitled "PQL" in the current rules is the practical quantitation limits that are required to be met for the method utilized from the suggested methods column. By deleting those two columns from the current rules, it will allow regulated entities to use

Notices of Rulemaking Intent

any appropriate analytical test methods in demonstrating compliance with the RCRA regulations and not limit the methods to SW-846 methods except for those regulatory provisions involving method-defined parameters.

AUTHORITY:

Environmental Quality Board; 27A O.S. §2-2-101, §2-2-201 and §2-10-201.

COMMENT PERIOD:

Oral comments may be made at the meeting of the Solid Waste Management Advisory Council to be held on September 20, 2007, and at the Environmental Quality Board on November 15, 2007. Written comments may be delivered or mailed to the contact person from August 15, 2007, through September 20, 2007.

PUBLIC HEARING:

Before the Solid Waste Management Advisory Council at 9:00 a.m. on September 20, 2007, in the Multi-Purpose Room, first floor of the Department of Environmental Quality, 707 N. Robinson, Oklahoma City, OK 73102.

Before the Environmental Quality Board at 9:30 a.m. on November 15, 2007, at Southwestern Oklahoma State University, 800 N. Custer, Student Union Bldg., Weatherford, Oklahoma 73096.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

The DEQ requests that business entities affected by this rule provide the DEQ, within the comment period, in dollar amounts if possible, the increase in the level of direct costs such as fees, and the indirect costs such as reporting, 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 rule.

COPIES OF PROPOSED RULE:

The proposed rule may be obtained from the contact person, viewed on the DEQ website at www.deq.state.ok.us, or may be viewed at the Department of Environmental Quality, 707 N. Robinson, Oklahoma City, Oklahoma, 73102.

RULE IMPACT STATEMENT:

The rule impact statement for the proposed rule may be obtained from the contact person, viewed on the DEQ website at www.deq.state.ok.us, or may be viewed at the Department of Environmental Quality, 707 N. Robinson, Oklahoma City, Oklahoma 73102.

CONTACT PERSON:

Contact Dee Ready at d.ready@deq.state.ok.us or (405) 702-5218 (phone) or (405) 702-5101 (fax). The DEQ is located at 707 N. Robinson, Oklahoma City, Oklahoma 73102. The mailing address is P.O. Box 1677, Oklahoma City, Oklahoma 73101-1677.

ADDITIONAL INFORMATION:

Persons with disabilities who desire to attend the rulemaking hearing and need an accommodation should

notify the contact person three (3) days in advance of the hearing, TDD Relay Number 1-800-522-8506.

[OAR Docket #07-1335; filed 7-26-07]

TITLE 252. DEPARTMENT OF ENVIRONMENTAL QUALITY CHAPTER 633. DRINKING WATER STATE REVOLVING FUND

[OAR Docket #07-1336]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

Subchapter 1. General Provisions

252:633-1-1. Purpose [AMENDED]

252:633-1-4. Authority [AMENDED]

252:633-1-5. Definitions [AMENDED]

Subchapter 3. General Program Requirements

252:633-3-3. Revenue program [AMENDED]

252:633-3-4. DWSRF Project Priority System [AMENDED]

252:633-3-8. Types of assistance [AMENDED]

252:633-3-9. Pre-application for funding [AMENDED]

252:633-3-13. ~~Submittals Plans and Specifications~~ [AMENDED]

252:633-3-14. Application for financial assistance [AMENDED]

252:633-3-16. Loan closing [AMENDED]

252:633-3-17. Refinancing construction loans [AMENDED]

252:633-3-19. Construction phase [AMENDED]

252:633-3-20. Project changes [AMENDED]

252:633-3-21. Building phase submittals [AMENDED]

252:633-3-22. Progress payments. [AMENDED]

252:633-3-25. Accounting [AMENDED]

Subchapter 5. Miscellaneous Provisions

252:633-5-5. Project or water project completion, inspection and audit [AMENDED]

Subchapter 7. Environmental Review Process

252:633-7-1. Requirement of environmental review [AMENDED]

Appendix A. Funding Priority Formula [REVOKED]

Appendix A. Funding Priority Formula [NEW]

SUMMARY:

The proposed changes to the DEQ's Drinking Water State Revolving Fund (DWSRF) rules implement changes to the Priority Project System and the Funding Priority Formula necessary to meet federal and state requirements. Additionally, some of the proposed changes to this chapter reconcile the requirements in Chapter 633 of the DEQ rules with the DWSRF requirements of the Oklahoma Water Resources Board. The remaining changes correct typographical errors and make other language clarification changes.

AUTHORITY:

Environmental Quality Board and Water Quality Management Advisory Council powers and duties, 27A O.S. §§ 2-2-101, 2-2-104, 2-2-201, 2-6-101 *et seq.*

COMMENT PERIOD:

Oral comments may be made at the meeting of the Water Quality Management Advisory Council to be held on October 2, 2007, and at the Environmental Quality Board on November 15, 2007. Written comments may be delivered or mailed to the contact person from August 15, 2007, through October 2, 2007.

PUBLIC HEARING:

Before the Water Quality Management Advisory Council at 1:00 p.m. on October 2, 2007, at the offices of the Oklahoma Department of Environmental Quality, 707 N. Robinson, Oklahoma City, Oklahoma 73102.

Before the Environmental Quality Board at 9:30 a.m. on November 15, 2007, at Southwestern Oklahoma State University, Student Union Building, 800 North Custer, Weatherford, Oklahoma 73096.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

The DEQ requests that business entities affected by this rule provide the DEQ, within the comment period, in dollar amounts if possible, the increase in the level of direct costs such as fees, and the indirect costs such as reporting, 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 rule.

COPIES OF PROPOSED RULE:

The proposed rule may be obtained from the contact person or reviewed at the Department of Environmental Quality, 707 N. Robinson, Oklahoma City, Oklahoma, 73102. Additionally, the proposed rules are available on-line at www.deq.state.ok.us/wqdnew/index.html under "what's new".

RULE IMPACT STATEMENT:

The rule impact statement for the proposed rule will be on file at the Department of Environmental Quality and may be requested from the contact person.

CONTACT PERSON:

Contact Donald D. Maisch at don.maisch@deq.state.ok.us or (405) 702-7189 (phone) or 702-7199 (fax). The DEQ is located at 707 N. Robinson, Oklahoma City, Oklahoma 73102. The mailing address is P.O. Box 1677, Oklahoma City, Oklahoma 73101-1677.

ADDITIONAL INFORMATION:

Persons with disabilities who desire to attend the rulemaking hearing and need an accommodation should notify the contact person three (3) days in advance of the hearing, TDD Relay Number 1-800-522-8506.

[OAR Docket #07-1336; filed 7-26-07]

Continued Hearings/Comment Periods

If an agency continues a hearing or comment period announced in a published Notice of Rulemaking Intent, the agency may submit a notice of such continuation to the Office of Administrative Rules (OAR). The OAR publishes the continuation notice in the *Register* if such publication can be achieved at least five days prior to the announced date of the continued hearing or closing date of the continued comment period.

For additional information on continued hearings and comment periods, see OAC 655:10-7-28.

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

[OAR Docket #07-1331]

RULEMAKING ACTION:

Continued comment period and public hearing

PROPOSED RULES:

Subchapter 1. General Provisions

435:20-1-1.1. Definitions [AMENDED]

Subchapter 7. Supervision of Physical Therapist Assistants

435:20-7-1. Supervision of Physical Therapist Assistants
[AMENDED]

REGISTER PUBLICATION OF NOTICE:

The Notice of Rulemaking Intent for this action was published at 24 Ok Reg 2491.

CONTINUED COMMENT PERIOD:

Original comment period: July 2, 2007 to August 9, 2007.

Continued to: November 1, 2007 to December 6, 2007.

CONTINUED PUBLIC HEARING:

Original public hearing: August 16, 2007

Continued to: December 13, 2007, 9:00 a.m. at the office of the Board, 5104 North Francis Avenue, Suite C, Oklahoma City, Oklahoma. Written notice of intent to make oral comment must be received by this office no later than December 6, 2007.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

n/a

COPIES OF PROPOSED RULES:

Copies of the proposed rules may be obtained at the office of the Board, 5104 North Francis Avenue, Suite C, Oklahoma City, Oklahoma after November 1, 2007.

RULE IMPACT STATEMENT:

A rule impact statement is available at the office of the Board, 5104 North Francis Avenue, Suite C, Oklahoma City, Oklahoma 73118.

CONTACT PERSON:

Jan Ewing, Deputy Director (405) 848-6841, ext. 104

[OAR Docket #07-1331; filed 7-25-07]

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 150. OKLAHOMA DEPARTMENT OF
COMMERCE
CHAPTER 130. OKLAHOMA QUALITY
INVESTMENT ACT**

[OAR Docket #07-1319]

RULEMAKING ACTION:

Gubernatorial approval of emergency rules

RULES:

150:130-1-1 [NEW]

150:130-1-2 [NEW]

150:130-1-3 [NEW]

150:130-1-4 [NEW]

150:130-1-5 [NEW]

150:130-1-6 [NEW]

150:130-1-7 [NEW]

150:130-1-8 [NEW]

GUBERNATORIAL APPROVAL:

July 13, 2007

[OAR Docket #07-1319; filed 7-23-07]

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 150. OKLAHOMA DEPARTMENT OF COMMERCE CHAPTER 130. OKLAHOMA QUALITY INVESTMENT ACT

[OAR Docket #07-1320]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

150:130-1-1 [NEW]
150:130-1-2 [NEW]
150:130-1-3 [NEW]
150:130-1-4 [NEW]
150:130-1-5 [NEW]
150:130-1-6 [NEW]
150:130-1-7 [NEW]
150:130-1-8 [NEW]

AUTHORITY:

The legislation establishing the Oklahoma Department of Commerce 74 O.S. §§ 5001 et seq., and Section 1 of House Bill 1619 of the 2nd Session of the 50th Oklahoma Legislature, executed by the Governor on February 21, 2006, and then approved by a vote of the people on November 7, 2006 by ratification of State Question 725.

DATES:

Adoption:

June 5, 2007

Approved by Governor:

July 13, 2007

Effective:

Immediately upon Approval by Governor or July 1, 2007, whichever is later.

Expiration:

Effective through July 14, 2008, unless superseded by another rule or disapproved by the Legislature

SUPERSEDED EMERGENCY ACTIONS:

N/A

INCORPORATIONS BY REFERENCE:

N/A

FINDING OF EMERGENCY:

Section 8 of House Bill 1169 of House Bill 1619 of the 2nd Session of the 50th Oklahoma Legislature, executed by the Governor on February 21, 2006, mandates the Oklahoma Department of Commerce to promulgate emergency rules for the Oklahoma Quality Investment Act. House Bill 1169 will be effective July 1, 2007.

ANALYSIS:

The Emergency Rules provide a systematic, equitable method for making application for Quality Investment Contracts and a framework for the Quality Investment Committee to make recommendations to the Contingency Review Board for Quality Investment Contracts.

CONTACT PERSON:

Donald R. Hackler, Jr. (405) 815-5359

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

150:130-1-1. Purpose

The purpose of these rules is to implement the Oklahoma Quality Investment Act at the Oklahoma Department of Commerce.

150:130-1-2. Definitions

In addition to those terms defined elsewhere in this chapter, the following words and terms when used in this subchapter shall have the following meaning unless the context clearly indicates otherwise.

"At-risk establishments" are those manufacturing establishments presently existing in Oklahoma which the Quality Investment Committee, as described in paragraph 6 of this section, finds would be lost within the state based on changes in global economies, establishment structure, consolidation of establishments, and which are structurally noncompetitive but which could regain a competitive position with new investment if incentives are offered.

"Capital costs" means costs for land, building, improvements to buildings, fixtures and for machinery and equipment as those terms are described in Section 2902 of Title 68 of the Oklahoma Statutes.

"Economic impact" means economic impact as described in analyses that identify the value in terms of sales tax and income tax revenues to the state and to the local community of the establishment that the retention and expansion or modernization of the manufacturing site provides. The Oklahoma Department of Commerce may contract for the performance of an economic impact analysis to aid it in determining whether to recommend entering into a Quality Investment Contract with a particular establishment.

"Historical contributions trends" means historical contributions of an establishment as described in analyses of direct and indirect historical contributions to the state and local economies that an establishment has had on jobs and tax base growth, and on payroll and tax revenue inputs and growth.

Emergency Adoptions

Analyses shall include consideration of positive trends attributable to suppliers of the establishment. The Oklahoma Department of Commerce may contract for the performance of an historical contributions analysis to aid the Quality Investment Committee in determining whether to recommend entering into a Quality Investment Contract with a particular establishment.

"Local community" means the town or city and the county of the location of the establishment; provided, a city or town and a county may jointly constitute the "local community".

"Quality Investment Committee" means the independent committee referenced in paragraph 6 of Section 23 of Article X of the Oklahoma Constitution that consists of the following members:

- (A) The Director of the Oklahoma Department of Commerce.
- (B) The Dean of Engineering of Oklahoma State University.
- (C) The Director of the Oklahoma Alliance for Manufacturing Excellence.
- (D) The Dean of the Price Business College of the University of Oklahoma.
- (E) The Executive Director for the Oklahoma Center for the Advancement of Science and Technology.
- (F) One small business representative from the Oklahoma Science and Technology Research and Development Board.
- (G) The State Director of Career Technology Education.

"Tax revenues projections" means a projection of anticipated tax revenues based upon an analysis of historic taxes collected from the establishment in the local community and in the state overall over the previous ten (10) years in order to determine: a. the average of the growth percentages to determine the projected growth in such revenues to the community and the state over the following ten (10) years if no retooling occurs but retention is assumed to be a constant and remains stagnant, b. the modernization or retooling project's estimated impact on tax revenues and growth rates over the following ten (10) years, and c. the projections of loss in tax revenues should the plant location close and operations, in whole or in part, are removed from the state. The Oklahoma Department of Commerce may contract with the Oklahoma Tax Commission for performance of tax revenues projections analyses to aid it in determining whether to enter into an agreement upon recommendation of the Quality Investment Committee. [68:4203(7)]

"Establishment" means a manufacturer that is a partnership, limited partnership, corporation, limited liability company, limited liability partnership, or sole proprietorship. The establishment may enter into a Quality Investment Contract pertaining to only one manufacturing site as that term is defined in Section 1352 of Title 68 of the Oklahoma Statutes. No combination of other locations of the establishment, or any related entities of the establishment is contemplated. An establishment may have multiple contracts due to multiple sites or multiple expansions due to retooling and modernization at one site.

"NAICS Manual" means any manual book or other publication containing the North American Industry Classification System, United States, 1997, or as updated or amended from time to time, promulgated by the Office of Management and Budget of the United States of America.

"Start date" means the date on which an establishment may begin accruing benefits for investment of new capital costs in a manufacturing site that is assigned in the agreement with the Oklahoma Department of Commerce.

"Commission" means the Oklahoma Tax Commission established pursuant to 68 O.S. Section 102, and any successor agencies thereto.

"Department" means the Oklahoma Department of Commerce. [68 O.S. § 4103]

150:130-1-3. Eligible entities

Eligible entities to make application to the Oklahoma Department of Commerce under the Oklahoma Quality Investment Act are establishments as defined at 68 O.S. § 4203(8).

150:130-1-4. Application and required information

(a) An establishment shall prepare a written application following the guidelines, forms, and procedures as set forth in the application prepared by the Oklahoma Department of Commerce and approved by the Quality Investment Committee. An establishment shall be required to provide the following information:

- (1) The location of the project and if the location is an economically distressed area of the State.
- (2) The number of jobs that are at risk and the average salary of the jobs at risk.
- (3) The calendar year and quarter in which the investment begins.
- (4) The projected employment and investment resulting from the project over three (3) years.
- (5) The third year average salary of the new workers hired in the new direct jobs.
- (6) A description of the establishment's operations and the lines of business and operations of the project for which an application is being submitted.
- (7) NAICS code number for the establishment.
- (8) Business plans.
- (9) Feasibility studies.
- (10) Financing proposals.
- (11) Financial statements for the previous three (3) years.
- (12) Marketing plans.
- (13) Registration with the Oklahoma Secretary of State.
- (14) Registration with the Commission.
- (15) Such other information as may be required by the Department for a full and detailed analysis of the project.

(b) The establishment shall also provide a copy of its basic health benefits plan offered to employees or a description of the plan that will be offered within twelve (12) months of the date that it enters into a Quality Investment Contract.

150:130-1-5. Quality investment contract

An establishment which meets the qualifications specified in the Oklahoma Quality Investment Act may apply to enter into a Quality Investment Contract with the Oklahoma Department of Commerce to receive annual incentive payments over a five-year period from the Oklahoma Tax Commission pursuant to the provisions of the Oklahoma Quality Investment Act pursuant to the requirements set forth in 68 O.S. § 4204, with the following specific requirements more fully set forth:

- (1) Be engaged in manufacturing in activities described under Industry Group Nos. 31 through 33 of the NAICS Manual;
- (2) Incur capital costs for new retooling or modernization projected to equal or exceed One Million Dollars (\$1,000,000.00) within twenty-four (24) months of the start date; and
- (3) Apply to and enter into a Quality Investment Contract specifying:
 - (A) The amount of capital investment the establishment must make within twenty-four (24) months of the start date in order to remain in the Oklahoma Quality Investment Program.
 - (B) The total minimum amount of Oklahoma taxable payroll it will maintain in this state during the course of the agreement.
 - (C) The total amount in incentive payments it may receive.
 - (D) If applicable, the amount of local revenues a county or municipality intends to apportion to the establishment annually, and
 - (E) That it will offer "basic health insurance" as defined in the Oklahoma Quality Jobs Program Act, within twelve (12) months of entering into a Quality Investment Contract.

150:130-1-6. Transmittal of information

The Department shall notify the Commission of each approved Quality Investment Contract. The Department shall provide the Commission with a copy of each approved Quality Investment Contract.

150:130-1-7. Claim for incentive payments

At the end of a calendar year for which an establishment has qualified to receive an incentive payment, the establishment shall file a claim with the Commission following the requirements and procedures established by the Commission and the requirements set forth at 68 O.S. § 4205.

150:130-1-8. Prohibition on receiving other credits or exemptions

Notwithstanding any other provision of law, if a qualified establishment receives an incentive payment pursuant to the provisions of this act, neither the qualified establishment nor its contractors or subcontractors shall be eligible to receive the credits or exemptions provided for in the following provisions of law in connection with the activity for which the incentive payment was received:

- (1) Section 625.1 of Title 36 of the Oklahoma Statutes (premium tax credits);
- (2) Paragraph 7 of Section 1359 of Title 68 of the Oklahoma Statutes (construction materials sales tax refunds);
- (3) Section 2357.4 of Title 68 of the Oklahoma Statutes (new jobs/investment income tax credits);
- (4) Section 2357.7 of Title 68 of the Oklahoma Statutes (venture capital investment credits);
- (5) Section 2-11-303 of Title 27A of the Oklahoma Statutes (pollution control equipment investment income tax credits);
- (6) Section 2357.22 of Title 68 of the Oklahoma Statutes (income tax credits for investment in clean-burning motor fuel vehicles);
- (7) Section 2357.31 of Title 68 of the Oklahoma Statutes (small business income tax credits);
- (8) Section 54003 of Title 68 of the Oklahoma Statutes (research and development or computer services sales tax refunds);
- (9) Subsections C and D of Section 2357.29 of Title 68 of the Oklahoma Statutes (recycling income tax credits);
- (10) Section 2902 of Title 68 of the Oklahoma Statutes (state reimbursement to communities for property tax exemptions to manufacturers);
- (11) Section 3601 et seq. of Title 68 of the Oklahoma Statutes (Oklahoma Quality Jobs Program Act);
- (12) Section 3701 et seq. of Title 68 of the Oklahoma Statutes (Saving Quality Jobs Act);
- (13) Section 3801 et seq. of Title 68 of the Oklahoma Statutes (Former Military Facilities Development Act);
- (14) Section 3901 et seq. of Title 68 of the Oklahoma Statutes (Small Employer Quality Jobs Incentive Act);
- (15) Sections 3651 through 3659 of Title 68 of the Oklahoma Statutes (Quality Jobs Incentive Leverage Act); and
- (16) Section 4101 et seq. of Title 68 of the Oklahoma Statutes (Oklahoma Specialized Quality Investment Act).

[OAR Docket #07-1320; filed 7-23-07]

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

[OAR Docket #07-1330]

RULEMAKING ACTION:
EMERGENCY adoption

RULES:
Subchapter 5. Individual Providers and Specialties
Part 9. Long Term Care Facilities
317:30-5-123. [AMENDED]
(Reference APA WF # 07-07A)

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:
April 12, 2007

Approved by Governor:
May 25, 2007

Emergency Adoptions

Effective:

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

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Effective through July 14, 2008, 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 implement a new Pre-Admission Screening and Resident Review (PASRR) compliance process. The new requirements are expected to increase the level of compliance demonstrated by nursing facility reporting practices.

ANALYSIS:

PASRR rules are being revised to reflect the new required PASRR form for a Level I screen for nursing home admission. The new form is LTC-300R, Nursing Facility Level of Care Assessment. As part of the federally mandated PASRR process, all Medicaid certified nursing facilities must fill out the form LTC-300R for all applicants that apply to reside in the facility regardless of pay source. The LTC-300R is the new Level I screening form which helps to identify persons with possible mental illness or mental retardation or related conditions who apply to reside in Medicaid certified nursing facilities. Rules also change the submission deadline requirements for this form from thirty days to ten days of resident admission. The change in the submission deadline is expected to increase the level of compliance demonstrated by nursing facility reporting practices.

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 JUNE 1 2007, WHICHEVER IS LATER:

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 9. LONG TERM CARE FACILITIES

317:30-5-123. Patient certification for long term care

(a) **Medical eligibility.** Initial approval of medical eligibility for long-term care is determined by the ~~OKDHS~~ Oklahoma Department of Human Services (OKDHS) area nurse, or nurse designee. The certification is obtained by the facility at the time of admission.

(1) **Pre-admission screening.** Federal Regulations govern the State's responsibility for Preadmission Screening and Resident Review (PASRR) for individuals with mental illness and mental retardation. PASRR applies to the screening or reviewing of all individuals for mental illness or mental retardation or related conditions who apply to or reside in Title XIX certified nursing facilities regardless of the source of payment for the nursing facility services and regardless of the individual's or resident's known diagnoses. The ~~NF~~ nursing facility (NF) must

independently evaluate the Level I PASRR Screen regardless of who completes the form and determine whether or not to admit an individual to the facility. ~~NFs~~ Nursing facilities which inappropriately admit a person without a PASRR Screen are subject to recoupment of funds. PASRR is a requirement for nursing facilities with dually certified (both Medicare and Medicaid) beds. There are no PASRR requirements for Medicare skilled beds that are not dually certified, nor is PASRR required for individuals seeking residency in an intermediate care facility for the mentally retarded (ICF/MR).

(2) **PASRR Level I screen.**

(A) ~~Form LTC 300A LTC-300R, Long Term Care Pre admission Screen, Section I Nursing Facility Level of Care Assessment, must be completed by an authorized NF official or designee. An authorized NF official or designee must consist of one of the following:~~

- ~~(i) A licensed nurse from OKDHS;~~
- ~~(ii) The nursing facility administrator or co-administrator;~~
- ~~(iii) A licensed nurse, social service director, or social worker, or other authorized NF official or designee from the nursing facility; or~~
- ~~(iv) A licensed nurse, social service director, or social worker from the hospital.~~

~~(B) Section II of the LTC 300A must be completed by an authorized NF official or designee.~~

~~(C) Prior to admission, the authorized NF official must evaluate the properly completed OHCA Form LTC 300A LTC-300R and the Minimum Data Set (MDS), if available. Any other readily available medical and social information is also used to determine if there currently exists any indication of mental illness (MI), mental retardation (MR), or other related condition, or if such condition existed in the applicant's past history. This evaluation Form LTC-300R constitutes the Level I PASRR Screen and is utilized in determining whether or not a Level II Assessment is necessary prior to allowing the patient to be admitted. The NF is also responsible for consulting with ~~LOCEU~~ the Level of Care Evaluation Unit (LOCEU) regarding any MI/MR related condition information that becomes known either from completion of the MDS or throughout the resident's stay.~~

~~(D) The nursing facility is responsible for determining from the evaluation whether or not the patient can be admitted to the facility. A "yes" response to any question from Form LTC 300A, Section I LTC-300R, Section E, will result in a consultation with require the nursing facility to contact the Level of Care Evaluation Unit (LOCEU) LOCEU for a consultation to determine if a Level II Assessment is needed. If there is any question as to whether or not there is evidence of MI, MR, or related condition, LOCEU should be contacted prior to admission. The LTC 300A original Form LTC-300R original form and copy, as well as a copy of the MDS, comprises~~

~~the PASRR eligibility information packet, and is to be must be submitted by mail to the LOCEU within 30 10 days of the resident admission. SoonerCare payment may not be made for a resident whose LTC-300R requirements have not been satisfied in a timely manner.~~

~~(E D) Upon receipt and review of the medical eligibility information packet Form LTC-300R, the LOCEU may, in coordination with the OKDHS area nurse, re-evaluate whether a Level II PASRR assessment may be required. If a Level II Assessment is not required, the process of determining medical eligibility continues. If a Level II is required, a medical decision is not made until the results of the Level II Assessment are known.~~

(3) **Level II Assessment for PASRR.**

(A) Any one of the following three circumstances will allow a patient to enter the nursing facility without being subjected to a Level II PASRR Assessment.

(i) The patient has no current indication of mental illness or mental retardation or other related condition and there is no history of such condition in the patient's past.

(ii) The patient does not have a diagnosis of mental retardation or related condition.

(iii) An individual may be admitted to an NF if he/she has indications of mental illness or mental retardation or other related condition, but is not a danger to self and/or others, and is being released from an acute care hospital as part of a medically prescribed period of recovery (**Exempted Hospital Discharge**). If an individual is admitted to an NF based on Exempted Hospital Discharge, it is the responsibility of the NF to ensure that the individual is either discharged by the 30th day or that a Level II has been requested and is in process. Exempted Hospital Discharge is allowed only if all three of the following conditions are met:

(I) The individual must be admitted to the NF directly from a hospital after receiving acute inpatient care at the hospital (not including psychiatric facilities);

(II) The individual must require NF services for the condition for which he/she received care in the hospital; and

(III) The attending physician must certify in writing before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. The NF will be required to furnish this documentation to OHCA upon request.

(B) If the patient has current indications of mental illness or mental retardation or other related condition, or if there is a history of such condition in the patient's past, the patient cannot be admitted to the nursing facility until the LOCEU is contacted for consultation to determine if a Level II PASRR Assessment must be performed. Results of any Level

II PASRR Assessment ordered must indicate that nursing facility care is appropriate prior to allowing the patient to be admitted.

(C) The OHCA, LOCEU, authorizes Advance Group Determinations for the MI and MR Authorities in the following categories listed in (i) through (iii) of this subparagraph. Preliminary screening by the LOCEU ~~should~~ may indicate eligibility for nursing facility level of care prior to consideration of the provisional admission.

(i) **Provisional admission in cases of delirium.** Any person with mental illness, mental retardation or related condition that is not a danger to self and or others, may be admitted to a Title XIX certified NF if the individual is experiencing a condition that precludes screening, i.e., effects of anesthesia, medication, unfamiliar environment, severity of illness, or electrolyte imbalance.

(I) A Level II evaluation is completed immediately after the delirium clears. The LOCEU must be provided with written documentation by a physician that supports the individual's condition which allows provisional admission as defined in (i) of this subparagraph.

(II) Payment for NF services will not be made after the provisional admission ending date. If an individual is determined to need a longer stay, the individual must receive a Level II evaluation before continuation of the stay may be permitted and payment made for days beyond the ending date.

(ii) **Provisional admission in emergency situations.** Any person with a mental illness, mental retardation or related condition, who is not a danger to self and/or others, may be admitted to a Title XIX certified nursing facility for a period not to exceed seven days pending further assessment in emergency situations requiring protective services. The request for Level II evaluation must be made immediately upon admission to the NF if a longer stay is anticipated. The LOCEU must be provided with written documentation from OKDHS Adult Protective Services which supports the individual's emergency admission. Payment for NF services will not be made beyond the emergency admission ending date.

(iii) **Respite care admission.** Any person with mental illness, mental retardation or related condition, who is not a danger to self and/or others, may be admitted to a Title XIX certified nursing facility to provide respite to in-home caregivers to whom the individual is expected to return following the brief NF stay. Respite care may be granted up to 15 consecutive days per stay, not to exceed 30 days per calendar year.

(I) In rare instances, such as illness of the caregiver, an exception may be granted to allow 30 consecutive days of respite care. However,

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in no instance can respite care exceed 30 days per calendar year.

(II) Respite care must be approved by LOCEU staff prior to the individual's admission to the NF. The NF provides the LOCEU with written documentation concerning circumstances surrounding the need for respite care, the date the individual wishes to be admitted to the facility, and the date the individual is expected to return to the caregiver. Payment for NF services will not be made after the respite care ending date.

(4) **Resident Review.**

(A) The nursing facility's routine resident assessment will identify those individuals previously undiagnosed as MR or MI. A new condition of MR or MI must be referred to LOCEU by the NF for determination of the need for the Level II Assessment. The facility's failure to refer such individuals for a Level II Assessment may result in recoupment of funds.

(B) A Level II Resident Review may be conducted the following year for each resident of a nursing facility who was found to experience a serious mental illness with no primary diagnosis of dementia on his or her pre-admission Level II, to determine whether, because of the resident's physical and mental condition, the resident requires the level of services provided by a nursing facility and whether the resident requires specialized services.

(C) A significant change in a resident's mental condition could trigger a Level II Resident Review. If such a change should occur in a resident's condition, it is the responsibility of the nursing facility to notify the LOCEU of the need to conduct a resident review.

(5) **Results of Level II Pre-Admission Assessment and Resident Review.** Through contractual arrangements between the OHCA and the MI/MR authorities, individualized assessments are conducted and findings presented in written evaluations. The evaluations determine if nursing facility services are needed, if specialized services or less than specialized services are needed, and if the individual meets the federal PASRR definition of mental illness or mental retardation or related conditions. Evaluations are delivered to the LOCEU to process formal, written notification to patient, guardian, NF and interested parties.

(6) **Readmissions, and interfacility transfers.** The Preadmission Screening process does not apply to readmission of an individual to an NF after transfer for a continuous hospital stay, and then back to the NF. There is no specific time limit on the length of absence from the nursing facility for the hospitalization. Inter-facility transfers are also subject to preadmission screening. In the case of transfer of a resident from an NF to a hospital or to another NF, the transferring NF is responsible for ensuring that copies of the resident's most recent ~~LTC-300A~~ LTC-300R and any PASRR evaluations accompany the transferring resident. The receiving NF must submit an

updated ~~LTC-300A~~ LTC-300R that reflects the resident's current status to LOCEU within ~~30~~ 10 days of the transfer. Failure to do so could result in possible recoupment of funds. LOCEU should also be contacted prior to admitting out-of-state NF applicants with mental illness or mental retardation or related condition, so that PASRR needs can be ascertained. Any PASRR evaluations previously completed by the referring state should be forwarded to LOCEU as part of this PASRR consultation.

(7) **PASRR appeals process.**

(A) Any individual who has been adversely affected by any PASRR determination made by the State in the context of either a preadmission screening or an annual resident review may appeal that determination by requesting a fair hearing. If the individual does not consider the PASRR decision a proper one, the individual or their authorized representative must contact the local county OKDHS office to discuss a hearing. Forms for requesting a fair hearing (OKDHS Form 13MP001E, Request for a Fair Hearing), as well as assistance in completing the forms, can be obtained at the local county OKDHS office. Any request for a hearing must be made no later than 20 days following the date of written notice. Appeals of these decisions are available under OAC 317:2-1-2. All individuals seeking an appeal have the same rights, regardless of source of payment. Level I determinations are not subject to appeal.

(B) When the individual is found to experience MI, MR, or related condition through the Level II Assessment, the PASRR determination made by the MR/MI authorities cannot be countermanded by the ~~state Title XIX agency Oklahoma Health Care Authority,~~ either in the claims process or through other utilization control/review processes, or by the ~~state survey and certification agency Oklahoma State Department of Health.~~ Only appeals determinations made through the fair hearing process may overturn a PASRR determination made by the MR/MI authorities.

(b) **Determination of Title XIX medical eligibility for long term care.** The determination of medical eligibility for care in a nursing facility is made by the OKDHS area nurse, or nurse designee. The procedures for determining Nursing Facility (NF) program medical eligibility are found in OAC 317:35-19. Determination of ICF/MR medical eligibility is made by LOCEU. The procedures for obtaining and submitting information required for a decision are outlined below.

(1) **Pre-approval of medical eligibility.** Pre-approval of medical eligibility for private ICF/MR care is based on results of a current comprehensive psychological evaluation by a licensed psychologist or state staff psychologist, documentation of MR or related condition prior to age 22, and the need for active treatment according to federal standards. Pre-approval is made by LOCEU analysts.

(2) **Medical eligibility for ICF/MR services.** Within ~~30~~ 10 calendar days after services begin, the facility must submit the original of the ~~Long Term Care Assessment form (LTC-300)~~ Nursing Facility Level of Care

Assessment (Form LTC-300R) to LOCEU. Required attachments include current (within 90 days of requested approval date) medical information signed by a physician, a current (within 12 months of requested approval date) psychological evaluation, a copy of the pertinent section of the Individual Developmental Plan or other appropriate documentation relative to discharge planning and the need for ICF/MR level of care, and a statement that the client member is not an imminent threat of harm to self or others (i.e., suicidal or homicidal). If pre-approval was determined by LOCEU and the above information is received, medical approval will be entered on MEDATS.

(3) **Categorical relationship.** Categorical relationship must be established for determination of eligibility for long-term medical care. If categorical relationship to disability has not already been established, the proper forms and medical information are submitted to LOCEU. (Refer to OAC 317:35-5-4). In such instances, LOCEU will render a decision on categorical relationship using the same definition as used by SSA the Social Security Administration (SSA). A follow-up is required by the OKDHS worker with ~~the Social Security Administration~~ SSA to be sure that their disability decision agrees with the decision of LOCEU.

[OAR Docket #07-1330; filed 7-24-07]

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

[OAR Docket #07-1323]

RULEMAKING ACTION:
EMERGENCY adoption

RULES:
Subchapter 5. Individual Providers and Specialties
Part 9. Long Term Care Facilities
317:30-5-131. [AMENDED]
317:30-5-133. [AMENDED]
(Reference APA WF # 07-17)

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

of the 50th Oklahoma Legislature. Revisions allow for the development of an incentive reimbursement rate plan for evidence-based quality improvements in nursing facilities.

ANALYSIS:

Agency rules are revised to allow for the development of an incentive reimbursement rate plan for evidence-based quality improvements in nursing facilities. House Bill 2842 of the 2nd Session of the 50th Oklahoma Legislature amended state statutes to authorize the Oklahoma Health Care Authority (OHCA) to develop an incentive reimbursement rate plan for nursing facilities. Through a competitive bid process, OHCA awarded My InnerView, Inc. the contract to develop the incentive-based payment program for nursing facilities. The overall program consolidates and serves three interrelated public and social policy goals in a single, integrated program: value-based purchasing, provider improvement, and consumer information. All three objectives will be guided by a set of eleven performance data components that will be used to reward demonstrated value, support evidence-based quality improvement by nursing homes, and furnish consumers with frequently updated information by which to compare and choose nursing homes based on their quality of care rating. The revisions remove the nursing facility payment methodology from rules and reference the Medicaid State Plan for the methodology. Rules are revised to comply with House Bill 2842 of the 2nd Session of the 50th Oklahoma Legislature.

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 JULY 1, 2007, WHICHEVER IS LATER:

**SUBCHAPTER 5. INDIVIDUAL PROVIDERS
AND SPECIALTIES**

PART 9. LONG TERM CARE FACILITIES

317:30-5-131. Rates of payments

(a) Rates of payments shown on the Fee Schedule for Nursing Facilities and ICF/MR's are based on the cost of the nursing facility level of care provided and the nursing care staffing pattern. The rate of payment to a nursing facility is also determined by the type of facility and quality of care rating.

(b) A rate of payment established by the facility for private patients is not under the jurisdiction of OHCA. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State Plan for all individuals regardless of source of payment. The facility may charge any amount for services furnished to non-Medicaid residents consistent with the written notice requirements describing the charges found at 42 CFR 483.10.

317:30-5-133. Payment methodologies

(a) **Private Nursing Facilities.**

- (1) **Facilities.** Private Nursing Facilities include:
 - (A) Nursing Facilities serving adults (NF),
 - (B) Nursing Facilities serving Aids Patients (NF-Aids),

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(C) Nursing Facilities serving Ventilator Patients (NF-Vents),

(D) Intermediate Care Facilities for the Mentally Retarded (ICF/MR),

(E) Intermediate Care Facilities with 16 beds or less serving Severely or Profoundly Retarded Patients (Acute ICF/MR), and

(F) Payment will be made for non-routine nursing facility services identified in an individual treatment plan prepared by the State MR Authority. Services are limited to individuals approved for NF and specialized services as the result of a PASRR/MR Level II screen. The per diem add-on is calculated as the difference in the statewide standard private MR base rate and the statewide NF facility base rate.

(2) **Reimbursement calculations.** Rates for Private Nursing Facilities will be reviewed periodically and adjusted as necessary through a public process. Payment will be made to Private Nursing Facilities pursuant to the methodology described in the Oklahoma Title XIX State Plan. The rates are based on a statewide rate for each type of facility which consists of the sum of one or more of four components:

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

~~(B) **Discretionary Inflation Rate component.** A Discretionary Inflation Rate component may be added to the Base Year Rate component dependent upon the factors listed in (i) (vii) of this paragraph. These factors may be reviewed individually or in the aggregate. Nothing in this paragraph shall mandate the State give majority consideration to any one factor or all factors. The factors include:~~

- ~~(i) access to Medicaid Services;~~
- ~~(ii) Medicaid utilization;~~
- ~~(iii) Cost Report analyses;~~
- ~~(iv) National and State specific trends and costs including trends and salary levels and changes in minimum wage levels;~~
- ~~(v) analyses of economic impact of changes in law or regulation;~~
- ~~(vi) budget appropriations to OHCA; and~~
- ~~(vii) Industry efforts to:~~

~~(I) reduce or contain employee benefits expenditures.~~

~~(II) consolidate or centralize personnel or departmental functions to reduce costs.~~

~~(III) review departmental staffing levels and to use lesser skilled employees or reduce numbers of full time equivalent employees where possible to do so without adversely affecting the quality of patient care.~~

~~(IV) standardize drugs and medical supplies in order to reduce costs that are unnecessary.~~

~~(V) expedite billings.~~

~~(VI) use volunteer service and fund raising.~~

~~(VII) control utility costs~~

~~(VIII) reduce the incidence of employee injuries.~~

~~(IX) reduce employee turnover and to involve employees in cost containment efforts.~~

~~(X) review contractual arrangements to determine if more cost effective ways of providing services and supplies can be achieved.~~

~~(XI) incorporate efficiency incentives into the compensation systems of employees.~~

~~(XII) use management information systems to plan and achieve efficiencies in operations (including but not limited to flexible budgeting, cost accounting, case mix, group purchasing, etc.).~~

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

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

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

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

~~(I) additional nursing hours;~~

~~(II) medical equipment and supplies;~~

~~(III) nutritional therapy; and~~

- (IV) respiratory therapy.
- (ii) Reimbursement for the enhanced rate requires prior authorization. In order for Medicaid eligible patients to be considered for prior authorization, the facility submits the treatment plan and most recent doctor's orders and/or hospital discharge summary for each ventilator dependent patient to OHCA.
- (iii) The enhanced rate will be reviewed periodically and adjusted as necessary through a public process.
- (F) **Nursing Facilities Serving Adults.** Base Rate when used in this subpart is defined as the rate in effect on June 30, 2005, adjusted for any changes as described in (B) through (E) for which the legislature has specified appropriated funds. Direct Care Costs are defined as those costs for salaries, benefits and training for registered nurses, licensed practical nurses, nurse aides and certified medication aides. Other Costs are defined as the total allowable routine and ancillary costs of nursing facility care less the Direct Care Costs. As of July 1, 2005, Nursing Facilities Serving Adults will be reimbursed as follows:
 - (i) The rate for each facility will be the sum of the Base Rate plus the add-ons for Direct Care and Other Costs as described below.
 - (ii) Annually, any funds over and above those to cover the Base Rate described above will be used to create two pools of funds used to adjust the rates as follows:
 - (I) The first pool will be 30% of the total available funds and will be used to adjust the rates equally (a statewide adjustment) for Other Costs.
 - (II) The second pool will be 70% of the total available funds and will be used to adjust rates on a facility specific basis for Direct Care Costs. The add-on for each facility will be determined by multiplying each facility's reported direct care cost per day (with a maximum limit set at the 90th percentile) by the percent increase in the total direct care expenditures due to the addition of the direct care pool funds.
 - (iii) The available funds for establishing these pools and the subsequent add-ons for Direct Care and Other Costs will be re-determined and re-calculated annually and adjusted for changes in available funds and federal matching percentages.
- (b) **Public Nursing Facilities.** Reimbursement for public Intermediate Care Facilities for the Mentally Retarded (ICF/MR) shall be based on each facility's reasonable cost and shall be paid on an interim basis with an annual retroactive adjustment. Reasonable costs shall be based on Medicare principles of cost reimbursement. Rates for Public facilities will be reviewed periodically and adjusted as necessary through a public process.

[OAR Docket #07-1323; filed 7-24-07]

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

[OAR Docket #07-1328]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 5. Individual Providers and Specialties

Part 9. Long Term Care Facilities

317:30-5-131.2 [AMENDED]

(Reference APA WF # 07-16)

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

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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 move the due date for the payment of the Quality of Care Assessment from the 10th to the 15th of the month following the assessment. This change will allow Licensed Nursing Facilities a more reasonable time frame in which to make their payments and help bring facilities who are making a good faith effort to file timely into compliance.

ANALYSIS:

Agency rules are revised to move the due date for the payment of the Quality of Care Fee for Licensed Nursing Facilities (LNFs) from the 10th to the 15th of the month following the assessment. Currently, due to the short time frame, LNFs that are making good faith efforts to comply but missing the due date are being penalized and fined. This change will allow for a longer time frame for LNFs to submit their payment. The postmark due date will be changed from the 8th to the 13th to coincide with the new due date. Changes are also being made for the payment of the Quality of Care Assessment to be made to the Opportunities for Living Life Division, Long Term Care Quality Initiatives Unit rather than the Provider Compliance Audits Unit.

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 JUNE 1, 2007, WHICHEVER IS
LATER:**

**SUBCHAPTER 5. INDIVIDUAL PROVIDERS
AND SPECIALTIES**

PART 9. LONG TERM CARE

Emergency Adoptions

317:30-5-131.2. Quality of care fund requirements and report

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

- (1) **"Nursing Facility and Intermediate Care Facility for the mentally retarded"** means any home, establishment, or institution or any portion thereof, licensed by the State Department of Health as defined in Section 1-1902 of Title 63 of the Oklahoma Statutes.
- (2) **"Quality of Care Fee"** means the fee assessment created for the purpose of quality care enhancements pursuant to Section 2002 of Title 56 of the Oklahoma Statutes upon each nursing facility and intermediate care facility for the mentally retarded licensed in this State.
- (3) **"Quality of Care Fund"** means a revolving fund established in the State Treasury pursuant to Section 2002 of Title 56 of the Oklahoma Statutes.
- (4) **"Quality of Care Report"** means the monthly report developed by the Oklahoma Health Care Authority to document the staffing ratios, total patient gross receipts, total patient days, and minimum wage compliance for specified staff for each nursing facility and intermediate care facility for the mentally retarded licensed in the State.
- (5) **"Staffing ratios"** means the minimum direct-care-staff-to-resident ratios pursuant to Section 1-1925.2 of Title 63 of the Oklahoma Statutes and pursuant to OAC 310:675-1 et seq.
- (6) **"Peak In-House Resident Count"** means the maximum number of in-house residents at any point in time during the applicable shift.
- (7) **"Staff Hours worked by Shift"** means the number of hours worked during the applicable shift by direct-care staff.
- (8) **"Direct-Care Staff"** means any nursing or therapy staff who provides direct, hands-on care to residents in a nursing facility and intermediate care facility for the mentally retarded pursuant to Section 1-1925.2 of Title 63 of the Oklahoma Statutes, pursuant to OAC 310:675-1 et seq., and as defined in subsection (c) of this Section.
- (9) **"Major Fraction Thereof"** is defined as an additional threshold for direct-care-staff-to-resident ratios at which another direct-care staff person(s) is required due to the peak in-house resident count exceeding one-half of the minimum direct-care-staff-to-resident ratio pursuant to Section 1-1925.2 of Title 63 of the Oklahoma Statutes.
- (10) **"Minimum wage"** means the amount paid per hour to specified staff pursuant to Section 5022.1 of Title 63 of the Oklahoma Statutes.
- (11) **"Specified staff"** means the employee positions listed in the Oklahoma Statutes under Section 5022.1 of Title 63 and as defined in subsection (d) of this Section.
- (12) **"Total Patient Days"** means the monthly patient days that are compensable for the current monthly Quality of Care Report.
- (13) **"Total Gross Receipts"** means all cash received in the current Quality of Care Report month for services rendered to all residents in the facility. Receipts should

include all Medicaid, Medicare, Private Pay and Insurance including receipts for items not in the normal per diem rate. Charitable contributions received by the nursing facility are not included.

(14) **"Service rate"** means the minimum direct-care-staff-to-resident rate pursuant to Section 1-1925.2 of Title 63 of Oklahoma Statutes and pursuant to OAC 310:675-1 et seq.

(b) **Quality of care fund assessments.**

(1) The Oklahoma Health Care Authority (OHCA) was mandated by the Oklahoma Legislature to assess a monthly service fee to each Licensed Nursing Facility in the State. The fee is assessed on a per patient day basis. The amount of the fee is uniform for each facility type. The fee is determined as six percent (6%) of the average total gross receipts divided by the total days for each facility type.

(2) In determination of the fee for the time period beginning October 1, 2000, a survey was mailed to each licensed nursing facility requesting calendar year 1999 Total Patient Days, Gross Revenues and Contractual Allowances and Discounts. This data is used to determine the amount of the fee to be assessed for the period of 10-01-00 through 06-30-01. The fee is determined by totaling the "annualized" gross revenue and dividing by the "annualized" total days of service. "Annualized" means that the surveys received that do not cover the whole year of 1999 are divided by the total number of days that are covered and multiplied by 365.

(3) The fee for subsequent State Fiscal Years is determined by using the monthly gross receipts and census reports for the six month period October 1 through March 31 of the prior fiscal year, annualizing those figures, and then determining the fee as defined above.

(4) Monthly reports of Gross Receipts and Census are included in the monthly Quality of Care Report. The data required includes, but is not limited to, the Total Gross Receipts and Total Patient Days for the current monthly report.

(5) The method of collection is as follows:

(A) The Oklahoma Health Care Authority assesses each facility monthly based on the reported patient days from the Quality of Care Report filed two months prior to the month of the fee assessment billing. As defined in this subsection, the total assessment is the fee times the total days of service. The Oklahoma Health Care Authority notifies the facility of its assessment by the end of the month of the Quality of Care Report submission date.

(B) Payment is due to the Oklahoma Health Care Authority by the ~~10th~~ 15th of the following month. Failure to pay the amount by the ~~10th~~ 15th or failure to have the payment mailing postmarked by the ~~8th~~ 13th will result in a debt to the State of Oklahoma and is subject to penalties of 10% of the amount and interest of 1.25% per month. The Quality of Care Fee must be submitted no later than the ~~10th~~ 15th of the month. If the ~~10th~~ 15th falls upon a holiday or

weekend (Saturday-Sunday), the fee is due by 5 p.m. (Central Standard Time) of the following business day (Monday-Friday).

(C) The monthly assessment including applicable penalties and interest must be paid regardless of any appeals action requested by the facility. If a provider fails to pay the Authority the assessment within the time frames noted on the second invoice to the provider, the assessment, applicable penalty, and interest will be deducted from the facility's payment. Any change in payment amount resulting from an appeals decision will be adjusted in future payments. Adjustments to prior months' reported amounts for gross receipts or patient days may be made by filing an amended part C of the Quality of Care Report.

(D) The Quality of Care fee assessments excluding penalties and interest are an allowable cost for Oklahoma Health Care Authority Cost Reporting purposes.

(E) The Quality of Care fund which contains assessments collected excluding penalties and interest as described in this subsection and any interest attributable to investment of any money in the fund must be deposited in a revolving fund established in the State Treasury. The funds will be used pursuant to Section 2002 of Title 56 of the Oklahoma Statutes.

(c) **Quality of care direct-care-staff-to resident-ratios.**

(1) Effective September 1, 2000, all nursing facilities and intermediate care facilities for the mentally retarded (ICFs/MR) subject to the Nursing Home Care Act, in addition to other state and federal staffing requirements, must maintain the minimum direct-care-staff-to-resident ratios or direct-care service rates as cited in Section 1-1925.2 of Title 63 of the Oklahoma Statutes and pursuant to OAC 310:675-1 et seq.

(2) For purposes of staff-to-resident ratios, direct-care staff are limited to the following employee positions:

- (A) Registered Nurse
- (B) Licensed Practical Nurse
- (C) Nurse Aide
- (D) Certified Medication Aide
- (E) Qualified Mental Retardation Professional (ICFs/MR only)
- (F) Physical Therapist
- (G) Occupational Therapist
- (H) Respiratory Therapist
- (I) Speech Therapist
- (J) Therapy Aide/Assistant
- (K) Social Services Director/Social Worker
- (L) Other Social Services Staff
- (M) Activities Director
- (N) Other Activities Staff
- (O) Combined Social Services/Activities

(3) Prior to September 1, 2003, activity and social services staff who are did not providing provide direct, hands-on care may be included in the direct-care-staff-to-resident ratio in any shift or direct-care

service rates. On and after September 1, 2003, such persons are not included in the direct-care-staff-to-resident ratio or direct-care service rates.

(4) In any shift when the direct-care-staff-to-resident ratio computation results in a major fraction thereof, direct-care staff is rounded to the next higher whole number.

(5) To document and report compliance with the provisions of this subsection, nursing facilities and intermediate care facilities for the mentally retarded must submit the monthly Quality of Care Report pursuant to subsection (e) of this Section.

(d) **Quality of care minimum wage for specified staff.**

Effective November 1, 2000, all nursing facilities and private intermediate care facilities for the mentally retarded receiving Medicaid payments, in addition to other federal and state regulations, must pay specified staff not less than in the amount of \$6.65 per hour. Employee positions included for purposes of minimum wage for specified staff are as follows:

- (1) Registered Nurse
- (2) Licensed Practical Nurse
- (3) Nurse Aide
- (4) Certified Medication Aide
- (5) Other Social Service Staff
- (6) Other Activities Staff
- (7) Combined Social Services/Activities
- (8) Other Dietary Staff
- (9) Housekeeping Supervisor and Staff
- (10) Maintenance Supervisor and Staff
- (11) Laundry Supervisor and Staff

(e) **Quality of care reports.** Effective September 1, 2000, all nursing facilities and intermediate care facilities for the mentally retarded must submit a monthly report developed by the Oklahoma Health Care Authority, the Quality of Care Report, for the purposes of documenting the extent to which such facilities are compliant with the minimum direct-care-staff-to-resident ratios or direct-care service rates.

(1) The monthly report must be signed by the preparer and by the Owner, authorized Corporate Officer or Administrator of the facility for verification and attestation that the reports were compiled in accordance with this section.

(2) The Owner or authorized Corporate Officer of the facility must retain full accountability for the report's accuracy and completeness regardless of report submission method.

(3) Penalties for false statements or misrepresentation made by or on behalf of the provider are provided at 42 U.S.C. Section 1320a-7b which states, in part, "*Whoever... (2) at any time knowingly and willfully makes or causes to be made any false statement of a material fact for use in determining rights to such benefit or payment... shall (1) in the case of such statement, representation, concealment, failure, or conversion by any person in connection with furnishing (by that person) of items or services for which payment is or may be made under this title (42 U.S.C. §1320 et seq.), be guilty of a felony and upon conviction thereof fined not more than \$25,000 or imprisoned for not more than five years or both, or (ii) in*

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the case of such a statement, representation, concealment, failure or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than \$10,000 or imprisoned for not more than one year, or both."

(4) The Quality of Care Report must be submitted by 5 p.m. (CST) on the 15th of the following month. If the 15th falls upon a holiday or a weekend (Saturday-Sunday), the report is due by 5 p.m. (CST) of the following business day (Monday - Friday).

(5) The Quality of Care Report will be made available in an electronic version for uniform submission of the required data elements.

(6) Facilities must submit the monthly report either through electronic mail to the ~~Provider Compliance Audits Unit~~ Opportunities for Living Life Division, Long Term Care Quality Initiatives Unit or send the monthly report in disk or paper format by certified mail and pursuant to subsection (e)(14) of this section. The submission date is determined by the date and time recorded through electronic mail or the postmark date and the date recorded on the certified mail receipt.

(7) Should a facility discover an error in its submitted report for the previous month only, the facility must provide to the ~~Provider Compliance Audits Unit~~ Opportunities for Living Life Division, Long Term Care Quality Initiatives Unit written notification with adequate, objective and substantive documentation within five business days following the submission deadline. Any documentation received after the five business day period will not be considered in determining compliance and for reporting purposes by the Oklahoma Health Care Authority.

(8) An initial administrative penalty of \$150.00 is imposed upon the facility for incomplete, unauthorized, or non-timely filing of the Quality of Care Report. Additionally, a daily administrative penalty will begin upon the Authority notifying the facility in writing that the report was not complete or not timely submitted as required. The \$150.00 daily administrative penalty accrues for each calendar day after the date the notification is received. The penalties are deducted from the Medicaid facility's payment. For 100% private pay facilities, the penalty amount(s) is included and collected in the fee assessment billings process. Imposed penalties for incomplete reports or non-timely filing are not considered for Oklahoma Health Care Authority Cost Reporting purposes.

(9) The Quality of Care Report includes, but is not limited to, information pertaining to the necessary reporting requirements in order to determine the facility's compliance with subsections (b) and (c) of this Section. Such reported information includes, but is not limited to: staffing ratios; peak in-house resident count; staff hours worked by shift; total patient days; total gross receipts; and direct-care service rates.

(10) Audits may be performed to determine compliance pursuant to subsections (b), (c) and (d) of this Section. Announced/unannounced on-site audits of reported information may also be performed.

(11) Direct-care-staff-to-resident information and on-site audit findings pursuant to subsection (c), will be reported to the Oklahoma State Department of Health for their review in order to determine "willful" non-compliance and assess penalties accordingly pursuant to Title 63 Section 1-1912 through Section 1-1917 of the Oklahoma Statutes. The Oklahoma State Department of Health informs the Oklahoma Health Care Authority of all final penalties as required in order to deduct from the Medicaid facility's payment. Imposed penalties are not considered for Oklahoma Health Care Authority Cost Reporting purposes.

(12) If a Medicaid provider is found non-compliant pursuant to subsection (d) based upon a desk audit and/or an on-site audit, for each hour paid to specified staff that does not meet the regulatory minimum wage of \$6.65, the facility must reimburse the employee(s) retroactively to meet the regulatory wage for hours worked. Additionally, an administrative penalty of \$25.00 is imposed for each non-compliant staff hour worked. For Medicaid facilities, a deduction is made to their payment. Imposed penalties for non-compliance with minimum wage requirements are not considered for Oklahoma Health Care Authority Cost Reporting purposes.

(13) Under OAC 317:2-1-2, Long Term Care facility providers may appeal the administrative penalty described in (b)(5)(B) and (e)(8) and (e)(12) of this section.

(14) Facilities that have been authorized by the Oklahoma State Department of Health (OSDH) to implement flexible staff scheduling must comply with OAC 310:675-1 et seq. The authorized facility ~~are~~ is required to complete the flexible staff scheduling section of Part A of the Quality of Care Report. The Owner, authorized Corporate Officer or Administrator of the facility must complete the flexible staff scheduling signature block, acknowledging their OSDH authorization for Flexible Staff Scheduling.

[OAR Docket #07-1328; filed 7-24-07]

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

[OAR Docket #07-1325]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 5. Individual Providers and Specialties

Part 1. Physicians

317:30-5-8. [AMENDED]

317:30-5-10. [AMENDED]

Part 45. Optometrists

317:30-5-431. [AMENDED]

(Reference APA WF # 07-08)

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 431.123

DATES:

Adoption:

March 8, 2007

Approved by Governor:

April 2, 2007

Effective:

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

Expiration:

Effective through July 14, 2008, unless superseded by another rule or disapproved by the Legislature.

Gubernatorial approval:

January 30, 2007

Register publication:

24 Ok Reg 67

Docket number:

07-324

SUPERSEDED EMERGENCY ACTIONS:

Superseded rules:

Subchapter 5. Individual Providers and Specialties

Part 1. Physicians

317:30-5-8. [AMENDED]

(Reference APA WF # 06-40)

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 rules to replace language with nationally recognized terminology to assist providers to accurately file claims. Without this information, provider reimbursement may be denied or delayed and may ultimately hinder provider access for Medicaid members.

ANALYSIS:

Agency rules are revised to clarify terminology for cataract surgery by using nationally recognized terminology. The listing of specific CPT codes in rules is limiting as codes are constantly being modified and added. One of the basic objectives of our policy clarification and simplification is to remove specific codes throughout rules. Pricing of the surgical modifiers is standard in the industry and it is redundant to have it in agency rules. Rules regarding surgery are revised to clarify the processing of claims with modifiers. Rules are needed to provide accurate information to providers that do not hinder provider reimbursement or provider access for Medicaid members.

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 MAY 1, 2007, WHICHEVER IS LATER:

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 1. PHYSICIANS

317:30-5-8. Surgery

(a) **Use of medical and surgical modifiers.** The Physicians' Current Procedural Terminology (CPT) provides for 2-digit surgical modifiers to further describe surgical services. ~~All of these~~ 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. Refer to the CPT for a complete description of modifiers.~~

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

(1) ~~-20 Microsurgery~~ OHCA does not make an additional payment for this modifier. ~~The procedure will be paid at the regular OHCA allowable.~~ -26 Professional component;

(2) ~~-22 Unusual services~~ OHCA does not make an additional payment for this modifier. ~~The procedure will be paid at the regular OHCA allowable.~~ -50 Bilateral procedure;

(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.~~ -51 Multiple procedures;

(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. -52 Reduced service;

(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. -54 Surgical care only;

(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

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- 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.~~ 55 Post-operative care only;
- (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.~~ 62 Two surgeons;
- (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 postoperative 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.~~ 80 Assistant surgeon;
- (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.~~ 82 Assistant surgeon (when a qualified resident surgeon is not available);
- (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 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. **Modifiers resulting in denial.** The

use of the medical and surgical modifiers listed in this subsection results in denial of the procedure performed:

(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." -56 Pre-operative management only;

(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. -81 Minimum assistant surgeon;

(3) -90 Reference laboratory;

(4) -99 Multiple modifiers.

(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. **Modifiers subject to review.** The medical and surgical modifiers listed in this subsection are subject to review and may affect claims processing.

(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. -21 Prolonged evaluation and management (E&M) services;

(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. -22 Unusual procedural services;

(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: -23 Unusual anesthesia;

(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.

(4) -24 Unrelated E&M services by the same provider during the post-operative period;

(5) -25 Significant, separately identifiable E&M service by the same provider on the same day of a procedure or other service;

(6) -32 Mandated service;

(7) -47 Anesthesia by surgeon;

(8) -53 Disconnected procedure;

(9) -57 Decision for surgery;

(10) -58 Staged or related procedure;

(11) -59 Distinct procedural service;

(12) -63 Procedure performed on infants;

(13) -66 Surgical team;

(14) -76 Repeat procedure by same provider;

(15) -77 Repeat procedure by same provider;

(16) -78 Return to operating room;

(17) -79 Unrelated procedure; and

(18) -91 Repeat clinical diagnostic laboratory test.

(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. **General information regarding surgery.**

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- (1) The OHCA uses nationally recognized coding and editing guidelines for determination of reimbursement logic related to situations including, but not limited to, multiple, bilateral, assistant surgery, incidental, and mutually exclusive procedure codes. When a procedure is performed for which specific procedure codes exist, the specific procedure code must be used. A claim submitted with an "unlisted" procedure code is subject to medical review and requires the submission of all pertinent medical records for determination of payment.
- (2) 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. Payment for the preoperative visit 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 surgery. All surgical procedures are considered to include typical, uncomplicated, follow-up care unless otherwise indicated.
- (3) A cochlear implant is covered for members under 18 years of age based on medical necessity; prior authorization is required.
- (4) Postoperative care following cataract surgery may be performed by an optometrist or an ophthalmologist. When a physician transfers the care of a SoonerCare member to another provider for postoperative care, the appropriate CPT modifier (54 or 55) must be added to the surgical procedure code.
- (5) Reduction mammoplasty is covered only when the procedure has been determined medically necessary; prior authorization is required.
- (6) Intradermal introduction of pigments or tattooing is compensable when related to breast cancer reconstruction after surgery for breast cancer, prior authorization is required.
- (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.~~
 - ~~(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) ~~Umbilical 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 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 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 members under 21 years of age. A postpartum 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 members between the ages of 21 and 65. Cochlear implant is covered for 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) 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. Payment for the pre-operative visit, 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 typical, uncomplicated follow up care unless otherwise indicated.

(10) Additional payment is not allowed for suprapubic cystostomy performed in conjunction with abdominal bladder or urethral surgery (Marshall Marchetti). When suprapubic cystostomy 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 authorization is required.

317:30-5-10. Ophthalmology services

(a) Covered services for adults.

(1) Payment can be made for medical services that are reasonable and necessary for the diagnosis and treatment of illness or injury up to the patient's maximum number of allowed office visits per month.

(2) Payment is made for treatment of eye disease not related to refractive errors. There is no provision for routine exams, treatment of refractive errors, lenses, frames, eye examinations for the purpose of prescribing glasses or for the purchase of visual aids.

(3) In cataract participatory surgery, a separate payment can be made to the optometrist for postoperative care. Payment to the ophthalmologist will be 80 percent of the surgical allowable. Payment to the optometrist for postoperative care will be made at 20% of the surgical allowable. The global surgery fee schedule allowance includes preoperative evaluation and management services rendered the day before or the day of surgery, the surgical procedure, and routine postoperative period. Postoperative care for cataract surgery should be filed using appropriate CPT codes, modifiers and guidelines. The optometrist's name must be present on the claim in the referring physician's block. If an optometrist has agreed to provide postoperative care the optometrist's information must be in the referring provider's section of the claim.

(b) Covered services for children.

(1) Payment can be made for medical services that are reasonable and necessary for the diagnosis and treatment of illness, injury, amblyopia, and significant refractive errors or strabismus.

(2) Within the scope of the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT), payment will be made for periodic visual screenings as set forth in the periodicity schedule adopted by the Oklahoma Health Care Authority (OHCA) in accordance with the American Academy of Pediatrics. Payment will be made for lenses and frames required to correct visual defects or to protect children with monocular vision. In addition to periodic visual screenings, payment will be made for interperiodic visual screenings when medically necessary.

(c) Procedure codes.

(1) Routine checkups and eye examinations for the purpose of prescribing, fitting or changing eyeglasses and eye refractions are billed using the General Ophthalmological Services CPT codes for the Intermediate exam. CPT manual guidelines are the basis for this policy and coverage of services is dependent on the purpose of the examination rather than on the ultimate diagnosis. A routine examination is still routine even if a pathologic condition is identified.

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- (2) Evaluation and Management codes should be used when the primary purpose of the examination is examination and treatment of a medical or surgical condition.
- (3) Frames are billed using the appropriate HCPC code. Payment includes the dispensing fee.
- (4) Visual screening, a component of the EPSDT exam of an asymptomatic child, is included in a routine exam and is not billed separately. Use the appropriate visual acuity screening test CPT code (see CPT section AOther Services and Procedures@) when billing visual screening separately from a routine eye exam.
- (d) **Payment.** The Medicaid payment for frames and/or lenses represents payment in full. No difference can be collected from the patient or family.
- (e) **Non-covered items.** Non-covered items, for example, progressive lenses, aspheric lenses, tints, coatings and photochromic lenses are non-compensable and may be billed to the patient.
- (f) **Prior authorization.** Contact lenses for aphakia and keratoconus are a covered benefit. Other contact lenses require prior authorization and medical necessity. The appropriate HCPC code should be used. Bifocal lenses for the treatment of accommodative esotropia are a covered benefit. Other multifocal lenses for children require prior authorization and medical necessity. Polycarbonate lenses are covered for children when medically necessary.

PART 45. OPTOMETRISTS

317:30-5-431. Coverage by category

Payment is made to optometrists as set forth in this Section.

- (1) **Adults.** Payment can be made for medical services that are reasonable and necessary for the diagnosis and treatment of illness or injury up to the patient's maximum number of allowed office visits per month.
- (A) Payment is made for treatment of eye disease not related to refractive errors. There is no provision for routine exams, treatment of refractive errors, lenses, frames, eye examinations for the purpose of prescribing glasses or for the purchase of visual aids.
- (B) ~~In cataract participatory surgery, separate payment can be made to the optometrist for postoperative care. Payment for postoperative care will be made at 20% of the surgical allowable. The global surgery fee schedule allowance includes preoperative evaluation and management services rendered the day before or the day of surgery, the surgical procedure, and routine postoperative period.~~ Postoperative care for cataract surgery ~~should be~~ is filed using appropriate CPT codes, modifiers and guidelines. ~~The surgeon's name must be present on the claim in the referring physician's block or payment will be denied. If an optometrist has agreed to provide postoperative care the optometrist's information must be in the referring provider's section of the claim.~~

(C) Payment for laser surgery to optometrist is limited to those optometrists certified by the Board of Optometry as eligible to perform laser surgery.

- (2) **Children.**
- (A) Payment can be made for medical services that are reasonable and necessary for the diagnosis and treatment of illness, injury, amblyopia and significant refractive errors or strabismus.
- (B) Within the scope of the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT), payment will be made for periodic visual screenings as set forth in the periodicity schedule found at OAC 317:30-3-65.7. Payment will be made for lenses and frames required to correct visual defects or to protect children with monocular vision. In addition to periodic visual screenings, payment will be made for interperiodic visual screenings when medically necessary.
- (3) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services.

[OAR Docket #07-1325; filed 7-24-07]

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

[OAR Docket #07-1329]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 5. Individual Providers and Specialties
Part 21. Outpatient Behavioral Health Services
317:30-5-240. through 317:30-5-241. [AMENDED]
317:30-5-248. [AMENDED]
(Reference APA WF # 07-14)

AUTHORITY:

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR 440.60

DATES:

Adoption:

April 12, 2007

Approved by Governor:

May 25, 2007

Effective:

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

Expiration:

Effective through July 14, 2008, 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, at the request of the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS), removes coverage for Clubhouse services. The Centers for Medicare/Medicaid Services will not allow reimbursement for this service.

ANALYSIS:

Outpatient behavioral health rules are being revised to: (1) streamline documentation; (2) broaden SoonerCare member accessibility to providers; (3) increase consistency among Oklahoma state agencies that deal with mental health services; and (4) eliminate coverage for Clubhouse services at the request of ODMHSAS. Outpatient behavioral health services are covered for adults and children when provided in accordance with a documented individualized service plan, developed to treat the identified mental health and/or substance abuse disorder(s). All services are to be for the goal of improvement of functioning, independence, or well being of the SoonerCare member. The member must be able to actively participate in the treatment. Active participation means that the member must have sufficient cognitive abilities, communication skills, and short term memory to derive a reasonable benefit from the treatment.

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 JULY 1, 2007, WHICHEVER IS LATER:

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 21. OUTPATIENT BEHAVIORAL HEALTH SERVICES

317:30-5-240. Eligible providers

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

- (1) **"AOA"** means American Osteopathic Association.
- (2) **"AOD"** means Alcohol and Other Drug.
- (3) **"AODTP"** means Alcohol and Other Drug Treatment Professionals.
- (4) **"ASAM"** means the American Society of Addiction Medicine.
- (5) **"ASI"** means the Addiction Severity Index.
- (6) **"BHRS"** means Behavioral Health Rehabilitation Specialist. **"CAR"** means Clinical Assessment Record.
- (7) **"CARF"** means Commission on Accreditation of Rehabilitation Facilities.
- (8) **"CHCs"** means Community Health Centers.
- (9) **"CMHCs"** means Community Mental Health Centers.
- (10) **"COA"** means Council on Accreditation of Services for Families and Children, Inc.
- (11) **"Cultural Competency"** means the ability to recognize, respect, and address the unique needs, worth, thoughts, communications, actions, customs, beliefs, and values that reflect an individual's racial, ethnic, age group, religious, sexual orientation, and/or social group.
- (12) **"DSM"** means the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

~~(13)~~ **"EBP"** means an Evidenced Based Practice per SAMHSA.

~~(14)~~ **"FQHC"** means Federally Qualified Health Centers that are entities known as Community Health Centers.

~~(14)~~ **"ICCD"** means International Center for Clubhouse Development.

(15) **"ICF/MR"** means Intermediate Care Facility for the Mentally Retarded.

(16) **"I/T/U"** means Indian Health Services/Tribal Clinics/Urban Tribal Clinic facilities.

(17) **"JCAHO"** means Joint Commission on Accreditation of Healthcare Organizations.

~~(18)~~ **"MHP"** means Mental Health Professional. **"LBHP"** means a Licensed Behavioral Health Professional.

(19) **"OAC"** means Oklahoma Administrative Code, the publication authorized by 75 O.S. 256 known as The Oklahoma Administrative Code, or, prior to its publication, the compilation of codified rules authorized by 75 O.S. 256(A)(1)(a) and maintained in the Office of Administrative Rules.

(20) "Objectives" means a specific statement of planned accomplishments or results that are specific, measurable, attainable, realistic, and time-limited.

~~(21)~~ **"ODMHSAS"** means the Oklahoma Department of Mental Health and Substance Abuse Services.

~~(22)~~ **"ODMHSAS Contracted Facilities"** means those providers that have a contract with the ODMHSAS to provide mental health or substance abuse treatment services, and also contract directly with the Oklahoma Health Care Authority to provide Outpatient Behavioral Health Services.

~~(23)~~ **"OHCA"** means the Oklahoma Health Care Authority.

~~(24)~~ **"Private Facilities"** means those providers that contract directly with the Oklahoma Health Care Authority to provide Outpatient Behavioral Health Services.

(25) "PSRS" means Psychiatric-Social Rehabilitation Specialist.

~~(26)~~ **"Public Facilities"** means those providers who are regionally based Community Mental Health Centers who are also contract directly with the Oklahoma Health Care Authority to provide Outpatient Behavioral Health Services.

~~(27)~~ **"RBMS"** means Residential Behavioral Management Services within a group home or therapeutic foster home.

~~(28)~~ **"RHC"** means Rural Health Clinic.

(29) "Recovery" means an ongoing process of discovery and/or rediscovery that must be self defined, individualized and may contain some, if not all, of the ten fundamental components of recovery as outlined by SAMHSA.

~~(30)~~ **"SAMHSA"** means the Substance Abuse and Mental Health Services Administration.

(31) "T-ASI" means the Teen Alcohol Severity Index.

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(32) **"Trauma Informed"** means the recognition and responsiveness to the presence of the effects of past and current traumatic experiences in the lives of members.

(b) **Provider Agency Requirements.** Rehabilitative services are provided by:

(1) Community based outpatient behavioral health organizations, that have a current accreditation status as a provider of behavioral health services, from the CARF, JCAHO, or COA. Providers accredited by CARF/JCAHO/COA must be able to demonstrate that the Scope of the current accreditation includes all programs, services and sites where ~~Medicaid SoonerCare~~ compensated services are rendered. CARF/JCAHO/COA accredited providers will only receive ~~Medicaid SoonerCare~~ reimbursement for services provided under the programs, which are accredited. ~~Programs that serve adults (over 17) with serious mental illness utilizing clubhouse model may substitute accreditation from the International Center for Clubhouse Development (ICCD) in lieu of CARF, JCAHO, or COA accreditation.~~

(A) Psychiatric Hospitals appropriately licensed and certified by the State Survey Agency as meeting Medicare psychiatric hospital standards including JCAHO accreditation. Psychiatric Hospitals must be able to demonstrate the scope of the current accreditation includes all programs and sites where ~~Medicaid SoonerCare~~ Outpatient Behavioral services will be performed.

(B) Acute Care Hospitals appropriately licensed and certified by the State Survey Agency as meeting Medicare standards, including a JCAHO or AOA certification. Acute Care Hospitals must be able to demonstrate the scope of the current accreditation includes all programs and sites where Medicaid Outpatient Behavioral Health Services will be performed.

(C) Providers of Alcohol and other Drug Treatment Disorders must be certified by the designated state certifying agency, the ODMHSAS. ~~Providers certified by ODMHSAS must be actively working toward accreditation by one of the three recognized accrediting bodies.~~ Providers in this category must have achieved accreditation from JCAHO, CARF, or COA for the provision of outpatient alcohol and other drug treatment services ~~by January 1, 2007.~~

(2) Eligible organizations must meet one of the following standards and criteria:

(A) Be an incorporated organization governed by a board of directors; or

(B) A state-operated program under the direction of the ODMHSAS.

(3) Eligible organizations must meet each of the following:

(A) Have a well-developed plan for rehabilitation services designed to meet the recovery needs of the individuals served.

(B) Have a multi-disciplinary, professional team. This team must include all of the following:

(i) One of the following licensed behavioral health professionals:

(I) A Psychologist, Clinical Social Worker, Professional Counselor, Behavioral Practitioner, Marriage and Family Therapist, or Alcohol and Drug Counselor licensed in the state in which the services are delivered, or

(II) An Advanced Practice Nurse (certified in a psychiatric mental health specialty), licensed as a registered nurse with a current certification of recognition from the board of nursing in the state in which services are provided, or

(III) An allopathic or osteopathic physician with a current license and board certification in psychiatry in the state in which the service is delivered, or board eligible.

(ii) A Behavioral Health Rehabilitation Specialist as described in subsection (e) of this section, if individual or group rehabilitative services for mental illnesses are provided.

(iii) An Alcohol and Other Drug Treatment Professional if treatment of alcohol and other drug disorders is provided.

(iv) A registered nurse or physician assistant, with a current license to practice in the state in which the services are delivered if Medication Training and Support service is provided.

(v) The member for which the services will be provided, and parent/guardian for those under 18 years of age.

(vi) A member treatment advocate if desired and signed off on by the member.

(C) Demonstrate the ability to provide each of the following outpatient behavioral health treatment services as described in OAC 317:30-5-241: ~~ICCD certified clubhouses, sites as identified by ODMHSAS as exclusively providing Community-based structured emergency care, or Program for Assertive Community Treatment services are exempted from this requirement, as applicable to their program.~~ Providers must provide proper referral and linkage to providers of needed services if their agency does not have appropriate services.

(i) Mental Health Assessments and/or Alcohol and Drug assessments;

(ii) Individual, Group, and Family Psychotherapy;

(iii) Individual and Group Rehabilitative services ~~relevant to the population to be served~~ and Alcohol and other Drug Related Services Skill development services ~~if offered by the provider;~~

(iv) Mental Health and/or Substance Abuse Services Plan done by a non-physician (moderate and low complexity; and

(v) Crisis Intervention services.

(D) Be available 24 hours a day, seven days a week, for Crisis Intervention services. ~~ICCD-certified clubhouses must have an arrangement by which crisis intervention services are available.~~

(E) Provide or have a plan for referral to physician and other behavioral health services necessary for the treatment of the behavioral disorders of the population served.

(F) Comply with all applicable Federal and State Regulations.

(G) Have appropriate written policy and procedures regarding confidentiality and protection of information and records, member grievances, member rights and responsibilities, and admission and discharge criteria, which shall be posted publicly and conspicuously. ~~Discharge criteria is not required for ICCD-certified clubhouses.~~

(H) Demonstrate the ability to keep appropriate records and documentation of services performed.

(I) Maintain and furnish, upon request, a current report of fire and safety inspections of facilities clear of any deficiencies.

(J) Maintain and furnish, upon request, all required staff credentials including certified transcripts documenting required degrees.

(4) Provider Specialties.

(A) Public and ODMHSAS Contracted Programs Facilities - Public facilities are the regionally based Community Mental Health Centers and ODMHSAS contracted programs are providers that have a contract with the ODMHSAS to provide Mental Health and/or Substance Abuse Treatment Services.

(B) Private Programs - Private facilities are those facilities that contract directly with the Oklahoma Health Care Authority to provide Outpatient Behavioral Health Services.

(C) Federally Qualified Health Centers/Community Health Centers - FQHCs are those facilities that qualify under OAC 317:30-5-660.

(D) Indian Health Services/Tribal Clinics/Urban Tribal Clinics - I/T/Us are those facilities that qualify under Federal regulation.

(E) Rural Health Clinics - RHCs are those facilities that qualify under OAC 317:30-5-355.

(c) **Provider enrollment and contracting.**

(1) Organizations who have JCAHO, CARF, ~~ICCD~~, COA or AOA accreditation will supply the documentation from the accrediting body, along with other information as required for contracting purposes to the OHCA. If the application is approved, a separate provider identification number for each outpatient Behavioral Health Service site will be assigned. The contract must include copies of all required state licenses, accreditation and ~~Medicaid~~ SoonerCare certifications.

(2) Each site operated by an outpatient mental health facility must have a separate provider number. A site is defined as an office, clinic, or other business setting where outpatient behavioral health services are routinely

performed. When services are rendered at the member's residence, a school, or when provided occasionally at an appropriate community based setting, a site is determined according to where the professional staff perform administrative duties and where the member's chart and other records are kept. Failure to obtain and utilize site specific provider numbers will result in disallowance of services.

(d) ~~Mental Licensed Behavioral Health Professional.~~ Mental Licensed Behavioral Health Professionals (MHPs) (LBHP) are defined as follows for the purpose of Outpatient Behavioral Health Services:

(1) Allopathic or Osteopathic Physicians with a current license and board certification in psychiatry or board eligible in the state in which services are provided, or a current resident in psychiatry practicing as described in OAC 317:30-5-2.

(2) Practitioners with a license to practice in the state in which services are provided or those actively and regularly receiving board approved supervision, and extended supervision by a fully licensed clinician if board's supervision requirement is met but the individual is not yet licensed, to become licensed by one of the licensing boards listed in (A) through (F) below. The exemptions from licensure under 59 §1353(4) (Supp. 2000) and (5), 59 §1903(C) and (D) (Supp. 2000), 59 §1925.3(B) (Supp. 2000) and (C), and 59 §1932(C) (Supp. 2000) and (D) do not apply to Outpatient Behavioral Health Services.

(A) Psychology,

(B) Social Work (clinical specialty only),

(C) Professional Counselor,

(D) Marriage and Family Therapist,

(E) Behavioral Practitioner, or

(F) Alcohol and Drug Counselor.

(3) Advanced Practice Nurse (certified in a psychiatric mental health specialty), licensed as a registered nurse with a current certification of recognition from the board of nursing in the state in which services are provided.

(e) ~~Behavioral Health Psychiatric-Social Rehabilitation Specialist.~~ The definition of a Behavioral Health Psychiatric-Social Rehabilitation Specialist (BHR) (PSRS) is as follows:

(1) Bachelor or master degree in a behavioral health related field including, but not limited to, psychology, social work, occupational therapy, human resources/services counseling, human developmental psychology, gerontology, early childhood development, chemical dependency, rehabilitative services, sociology, school guidance and counseling, criminal justice family studies; ~~or~~ earned from a regionally accredited college or university recognized by the United States Department of Education; or

(2) Bachelor or master degree that demonstrates the individual completed and passed equivalent college level course work to meet the degree requirements of (1) of this subsection, as reviewed and approved by OHCA or its designated agent; or

(3) A current license as a registered nurse in ~~Oklahoma~~ the state where services are provided with behavioral health experience; or

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(4) Certification as an Alcohol and Drug Counselor. Allowed to provide substance abuse rehabilitative treatment to those with alcohol and/or other drug dependencies or addictions as a primary or secondary DSMIV Axis I diagnosis; or

(5) Current certification as a Behavioral Health Case Manager from ODMHSAS and meets OHCA requirements to perform case management services, as described in OAC 317:30-5-585(1).

(f) **Alcohol and other Drug (AOD) Treatment Professionals (AODTP).** Alcohol and other Drug Treatment Professionals are defined as practitioners who are:

(1) Licensed to practice as an Alcohol and Drug Counselor in the state in which services are provided, or those actively and regularly receiving board approved supervision to become licensed;

(2) Certified as an Advanced Alcohol and Drug Counselor as recognized and approved by an ODMHSAS AOD treatment certifying and/or licensing body;

(3) Certified as an Alcohol and Drug Counselor as recognized and approved by an ODMHSAS AOD treatment certifying and/or licensing body; or

(4) A MHP Licensed Behavioral Health Professional with a current license, or those actively and regularly receiving board approved supervision to become licensed, and extended supervision by a fully licensed clinician if board's supervision requirement is met but the individual is not yet licensed, to practice who can demonstrate competency in the area of alcohol and drug counseling and treatment.

317:30-5-241. Coverage for adults and children

(a) **Service descriptions and conditions.** Outpatient behavioral health services are covered for adults and children as set forth in this Section, unless specified otherwise, and when provided in accordance with a documented individualized service plan, developed to treat the identified mental health and/or substance abuse disorder(s). All services are to be for the goal of improvement of functioning, independence, or well being of the member. The services and treatment plans are to be recovery focused, trauma and co-occurring specific. The member must be able to actively participate in the treatment. Active participation means that the member must have sufficient cognitive abilities, communication skills, and short-term memory to derive a reasonable benefit from the treatment. The assessment must include a DSM multi axial diagnosis completed for all five axes from the most recent DSM version. All services will be subject to medical necessity criteria and will require prior authorization. For ~~ODMHSAS Contracted, FQHCs, CHCs, RHCs, I/T/Us facilities, and Private facilities,~~ an agent designated by the Oklahoma Health Care Authority will apply the medical necessity criteria. For public facilities (regionally based CMHCs), the medical necessity criteria will be self administered following the same required prior authorization elements as the private and contracted (ODMHSAS) ~~agencies under OAC 317:30-5-241(b)(4)(B)(i) all outpatient behavioral health facilities, the OHCA, or its designated agent, will comply with established medical necessity criteria.~~ Non

prior authorized services will not be ~~Medicaid~~ SoonerCare compensable with the exception of Mental Health Assessment by a Non-Physician, Alcohol and Drug Assessment, Mental Health Service Plan Development (moderate complexity), Alcohol and/or Substance Abuse Services Treatment Plan Development (moderate complexity), Crisis Intervention Services (by a ~~MHP LBHP~~ and Facility based for adults), and Program of Assertive Community Treatment Services (PACT). Payment is not made for Outpatient Behavioral Health Services for children who are receiving Residential Behavioral Management Services in a Group Home or Therapeutic Foster Care unless authorized by the OHCA or its designated agent as medically necessary. Adults and children in Facility Based Crisis Intervention Services cannot receive additional Outpatient Behavioral Health Services outside of the admission and discharge dates. Residents of nursing facilities are not eligible for Outpatient Behavioral Health services.

(1) **Mental Health Assessment by a Non-Physician.** ~~includes a history of psychiatric symptoms, concerns and problems, an evaluation of mental status, a psychosocial and medical history, a full five axes diagnosis and evaluation of current functioning, and an evaluation and assessment of alcohol and other drug use (historic and present). The service must also include an evaluation of the member's strengths and information regarding the member's treatment preferences. For adults, it may include interviews or communications with family, caretakers, or other support persons as permitted by the member. For children under the age of 18, it must include an interview with a parent, or other adult caretaker. For children, the assessment must also include information on school performance and school based services. This service is performed by an MHP. The minimum face to face time spent in assessment with the member and others as identified previously in this paragraph for a low complexity Mental Health Assessment by a Non-Physician is one and one half hours. For a moderate complexity, it is two hours or more. This service is compensable on behalf of a member who is seeking services for the first time from the contracted agency. This service is not compensable if the member has previously received or is currently receiving services from the agency, unless there has been a gap in services of more than six months and it has been more than one year since the previous assessment. All agencies must assess the medical necessity of each individual to determine the appropriate level of care. The assessment must contain but is not limited to the following:~~

(A) Date, to include month, day and year of the assessment sessions(s), more than one session can be billed in multiple units;

(B) Source of information;

(C) Member's first name, middle initial and last name;

(D) Gender;

(E) Birth date;

(F) Home address;

(G) Telephone number;

(H) Referral source;

- (I) Reason for referral;
- (J) Person to be notified in case of emergency;
- (K) Presenting reason for seeking services;
- (L) Psychiatric social information, which must include: personal history, including; family - social; educational; cultural and religious orientation; occupational - military; sexual; marital; domestic violence or sexual assault (including child abuse/neglect and child welfare involvement); recreation and leisure; financial; clinical treatment history including past and current medical and psychiatric diagnoses, symptoms, and treatment recommendations; legal or criminal record, including the identification of key contacts, i.e. attorneys, probation officers, etc. when appropriate; substance abuse and dependence, both current and historical; gambling abuse and dependence, both current and historical; and present life situation.
- (M) Mental status information, including questions regarding:
 - (i) physical presentation, such as general appearance, motor activity, attention and alertness, etc.;
 - (ii) affective process, such as mood, affect, manner and attitude, etc., and
 - (iii) cognitive process, such as intellectual ability, social-adaptive behavior, thought processes, thought content, and memory, etc; and
 - (iv) Full Five Axes DSM diagnosis.
- (N) A section on health history and pharmaceutical information, with pharmaceutical information to include the following for both current and past medications:
 - (i) name of medication;
 - (ii) strength and dosage of medication;
 - (iii) length of time on the medication;
 - (iv) benefit(s) and side effects of medication; and
 - (v) level of functionality.
- (O) Identification of the member's strengths, needs, abilities, and preferences:
 - (i) LBHP's interpretation of findings;
 - (ii) signature and credentials of LBHP.
- (P) The assessment must include all elements and tools required by the OHCA. For adults, it may include interviews or communications with family, caretakers, or other support persons as permitted by the member. For children under the age of 18, it must include an interview with a parent, or other adult caretaker. For children, the assessment must also include information on school performance and school based services. This service is performed by an LBHP. The minimum face-to-face time spent in assessment session(s) with the member and others as identified previously in this paragraph for a low complexity Mental Health Assessment by a Non-Physician is one and one half hours. For a moderate complexity, it is two hours or more.

This service can be billed in partial units to allow for shorter assessment sessions as needed by the member. This service is compensable on behalf of a member who is seeking services for the first time from the contracted agency. This service is not compensable if the member has previously received or is currently receiving services from the agency, unless there has been a gap in services of more than six months and it has been more than one year since the previous assessment.

- (2) **Alcohol and Drug Assessment.** Alcohol and Drug Assessment includes an assessment of past and present alcohol and other drug use. The ASI is to be completed. This service includes an evaluation of current and past functioning in all major life areas and an evaluation of potential mental illnesses that may also impact treatment. It includes a full five axes diagnosis. The service must also include an evaluation of the member's strengths and weaknesses and information regarding the member's treatment preferences. For adults, it may include interviews and/or communication with family, caretakers or other support persons as permitted by the member. For children under the age of 18, it must include an interview with a parent or other adult caretaker. For children, the assessment must also include information on school performance and school based services. This service is performed by an AODTP. The minimum face to face time spent in assessment with the member (and other family or caretakers as previously described in this paragraph) for a low complexity is one and one half hours. For a moderate complexity it is two hours or more. This service is compensable on behalf of a member who is seeking services for the first time from the contracted agency. The service is not compensable if the member has previously received or is currently receiving services from the agency, unless there has been a gap in services of more than six months and it has been more than one year since the previous assessment. This service is not allowed for Mental Health Providers. All providers must assess the medical necessity of each individual to determine the appropriate level of care. The assessment will contain but is not limited to the following:
 - (A) Date, to include month, day and year of the assessment sessions(s), more than one session can be billed in multiple units;
 - (B) Source of information;
 - (C) Member's first name, middle initial and last name;
 - (D) Gender;
 - (E) Birth date;
 - (F) Home address;
 - (G) Telephone number;
 - (H) Referral source;
 - (I) Reason for referral;
 - (J) Person to be notified in case of emergency;
 - (K) Presenting reason for seeking services; and
 - (L) Psychiatric social information, which must include:

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- (i) personal history, including: family - social; educational; cultural and religious orientation; occupational - military; sexual; marital; domestic violence or sexual assault (including child abuse/neglect and child welfare involvement); recreation and leisure; and financial;
- (ii) clinical treatment history including past and current medical and psychiatric diagnoses, symptoms, and treatment recommendations;
- (iii) legal or criminal record, including the identification of key contacts, i.e. attorneys, probation officers, etc. when appropriate;
- (iv) substance abuse and dependence, both current and historical;
- (v) gambling abuse and dependence, both current and historical;
- (M) Present life situation;
- (N) Mental status information, including questions regarding:
 - (i) physical presentation, such as general appearance, motor activity, attention and alertness, etc.;
 - (ii) affective process, such as mood, affect, manner and attitude, etc.; and
 - (iii) cognitive process, such as intellectual ability, social-adaptive behavior, thought processes, thought content, and memory, etc.;
- (O) Full Five Axes DSM diagnosis;
- (P) A section on health history and pharmaceutical information, with pharmaceutical information to include the following for both current and past medications:
 - (i) name of medication;
 - (ii) strength and dosage of medication;
 - (iii) length of time on the medication;
 - (iv) benefit(s) and side effects of medication; and
 - (v) level of functionality;
- (Q) Identification of the member's strengths, needs, abilities, and preferences:
 - (i) AODTP OR BHP's interpretation of findings; and
 - (ii) signature and credentials of AODTP OR LBHP;
- (R) The assessment must include all elements and tools required by the OHCA; and
- (S) For adults, it may include interviews and/or communication with family, caretakers or other support persons as permitted by the member. For children under the age of 18, it must include an interview with a parent or other adult caretaker. For children, the assessment must also include information on school performance and school based services. This service is performed by an AODTP or LBHP. The minimum face to face time spent in assessment with the member (and other family or caretakers as previously described in this paragraph) for a low complexity is one and one-half hours. For a moderate complexity it is

two hours or more. This service can be billed in partial units to allow for shorter assessment sessions as needed by the member. This service is compensable on behalf of a member who is seeking services for the first time from the contracted agency. The service is not compensable if the member has previously received or is currently receiving services from the agency, unless there has been a gap in services of more than six months and it has been more than one year since the previous assessment.

(3) Mental Health Services Plan Development by a Non-Physician (moderate complexity).

(A) Mental Health Services Plan Development by a Non-Physician (moderate complexity) is to be performed by the practitioners and others who will comprise the treatment team. It is performed with the direct active participation of the member and a member support person or advocate if requested by the member. In the case of children under the age of 18, it is performed with the participation of the parent or guardian and the child as age and developmentally appropriate.

(B) The Mental Health Services Plan is developed based on information obtained in the mental health assessment and includes the evaluation of assessment and determined diagnosis by the practitioners and the member of all pertinent information. It includes a discharge plan. It is a process whereby an individualized rehabilitation plan is developed that addresses the member's strengths, functional assets, weaknesses or liabilities, treatment goals, objectives and methodologies that are specific and time limited.

(C) For adults, it must be focused on recovery and achieving maximum community interaction and involvement including goals for employment, independent living, volunteer work, or training. For children, the service plan must address school and educational concerns and assisting the family in caring for the child in the least restrictive level of care. ~~Each type of service to be received must be delineated in the service plan and the practitioner who will be providing and responsible for each service must be identified. In addition, the anticipated frequency of each type of service must be included. This service is provided by the member treatment team. This includes all staff responsible for the treatment services delineated in the plan, the member (if over age 14), and the parent/guardian if under age 18. The service plan is not valid until it is signed and dated by the responsible MHP, the member, the guardian (if applicable), and any other direct service provider, and all requirements have been met. The clinician performing a service must be the same clinician as delineated on the treatment plan. Any provider changes made during a treatment plan period would need to be noted with a statement documenting the change on the treatment plan with new signatures and dates by the provider and the member. Each signature~~

must have the date written by the signing party on the date of signing. One unit per Medicaid recipient per provider is allowed without prior authorization. If determined by OHCA or its designated agent, one additional unit per year may be authorized.

(D) Comprehensive and ingrafted service plan content shall address the following:

- (i) member strengths, needs, abilities, and preferences;
- (ii) identified presenting challenges, problems, needs, and diagnosis;
- (iii) specific goals for the member;
- (iv) objectives that are specific, measurable, attainable, realistic, and time-limited;
- (v) each type of service and estimated frequency to be received;
- (vi) each treatment methodology for individual, interactive, group and family psychotherapies the provider will utilize;
- (vii) the practitioner(s) name and credentials that will be providing and responsible for each service;
- (viii) any needed referrals for services;
- (ix) specific discharge criteria;
- (x) description of the member's involvement in, and responses to, the treatment plan, and his/her signature and date;
- (xi) service plans are not valid until all signatures are present (signatures are required from the member, the parent/guardian when applicable, and the primary LBHP); and
- (xii) changes in service plans can be documented in a service plan update (low complexity) or in the progress notes until time for the update (low complexity).

(E) One unit per SoonerCare member per provider is allowed without prior authorization. If determined by the OHCA or its designated agent, one additional unit per year may be authorized.

(4) Mental Health Services Plan Development by a Non-Physician (low complexity).

(A) Mental Health Services Plan Development by a Non-Physician (low complexity) is for the purpose of reviewing, revising and updating an established Mental Health Services Plan. All elements of the plan must be reviewed with the member and treatment progress assessed. When significant progress toward recovery and the treatment goals is not occurring, the service plan must be altered in order to support and maximize progress toward recovery. When significant progress has been made, the plan must be updated to reflect the improved member's abilities and strengths and services adjusted accordingly. Mental Health Services Plan Development by a Non-Physician (low complexity) will be provided by the treatment team members. The review is not valid until signed and separately dated by the responsible MHP, the member, the guardian (if applicable), and

any other direct service provider, and all requirements have been met. The clinician performing a service must be the same clinician as delineated on the treatment plan. Any provider changes made during a treatment plan period would need to be noted with a statement documenting the change on the treatment plan with new signatures and dates by the provider and the member.

(B) Updates to goals, objectives, service provider, services, and service frequency, can be documented in a progress note until the six month review/update is due.

(C) Service plan updates shall address the following:

- (i) progress, or lack of, on previous service plan goals and/or objectives;
- (ii) a statement documenting a review of the current service plan and an explanation if no changes are to be made to the service plan;
- (iii) change in goals and/or objectives (including target dates) based upon member's progress or identification of new need, challenges and problems;
- (iv) change in frequency and/or type of services provided;
- (v) change in treatment methodology(ies) for individual, interactive, group and family psychotherapies the provider will utilize;
- (vi) change in practitioner(s) who will be responsible for providing services on the plan;
- (vii) additional referrals for needed services;
- (viii) change in discharge criteria;
- (ix) description of the member's involvement in, and responses to, the treatment plan, and his/her signature and date; and
- (x) service plans are not valid until all signatures are present. The required signatures are: the member (if over age 14), the parent/guardian (if under age 18 or otherwise applicable), and the primary LBHP.

(D) Service Plan updates are required every six months during active treatment. Updates can be conducted whenever needed as determined by the provider and member.

(5) Alcohol and/or Substance Abuse Services, Treatment Plan Development (moderate complexity).

(A) Alcohol and Substance Abuse Treatment Plan Development (moderate complexity) is to be performed by the AODTP practitioners and others who will comprise the treatment team. The current edition of the ASAM criteria or other required tool is to be utilized and followed.

(B) The service is performed with the direct active participation of the member and a member support person or advocate if requested by the member. In the case of children under the age of 18, it is performed with the participation of the parent or guardian and the child as age and developmentally appropriate. The

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Plan is developed based on information obtained in the assessment and includes the evaluation of all pertinent information by the practitioners and the member. The service includes a discharge plan. The service is a process whereby an individualized rehabilitation plan is developed that addresses the member's strengths, functional assets, weaknesses or liabilities, treatment goals, objectives and methodologies that are specific and time limited.

(C) For adults, it must be focused on recovery and achieving maximum community interaction and involvement including goals for employment, independent living, volunteer work, or training. For children, the service plan must address school and educational concerns and assisting the family in caring for the child in the least restrictive level of care. ~~Each type of service to be received must be delineated in the service plan and the practitioner who will be providing and responsible for each service must be identified. In addition, the anticipated frequency of each type of service must be included. This service is provided by the treatment team. This includes all staff responsible for the treatment services delineated in the plan, the member (if over age 14), and the parent/guardian if under age 18. The service plan is not valid until it is signed and dated by the responsible AODTP, the member, the guardian (if applicable), and any other direct service provider, and all requirements have been met. Each signature must have the date written by the signing party on the date of signing. The clinician performing a service must be the same clinician as delineated on the treatment plan. Any provider changes made during a treatment plan period would need to be noted with a statement documenting the change on the treatment plan with new signatures and dates by the provider and the member. One unit per Medicaid recipient per provider is allowed without prior authorization. If determined by OHCA or its designated agent, one additional unit per year may be authorized.~~

(D) Comprehensive and integrated service plan contents must address the following:

- (i) member strengths, needs, abilities, and preferences;
- (ii) identified presenting challenges and problems, needs, and diagnosis;
- (iii) specific goals for the member;
- (iv) objectives that are specific, measurable, attainable, realistic and time-limited;
- (v) each type of service and estimated frequency to be received;
- (vi) each treatment methodology for individual, interactive, group and family psychotherapies the provider will utilize;
- (vii) the practitioner(s) name and credentials who will be providing and responsible for each service;
- (viii) any needed referrals for services;

- (ix) specific discharge criteria;
- (x) description of the member's involvement in, and responses to, the treatment plan, and his/her signature and date;
- (xi) service plans are not valid until all signatures are present. The required signatures are: the member (if over age 14), the parent/guardian (if under age 18 or otherwise applicable), and the primary LBHP; and
- (xii) changes in service plans can be documented in a Service Plan Update (low complexity) or in the progress notes until time for the Update (low complexity).

(6) Alcohol and/or Substance Abuse Treatment Plan Development (low complexity).

~~(A) Alcohol and/or Substance Abuse Treatment Plan Development (low complexity) is for the purpose of reviewing, revising and updating an established Mental Health Services Plan. The ASAM criteria or other required tool will be utilized in the development of the Plan. All elements of the plan must be reviewed with the member and treatment progress assessed. When significant progress toward recovery and the treatment goals is not occurring, the service plan must be altered in order to support and maximize progress toward recovery. When significant progress has been made, the plan must be updated to reflect the improved member's abilities and strengths and services adjusted accordingly. Alcohol and/or Substance Abuse Treatment Plan Development (low complexity) will be provided by the treatment team members. The review is not valid until signed and separately dated by the responsible AODTP, the member, the guardian (if applicable), and any other direct service provider, and all requirements have been met. The clinician performing a service must be the same clinician as delineated on the treatment plan. Any provider changes made during a treatment plan period would need to be noted with a statement documenting the change on the treatment plan with new signatures and dates by the provider and the member.~~

(B) Alcohol and/or Substance Abuse Treatment Plan Development (low complexity) will be provided by the treatment team members.

(C) Service plan updates shall address the following:

- (i) progress, or lack of, on previous service plan goals and/or objectives;
- (ii) a statement documenting a review of the current service plan and an explanation if no changes are to be made to the service plan;
- (iii) change in goals and/or objectives (including target dates) based upon member's progress or identification of new need, challenges and problems;
- (iv) change in frequency and/or type of services provided;

(v) change in treatment methodology(ies) for individual, interactive, group and family psychotherapies the provider will utilize;

(vi) change in practitioner(s) who will be responsible for providing services on the plan;

(vii) additional referrals for needed services;

(viii) change in discharge criteria;

(ix) description of the member's involvement in, and responses to, the treatment plan, and his/her signature and date;

(x) service plans are not valid until all signatures are present. The required signatures are the:

(I) member (if over age 14),

(II) parent/guardian (if under age 18 or otherwise applicable), and

(III) primary LBHP.

(D) Updates to goals, objectives, service provider, services, and service frequency, can be documented in a progress note until the 6 month review/update is due.

(E) Service Plan updates are required every six months during which services are provided. Updates can be conducted whenever needed as determined by the provider and member.

(7) Individual/Interactive Psychotherapy.

(A) Individual Psychotherapy is a face-to-face treatment for mental illnesses and behavioral disturbances, in which the clinician, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior and encourage growth and development. Insight oriented, behavior modifying and/or supportive psychotherapy refers to the development of insight of affective understanding, the use of behavior modification techniques, the use of supportive interactions, the use of cognitive discussion of reality, or any combination of these items to provide therapeutic change.

(B) Interactive Psychotherapy is individual psychotherapy that involves the use of play therapy equipment, physical aids/devices, language interpreter, or other mechanisms of nonverbal communication to overcome barriers to the therapeutic interaction between the clinician and the member who has not yet developed or who has lost ~~either the expressive language communication skills to explain his/her symptoms and response to treatment, or the receptive communication skills to understand the clinician.~~ The service may be used for adults who are hearing impaired and require the use of a language interpreter due to language barriers. requires the use of a mechanical devices in order to progress in treatment, or the receptive communication skills to understand the clinician. The service may be used for adults who are hearing impaired and require the use of language interpreter.

(C) There are a total of six different compensable units of individual/interactive psychotherapy,

three each for interactive and individual psychotherapy. They are Individual Insight Oriented, Behavior Modifying and/or Supportive Psychotherapy in an Outpatient Setting (20 - 30 minutes, 45 - 50 minutes, and 75 - 80 minutes), and Interactive Psychotherapy in an office or Outpatient Setting (20 - 30 minutes, 45 - 50 minutes, and 75 - 80 minutes). There is a maximum of one unit of either Individual or Interactive Psychotherapy per day. With the exception of a qualified interpreter if needed, only the member and the ~~MHP LBPH~~ or AODTP should be present and the setting must protect and assure confidentiality. Ongoing assessment of the member's status and response to treatment as well as psycho-educational intervention are appropriate components of individual counseling. The counseling must be goal directed, utilizing techniques appropriate to the service plan and the member's developmental and cognitive abilities.

(D) Individual/Interactive counseling must be provided by a MHP when treatment is for a mental illness and by an AODTP when treatment is for an alcohol or other drug disorder.

(8) Group Psychotherapy.

(A) Group psychotherapy is a method of treating behavioral disorders using the interaction between the MHP when treating mental illness or the AODTP when treating alcohol and other drug disorders, and two or more individuals to promote positive emotional or behavioral change. The focus of the group must be directly related to the goals and objectives in the individual member's current service plan. This service does not include social or daily living skills development as described under Individual and Group Psychosocial Rehabilitation Services, or Alcohol and/or Substance Abuse Services Skills Development.

(B) Group Psychotherapy must take place in a confidential setting limited to the ~~MHP LBHP~~ or the AODTP conducting the service, an assistant or co-therapist, if desired, and the group psychotherapy participants. Group Psychotherapy is limited to a total of eight adult individuals except when the individuals are residents of an ICF/MR where the maximum group size is six. For all children under the age of 18, the total group size is limited to six. The typical length of time for a group psychotherapy session is one hour to one and one-half hours. A maximum of two Group Psychotherapy sessions per day are allowed. Partial units are acceptable when the whole unit of time/service is not utilized. The individual member's behavior, the size of the group, and the focus of the group must be included in each member's medical record. As other members' personal health information cannot be included, the agency may keep a separate group log which contains detailed data on the group's attendees. A group may not consist solely of related individuals.

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(C) Group psychotherapy will be provided by a MHP LBHP when treatment is for a mental illness and by an AODTP when treatment is for an alcohol or other drug disorder.

(9) **Family Psychotherapy.**

(A) Family Psychotherapy is a face-to-face psychotherapeutic interaction between a MHP LBHP or an AOD and the member's family, guardian, and/or support system. It is typically inclusive of the identified member, but may be performed if indicated without the member's presence. When the member is an adult, his/her permission must be obtained in writing. Family psychotherapy must be provided for the direct benefit of the Medicaid-recipient Sooner-Care member to assist him/her in achieving his/her established treatment goals and objectives and it must take place in a confidential setting. This service may include the Evidence Based Practice titled Family Psychoeducation.

(B) The length of a Family Psychotherapy session is one hour to one and one-half hour. No more than two sessions of Family Psychotherapy are allowed per day. This is also the maximum per family unit (unless prior authorization is given by OHCA or its designated agent). Partial units are acceptable when the whole unit of time/service is not utilized. Family Psychotherapy must be provided by a MHP LBHP when treatment is for a mental illness and by an AODTP when treatment is for an alcohol or other drug disorder.

(10) **Psychosocial Psychiatric Social Rehabilitation Services (group).**

(A) Psychosocial Psychiatric Social Rehabilitation Services (PSR) are behavioral health remedial services which are necessary to improve the member's ability to function in the community. They are performed to improve the skills and abilities of members to live interdependently in the community, improve self-care and social skills, and promote lifestyle change and recovery practices. This service may include the Evidence Based Practice of Illness, Management, and Recovery. This service is generally performed with only the members, but may include a member and the member's family/support system group that focuses on the member's diagnosis, management, and recovery based curriculum. This service may take the form of a work units component in a General PSR program certified through the ODMHSAS. Each day of PSR must be reflected by documentation in the member's records, and must include the following:

- (i) date;
- (ii) start and stop time(s) for each day of service;
- (iii) signature of the primary rehabilitation clinician;
- (iv) credentials of the primary rehabilitation clinician;

(v) specific goal(s) and/or objectives addressed (these must be identified on recovery plan);

(vi) type of skills training provided;

(vii) progress made toward goals and objectives;

(viii) member's report of satisfaction with staff intervention; and

(ix) any new needed supports identified during service.

(B) Compensable Psychosocial Psychiatric Rehabilitation Services are provided to members who have the ability to benefit from the service. The services performed must have a purpose that directly relates to the goals and objectives of the member's current service plan. A member who at the time of service is not able to cognitively benefit from the treatment due to active hallucinations, substance use, or other impairments is not suitable for this service.

(C) Travel time to and from PSR treatment is not compensable. Breaks, lunchtime and times when the member is unable or unwilling to participate are not compensable. The minimum staffing ratio is fourteen members for each BHRS PSRS, AODTP, or MHP LBHP for adults and eight to one for children under the age of eighteen. Countable professional staff must be appropriately trained in a recognized behavioral/management intervention program such as MANDT or CAPE or trauma informed methodology. In order to develop and improve the member's community and interpersonal functioning and self care abilities, rehabilitation may take place in settings away from the Outpatient Behavioral Health agency site. When this occurs, the BHRS PSRS, AODTP, or MHP LBHP must be present and interacting, teaching, or supporting the defined learning objectives of the member for the entire claimed time. The service is a fifteen minute time frame and may be billed up to a maximum of 24 units per day for adults and 16 units per day for children. The rate of compensation for this service includes the cost of providing transportation for recipients members who receive this service, but do not have their own transportation or do not have other support persons able to provide or who are responsible for the transportation needs. ~~The OHCA transportation program will arrange for transportation for those who require specialized transportation equipment.~~ Residents of ICF/MR facilities and children receiving RBMS in a group home or therapeutic Foster Home are not eligible for this service, unless prior approved by OHCA or its designated agent.

(D) A BHRS PSRS, AODTP (~~when treatment is for an alcohol or other drug disorder~~), or MHP LBHP may perform group psychosocial psychiatric social rehabilitation services, using a treatment curriculum approved by a MHP.

~~(E) Mental Health Clubhouse Services. Mental Health Clubhouse Services are provided within an~~

ICCD certified clubhouse, and promote the principles and practices of a work ordered day. Services are provided to individuals 18 years of age or older with serious mental illness, and are performed to improve the member's ability to function in the community. Services are focused on improving the skills and abilities of member to live interdependently in the community, assisting members with social, financial, and vocational goals, and the promotion of lifestyle change and recovery practices. ~~Compensable Mental Health Clubhouse Services are provided to members who have the ability to benefit from the service. The services performed must have a purpose that directly relates to the goals of the member's current Recovery Plan. The Recovery Plan is to be developed by the member, or advocate if requested by the member, and the rehabilitation treatment team. The Recovery Plan is developed based on review of the diagnostic and history information, received through clinical records acquisition, necessary to confirm that an individual meets criteria for a serious mental illness, and the completion of an Assessment Records or other assessment approved by OHCA. The plan is to address the member's strengths, functional assets, individual goals, and supports needed to achieve those goals. The Recovery Plan is not valid until it is signed and dated by the responsible MHP, the member, the guardian (if applicable), and any other direct service provider, and all requirements have been met. Each signature must have the date written by the signing party on the date of signing.~~

~~(F) Mental Health Clubhouse Services are provided following the standards of the ICCD. A BHRS or MHP may perform Mental Health Clubhouse Services. The minimum staffing ratio is fourteen members for each BHRS or MHP. The service unit is a 15 minute unit with a maximum of 24 units per day inclusive of rehabilitation services provided through the work ordered day. Medicaid recipients who are receiving this service may not receive other Rehabilitation Services.~~

~~(G) Each day of Mental Health Clubhouse Services must be reflected by documentation in the member's records and must include the following:~~

- ~~(i) date;~~
- ~~(ii) start and stop time(s) for each day of service;~~
- ~~(iii) signature of the rehabilitation clinician;~~
- ~~(iv) credentials of the rehabilitation clinician;~~
- ~~(v) specific goal(s) addressed (goal must be identified on recovery plan);~~
- ~~(vi) type of skills training provided;~~
- ~~(vii) progress made toward goals;~~
- ~~(viii) member's satisfaction with the services; and~~
- ~~(ix) any new needed supports identified during service.~~

(11) Psychosocial Psychiatric Social Rehabilitation Services (individual).

(A) ~~Psychosocial Psychiatric Social Rehabilitation (PSR) Services (individual) is performed for the same purposes and under the same description and requirements as Psychosocial Rehabilitation Services (group) [Refer to paragraph (10) of this subsection]. The service is generally performed with only the member present, but may include the member's family or support system in order to educate them about the rehabilitative activities, interventions, goals and objectives. This service may include the Evidence Based Practice of Illness, Management, and Recovery.~~

~~(B) A BHRS PSRS, AODTP (when treatment is for an alcohol or other drug disorder, or MHP LBHP must provide this service. Residents of ICF/MR facilities and children receiving RBMS in a group home or therapeutic Foster Home are not eligible for this service, unless prior approved by OHCA or its designated agent. This billing unit is fifteen minutes and no more than six units per day are compensable. Children under an ODMHSAS Systems of Care program may be prior authorized additional units as part of an intensive transition period.~~

(12) Assessment/Evaluation testing.

(A) Assessment/Evaluation testing is provided by a clinician utilizing tests selected from currently accepted assessment test batteries. Test results must be reflected in the Mental Health Services plan. The medical record must clearly document the need for the testing and what the testing is expected to achieve.

~~(B) Assessment/Evaluation testing will be provided by a psychologist, certified psychometrist, or a psychological technician of a psychologist or a MHP LBHP. For assessment conducted in a school setting, the Oklahoma State Department of Education requires that a licensed supervisor sign the assessment.~~

(13) Alcohol and/or Substance Abuse Services, Skills Development (group).

(A) Alcohol and/or Substance Abuse Services, Skills Development (group) consists of the therapeutic education of members regarding their AOD addiction or disorder. The service may also involve teaching skills to assist the individual in how to live independently in the community, improve self care and social skills and promote and support recovery. The services performed must have a purpose that directly relates to the goals and objectives of the member's current service plan. A member who at the time of service is not able to cognitively benefit from the treatment due to active hallucinations, substance use, or other impairments is not suitable for this service. This service is generally performed with only the members, but may include a member and member family/support system group that focuses on the member's diagnosis, management, and recovery based curriculum.

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(B) Travel time to and from Alcohol and/or Substance Abuse Services, Skills Development is not compensable. Breaks, lunchtime and times when the member is unable or unwilling to participate are not compensable. The minimum staffing ratio is fourteen members for each AODTP for adults and eight to one for children under the age of eighteen. This service may be performed by an AODTP, LBHP, or a ~~BHRS~~ PSRS. In order to develop and improve the member's community and interpersonal functioning and self care abilities, services may take place in settings away from the ~~Outpatient Behavioral Health~~ agency site. When this occurs, the AODTP or ~~BHRS~~ PSRS must be present and interacting, teaching, or supporting the defined learning objectives of the member for the entire claimed time. The service is a fifteen minute time frame and may be billed up to a maximum of 24 units per day for adults and 16 units per day for children. The rate of compensation for this service includes the cost of providing transportation for ~~recipients~~ members who receive this service, but do not have their own transportation or do not have other support persons able to provide or who are responsible for the transportation needs. The OHCA transportation program will arrange for transportation for those who require specialized transportation equipment. Residents of ICF/MR facilities and children receiving RBMS in a group home or therapeutic Foster Home are not eligible for this service, unless prior approved by OHCA or its designated agent.

(C) Alcohol and/or Substance Abuse Services, Skills Development are provided utilizing a treatment curriculum approved by an AODTP or LBHP.

(14) Alcohol and/or Substance Abuse Services, Skills Development (individual).

(A) Alcohol and/or Substance Abuse Services, Skills Development (individual) is performed for the same purposes and under the same description and requirements as Alcohol and/or Substance Abuse Services, Skills Development (group) [Refer to paragraph (13) of this subsection]. It is generally performed with only the member present, but may include the member's family or support system in order to educate them about the rehabilitative activities, interventions, goals and objectives.

(B) An AODTP, LBHP, or ~~BHRS~~ PSRS must provide this service. Residents of ICF/MR facilities and children receiving RBMS in a group home or therapeutic Foster Home are not eligible for this service, unless prior approved by OHCA or its designated agent. This billing unit is fifteen minutes and no more than six units per day are compensable.

(15) Medication Training and Support.

(A) Medication Training and Support is a documented review and educational session by a registered nurse, or physician assistant focusing on a member's response to medication and compliance

with the medication regimen. The review must include an assessment of medication compliance and medication side effects. Vital signs must be taken including pulse, blood pressure and respiration and documented within the progress notes. A physician is not required to be present, but must be available for consult. Medication Training and Support is designed to maintain the member on the appropriate level of the least intrusive medications, encourage normalization and prevent hospitalization. Medication Training and Support may not be billed for ~~Medicaid recipients~~ SoonerCare member who reside in ICF/MR facilities. One unit is allowed per month per patient without prior authorization.

(B) Medication Training and Support must be provided by a licensed registered nurse, or a physician assistant as a direct service under the supervision of a physician.

(16) Crisis Intervention Services.

(A) Crisis Intervention Services are for the purpose of responding to acute behavioral or emotional dysfunction as evidenced by psychotic, suicidal, homicidal or severe psychiatric distress. The crisis situation including the symptoms exhibited and the resulting intervention or recommendations must be clearly documented. Crisis Intervention Services are not compensable for ~~Medicaid recipients~~ SoonerCare members who reside in ICF/MR facilities, or who receive RBMS in a group home or Therapeutic Foster home, or ~~recipients—members~~ who, while in attendance for other behavioral health services, experience acute behavioral or emotional dysfunction. The unit is a fifteen minute unit with a maximum of eight units per month, established mobile crisis response teams can bill a maximum of sixteen units per month, and 40 units each 12 months per ~~recipient~~ member.

(B) Crisis Intervention Services must be provided by a ~~MHP~~ LBHP.

(17) Crisis Intervention Services (facility based stabilization). Crisis Intervention Services (facility based stabilization) are emergency psychiatric and substance abuse services to resolve crisis situations. The services provided are emergency stabilization, which includes a protected environment, chemotherapy, detoxification, individual and group treatment, and medical assessment. Crisis Intervention Services (facility based stabilization) will be under the supervision of a physician aided by a licensed nurse, and will also include MHPs for the provision of group and individual treatments. A physician must be available. This service is limited to providers who contract with or are operated by the ODMHSAS to provide this service within the overall behavioral health service delivery system. Crisis Intervention Services (facility based stabilization) are compensable for child and adult ~~Medicaid recipients~~ SoonerCare member. The unit of service is per hour. Providers of this service must meet the requirements delineated in the Oklahoma Administrative

Code. Children's facility based stabilization (0-18 years of age) requires prior authorization.

(18) Program of Assertive Community Treatment (PACT) Services.

(A) Program of Assertive Community Treatment (PACT) Services are those delivered within an assertive community based approach to provide treatment, rehabilitation, and essential behavioral health supports on a continuous basis to individuals 18 years of age or older with serious mental illness with a self contained multi-disciplinary team. The team must use an integrated service approach to merge essential clinical and rehabilitative functions and staff expertise. This level of service is to be provided only for persons most clearly in need of intensive ongoing services. Services must satisfy all statutory required program elements as articulated in the Oklahoma Administrative Code 450:55. At a minimum, the services must include:

- (i) Assessment and evaluation;
- (ii) Treatment planning;
- (iii) Crisis intervention to cover psychiatric crisis and drug and alcohol crisis intervention;
- (iv) Symptom assessment, management, and individual supportive psychotherapy;
- (v) Medication evaluation and management, administration, monitoring and documentation;
- (vi) Rehabilitation services;
- (vii) Substance abuse treatment services;
- (viii) Activities of daily living training and supports;
- (ix) Social, interpersonal relationship, and related skills training; and,
- (x) Case management services.

(B) Providers of PACT services are specific teams within an established organization and must be operated by or contracted with and must be certified by the ODMHSAS in accordance with 43A O.S. 319 and Oklahoma Administrative Code 450:55. The unit is a per diem inclusive of all services provided by the PACT team. No more than 12 days of service per month may be claimed. ~~Medicaid recipients~~ Sooner-Care members who are enrolled in this service may not receive other Outpatient Behavioral Health Services except for Crisis Intervention Services (facility based stabilization).

(19) Behavioral Health Aide. This service is limited to children with serious emotional disturbance who are in an ODMHSAS contracted systems of care community based treatment program, or are under OKDHS or OJA custody residing within a RBMS Level of care, who need intervention and support in their living environment to achieve or maintain stable successful treatment outcomes. Behavioral Health Aides provide behavior management and redirection and behavioral and life skills remedial training. The behavioral aide also provides monitoring and observation of the child's emotional/behavioral status and responses, providing interventions, support and

redirection when needed. Training is generally focused on behavioral, interpersonal, communication, self help, safety and daily living skills.

(A) Behavioral Health Aides must have completed 60 hours or equivalent of college credit ~~or to meet the requirement as a BHRS~~ or may substitute one year of relevant employment and/or responsibility in the care of ~~emotionally disturbed children~~ with complex emotional needs for up to two years of college experience, and:

- (i) must have successfully completed the specialized training and education curriculum provided by the ODMHSAS; and
- (ii) must be ~~directly and closely~~ supervised by a ~~licensed Mental Health Professional~~ bachelor's level individual with a minimum of two years case management experience. Treatment plans must be overseen and approved by a LBHP; and
- (iii) function under the general direction of the established systems of care team and the current treatment plan.

(B) These services must be prior authorized by OHCA (or its designated agent). The Behavioral Health Aide cannot bill for more than one individual during the same time period.

(20) Family Support and Training. Family Support and Training is designed to benefit the ~~Medicaid~~ Sooner-Care eligible child experiencing a serious emotional disturbance who is in an ODMHSAS contracted systems of care community based treatment program and who without these services would require psychiatric hospitalization. This service provides the training and support necessary to ensure engagement and active participation of the family in the treatment planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. Child Training is provided to family members to increase their ability to provide a safe and supportive environment in the home and community for the child. This involves assisting the family in the acquisition of knowledge and skills necessary to understand and address the specific needs of the child in relation to their mental illness and treatment; development and enhancement of the families specific problem-solving skills, coping mechanisms, and strategies for the child's symptom/behavior management; assisting the family in understanding various requirements, such as the crisis plan and plan of care process; training on the child's medications or diagnoses; interpreting choice offered by service providers; and assisting with understanding policies, procedures and regulations that impact the child with mental illness while living in the community. Parent Support ensures the engagement and active participation of the family in the treatment planning process and guides families toward taking a proactive role in their child's treatment. Parent Training is assisting the family with the acquisition of the skills and knowledge necessary to facilitate an awareness of their child's needs and the development and enhancement of the family's

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specific problem-solving skills, coping mechanisms, and strategies for the child's symptom/behavior management. Services are goal directed as identified in the child's individualized plan of care and provided under the direction of a child and family treatment team and are intended to support the family with maintaining the child in the home and community. For the purposes of this service, "family" is defined as the persons who live with or provide care to a person served and may include a parent, spouse, children, relatives, foster family, or in-laws. "Family" does not include individuals who are employed to care for the member.

(A) The family support and training worker must meet the following criteria:

- (i) have a high school diploma or equivalent;
- (ii) be 21 years of age and have successful experience as a family member of a child or youth with serious emotional disturbance, or a minimum of 2 years experience working with children with serious emotional disturbance or be equivalently qualified by education in the human services field or a combination of work experience and education with one year of education substituting for one year of experience (preference is given to parents or care givers of child with SED);
- (iii) successful completion of Family Support Training according to a curriculum approved by the ODMHSAS prior to providing the service;
- (iv) pass OSBI and OKDHS child abuse check as well as adult abuse registry and motor vehicle screens; and
- (v) receive ongoing and regular supervision by a person meeting the qualifications of a ~~Mental Health Professional (MHP)~~ LBHP. A ~~MHP-LBHP~~ must be available at all times to provide back up, support, and/or consultation.

(B) These services may be retrospectively reviewed by OHCA or its designated agent.

(21) **Community Recovery Support.** Recovery Support is a service delivery role in the ODMHSAS public and contracted provider system throughout the mental health care system where the provider understands what creates recovery and how to support environments conducive of recovery. The role is not interchangeable with traditional staff that usually work from the perspective of their training and/or their status as a licensed mental health provider; rather, this provider works from the perspective of their experiential expertise and specialized credential training. They lend unique insight into mental illness and what makes recovery possible because they are in recovery. Each provider must successfully complete over 40 hours of specialized training, demonstrate integration of newly acquired skills and pass a written exam in order to become credentialed. A code of ethics and continuing education opportunities are components which inform the continued professional development of this provider.

(A) The community/recovery support worker must meet the following criteria:

- (i) High School diploma or GED;
- (ii) minimum one year participation in local or national member advocacy or knowledge in the area of mental health recovery;
- (iii) current or former member of mental health services; and
- (iv) successful completion of the ODMHSAS Recovery Support Provider Training and Test to be credentialed.

(B) These services may be retrospectively reviewed by OHCA or its designated agent.

(C) Example of work performed:

(i) Utilizing their knowledge, skills and abilities will:

- (I) teach and mentor the value of every individual's recovery experience;
- (II) model effective coping techniques and self-help strategies;
- (III) assist ~~service recipients~~ members in articulating personal goals for recovery; and
- (IV) assist ~~service recipients~~ members in determining the objectives needed to reach his/her recovery goals.

(ii) Utilizing ongoing training may:

- (I) proactively engage members and possess communication skills/ability to transfer new concepts, ideas, and insight to others;
- (II) facilitate peer support groups;
- (III) assist in setting up and sustaining self-help (mutual support) groups;
- (IV) support members in using a Wellness Recovery Action Plan (WRAP);
- (V) assist in creating a crisis plan/Psychiatric Advanced Directive;
- (VI) utilize and teach problem solving techniques with members;
- (VII) teach members how to identify and combat negative self-talk and fears;
- (VIII) support the vocational choices of members and assist him/her in overcoming job-related anxiety;
- (IX) assist in building social skills in the community that will enhance quality of life. Support the development of natural support systems;
- (X) assist other staff in identifying program and service environments that are conducive to recovery; and
- (XI) attend treatment team and program development meetings to ensure the presence of the member's voice and to promote the use of self-directed recovery tools.

(iii) Possess knowledge about various mental health settings and ancillary services (i.e., Social Security, housing services, advocacy organizations).

(iv) Maintain a working knowledge of current trends and developments in the mental health field

by reading books, journals and other relevant material.

- (I) attend continuing education assemblies when offered by or approved by the ODMHSAS's Office of Consumer Affairs; and
- (II) develop and share recovery oriented material at member specific continuing education trainings.
- (v) Serve by:
 - (I) providing and advocating for effective recovery oriented services;
 - (II) assisting members in obtaining services that suit that individual's recovery needs;
 - (III) informing members about community and natural supports and how to utilize these in the recovery process; and
 - (IV) assisting members in developing empowerment skills through self-advocacy.
- (vi) Develop specific competencies which will enhance their work skills and abilities. Identified tasks include, but are not limited to:
 - (I) becoming a trained facilitator of Double Trouble in Recovery (DTR);
 - (II) becoming a trained facilitator of Wellness Recovery Action Plan (WRAP);
 - (III) pursuing the USpra credential of Certified Psychiatric Rehabilitation Practitioner (CPRP).

(b) Prior authorization and review of services requirements.

(1) General requirement.

~~(A) All Medicaid SoonerCare providers who provide outpatient behavioral health services are required to have the services they provide either prior authorized by the OHCA or its designated agent, or retroactively reviewed by a contractor of OHCA.~~

~~(i) Private behavioral health providers, public and private community mental health centers, providers identified by the ODMHSAS as contracted providers, FQHCs, CHCs, RHCs, and I/T/U facilities are required to have all services prior authorized with the exception of the three services listed in paragraph (2)(A) of this subsection: Mental Health Assessment by a Non-Physician, Mental Health Service Plan Development by a Non-Physician (moderate complexity), and Crisis Intervention Services and Adult Facility Based Crisis Intervention.~~

~~(B) CMHC's, as identified by the ODMHSAS, are required to have all services retroactively reviewed by a contractor of OHCA and must contain the same prior authorization elements required of the private and contracted (ODMHSAS) providers under OAC 317:30-5-241(b)(4)(B)(i).~~

(2) Prior authorization and review of services.

~~(A) All Medicaid services identified in subsection (a) of this Section must be prior authorized or reviewed as set forth in paragraph (1) of this subsection except for the following services:~~

- ~~(i) Mental Health Assessment by a Non-Physician [see subsection (a)(1) of this Section] or Alcohol and Drug Assessment;~~
- ~~(ii) Mental Health Services Plan Development by a Non-Physician (moderate complexity) [see subsection (a)(2) of this Section] or Alcohol and/or Substance Abuse Services, Treatment Plan Development (moderate complexity); and~~
- ~~(iii) Crisis Intervention Services and Adult Facility Based Crisis Intervention [see subsection (a)(17) and (18) of this Section]. Children's Facility Based Stabilization requires prior authorization.~~

~~(B) Prior authorization means the authorization of services prior to services being rendered. Should a provider perform services prior to the authorization, those services are performed at the risk of nonpayment by OHCA.~~

~~(3) **Contractor for prior authorization and review of services.** The contractor OHCA or its designated agent who performs the services identified in paragraph (1) of this subsection uses its independent medical judgment to perform both the review of services and the prior authorization of services. OHCA does retain final administrative review over both prior authorization and review of services as required by 42 CFR 431.10.~~

(4) Prior authorization process.

(A) Definitions. The following definitions apply to the process of applying for an outpatient behavioral health prior authorization.

- (i) **"Outpatient Request for Prior Authorization"** means the form used to request the OHCA ~~contractor~~ or its designated agent to approve services.
- (ii) **"Authorization Number"** means the number that is assigned per recipient member and per provider that authorizes payment after services are rendered.
- (iii) **"Initial Request for Treatment"** means a request to authorize treatment for a recipient member that has not received outpatient treatment in the last six months.
- (iv) **"Extension Request"** means a request to authorize treatment for a recipient member who has received outpatient treatment in the last six months.
- (v) **"Modification of Current Authorization Request"** means a request to modify the current array or amount of services a recipient member is receiving.
- (vi) **"Correction Request"** means a request to change a prior authorization error made by ~~OHCA's contractor~~ the OHCA or its designated agent.

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(vii) **"Provider change in demographic information notification"** means a request to change a provider's name, address, phone, and/or fax numbers, or provider identification numbers. Change in demographics will require contractual changes with OHCA. Providers should contact OHCA's Contracts Services Division for more information.

(viii) **"Status request"** means a request to ask the OHCA ~~contractor~~ or its designated agent the status of a request.

(ix) **"Important notice"** means a notice that informs the provider that information is lacking regarding the approval of any prior authorization request.

(x) **"Letter of collaboration"** means an agreement between the ~~recipient member~~ and two providers when a ~~recipient member~~ chooses more than one provider during a course of treatment.

(B) **Process.** A provider must submit an Initial Request for Treatment, an Extension Request, a Modification of Current Authorization Request, or a Correction Request on a form provided by the OHCA ~~contractor~~ or its designated agent, prior to rendering the initial services or any additional array of services, with the exception of ~~the three services noted in paragraph (2) of this subsection~~ Mental Health Assessment by a Non-Physician; Mental Health Service Plan Development by a Non-Physician (moderate complexity); and Crisis Intervention Services and Adult Facility Based Crisis Intervention.

(i) These request forms must be fully completed including the following:

(I) pertinent demographic and identifying information;

(II) complete and current ~~Client Assessment Record (CAR) CAR or ASI~~ unless another appropriate assessment tool is authorized by ~~contractor~~ the OHCA or its designated agent;

(III) complete multi axial, ~~Diagnostic and Statistical Manual (DSM) DSM~~ diagnosis using the most current edition;

(IV) psychiatric and treatment history;

(V) ~~if requested by OHCA or their designated agent, service plan with goals, objectives, treatment duration for ICCD certified clubhouses recovery plan, with goals, steps, and needed supports); and~~

(VI) services requested; .

(VII) ~~if requested by OHCA or their designated agent, signature of member on service plan; and~~

(VIII) ~~if requested by OHCA or their designated agent, appropriate provider signature on all forms.~~

(ii) The OHCA ~~contractor~~ or its designated agent may also require supporting documentation for any data submitted by the provider. The

request may be denied if such information is not provided within ten calendar days of notification of the Important Notice.

(iii) Failure to provide a complete request form may result in a delay in the start date of the prior authorization.

(C) **Authorization for services.**

(i) Services are authorized by the ~~contractor exercising independent medical judgment based upon the medical data provided by the provider. The medical data provided, including the functional assessment (including frequency, duration and severity of behaviors), diagnosis and other medical history, is of paramount importance~~ OHCA or its designated agent using independent medical judgement to perform the review of prior authorization requests to determine whether the request meets medical necessity criteria. If services are authorized, a treatment course of one to six months will be authorized. The authorization of services is based upon six levels of care for children and five levels of care for adults. The numerically based levels of care are designed to reflect the member's acuity as each level of care, in ascending order, ~~provides for more services for the recipient's care. For example, a Level I (adult) designation provides for 1-12 RVU's while a Level II provides for 1-20 RVU's per month. The range of RVU's between the Level I and Level IV for both children and adults is 1 RVU per month to 62 RVU's per month. Other Additional~~ levels of care are known as Exceptional Case, 0-36 months, ICF/MR, and RBMS.

(ii) If the provider requests services beyond the initial prior authorization period, additional documentation is required in the Extension Request.

(D) **Appeals process.** ~~After the contractor issues a decision regarding an Initial Prior Authorization request, an Extension Request, a Modification Request or a Correction Request, the provider has five business days of receipt of the decision to request the contractor to reconsider its decision. The issues which a provider may ask for reconsideration are the number and type of services designated by the contractor and the length of treatment approved by the contractor. The reconsideration process outlined in this subparagraph will end on July 1, 2006. The reasoning or propriety of an Important Notice or a denial based upon insufficient data may not be reconsidered.~~

317:30-5-248. Documentation of records

All outpatient behavioral health services must be reflected by documentation in the member records.

(1) All assessment and treatment services must include the following:

(A) date;

(B) ~~person(s) to whom services were rendered;~~

- ~~(C) start and stop time for each timed treatment session or service;~~
- ~~(D) original signature of the therapist/service provider. In circumstances where it is necessary to fax a service plan to someone for review and then have them fax back their signature, this is acceptable; however, the provider must obtain the original signature for the clinical file within 30 days and no stamped or Xeroxed signatures are allowed;~~
- ~~(E) credentials of therapist/service provider;~~
- ~~(F) specific treatment plan problems(s), goals and/or objectives addressed;~~
- ~~(G) services provided and methods used to address problem(s), goals and/or objectives;~~
- ~~(H) progress or lack of progress made in treatment as it relates to the goals and/or objectives;~~
- ~~(I) member (and family, when applicable) response to the session or intervention;~~
- ~~(J) any new problem(s), goals and/or objectives identified during the session or service; and~~
- ~~(K) where services were rendered.~~
- (2) In addition to the items listed in (1) of this subsection:
 - (A) Crisis Intervention Service notes must also include:
 - (i) a detailed description of the crisis; and
 - (ii) level of functioning assessment.
 - (B) For each Group rehabilitative or counseling session a list of participants and facilitating BHRS, MHP, or AODTP must be maintained.
 - (C) For medication training and support, vital signs must be recorded in the progress note, but are not required on the mental health services plan.
- (1) For Mental Health and Alcohol and Drug Assessments (see 317:30-5-241), no progress note are required.
- (2) For Mental Health Services Plan and Alcohol and/or Substance Abuse Services, Treatment Plan (see 317:30-5-241), no progress note are required.
- (3) Treatment Services documented by progress notes.
 - (A) Progress notes shall chronologically describe the services provided, the member's response to the services provided and the member's progress, or lack or, in treatment and must include the following:
 - (i) Date;
 - (ii) Person(s) to whom services were rendered, must be HIPAA compliant if other individuals in session are mentioned;
 - (iii) SoonerCare number for member;
 - (iv) Start and stop time for each timed treatment session or service;
 - (v) Original signature of the therapist/service provider; in circumstances where it is necessary to fax a service plan to someone for review and then have them fax back their signature, this is acceptable; however, the provider must obtain the original signature for the clinical file within 30 days and no stamped or Xeroxed signatures are

- allowed. Electronic signatures are acceptable following OAC 317:30-3-4.1 and 317:30-3-15;
- (vi) Credentials of therapist/service provider;
- (vii) Specific treatment plan problems(s), goals and/or objectives addressed;
- (viii) Services provided to address need(s), goals and/or objectives;
- (ix) Progress or barriers to progress made in treatment as it relates to the goals and/or objectives;
- (x) Member (and family, when applicable) response to the session or intervention; (what did the member do in session? What did the provider do in session?);
- (xi) Any new need(s), goals and/or objectives identified during the session or service.
- (4) In addition to the items listed in (1) of this subsection:
 - (A) Crisis Intervention Service notes must also include a detailed description of the crisis and level of functioning assessment;
 - (B) a list of participants for each Group rehabilitative or counseling session and facilitating PSRS, LBHP, or AODTP must be maintained; and
 - (C) for medication training and support, vital signs must be recorded in the progress note, but are not required on the mental health services plan;
- (5) Progress notes for intensive outpatient mental health, substance abuse, or integrated programs may be in the form of daily summary or weekly summary notes and must include the following:
 - (A) Curriculum sessions attended each day and/or dates attended during the week;
 - (B) Start and stop times for each day attended;
 - (C) Specific goal(s) and objectives addressed during the week;
 - (D) Type of Skills Training provided each day and/or during the week;
 - (E) Member satisfaction with staff intervention(s);
 - (F) Progress, or barriers to, made toward goals, objectives;
 - (G) New goal(s) or objective(s) identified;
 - (H) Signature of the lead PSRS; and
 - (I) Credentials of the lead PSRS.

[OAR Docket #07-1329; filed 7-24-07]

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

[OAR Docket #07-1322]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 5. Individual Providers and Specialties
Part 65. Case Management Services for Over 21

Emergency Adoptions

317:30-5-585. through 317:30-5-586.1. [AMENDED]

317:30-5-587. through 317:30-5-588. [REVOKED]

317:30-5-589. [AMENDED]

(Reference APA WF # 07-13)

AUTHORITY:

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR 440.60

DATES:

Adoption:

April 12, 2007

Approved by Governor:

May 25, 2007

EFFECTIVE:

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

Expiration:

Effective through July 14, 2008, 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 the recommended changes made by the State's Behavioral Health Collaborative. These revisions expand educational standards required for individuals to be qualified for Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) certification as Adult Case Managers and increases access to professional providers for SoonerCare members.

ANALYSIS:

Adult case management rules are revised to expand educational standards required for individuals to be qualified for ODMHSAS certification as Adult Case Managers and to update language on documentation requirements to maintain consistency and clarity between state agencies. The target group for case management services is the chronically and/or severely mentally ill. Chronically and/or severely mentally ill individuals refers to institutionalized adults or adults at risk of institutionalization. Case management services are provided to assist members to gain access to needed medical, social, educational and other services essential to meeting basic human needs.

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 JULY 1, 2007, WHICHEVER IS LATER:

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 65. CASE MANAGEMENT SERVICES FOR OVER 21

317:30-5-585. Eligible providers

Services are provided by case management agencies established for the purpose of providing case management services.

- (1) **Program Provider agency requirements.** ~~Programs must be reviewed in the areas of substance abuse and/or mental health by the Department of Mental Health~~

~~and Substance Abuse Services (DMHSAS) as an agent of the OHCA in accordance with a current Interagency Agreement for such purposes. The program must be found to be in compliance with the applicable approved OHCA standards for the purpose of providing case management services. Only organizations that have submitted a completed OHCA Case Management Provider Application to DMHSAS before July 1, 2003, will be eligible to be reviewed by DMHSAS for such purposes. On or after July 1, 2003, any organization seeking to be a provider of case management services not having a valid Memorandum of Agreement as an OHCA case management provider, or a completed OHCA Case Management Provider Application with DMHSAS, must demonstrate JCAHO, CARE, COA, or AOA accreditation. Beginning July 1, 2004, the DMHSAS review, in accordance with the above referenced DMHSAS/OHCA Interagency Agreement, will no longer qualify any organization to be a provider of case management services. As set forth in the current DMHSAS/OHCA Interagency Agreement, reviews conducted by DMHSAS will be limited to determinations that applications for initial and/or continued Medicaid case management provider status meets standards approved by OHCA in accordance with protocol approved by OHCA. The agency must demonstrate its capacity to deliver case management services in terms of the following:~~

(A) On or after July 1, 2007, the OHCA will require agencies to have accreditation appropriate to case management from JCAHO, CARE, COA, or AOA, and meet the standards of the accreditation agency at all times.

(B) The OHCA reserves the right to obtain a copy of any accreditation audit and/or site visit reports from the provider and/or the accreditation agency.

(C) Agencies that are eligible to contract with the OHCA to provide case management services for seriously mentally ill adults must be community based.

(D) Agencies must be able to demonstrate the ability to develop and maintain appropriate patient records including, but not limited to, assessments, service plans, and progress notes.

(E) An agency's behavioral health case management staff must serve the target group on a 24 hour on call basis.

(F) Each site operated by a case management facility must have a separate provider number. A site is defined as an office, clinic, or other business setting where case management services are routinely performed. When services are rendered at the patient's residence, a school, or an appropriate community based setting, a site is determined according to where the professional staff conduct administrative duties and where the patient's chart and other records are kept. Failure to obtain and utilize site specific provider numbers will result in disallowance of services.

(2) **Provider requirements.** The agency must demonstrate its capacity to deliver case management services in terms of the following items:

- (A) Case management staff to serve the target group and be available on a 24 hour on call basis.
- (B) Administrative capacity to fulfill State and Federal requirements.
- (C) Maintenance of programmatic and financial records. Program records should show that the agency is able to develop and maintain assessment records. The financial records should include development of a management system which tracks costs associated with worker activities.
- (D) Be an agency which agrees to comply with applicable Federal and State regulations, as set forth in the contractual agreement.
- (E) On or after July 1, 2004, OHCA will require agencies to have accreditation appropriate to case management from JCAHO, CARE, COA, or AOA, and meet the standards of the accreditation agency at all times.
- (F) Agencies will be required to maintain the Code of Federal Regulations (CFR) requirements as required by the Health Care Financing Administration at all times.
- (G) OHCA reserves the right to obtain a copy of any accreditation audit and/or site visit reports from the provider and/or the accreditation agency.
- (H) Agencies that are eligible to contract with OHCA to provide case management services for seriously mentally ill adults must be community based with a history of serving adults who have a serious mental illness.

(3) **Application to become a provider by the Department of Mental Health.** On or before July 1, 2003, an application as an eligible provider for case management services must be requested from the Department of Mental Health and Substance Abuse Services. This process is in addition to any other application submitted to the Department of Mental Health. The application will be reviewed and the provider will be notified within ten (10) days from receipt of application of the determination. An application must be submitted prior to the beginning of each contract period.

(4) **Memorandum of agreement.** The Oklahoma Health Care Authority and the Department of Mental Health and Substance Abuse Services have developed a memorandum of agreement that provides for responsibility of payment of the Medicaid state share required for federal financial participation. In accordance with this agreement, DMHSAS has agreed to pay the state share for case management services provided by Public facilities and DMHSAS facilities.

(5) **Provider types.**

(A) **ODMHSAS Public public and private facilities.** Public ODMHSAS facilities are the regionally based Community Mental Health Centers. Private

ODMHSAS facilities are providers that have contracted with the ODMHSAS to provide mental health, substance abuse, and case management treatment services. The Department of Mental Health and Substance Abuse Services (DMHSAS) is responsible for the State's share of adult Medicaid services. Reimbursement will be at the Public rate. Both of these provider types must also contract with the OHCA directly to receive SoonerCare reimbursement.

(B) **DMHSAS Contracted facilities.** DMHSAS Contracted facilities are those facilities who contract with the DMHSAS to provide services. These facilities receive an appropriation from the DMHSAS and report to DMHSAS via the OMHSIS system. The Department of Mental Health and Substance Abuse Services is responsible for the State's share of adult Medicaid services. Reimbursement will be at the Public rate.

(C) **Private facilities.** Private facilities are those facilities who that contract directly with the Oklahoma Health Care Authority to provide case management services. The State's share of Medicaid services is included in the OHCA budget. Reimbursement will be at the Private rate.

(6) **Service provider education and experience requirements before July 1, 2001.** For case management services to be compensable by Medicaid SoonerCare, the case manager performing the service must maintain current case management certification from the Department of Mental Health and Substance Abuse Services. For those case managers who are certified on or before July 1, 2001, the following education and experience requirements apply:

- (A) Associate's degree in a related human service field, OR;
- (B) Two years of college education plus two years or more human service experience, OR;
- (C) Bachelor's degree in a related human service field plus one year or more human service experience, OR;
- (D) Master's degree in a related human service field.

(7) **Service provider education and experience requirements after July 1, 2001.** The following education and experience requirements apply after July 1, 2001.

- (A) Bachelor's or Master's degree in a mental health related field including, but not limited to psychology, social work, occupational therapy, family studies, sociology, criminal justice, school guidance and counseling, OR
- (B) A current license as a registered nurse in Oklahoma; OR
- (C) Certification as an alcohol and drug counselor allowed to provide substance abuse case management to those with alcohol and/or other drug-dependencies or addictions as a primary or secondary DSMIV Axis I diagnosis, AND

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(D) Current case management certification from the Department of Mental Health and Substance Abuse Services.

(5) Service provider education and experience requirements after July 1, 2007. For behavioral health case management services to be compensable by SoonerCare, the case manager performing the service must have and maintain a current behavioral health case manager certification from the ODMHSAS and meet either (A), (B), or (C) below, and (D):

(A) Certified Behavioral Health Case Manager III - meets the Licensed Behavioral Health Professional status as defined at OAC 317:30-5-240, and passes the ODMHSAS web-based Case Management Competency Exam.

(B) Certified Behavioral Health Case Manager II - a bachelor's or master's degree in a behavioral health field, earned from a regionally accredited college or university recognized by the United States Department of Education, which includes but is not limited to psychology, social work/sociology, occupational therapy, family studies, human resources/services counseling, human developmental psychology, gerontology, early childhood development, chemical dependency studies, school guidance/counseling/education, rehabilitative services, and/or criminal justice; a current license as a registered nurse in Oklahoma with experience in behavioral health care; or a current certification as an alcohol and drug counselor in Oklahoma, and pass the ODMHSAS web-based Case Management Competency Exam, and complete seven hours of ODMHSAS specified CM training.

(C) Certified Behavioral Health Case Manager I - meets the following requirements:

- (i) completed 60 college credit hours; or**
- (ii) high school diploma with 36 total months of experience working with persons who have a mental illness. Documentation of experience must be on file with ODMHSAS; and**
- (iii) passes the ODMHSAS web-based Case Management Competency Exam, and completes 14 hours of ODMHSAS specified CM training.**

(D) All certified case managers must fulfill the continuing education requirements as laid out in OAC 450:50-5-4.

case management services will be subject to medical necessity criteria. The criteria will be applied to each individual case by an agent designated by the ~~Oklahoma Health Care Authority~~ OHCA or its designated agent.

(i) Behavioral health Case case management services are provided to assist consumers in gaining access to needed medical, social, educational and other services essential to meeting basic human needs. The behavioral health case manager provides referral, linkage and advocacy on behalf of consumers, to help consumers access appropriate community resources. Case management is designed to assist individuals in accessing services for themselves. The consumer has the right to refuse case management and cannot be restricted from other services because of a refusal of case management services. However, in referring a consumer for medical services, the case manager should be aware that the Medicaid SoonerCare program is limited in scope. The behavioral health case manager must monitor the progress in gaining access to services and continued appropriate utilization of necessary community resources. Behavioral case management is designed to promote recovery, maintain community tenure, and to assist individuals in accessing services for themselves following the case management guidelines established by the ODMHSAS. In order to be compensable, the service must be performed utilizing the ODMHSAS Strengths Based model of case management. This model of case management assists individuals in identifying and securing the range of resources, both environmental and personal, needed to live in a normally interdependent way in the community. The focus for the helping process is on strengths, interests, abilities, knowledge and capacities of each person, not on their diagnosis, weakness or deficits. The relationship between the service member and the behavioral health case manager is characterized by mutuality, collaboration, and partnership. Helping activities are designed to occur primarily in the community, but may take place in the behavioral health case manager's office, if more appropriate. The community based behavioral health case management agency will coordinate with the member by phone or face-to-face, to identify immediate needs for return to home/community. The case manager will provide linkage/referral to physicians/medication services, counseling services, rehabilitation and/or support services as described in the case management service plan. During the follow-up phase of these referrals or links, the behavioral health case manager will provide aggressive outreach if appointments or contacts are missed within two business days of the missed appointments. Community/home

317:30-5-586. Coverage by category

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

(1) **Adults.** Payment is made for services to adults as follows:

(A) Description of case management services. Services under case management are not comparable in amount, duration and scope. The target group for case management services is the chronically and/or severely mentally ill. Chronically and/or severely mentally ill individuals refer to institutionalized adults or adults at risk of institutionalization. All

based case management to assess the needs for services will be scheduled as reflected in the case management service plan, but not less than one time per month.

(ii) ~~Provision of case management services~~ An eligible member/parent/guardian will not restrict a consumer's free choice of providers be restricted and will have the freedom to choose a behavioral health case management provider as well as providers of other medical care. Eligible recipients have the freedom to choose a case management provider as well as providers of other medical care.

(iii) In order to ensure that case management services are not duplicated by other staff, case management activities will be provided in accordance with a comprehensive individualized treatment/service plan. ~~The development of this plan includes clinical staff participation, thus ensuring that staff knows a client has a case manager. The treatment service plan includes goals and objectives that are measurable and time limited. The plan also includes specific activities. Time spent in planning case management activities or service development is compensated if the consumer is present. If there are outpatient behavioral health services in addition to case management services, the treatment plan must be reviewed and signed by the responsible mental health professional, consumer, and physician (if applicable).~~

(iv) The service plan must include general goals and objectives pertinent to the overall recovery needs of the member. Progress notes must relate to the service plan and describe the specific activities performed. Behavioral health case management service plan development is compensable time if the time is spent communicating with the participation by, as well as, reviewed and signed by the member, the behavioral health case manager, and a licensed behavioral health professional as defined at OAC 317:30-5-240.

(v) SoonerCare reimbursable behavioral health case management services include the following:

(I) Gathering necessary psychological, educational, medical, and social information for the purpose of service plan development.

(II) Face-to-face meetings with the child and/or the parent/guardian/family member for the implementation of activities delineated in the service plan.

(III) Face-to-face meetings with treatment or service providers, necessary for the implementation of activities delineated in the service plan.

(IV) Supportive activities such as non face-to-face communication with the child

and/or parent/guardian/family member or the behavioral health case manager's travel time to and from meetings for the purpose of development or implementation of the service plan.

(V) Non face-to-face communication with treatment or service providers necessary for the implementation of activities delineated in the service plan.

~~(iv vi) Medicaid—reimbursable~~ Reimbursable case management does not include:

(I) Physically physically escorting or transporting a ~~consumer—member~~ to scheduled appointments or staying with the ~~consumer member~~ during an appointment; or

(II) Monitoring monitoring financial goals; or

(III) Providing providing specific services such as shopping or paying bills; or

(IV) Delivering delivering bus tickets, food stamps, money, etc.; or

(V) Services services to nursing home ~~consumers residents~~; or

(VI) Counseling counseling or rehabilitative services, psychiatric assessment, or discharge; or

(VII) Filling filling out forms, applications, etc., on behalf of the ~~consumer member~~ when the ~~consumer member~~ is not present; or

(VIII) Filling filling out Medicaid SoonerCare forms, applications, etc., or;

(IX) Services services to ~~consumers members~~ residing in ICF/MR facilities.

(B) **Providers.** Case management services must be provided by a Community Mental Health Center or other qualifying provider agency of case management. Two different provider agencies may not bill case management service(s) for the same ~~consumer member~~ on the same day.

(2) **Children.** Coverage for children is found in OAC 317:30-5-596.

(3) **Individuals eligible for Part B of Medicare.** Case management services provided to Medicare eligible ~~recipients members~~ should be filed directly with the fiscal agent.

317:30-5-586.1. Prior authorization

(a) Prior authorization of behavioral health services and requirements to be authorized to provide case management services ~~is~~ are mandatory. The provider must request prior authorization from the OHCA or its designated agent. In order for the services to be prior authorized, ~~consumer—member~~ information requested must be submitted. ~~Consumer Member~~ information includes but is not limited to the following:

(1) Complete multi-axial DSM IV diagnosis with supportive documentation and mental status examination summary; and

(2) Treatment history; and

(3) Current ~~psycho~~ psychiatric social information; and

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- (4) Psychiatric history; and
 - (5) Fully developed case management service plan, with goals, objectives, and time frames for services.
- (b) ~~Medicaid recipients~~ SoonerCare members will be considered for prior authorization after receipt of complete and appropriate information submitted by the provider. Based on diagnosis, functional assessment, history and other ~~Medicaid~~ SoonerCare services being received, the ~~Medicaid recipient~~ SoonerCare member may be approved to receive case management services. ~~Medicaid recipients~~ SoonerCare members who reside in nursing facilities, residential behavior management services, group or foster homes, or ICF/MR's may not receive ~~Medicaid~~ SoonerCare compensable case management services. A ~~Medicaid recipient~~ SoonerCare member may be approved for a time frame of one to six months. The OHCA (or its designated agent) will review the request for ~~completeness and appropriateness.~~ The provider will be notified within 24 hours (excluding weekends and holidays) if the request is incomplete, deficient, or inappropriate, and, if so, additional information will be requested. A completed request will be reviewed and processed within 72 working hours in accordance with the guidelines for prior authorization in the Outpatient Behavioral Health Provider Manual. Requests will be reviewed by licensed ~~master's prepared therapists (Licensed Clinical Social Workers, Licensed Professional Counselors, Licensed Marriage and Family Therapists) with experience in behavioral health care, Licensed Registered Nurses with experience in behavioral health care, Psychiatrists (M.D. and D.O.), or Psychologists possessing current state licensure behavioral health professionals under OAC 317:30-5-240.~~
- (c) A prior authorization decision may be appealed by the ~~consumer member~~ if filed within 20 days of receipt of the decision. Until July 1, 2006, a provider may request a reconsideration from OHCA's designated agent within five working days of receipt of the decision. The designated agent's decision regarding a reconsideration requests is final.
- (d) Providers seeking prior authorization will follow OHCA's designated agent's Outpatient Behavioral Health Prior Authorization Manual guidelines for submitting requests on behalf of the ~~Medicaid recipient~~ SoonerCare member.

317:30-5-587. Reimbursement [REVOKED]

- (a) ~~Payment rates for case management services are established with a methodology that uses the average cost (from the last available cost reports) of furnishing one unit of each service multiplied by the Consumer Price Index for Labor Costs for Hospital Workers to arrive at a prospective rate for the next state fiscal year (July 1 through June 30).~~
- (b) ~~Reimbursement for adult case management services is determined using a Relative Value Unit (RVU) fee schedule. Two monetary conversion factors (CF) will be used to determine the overall level of payments to providers. The formula for calculating the rates is as follows: RVU x CF = RATE.~~
- (1) ~~Public rate.~~ The conversion factor for Public rate uses 1996 baseline payment data, trended forward using the Consumer Price Index for Hospital Workers.

- (2) ~~Private rate.~~ The conversion factor for Private rate uses 1996 baseline payment data, adjusted to reduce Medicaid's payment of fixed costs.
- (e) ~~Case management is reimbursed in 15 minute increments.~~

317:30-5-588. Billing [REVOKED]

- (a) ~~Billing for case management services will be on Form HCFA 1500. Claims should not be submitted until Medical eligibility of the individual has been determined. However, a claim must be received by OHCA within 12 months of the date of service. If the eligibility of the individual has not been determined after ten months from the date of service, a claim should be submitted in order to assure that the claim is timely filed and reimbursement from Title XIX funds can be made should the individual be determined eligible at a later date.~~
- (b) ~~Claims for prior authorized services must include a prior authorization number in Block 23 of the HCFA 1500.~~

317:30-5-589. Documentation of records

All behavioral health case management services rendered must be reflected by documentation in the records. ~~Documentation~~ In addition to a complete behavioral health case management service plan documentation of each session must include, but is not limited to:

- (1) goals and objectives addressed, date;
- (2) progress toward goals and objectives, person(s) to whom services are rendered;
- (3) start and stop times for each service ;
- (4) date, original signature of the service provider (original signatures for faxed items must be added to the clinical file within 30 days);
- (5) staff signature and credentials of the service provider ; and ;
- (6) specific resources to which the consumer was referred; service plan needs, goals and/or objectives addressed;
- (7) specific activities performed by the behavioral health case manager on behalf of the child related to advocacy, linkage, referral, or monitoring used to address needs, goals and/or objectives;
- (8) progress or barriers made towards goals and/or objectives;
- (9) member (family when applicable) response to the service;
- (10) any new service plan needs, goals, and/or objectives identified during the service; and
- (11) member satisfaction with staff intervention.

[OAR Docket #07-1322; filed 7-24-07]

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

[OAR Docket #07-1326]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 5. Individual Providers and Specialties
Part 67. ~~Behavior~~Behavioral Health Case Management Services for
Individuals Under 21 Years of Age
317:30-5-595. through 317:30-5-596.1. [AMENDED]
317:30-5-599. [AMENDED]
(Reference APA WF # 07-09)

AUTHORITY:

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR 440.60

DATES:

Adoption:

April 12, 2007

Approved by Governor:

May 25, 2007

Effective:

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

Expiration:

Effective through July 14, 2008, 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 the recommended changes made by the State's Children's Behavioral Health Collaborative. The revisions expand educational standards required for individuals to be qualified for Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) certification as Case Managers for children and will increase access to professional providers for SoonerCare members.

ANALYSIS:

Children's case management rules are revised to expand educational standards required for individuals to be qualified for ODMHSAS certification as Case Managers for children and to update language on documentation requirements to maintain consistency and clarity between state agencies. The target group for children's behavioral health case management services consists of persons under age 21 who are in imminent risk of out-of-home placement for psychiatric or substance abuse reasons or are in out-of-home placement due to psychiatric or substance abuse reasons. Behavioral health case management services are provided to assist eligible individuals in gaining access to needed medical, social, educational and other services essential to meeting basic human needs.

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 JULY 1, 2007, WHICHEVER IS LATER:

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 67. BEHAVIOR BEHAVIORAL HEALTH CASE MANAGEMENT SERVICES FOR INDIVIDUALS UNDER 21 YEARS OF AGE

317:30-5-595. Eligible providers

Services are provided by case management agencies established for the purpose of providing case management services.

(1) **Provider agency requirements.** The agency must demonstrate its capacity to deliver behavioral health case management services in terms of the following items:

~~(A) On or after July 1, 2003, any organization seeking to be a provider of behavioral health case management services not having a valid Memorandum of Agreement as an OHCA case management provider, or a completed OHCA Case Management Provider Application with ODMHSAS, must demonstrate appropriate JCAHO, CARF, COA, or AOA accreditation. Beginning July 1, 2004, the ODMHSAS review, in accordance with ODMHSAS/OHCA Interagency Agreement, will no longer qualify any organization to be a provider of behavioral health case management services. As set forth in the current ODMHSAS/OHCA Interagency Agreement, reviews conducted by ODMHSAS will be limited to determinations that applications for initial and/or continued behavioral health case management provider status meets standards approved by OHCA in accordance with protocol approved by OHCA.~~

~~(B) A) On or after July 1, 2004, OHCA will require agencies to have accreditation appropriate to behavioral health case management from JCAHO, CARF, COA, or AOA, and maintain the standards of the accreditation at all times.~~

~~(C) B) OHCA reserves the right to obtain a copy of any accreditation audit and/or site visit reports from the provider and/or the accreditation agency.~~

~~(D) C) Agencies that are eligible to contract with OHCA to provide behavioral health case management services to eligible individuals under the age of 21 must be community based with a history of serving seriously emotionally disturbed (SED) children and their families.~~

~~(E) D) The agency must be able to demonstrate the ability to develop and maintain appropriate patient records including but not limited to assessments, service plans, and progress notes. The financial records should include development of a management system which tracks costs associated with worker activities.~~

~~(F) E) An agency must agree to follow the Oklahoma Department of Mental Health and Substance Abuse Services established behavioral health case management rules found in OAC 450:50.~~

~~(G) F) An agency's behavioral health case management staff must serve the target group on a 24 hour on call basis.~~

~~(H) An agency must agree to comply with applicable Federal and State regulations, as set forth in the contractual agreement.~~

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- (F) ~~Agencies will be required to maintain the Code of Federal Regulations (CFR) requirements as required by the Centers for Medicare and Medicaid Services (CMS) at all times.~~
- (FG) Each site operated by a case management facility must have a separate provider number. A site is defined as an office, clinic, or other business setting where case management services are routinely performed. When services are rendered at the patient's residence, a school, or an appropriate community based setting, a site is determined according to where the professional staff ~~perform~~ conduct administrative duties and where the patient's chart and other records are kept. Failure to obtain and utilize site specific provider numbers will result in disallowance of services.
- (2) **Provider types.**
- (A) **ODMHSAS Public public and private facilities.** ~~Public and ODMHSAS Contracted Programs Facilities (Public facilities) facilities are the regionally based Community Mental Health Centers. ODMHSAS contracted programs are Private ODMHSAS facilities~~ are providers that have a contract with the ODMHSAS to provide Mental Health, Substance Abuse, and Case Management Treatment Services. Both of these provider types must also contract with the OHCA directly to receive SoonerCare reimbursement.
- (B) **Private facilities.** Private facilities are those facilities ~~who~~ that contract directly with the Oklahoma Health Care Authority to provide case management (CM) services.
- (3) **Service provider education and experience requirements before July 1, 2001.** For case management services to be compensable by ~~Medicaid~~ SoonerCare, the case manager performing the service must maintain current case management certification from the Oklahoma Department of Mental Health and Substance Abuse Services. For those case managers who are certified on or before July 1, 2001, the following education and experience requirements apply:
- (A) Associate's degree in a related human service field, OR;
- (B) Two years of college education plus two years or more human service experience, OR;
- (C) Bachelor's degree in a related human service field plus one year or more human service experience, OR;
- (D) Master's degree in a related human service field.
- (4) **Service provider education and experience requirements after July 1, 2001.** For behavioral health case management services to be compensable by ~~Medicaid~~ SoonerCare, the case manager performing the service must have and maintain a current children's behavioral health case manager certification from the ~~Oklahoma Department of Mental Health and Substance Abuse Services (refer to OAC 450:50)~~ ODMHSAS and have a:
- (A) Bachelor's or Master's degree in a mental health related field including, but not limited to psychology, social work, occupational therapy, family studies, sociology, criminal justice, school guidance and counseling; OR
- (B) A current license as a registered nurse in Oklahoma with experience in behavioral health care; OR
- (C) Certification as an alcohol and drug counselor allowed to provide substance abuse case management to those with alcohol and/or other drug dependencies or addictions as a primary or secondary DSMIV Axis I diagnosis; and
- (D) Current case management certification from the ODMHSAS.
- (5) **Service provider education and experience requirements after July 1, 2007.** For behavioral health case management services to be compensable by ~~SoonerCare~~, the case manager performing the service must have and maintain a current children's behavioral health case manager certification from the ODMHSAS and meet either (A), (B), or (C) below, and (D):
- (A) Certified Behavioral Health Case Manager III - meets the Licensed Behavioral Health Professional status as defined at OAC 317:30-5-240, and passes the ODMHSAS web-based Case Management Competency Exam.
- (B) Certified Behavioral Health Case Manager II - a bachelor's or master's degree in a behavioral health field, earned from a regionally accredited college or university recognized by the United States Department of Education, which includes but is not limited to psychology, social work/sociology, occupational therapy, family studies, human resources/services counseling, human developmental psychology, gerontology, early childhood development, chemical dependency studies, school guidance/counseling/education, rehabilitative services, and/or criminal justice; a current license as a registered nurse in Oklahoma with experience in behavioral health care; or a current certification as an alcohol and drug counselor in Oklahoma, and pass the ODMHSAS web-based Case Management Competency Exam, and complete seven hours of ODMHSAS specified CM training.
- (C) Certified Behavioral Health Case Manager I - meets the requirements in either (i) or (ii), and (iii):
- (i) completed 60 college credit hours; or
- (ii) has a high school diploma with 36 total months of experience working with persons who have a mental illness. Documentation of experience on file with ODMHSAS; and
- (iii) passes the ODMHSAS web-based Case Management Competency Exam, and completes 14 hours of ODMHSAS specified CM training.
- (D) All certified case managers must fulfill the continuing education requirements as outlined under OAC 450:50-5-4.

317:30-5-596. Coverage by category

Payment is made for behavioral health case management services as set forth in this Section.

(1) **Adults.** Coverage for adults is found in OAC 317:30-5-586.

(2) **Children.** Payment is made for services to persons under age 21 as follows:

(A) **Description of behavioral health case management services.** Services under behavioral health case management are not comparable in amount, duration and scope. The target group for behavioral health case management services are persons under age 21 who are in imminent risk of out-of-home placement for psychiatric or substance abuse reasons or are in out-of-home placement due to psychiatric or substance abuse reasons. All behavioral health case management services will be subject to medical necessity criteria.

(i) Behavioral health case management services are provided to assist eligible individuals in gaining access to needed medical, social, educational and other services essential to meeting basic human needs. The behavioral health case manager provides referral, linkage and advocacy on behalf of the child to gain access to appropriate community resources. The behavioral health case manager must monitor the progress in gaining access to services and continued appropriate utilization of necessary community resources. Behavioral case management is designed to promote recovery, maintain community tenure, and to assist individuals in accessing services for themselves following the case management guidelines established by the Oklahoma Department of Mental Health and Substance Abuse Services. In order to be compensable, the service must be performed utilizing the ODMHSAS Strengths Based model of case management. This model of case management assists individuals in identifying and securing the range of resources, both environmental and personal, needed to live in a normally interdependent way in the community. The focus for the helping process is on strengths, interests, abilities, knowledge and capacities of each person, not on their diagnosis, weakness or deficits. The relationship between the service ~~recipient~~ member and the behavioral health case manager is characterized by mutuality, collaboration, and partnership. ~~Helping~~ Assistive activities are designed to occur primarily in the community, but may take place in the behavioral health case manager's office, if more appropriate. The community based behavioral health case management agency will coordinate with the child and family by phone or face-to-face, to identify immediate needs for return to home/community no more than 72 hours after notification that the family requests case management services. For children discharging

from an out of home placement, the out of home agency/placement is responsible for scheduling an appointment with a case management agency for services post discharge. The case manager will make contact with the child and family within 72 hours of discharge, then conduct a face-to-face follow-up appointment within 7 seven days. The case manager will provide linkage/referral to physicians/medication services, counseling services, rehabilitation and/or support services as described in the case management service plan. During the follow-up phase of these referrals or links, the behavioral health case manager will provide aggressive outreach if appointments or contacts are missed within 2 business days of the missed appointments. Community/home based case management to assess the needs for services will be scheduled as reflected in the case management service plan, but not less than one time per month. The ~~recipient/parent/guardian~~ member/parent/guardian has the right to refuse behavioral health case management and cannot be restricted from other services because of a refusal of behavioral health case management services.

(ii) An eligible ~~recipient/parent/guardian~~ member/parent/guardian will not be restricted and will have the freedom to choose a behavioral health case management provider as well as providers of other medical care.

(iii) In order to ensure that behavioral health case management services appropriately meet the needs of the child and family and are not duplicated, behavioral health case management activities will be provided in accordance with an individualized ~~service~~ plan of care.

(iv) The ~~service~~ individual plan of care must include general goals and objectives pertinent to the overall recovery of the child and family's needs. Progress notes must relate to the individual plan of care and that are measurable and time limited and must describe the specific activities to be performed. Behavioral health case management ~~service~~ individual plan of care development is compensable if the time is spent communicating with the child, parent/guardian/family member or provider of other services. The individual plan of care must be developed with participation by, as well as, reviewed and signed by the child (only if over 16 years of age), the parent or guardian, the behavioral health case manager, and a ~~mental health professional~~ Licensed Behavioral Health Professional as defined in OAC ~~317:30-5-240(e)~~ 317:30-5-240(d).

(v) ~~Medicaid~~ SoonerCare reimbursable behavioral health case management services include the following:

(I) Gathering necessary psychological, educational, medical, and social information

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for the purpose of ~~service~~ individual plan of care development.

(II) Face-to-face meetings with the child and/or the parent/guardian/family member for the implementation of activities delineated in the ~~service individual plan of care~~.

(III) Face-to-face meetings with treatment or service providers, necessary for the implementation of activities delineated in the ~~service individual plan of care~~.

(IV) Supportive activities such as non face-to-face communication with the child and/or parent/guardian/family member or the behavioral health case manager's travel time to and from meetings for the purpose of development or implementation of the ~~service individual plan of care~~.

(V) Non face-to-face communication with treatment or service providers necessary for the implementation of activities delineated in the ~~service individual plan of care~~.

(vi) ~~Medicaid~~ SoonerCare reimbursable behavioral health case management does not include the following activities:

(I) Physically escorting or transporting a child or family to scheduled appointments or staying with the child during an appointment; or

(II) Managing finances; or

(III) Providing specific services such as shopping or paying bills; or

(IV) Delivering bus tickets, food stamps, money, etc.; or

(V) Counseling, rehabilitative services, psychiatric assessment, or discharge planning; or

(VI) Filling out forms, applications, etc., on behalf of the child when the child is not present; or

(VII) Filling out ~~Medicaid~~ SoonerCare forms, applications, etc., or;

(VIII) Mentoring or tutoring; or

(IX) Provision of behavioral health case management services to the same family by two separate behavioral health case management agencies.

(B) The following ~~Medicaid recipients~~ SoonerCare members are not eligible for behavioral health case management services:

(i) Children/families for whom behavioral health case management services are available through OKDHS/OJA staff without special arrangements with OKDHS, OJA, and OHCA;

(ii) Children receiving services in Residential Behavior Management Services (RBMS) in a foster care or group home setting;

(iii) Residents of ICF/MR and nursing facilities; and

(iv) Children receiving Home and Community Based Waiver services.

(C) **Restriction.** Two different provider agencies may not bill case management services for the member on the same day.

(3) **Individuals eligible for Part B of Medicare.** Case management services provided to Medicare eligible ~~recipients~~ members should be filed directly with the fiscal agent.

317:30-5-596.1. Prior authorization

(a) Prior authorization of behavioral health case management services is mandatory. The provider must request prior authorization from the OHCA, or its designated agent.

(b) ~~Medicaid recipients~~ SoonerCare members who are eligible for services will be considered for prior authorization after receipt of complete and appropriate information submitted by the provider in accordance with the guidelines for behavioral health case management services developed by OHCA or its designated agent. Based on diagnosis, functional assessment, history and other ~~Medicaid~~ SoonerCare services being received, the ~~Medicaid recipient~~ SoonerCare member may be approved to receive case management services. ~~Medicaid recipients~~ SoonerCare members who reside in nursing facilities, residential behavior management services, group or foster homes, or ICF/MR's may not receive ~~Medicaid~~ SoonerCare compensable case management services. A ~~Medicaid recipient~~ SoonerCare member may be approved for a time frame of one to six months. The OHCA, or its designated agent will review the initial request in accordance with the guidelines for prior authorization in the Outpatient Behavioral Health Service Provider Manual. An initial request for case management services requires the provider to submit specific documentation to OHCA, or its designated agent. A fully developed ~~service individual plan of service~~ is not required at the time of initial request. The provider will be given a time frame to develop the ~~service individual plan of service~~ while working with the child and his/her family and corresponding units of service will be approved prior to the completion of the service plan. The provider will be required to engage with the child/family within 72 hours of discharge from an inpatient psychiatric hospital and/or within 72 hours of receiving the request for services from the family or other community resource. The expectation is for the behavioral health case manager to immediately engage with the child/family to prevent hospital readmission or other out-of-home placement, and refer to needed community resources. Prior authorization requests will be reviewed by licensed ~~mental health professionals (Licensed Clinical Social Workers, Licensed Professional Counselors, Licensed Marriage and Family Therapists, Licensed Behavioral Practitioners, and Licensed Alcohol and Drug Counselors), Licensed Registered Nurses with experience in behavioral health care, Psychiatrists (M.D. and D.O.), or Psychologists possessing current state licensure behavioral health professionals as defined at OAC 317:30-5-240.~~

(c) In the event that a ~~recipient member~~ disagrees with the decision by OHCA's contractor, it receives an evidentiary hearing under OAC 317:2-1-2(a). The ~~recipient's~~ member's request

for such an appeal must commence within 20 calendar days of the initial decision. ~~Providers may access a reconsideration process by OHCA's designated agent, whose decision is final. After the contractor issues a decision regarding an Initial Prior Authorization request, an Extension Request, a Modification Request or a Correction Request, the provider has five business days of receipt of the decision to request the contractor to reconsider its decision. The issues which a provider may ask for reconsideration are the number and type of services designated by the contractor and the length of treatment approved by the contractor. The reasoning or propriety of an Important Notice or a denial based upon insufficient data may not be reconsidered. The reconsideration process will end on July 1, 2006.~~

(d) Providers seeking prior authorization will follow OHCA's or its designated agent's prior authorization process guidelines for submitting behavioral health case management requests on behalf of the Medicaid recipient SoonerCare member.

317:30-5-599. Documentation of records

All behavioral health case management services rendered must be reflected by documentation in the records. In addition to a complete behavioral health case management service individual plan of service, documentation of each session must include but is not limited to:

- (1) date;
- (2) person(s) to whom services were rendered;
- (3) start and stop time for each service;
- (4) original signature of the service provider (in circumstances where it is necessary to fax a service plan to someone for review and then have them fax back their signature, this is acceptable; however, the provider needs to obtain the original signature for the clinical file within 30 days. No stamped or Xeroxed signatures are allowed);
- (5) credentials of service provider;
- (6) specific service plan ~~problem(s)~~ need(s), goals and/or objectives addressed;
- (7) specific activities performed by the behavioral health case manager on behalf of the child related to advocacy, linkage, referral, or monitoring used to address ~~problem(s)~~, goals and/or objectives;
- (8) progress or ~~lack of progress~~ barriers made towards goals and/or objectives;
- (9) client (and family, when applicable) response to the services;
- (10) any new service individual plan of service ~~problem(s)~~ need(s), goals and/or objectives identified during the service; and
- (11) where services were rendered; and member satisfaction with staff intervention(s).
- ~~(12) specific activities necessary for service plan development.~~

[OAR Docket #07-1326; filed 7-24-07]

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

[OAR Docket #07-1321]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 5. Individual Providers and Specialties
Part 83. Residential Behavior Management Services in Foster Care Settings

317:30-5-740. through 317:30-5-740.1. [AMENDED]

317:30-5-742. through 317:30-5-742.2. [AMENDED]

317:30-5-743.1. [AMENDED]

317:30-5-746. [AMENDED]

(Reference APA WF # 07-12)

AUTHORITY:

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR 440.60

DATES:

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

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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 Licensed Alcohol and Drug Counselors (LADC) to provide Residential Behavior Management Services (RBMS) to SoonerCare members. The addition of LADC will increase access to professional providers in RBMS settings for SoonerCare members.

ANALYSIS:

Residential Behavior Management Services (RBMS) rules are revised to: (1) allow Licensed Alcohol and Drug Counselors (LADC) to provide RBMS services; (2) add trauma informed methodology as an option to staff training requirements; (3) update terminology as recommended by the Behavioral Health Collaborative; and (4) add language to the inspection of care section for foster care settings to describe actions on contract deficiencies. Residential Behavior Management Services are provided in residential foster care programs for certain children and youth authorized by the designated agent of the Oklahoma Health Care Authority. The children and youth designated for this program have special psychological, social and emotional needs, requiring more intensive, therapeutic care than can be found in the traditional foster care setting. Providers must meet certain qualification and licensure requirements in order to provide these services. These revisions will recognize the Licensed Alcohol and Drug Counselor as a licensed provider for these services and expand the number of providers available to provide services to SoonerCare members.

Currently, OHCA requires staff providing behavior redirection services to have current certification and required updates in nationally recognized behavior management techniques. Rules are amended to include trauma informed methodology as an ongoing training option for RBMS staff who provide behavioral redirection services.

Rule revision also include adding language to the inspection of care section for foster care settings to describe actions on contract deficiencies. Current language describes the inspection of care process for which OHCA currently recoups monies for non-compensable services in acute and residential therapeutic care; however, there currently is no language that describes the recoupment for non-compensable services for therapeutic foster care. This revision will promote consistency for actions on contract deficiencies.

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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 JULY 1, 2007, WHICHEVER IS LATER:

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 83. RESIDENTIAL BEHAVIOR MANAGEMENT SERVICES IN FOSTER CARE SETTINGS

317:30-5-740. Eligible providers

(a) Eligible Residential Behavior Management Service (RBMS) agencies must:

- (1) have a current certification from the Oklahoma Department of Human Services (OKDHS) as a child placing agency, and
- (2) have a contract with the Division of Children and Family Services of the Oklahoma Department of Human Services, and
- (3) have a contract with the Oklahoma Health Care Authority.

(b) Effective July 1, 2002, an eligible RBMS must:

- (1) have a current certification from the Oklahoma Department of Human Services (OKDHS) as a child placing agency, and
- (2) have a contract with the Division of Children and Family Services of the Oklahoma Department of Human Services, and
- (3) have a contract with the Oklahoma Health Care Authority, and
- (4) have current accreditation status appropriate to provide behavioral management services in a foster care setting from:
 - (A) Joint Commission on Accreditation of Health Care Organization (JCAHO), or
 - (B) the Rehabilitation Accreditation Commission (CARF), or
 - (C) the Council on Accreditation (COA), or
 - (D) the American Osteopathic Association (AOA).

(c) For eligible RBMS agencies to bill the Oklahoma Health Care Authority for services performed by their providers, a provider of behavior management therapies must:

- (1) be a licensed psychologist, social worker (clinical specialty only), professional counselor, marriage and family therapist, or behavioral practitioner, or under Board approved supervision to be licensed in one of the above stated areas; or

(2) have one year of experience in a behavioral health treatment program and a master's degree in a mental health treatment field licensable in Oklahoma by one of the following licensing Boards:

- (A) Psychology,
- (B) Social work (clinical specialty only),
- (C) Professional counselor,
- (D) Marriage and family therapist, or
- (E) Behavioral practitioner; or

(3) have a baccalaureate degree in a behavioral health related field AND three or more years post-baccalaureate experience in providing direct patient care in a behavioral health treatment setting and be provided a minimum of weekly supervision by a staff member licensed as listed in paragraph (1) of this subsection; or

(4) be a registered psychiatric nurse; AND

(5) demonstrate a general professional or educational background in the following areas:

- (A) case management, assessment and treatment planning;
- (B) treatment of victims of physical, emotional, and sexual abuse;
- (C) treatment of children with attachment disorders;
- (D) treatment of children with hyperactivity or attention deficit disorders;
- (E) treatment methodologies for emotionally disturbed children and youth;
- (F) normal childhood development and the effect of abuse and/or neglect on childhood development;
- (G) treatment of children and families with substance abuse and chemical dependency disorders;
- (H) anger management; and
- (I) crisis intervention.

(d) For eligible RBMS agencies to bill the Oklahoma Health Care Authority for services of their providers for behavior management therapies in a foster care setting as of July 1, ~~2003~~ 2007, providers must have the following qualifications:

(1) be licensed in the state in which the services are delivered as a licensed psychologist, social worker (clinical specialty only), professional counselor, marriage and family therapist, or behavioral practitioner, alcohol and drug counselor, or under Board approved supervision to be licensed in one of the areas listed in (c)(2)(A-E) of this section, or

(2) be licensed as an advanced practice nurse certified in a psychiatric mental health specialty, licensed as a registered nurse with a current certification of recognition from the Board of Nursing in the state in which services are provided AND

(3) demonstrate a general professional or educational background in the following areas:

- (A) case management, assessment and treatment planning;
- (B) treatment of victims of physical, emotional, and sexual abuse;
- (C) treatment of children with attachment disorders;

- (D) treatment of children with hyperactivity or attention deficit disorders;
- (E) treatment methodologies for emotionally disturbed children and youth;
- (F) normal childhood development and the effect of abuse and/or neglect on childhood development;
- (G) treatment of children and families with substance abuse and chemical dependency disorders;
- (H) anger management; ~~and~~
- (I) crisis intervention; and
- (J) trauma informed methodology.

(e) For eligible RBMS agencies to bill the Oklahoma Health Care Authority for Group Rehabilitative Treatment Services in a foster care setting facilitated by their staff, providers must have the following qualifications:

- (1) be licensed in the state in which the services are delivered as a licensed psychologist, social worker (clinical specialty only), professional counselor, marriage and family therapist, alcohol and drug counselor, or behavioral practitioner, or under Board approved supervision to be licensed in one of the areas listed in (c)(2)(A-E) of this section; or
- (2) be licensed as an advanced practice nurse certified in a psychiatric mental health specialty, licensed as a registered nurse with a current certification of recognition from the Board of Nursing in the state in which services are provided; or
- (3) have a baccalaureate degree in a behavioral health field, a minimum of one year of experience in providing direct care and/or treatment to children and/or families, and have access to weekly consultation with a licensed mental health professional.

317:30-5-740.1. Eligible provider contracting requirements

(a) Eligible agency providers that are defined in section OAC 317:30-5-740 shall have written policies and procedures for the orientation of new staff and foster parents which is reviewed and updated annually, for the following:

- (1) pre-service training of foster parents in treatment methodologies and service needs of emotionally and behaviorally disturbed children;
- (2) treatment of victims of physical, emotional, and sexual abuse;
- (3) treatment of children with attachment disorders;
- (4) treatment of children with hyperactive or attention deficit disorders;
- (5) normal childhood development and the effect of abuse and/or neglect on childhood development;
- (6) treatment of children and families with substance abuse and chemical dependency disorders;
- (7) the Inpatient Mental Health and Substance Abuse Treatment of Minors Act;
- (8) anger management;
- (9) inpatient authorization procedures;
- (10) crisis intervention;
- (11) grief and loss issues for children in foster care; ~~and~~

- (12) the significance/value of birth families to children receiving services in residential behavior management services in a foster care setting; and
(13) trauma informed methodology.

(b) Eligible agency providers defined at OAC 317:30-5-740 ~~shall~~ must provide staff with access to professional psychiatric and/or psychological consultation as deemed necessary for the planning, implementation and appropriate management of the resident's treatment.

317:30-5-742. Description of services

(a) Behavior management services mean all the services listed in (1)-(8) of this subsection as provided in the ~~treatment~~ individual plan of care. Each of the service requirements has special duration and frequency requirements as set out in OAC 317:30-5-742.2.

- (1) Individual therapy;
- (2) Substance abuse/chemical dependency education, prevention, and therapy;
- (3) Group rehabilitative treatment;
- (4) Family therapy;
- (5) Basic living skills redevelopment;
- (6) Social skills redevelopment;
- (7) Crisis/behavior management redirection; and
- (8) Discharge planning.

(b) Behavior management services must be provided in the least restrictive, non-institutional therapeutic milieu. The foster care setting is restorative in nature, allowing children with emotional and psychological problems to develop the necessary control to function in a less restrictive setting. Behavior management services are considered an ancillary component of inpatient hospital care and residential treatment services provided in a less restrictive setting and as a less costly alternative to inpatient psychiatric hospital services and other residential treatment services.

(c) Behavioral Management Services must include ~~a treatment plan for each client~~ an individual plan of care for each member served. The ~~treatment plan~~ individual plan of care requirements are set out in OAC 317:30-5-742.2(1).

317:30-5-742.1. Residential behavior management reimbursement

(a) All Residential Behavioral Management Services must be prior authorized by the designated agent of the Oklahoma Health Care Authority before the service is rendered by an eligible service provider. Without prior authorization, payment is not authorized.

(b) The Oklahoma Health Care Authority will not reimburse for the services defined in OAC 317:30-5-742 for more than two children in a home at any one time unless additional cases are specifically authorized by the Oklahoma Department of Human Services, Division of Children and Family Services or Oklahoma Office of Juvenile Affairs.

(c) A child who is eligible for the services defined in OAC 317:30-5-742 ~~shall is~~ not to receive any other outpatient behavioral health services defined by OHCA unless prior authorized by OHCA or its designated agent. For example, separate

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individual therapy for a child eligible for Residential Behavioral Management Services will not generally be authorized because this service is part of the bundled service provided by a Residential Behavioral Management provider. If additional outpatient services are authorized by OHCA or its designated agent, the service provider may not be the provider of the Residential Behavioral Management Services.

(d) OHCA will not reimburse an eligible service provider for units of service that are not authorized before the service is delivered.

(e) Initial requests for residential foster care and the first extension request will be approved for a maximum of six months. All subsequent requests for services/extensions will be for a maximum time period not to exceed three months.

(f) No reimbursement ~~shall be~~ is made for a service for a ~~client member~~ without a written individual plan of care for each ~~client member~~ as described in OAC 317:30-5-742.2(1). Each ~~treatment plan~~ individual plan of care must contain all of the services required in OAC 317:30-5-742(a).

317:30-5-742.2. Required Residential Behavior Management Services

All residential behavior management services in a foster care setting (RBMS) are provided as a result of an individual assessment of the ~~resident's member's~~ needs and documented in the individual ~~treatment plan of care~~. Services including ~~treatment individual plan of care~~ development, individual therapy, family therapy, basic living skills (re)development, social skills (re)development, group rehabilitative treatment, substance abuse/chemical dependency education, prevention and therapy are provided per minimum requirements identified in this section. All services are based upon the ~~resident's member's treatment individual plan of care~~ and consistent with assessed needs. Individual therapy and family therapy may be provided in lieu of group rehabilitative therapy. Crisis behavior management and redirection services are provided as needed. The following represent the minimum service requirement for a ~~resident-member~~ receiving Residential Behavior Management Services:

(1) ~~Treatment Individual plan of care~~ requirement.

(A) A written ~~treatment individual plan of care~~ for each ~~resident member~~ shall must be formulated by the ~~Provider Agency provider agency~~ staff within 30 days of admission with documented input from the ~~resident member~~, legal guardian (OKDHS/OJA) staff, the foster parent and the treatment provider(s). It is acceptable in circumstances where it is necessary to fax a service plan to someone for review and have them fax back their signature; however, the provider must obtain the original signature for the clinical file within 30 days. No stamped or Xeroxed signatures are allowed. This plan ~~shall~~ must be revised and updated each 90 days with documented involvement of the legal guardian and resident.

(B) The ~~treatment individual plan of care~~ must be individualized and take into account the ~~resident's member's~~ age, history, diagnosis, assessed functional levels, ~~and culture, and the effect of past and current~~

~~traumatic experiences in the life of the member.~~ It includes the member's documented full five-axis DSM-IV diagnosis, appropriate long term and short term goals, and corresponding measurable objectives to obtain the stated goals within the expected time lines. Each ~~resident's member's treatment individual plan of care~~ shall is to also address the provider agency's plans with regard to the provision of services in each of the following areas:

- (i) ~~Individual individual~~ therapy;
- (ii) ~~Substance substance~~ abuse/chemical dependency education, prevention, and therapy;
- (iii) ~~Group group~~ rehabilitative treatment;
- (iv) ~~Family family~~ therapy;
- (v) ~~Basic basic~~ living skills (re)development;
- (vi) ~~Social social~~ skills (re)development;
- (vii) ~~Crisis/behavior crisis/behavior~~ management and redirection; and
- (viii) ~~Discharge discharge~~ planning.

(2) **Individual therapy.** The provider agency ~~shall~~ must provide individual therapy on a monthly basis to youth placed in the residential foster care homes. Individual therapy is a method of treating mental health and alcohol and other drug disorders using face to face, one to one interaction between a ~~Mental Licensed Behavioral Health Professional~~ as defined in OAC 317:30-5-240(e) ~~317:30-5-240(d)~~ and the ~~resident member~~ to promote behavioral, emotional or psychological change. Individual therapy is age appropriate and the techniques and modalities employed are relevant to the goals of the individual's ~~treatment plan of care~~. The required service for each ~~resident member~~ served is a minimum of four 30 minute sessions per month of individual therapy.

(3) **Group rehabilitative treatment.** The provider agency will provide group rehabilitative treatment as specified in the individual ~~treatment plan of care~~ for the treatment of mental health and behavioral disorders for a minimum of two 30 minute sessions per month. Group rehabilitative services provided for children receiving RBMS in a foster care setting include educational and supportive services such as basic living skills, social skills (re)development, interdependent living, self-care, lifestyle change and recovery principles. Services are provided in the least restrictive setting appropriate for the reduction of emotional and behavioral impairment and suitable to the restoration of the ~~resident's member's~~ functioning. Services are consistent with the requirements of age and appropriate to the ~~resident's member's~~ behavioral functioning and self sufficiency. Meeting with family members, legal guardian, and/or care givers is covered when the services are directed exclusively to the effective treatment of the individual ~~resident-member~~. Each service provided under this section must have a goal and purpose, which relates directly to the ~~resident's member's~~ individual ~~treatment plan of care~~. Compensable rehabilitative treatment services are provided to ~~residents members~~ who have the ability to benefit from the service. The ~~resident member~~ must be able to actively participate and must

possess the cognitive, developmental, and communication skills necessary to benefit from the service. Travel time to and from activities is not covered. Staff to resident ratio shall not exceed eight children to one staff member. Staff appropriately trained, including training and certification in a recognized anger management intervention technique, such as MANDT or Controlling Aggressive Patient Environment (CAPE), must be present in the group. Thirty minutes of individual therapy and/or family therapy may be provided in lieu of one hour of group rehabilitative treatment.

(4) **Family therapy.** The provider agency shall must provide family therapy as indicated on the resident's member's individual treatment plan of care. Family therapy is an interaction between a Mental Licensed Behavioral Health Professional as defined in OAC 317:30-5-240(c) 317:30-5-240(d) and the family member(s) designated on the treatment individual plan of care. The interaction is intended to facilitate behavioral, emotional, or psychological change and promote understanding through successful communication skills. Family therapy shall must be provided for a minimum of four 30-minute sessions per month. The ~~Agency shall~~ agency must:

(A) work with the caretaker to whom the resident member will be discharged, as identified by the OKDHS/OJA local worker;

(B) seek to support and enhance the child's relationships with nuclear and appropriate extended family members, if the OKDHS/OJA plan for the child indicates family reunification;

(C) arrange for and encourage regular contact and visitation between children and their parents and other family members as specified in the treatment individual plan of care;

(D) seek to involve the child's parents/legal guardian in treatment team meetings, plans and decisions and to keep them informed of the child's progress in the program;

(E) provide consultation to the residential foster care parents;

(F) provide regular support and technical assistance to residential foster parents in their implementation of the treatment individual plan of care and with regard to other responsibilities they undertake. Fundamental components of such technical assistance will be the design or revision of in-home treatment strategies including proactive goal-setting and planning, and the provision of ongoing child-specific skills training and problem-solving in the home during home visits. Other types of support and supervision must include emotional support and relationship-building, the sharing of information and general training to enhance professional development, assessment of the youth's progress, observation/assessment of family interactions and stress, and assessment of safety issues. Residential foster parents and their biological children shall must have access to counseling and therapeutic services arranged by the provider

agency for personal issues/problems caused or exacerbated by their work as residential foster parents. Such issues may include, for example, marital stress, or abuse of their own child(ren) by a child placed in their care by the provider agency.

(5) **Substance abuse/chemical dependency education, prevention and therapy.** The provider agency shall must provide substance abuse/chemical dependency therapy for all residents members who are identified by diagnosis or documented social history as having emotional or behavioral problems directly related to substance abuse and/or chemical dependency. If a resident member is identified as requiring substance abuse/chemical dependency therapy, the provider agency shall must provide age appropriate substance abuse/chemical dependency therapy. The modalities employed are provided in order to begin, maintain and enhance recovery from alcoholism, problem drinking, drug abuse, drug dependency addiction or nicotine use and addiction. For those clients members identified above, substance abuse/chemical dependency therapy must be provided a minimum of two one-hour sessions per month. In the case a resident member who has no identifiable emotional or behavioral problem directly related to substance abuse ~~and or~~ and/or chemical dependency, residents members must be provided age appropriate education and prevention activities. These may include self-esteem enhancement, violence alternatives, communication skills or other skill development curriculums. For clients members who do not need substance and/or chemical dependency therapy, a minimum of two hours of education and/or prevention therapy per three month period is required.

(6) **Basic living skills redevelopment.** The provider agency shall must provide goal directed activities for each resident member to restore, retain, and improve those basic skills necessary to independently function in a family or community. Basic living skills redevelopments are daily activities that are age appropriate and relevant to the goals of the treatment individual plan of care. This may include, but is not limited to, food planning and preparation, maintenance of personal hygiene and living environment, household management, personal and household shopping, community awareness and familiarization with community resources, mobility skills, and job application and retention skills. Basic living skill redevelopment therapy must occur a minimum of 30 minutes each day.

(7) **Social skills redevelopment.** The provider agency shall must provide goal directed activities for each resident member to restore, retain and improve the self help, communication, socialization, and adaptive skills necessary to reside successfully in home and community based settings. These will be daily activities that are age appropriate, culturally sensitive and relevant to the goals of the individual treatment plan of care. These may include self-esteem enhancement, violence alternatives, communication skills or other related skill development curriculums approved by the provider agency. Social skill

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redevelopment therapy must occur a minimum of two 30-minute activities each day.

(8) ~~Crisis behavior~~ **Crisis/behavior management and redirection.** The provider agency ~~shall~~ must provide crisis/behavior redirection by agency staff as needed 24 hours per day, 7 days per week. The ~~Agency shall~~ agency must ensure staff availability to respond to the residential foster parents in a crisis to stabilize ~~residents' members'~~ behavior and prevent placement disruption.

(9) **Discharge planning.** The provider agency ~~shall~~ must develop a discharge plan for each ~~resident member.~~ The discharge plan must be individualized, child-specific and include an after care plan that is appropriate to the ~~residents' member's~~ needs and in place at the time of discharge. The plan for children in parental custody must include, when appropriate, reunification plans with the parent(s)/legal guardian. The plan for children who remain in the custody of the Oklahoma Department of Human Services or the Office of Juvenile Affairs ~~shall~~ must be developed in collaboration with the case worker and in place at the time of discharge. The discharge plan ~~should~~ is to include at a minimum, recommendations for continued treatment services, educational services, and other appropriate community resources. Discharge planning provides a transition from foster care placement into a lesser restrictive setting within the community.

317:30-5-743.1. Inspection of Care

There will be an on site Inspection of Care of each Therapeutic Foster Care (TFC) ~~Agency~~ agency that provides care to ~~recipients members~~ which will be performed by the OHCA or its designated agent. The OHCA will designate the members of the Inspection of Care Team. This team will consist of two team members and will be comprised of Licensed ~~Mental-Behavioral~~ Health Professionals and/or Registered Nurses. The Inspection may include observation and contact with ~~recipients members.~~ The Inspection of Care (IOC) review will consist of ~~recipients members~~ present or listed as facility residents at the beginning of the Inspection of Care visit as well as ~~recipients members~~ on which claims have been filed with OHCA for TFC services. The review includes validation of certain factors, all of which must be met for the ~~Medicaid Services~~ services to be compensable. Following the on-site inspection, the Inspection of Care Team will report its findings to the facility. The facility will be provided with written notification if the findings of the Inspection of Care have resulted in any deficiencies. A copy of the final report will be sent to the facilities' accrediting agency. Deficiencies found during the IOC may result in a partial recoupment or a full recoupment of the compensation received. The individual plan of care is considered to be critical to the integrity of care and treatment and must be completed within the time lines designated at OAC 317:30-5-742.2. For each day that the individual plan of care is not contained within the member's records, those days will warrant full per-diem recoupment of the compensation received. If the review findings have resulted in a partial per-diem recoupment of \$10.00 per event, the days of service involved will be reported in the notification. If the review findings have resulted in

full per-diem recoupment status, the non-compensable days of service will be reported in the notification. Penalties of non-compensable days which are the result of the facility's failure to appropriately provide and document the services described herein, or adhere to applicable accreditation, certification, and/or state licensing standards, are not compensable or billable to the member or anyone financially responsible for the member.

317:30-5-746. Appeal of Prior Authorization Decision

If a denial decision is made, an appeal may be initiated by the ~~resident or the residential foster care agency member or the member's legal guardian.~~ The denial can be appealed to the Oklahoma Health Care Authority within 20 calendar days of the receipt of the notification of the denial by the OHCA or its designated agent.

[OAR Docket #07-1321; filed 7-24-07]

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

[OAR Docket #07-1327]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 5. Individual Providers and Specialties
Part 105. Residential Behavioral Management Services in Group Settings and Non-Secure Diagnostic and Evaluation Centers
317:30-5-1043. [AMENDED]
317:30-5-1046. [AMENDED]
(Reference APA WF # 07-10)

AUTHORITY:

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR 440.60

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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 Licensed Alcohol and Drug Counselors (LADC) to provide Residential Behavior Management Services (RBMS) to SoonerCare members. The LADC will increase access to professional providers in RBMS settings for SoonerCare members.

ANALYSIS:

Residential Behavior Management Services (RBMS) rules are revised to: (1) allow Licensed Alcohol and Drug Counselors (LADC) to provide RBMS services; (2) add trauma informed methodology as an option to staff training requirements; and, (3) update terminology as recommended by the Behavioral Health Collaborative. RBMS are provided by Organized Health Care Delivery

Systems (OHCDS) for children in the care and custody of the State who have special psychological, behavioral, emotional and social needs that require more intensive care than can be provided in a family or foster home setting. For eligible RBMS agencies to bill the Oklahoma Health Care Authority for services provided by their staff, providers must meet certain qualification and licensure requirements. These revisions will recognize Licensed Alcohol and Drug Counselor as a licensed provider for these services and expand the number of providers allowed to provide services to SoonerCare members. Rules are amended to include trauma informed methodology as an ongoing training option for RBMS staff who provide behavioral redirection services.

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 JULY 1, 2007, WHICHEVER IS LATER:

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 105. RESIDENTIAL BEHAVIORAL MANAGEMENT SERVICES IN GROUP SETTINGS AND NON-SECURE DIAGNOSTIC AND EVALUATION CENTERS

317:30-5-1043. Coverage by category

(a) **Adults.** Residential Behavioral Management Services ~~in~~ in Group Settings and Non-Secure Diagnostic and Evaluation Center Services are not covered for adults.

(b) **Children.** Residential Behavioral Management Services (RBMS) in Group Settings and Non-Secure Diagnostic and Evaluation Centers are covered for children as set forth in this subsection.

(1) **Description.** Residential Behavior Management Services are provided by Organized Health Care Delivery Systems (OHCDS) for children in the care and custody of the State who have special psychological, behavioral, emotional and social needs that require more intensive care than can be provided in a family or foster home setting. The behavior management services are provided in the least restrictive environment and within a therapeutic milieu. The group setting is restorative in nature, allowing children with emotional and psychological problems to develop the necessary control to function in a less restrictive setting. Residential Behavior Management Services are reimbursed in accordance with the intensity of supervision and treatment required for the group setting in which the ~~client~~ child is placed. ~~Clients~~ Members residing in a Level E and Intensive Treatment Services (ITS) Group Homes receive maximum supervision and treatment. In addition, ITS group homes provide crisis and stabilization intervention and treatment. ~~Clients~~ Members residing in a Level D+ Group Home receive highly intensive supervision and treatment. ~~Clients~~ Members

residing in a Level D Group home or in a wilderness camp receive close supervision and moderate treatment. ~~Clients~~ Members residing in a Level C Group Home receive minimum supervision and treatment. ~~Clients—Members~~ residing in Residential Diagnostic and Evaluation Centers receive intensive supervision and a 20 day comprehensive assessment. ~~Clients~~ Members residing in a Sanctions Home receive highly intensive supervision and treatment. ~~Clients~~ Members residing in an Independent Living Group Home receive intensive supervision and treatment. It is expected that RBMS in group settings are an all-inclusive array of treatment services provided in one day. In the case of a child who needs additional specialized services, under the Rehabilitation Option or by a psychologist, prior authorization by the OHCA or designated agent is required. Only specialized rehabilitation or psychological treatment services to address unique, unusual or severe symptoms or disorders will be authorized. If additional services are approved, the OHCDS ~~shall collaborate~~ collaborates with the provider of such services as directed by the OHCA or its agent. Any additional specialized behavioral health services provided to children in state custody ~~shall be~~ are funded in the normal manner. The OHCDS ~~shall—must~~ provide concurrent documentation that these services are not duplicative. The OHCDS determines the need for RBMS.

(2) **Medical necessity criteria.** The following medical necessity criteria must be met for residential behavior Management Services.

(A) Any DSM-IV AXIS I primary diagnosis, with the exception of V codes, with a detailed description of the symptoms supporting the diagnosis. A detailed description of the child's emotional, behavioral and psychological condition must be on file. A diagnosis is not required for behavior management services provided in Diagnostic and Evaluation centers.

(B) The child is medically stable and not actively suicidal or homicidal and not in need of substance abuse detoxification services.

(C) It has been determined by the OHCDS that the current disabling symptoms could not have been or have not been manageable in a less intensive treatment program.

(D) Documentation that the child's presenting emotional and/or behavioral problems prevent the child from living in a traditional family home. The child requires the availability of 24 hour crisis response/behavior management and intensive clinical interventions from professional staff.

(E) The Agency which has permanent or temporary custody of the child agrees to active participation in the child's treatment needs and planning.

(F) All of the medical necessity criteria must also be met for continued stay in residential group settings.

(3) **Treatment components.**

(A) ~~Treatment~~ Individual plan of care development. A comprehensive individualized ~~treatment~~ plan of care for each resident shall be formulated by

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the ~~Provider Agency~~ provider agency staff within 30 days of admission, for ITS level within 72 hours, with documented input from the ~~Agency~~ agency which has permanent or temporary custody of the child and when possible, the parent. This plan ~~shall~~ **must** be revised and updated at least every three months, every seven days for ITS, with documented involvement of the ~~Agency~~ agency which has permanent or temporary custody of the child. Documented involvement can be written approval of the ~~treatment individual plan of care~~ by the ~~Agency~~ agency which has permanent or temporary custody of the child and indicated by the signature of the ~~Agency~~ agency case worker or liaison on the ~~treatment individual plan of care~~. It is acceptable in circumstances where it is necessary to fax a service plan to someone for review and then have them fax back their signature; however, the provider obtains the original signature for the clinical file within 30 days. No stamped or Xeroxed signatures are allowed. ~~A treatment~~ **An individual plan of care** is considered inherent in the provision of therapy and is not covered as a separate item of behavior management services. The ~~treatment individual plan of care~~ is individualized taking into account the child's age, history, diagnosis, functional levels, and culture. It includes appropriate goals and time limited and measurable objectives. Each ~~resident's treatment member's individual plan of care~~ **shall** **must** also address the ~~Provider Agency's~~ provider agency's plans with regard to the provision of services in each of the following areas:

- (i) ~~Group~~ **group** therapy;
- (ii) ~~Individual~~ **individual** therapy;
- (iii) ~~Family~~ **family** therapy;
- (iv) ~~Alcohol~~ **alcohol** and other drug counseling;
- (v) ~~Basic~~ **basic** living skills redevelopment;
- (vi) ~~Social~~ **social** skills redevelopment;
- (vii) ~~Behavior~~ **behavior** redirection; and
- (viii) ~~The Provider Agency's~~ **the** provider agency's plan to access appropriate educational placement services. (Any educational costs are excluded from calculation of the daily rate for behavior management services.)

(B) **Individual therapy.** The ~~Provider Agency~~ **shall** **provider agency** **must** provide individual therapy on a weekly basis with a minimum of one or more sessions totaling one hour or more of treatment per week to children and youth receiving RBMS in Wilderness Camps, Level D, Level D+ homes, Level E Homes, Independent Living Homes, and Sanctions Homes. ITS Level residents will receive a minimum of five or more sessions totaling a minimum of five or more hours of individual therapy per week. ~~Clients~~ **Members** residing in Diagnostic and Evaluation Centers and Level C Group Homes receive Individual Therapy on an as needed basis. Individual therapy must be age appropriate and the techniques and modalities employed relevant to the goals and

objectives of the individual's ~~treatment plan of care~~. Individual counseling is a face to face, one to one service, and must be provided in a confidential setting.

(C) **Group therapy.** The ~~Provider Agency~~ **shall** **provider agency** **must** provide group therapy to children and youth receiving residential behavioral management services. Group therapy must be a face to face interaction, age appropriate and the techniques and modalities employed relevant to the goals and objectives of the individual's ~~treatment plan of care~~. The minimum expected occurrence would be one hour per week in Level D, Level C, Wilderness Camps and Independent Living. Two hours per week are required in Levels D+ and E. Ten hours per week are required in Sanctions Homes, Intensive Treatment Service Level. Group therapy is not required for Diagnostic and Evaluation Centers. Group size should not exceed six members and group therapy sessions must be provided in a confidential setting. One half hour of individual therapy may be substituted for one hour of group therapy.

(D) **Family therapy.** Family therapy is a face to face interaction between the therapist/counselor and family, to facilitate emotional, psychological or behavioral changes and promote successful communication and understanding. The ~~Provider Agency~~ **shall** **provider agency** **must** provide family therapy as indicated by the resident's individual ~~treatment plan of care~~. The ~~Agency~~ **shall** **agency** **must** work with the caretaker to whom the resident will be discharged, as identified by the OHCDs custody worker. The ~~Agency~~ **shall** **agency** **must** seek to support and enhance the child's relationships with family members (nuclear and appropriate extended), if the custody plan for the child indicates family reunification. The RBMS provider ~~shall~~ **must** also seek to involve the child's parents in treatment team meetings, plans and decisions and to keep them informed of the child's progress in the program. Any service provided to the family must have the child as the focus.

(E) **Alcohol and other drug abuse treatment education, prevention, therapy.** The ~~Provider Agency~~ **shall** **provider agency** **must** provide alcohol and other drug abuse treatment for residents who have emotional or behavioral problems related to substance abuse/chemical dependency, to begin, maintain and enhance recovery from alcoholism, problem drinking, drug abuse, drug dependency addiction or nicotine use and addiction. This service ~~shall be~~ **is** considered ancillary to any other formal treatment program in which the child participates for treatment and rehabilitation. For residents who have no identifiable alcohol or other drug use, abuse, or dependency, age appropriate education and prevention activities are appropriate. These may include self esteem enhancement, violence alternatives, communication skills or other skill development curriculums.

(F) **Basic living skills redevelopment.** The ~~Provider Agency shall~~ provider agency must provide goal directed activities designed for each resident to restore, retain, and improve those basic skills necessary to independently function in a family or community. Basic living skills redevelopment is age appropriate and relevant to the goals and objectives of the ~~treatment individual plan of care.~~ This may include, but is not limited to food planning and preparation, maintenance of personal hygiene and living environment, household management, personal and household shopping, community awareness and familiarization with community resources, mobility skills, job application and retention skills.

(G) **Social skills redevelopment.** The ~~Provider Agency shall~~ provider agency must provide goal directed activities designed for each resident to restore, retain and improve the self help, communication, socialization, and adaptive skills necessary to reside successfully in home and community based settings. These are age appropriate, culturally sensitive and relevant to the goals of the individual ~~treatment plan of care.~~ For ITS level of care, the minimum skill redevelopment per day is three hours. Any combination of basic living skills and social skills redevelopment that is appropriate to the need and developmental abilities of the child is acceptable.

(H) **Behavior redirection.** The ~~Provider Agency shall~~ provider agency must be able to provide behavior redirection management by agency staff as needed 24 hours a day, 7 days per week. The ~~Agency shall~~ agency must ensure staff availability to respond in a crisis to stabilize residents' behavior and prevent placement disruption. In addition, ITS group homes will be required to provide crisis stabilization interaction and treatment for new residents 24 hours a day, seven days a week.

(4) **Providers.** For eligible RBMS agencies to bill the Oklahoma Health Care Authority for services of their providers, the providers of individual, group and family therapies must:

(A) be a licensed psychologist, social worker (clinical specialty only), professional counselor, marriage and family therapist, or behavioral practitioner, or under Board Supervision to be licensed in one of the above stated areas; or

(B) have one year of experience in a behavioral health treatment program and a master's degree in a mental health treatment field licensable in Oklahoma by one of the following licensing boards:

- (i) Psychology,
- (ii) Social work (clinical specialty only),
- (iii) Licensed professional counselor,
- (iv) Licensed marriage and family therapist, or
- (v) Licensed behavioral practitioner; or

(C) have a baccalaureate degree in a mental health field in one of the stated areas listed in (B) of this

paragraph AND three or more years post-baccalaureate experience in providing direct patient care in a behavioral health treatment setting and be provided a minimum of weekly supervision by a staff member licensed as listed in (A) of this paragraph; or
(D) be a registered psychiatric nurse; AND
(E) demonstrate a general professional or educational background in the following areas:

- (i) case management, assessment and treatment planning;
- (ii) treatment of victims of physical, emotional, and sexual abuse;
- (iii) treatment of children with attachment disorders;
- (iv) treatment of children with hyperactivity or attention deficit disorders;
- (v) treatment methodologies for emotional disturbed children and youth;
- (vi) normal childhood development and the effect of abuse and/or neglect on childhood development;
- (vii) treatment of children and families with substance abuse and chemical dependency disorders;
- (viii) anger management; and
- (ix) crisis intervention.

(5) For eligible RBMS agencies to bill the Oklahoma Health Care Authority for services provided by their staff for behavior management therapies (Individual, Group, Family) as of ~~January 1, 2004~~ July 1, 2007, providers must have the following qualifications:

(A) be licensed in the state in which the services are delivered as a licensed psychologist, social worker (clinical specialty only), professional counselor, marriage and family therapist, or behavioral practitioner, alcohol and drug counselor or under Board approved Supervision to be licensed in one of the above stated areas; or

(B) be licensed as an Advanced Practice Nurse certified in a psychiatric mental health specialty, licensed as a registered nurse with a current certification of recognition from the Board of Nursing in the state in which services are provided, AND

(C) demonstrate a general professional or educational background in the following areas:

- (i) case management, assessment and treatment planning;
- (ii) treatment of victims of physical, emotional, and sexual abuse;
- (iii) treatment of children with attachment disorders;
- (iv) treatment of children with hyperactivity or attention deficit disorders;
- (v) treatment methodologies for emotionally disturbed children and youth;
- (vi) normal childhood development and the effect of abuse and/or neglect on childhood development;

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- (vii) treatment of children and families with substance abuse and chemical dependency disorders;
 - (viii) anger management; and
 - (ix) crisis intervention.
- (D) Staff providing basic living skills redevelopment, social skills redevelopment, and alcohol and other substance abuse treatment, ~~shall~~ must meet one of the following areas:
- (i) Bachelor's or Master's degree in a behavioral health related field including but not limited to, psychology, sociology, criminal justice, school guidance and counseling, social work, occupational therapy, family studies, alcohol and drug; or
 - (ii) a current license as a registered nurse in Oklahoma; or
 - (iii) certification as an Alcohol and Drug Counselor ~~is allowed~~ to provide substance abuse rehabilitative treatment to those with alcohol and/or other drug dependencies or addictions as a primary or secondary DSMIV Axis I diagnosis; or
 - (iv) current certification as a Behavioral Health Case Manager from DMHSAS and meets OHCA requirements to perform case management services, as described in OAC ~~317:30-5-595(7)~~ 317:30-5-595.
- (E) Staff providing behavior redirection services must have current certification and required updates in nationally recognized behavior management techniques, such as Controlling Aggressive Patient Environment (CAPE) or MANDT. Additionally, staff providing these services must receive initial and ongoing training in at least one of the following areas:
- (i) trauma informed methodology,
 - (ii) anger management,
 - (iii) crisis intervention,
 - (iv) normal child and adolescent development and the effect of abuse,
 - (v) neglect and/or violence on such development,
 - (vi) grief and loss issues for children in out of home placement,
 - (vii) interventions with victims of physical, emotional and sexual abuse,
 - (viii) care and treatment of children with attachment disorders,
 - (ix) care and treatment of children with hyperactive, or attention deficit, or conduct disorders,
 - (x) care and treatment of children, youth and families with substance abuse and chemical dependency disorders,
 - (xi) passive physical restraint procedures,
 - (xii) procedures for working with delinquents or the Inpatient Mental Health and Substance Abuse Treatment of ~~Minors~~ Minors Act.
- (F) In addition, Behavioral Management staff ~~shall~~ must have access to consultation with an appropriately licensed mental health professional.

317:30-5-1046. Documentation of records and records review

- (a) The OHCDs and the facilities with whom it contracts must maintain appropriate records system. Current ~~treatment~~ individual plans of care, case files, and progress notes are maintained in the facilities' files during the time the child or youth is receiving services. All services rendered must be reflected by documentation in the case records.
- (b) OHCA and the Centers for Medicare and Medicaid Services (CMS) may evaluate through inspection or other means, the quality, appropriateness and timeliness of services provided by the OHCDs or facilities with whom it contracts.
- (c) All residential behavioral management services in group settings and non-secure diagnostic and evaluation centers must be reflected by documentation in the ~~patient~~ patients' records. Individual, group, family, and alcohol and other drug counseling, and social and basic living skills development services must include all of the following:
 - (1) date;
 - (2) start and stop time for each session;
 - (3) signature of the therapist/staff providing service;
 - (4) credentials of therapist/staff providing service;
 - (5) specific problem(s) addressed (problem must be identified on ~~master treatment~~ individualized plan of care);
 - (6) methods used to address problem(s);
 - (7) progress made toward goals;
 - (8) patient response to the session or intervention; and
 - (9) any new problem(s) identified during the session.

[OAR Docket #07-1327; filed 7-24-07]

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

[OAR Docket #07-1324]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

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

Part 5. Determination of Medical Eligibility for ICF/MR, HCBW/MR, and Individuals Age 65 or Older in Mental Health Hospitals

317:35-9-45. [AMENDED]

Subchapter 19. Nursing Facility Services

317:35-19-9. [AMENDED]

317:35-19-14. [AMENDED]

317:35-19-16. [AMENDED]

317:35-19-18. [AMENDED]

(Reference APA WF # 07-07B)

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:

April 12, 2007

Approved by Governor:

May 25, 2007

Effective:

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

Expiration:

Effective through July 14, 2008, 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 implement a new Pre-Admission Screening and Resident Review (PASRR) compliance process. The new requirements are expected to increase the level of compliance demonstrated by nursing facility reporting practices.

ANALYSIS:

PASRR rules are being revised to reflect the new required PASRR form for a Level I screen for nursing home admission. The new form is LTC-300R, Nursing Facility Level of Care Assessment. As part of the federally mandated PASRR process, all Medicaid certified nursing facilities must fill out the form LTC-300R for all applicants that apply to reside in the facility regardless of pay source. The LTC-300R is the new Level I screening form which helps to identify persons with possible mental illness or mental retardation or related conditions who apply to reside in Medicaid certified nursing facilities. Rules also change the submission deadline requirements for this form from thirty days to ten days of resident admission. The change in the submission deadline is expected to increase the level of compliance demonstrated by nursing facility reporting practices.

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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 JUNE 1 2007, WHICHEVER IS LATER:

SUBCHAPTER 9. ICF/MR, HCBW/MR, AND INDIVIDUALS AGE 65 OR OLDER IN MENTAL HEALTH HOSPITALS

PART 5. DETERMINATION OF MEDICAL ELIGIBILITY FOR ICF/MR, HCBW/MR, AND INDIVIDUALS AGE 65 OR OLDER IN MENTAL HEALTH HOSPITALS

317:35-9-45. Determination of medical eligibility for care in a private ICF/MR

(a) **Pre-approval of medical eligibility.** Pre-approval of medical eligibility for private ICF/MR care is based on results of a current comprehensive psychological evaluation by a licensed psychologist or state staff psychologist, documentation of MR or related condition prior to age 22, and the need for active treatment according to federal standards. Pre-approval is not necessary for individuals who are severely or profoundly retarded. Pre-approval is made by LOCEU analysts.

(b) **Medical eligibility for ICF/MR services.** Within ~~30~~ 10 calendar days after services begin, the facility must submit the original of the ~~Long Term Care Assessment form (LTC 300)~~ Nursing Facility Level of Care Assessment (Form LTC-300R) to LOCEU. Required attachments include current (within 90

days of requested approval date) medical information signed by a physician, a current (within 12 months of requested approval date) psychological evaluation, a copy of the pertinent section of the Individual Developmental Plan or other appropriate documentation relative to discharge planning and the need for ICF/MR level of care, and a statement that the ~~client~~ member is not an imminent threat of harm to self or others (i.e., suicidal or homicidal). If pre-approval was determined by LOCEU and the above information is received, medical approval will be entered on MEDATS. Pre-approval is not needed for individuals who are classified as being severely or profoundly mentally retarded on current psychological evaluation.

(c) **Categorical relationship.** Categorical relationship must be established for determination of eligibility for long-term medical care. If categorical relationship has not already been established, the proper forms and medical information are submitted to LOCEU. (Refer to OAC 317:35-5-4). In such instances LOCEU will render a decision on categorical relationship using the same definition as used by ~~SSA~~ the Social Security Administration (SSA). A follow-up is required by the ~~DHS OKDHS~~ social worker with ~~the Social Security Administration SSA~~ to be sure that their disability decision agrees with the decision of LOCEU.

SUBCHAPTER 19. NURSING FACILITY SERVICES

317:35-19-9. PASRR screening process

(a) **Level I screen for PASRR.**

(1) OHCA Form ~~LTC 300A~~ LTC-300R, ~~Long Term Care Pre admission Screen, Section I Nursing Facility Level of Care Assessment~~, must be completed by an authorized NF official or designee. An authorized NF official or designee must consist of one of the following:

- (~~A~~) ~~A licensed nurse from OKDHS;~~
- (~~B~~) ~~The nursing facility administrator or co-administrator;~~
- (~~C~~) ~~A licensed nurse, social service director, or social worker, or other authorized NF official or designee from the nursing facility; or~~
- (~~D~~) ~~A licensed nurse, social service director, or social worker from the hospital.~~

(2) ~~Section II of the LTC 300A must be completed by an authorized NF official or designee.~~

(~~3~~) 2) Prior to admission, the authorized NF official must evaluate the properly completed OHCA Form ~~LTC 300A~~ LTC-300R and the Minimum Data Set (MDS), if available, as well as all other readily available medical and social information, to determine if there currently exists any indication of mental illness (MI), mental retardation (MR), or other related condition, or if such condition existed in the applicant's past history. ~~This evaluation Form LTC-300R~~ constitutes the Level I PASRR Screen and is utilized in determining whether or not a Level II is necessary prior to allowing the patient to be admitted.

(4) 3) The nursing facility is responsible for determining from the evaluation whether or not the patient can be

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admitted to the facility. A "yes" response to any question from ~~the Level I Screen Form LTC-300R, Section E, will result in a consultation with LOCEU for the~~ require the nursing facility to contact the Level of Care Evaluation Unit (LOCEU) for a consultation to determine if a Level II assessment prior to admission is needed. The NF is also responsible for consulting with the LOCEU regarding any MI/MR/related condition information that becomes known either from completion of the MDS or throughout the resident's stay. ~~The original LTC-300A Form LTC-300R form and copy, as well as a copy of the MDS, comprises the PASRR eligibility information packet, and is to be~~ must be submitted to the LOCEU by mail within 30 10 days of the resident's admission. SoonerCare payment may not be made for a resident whose LTC-300R requirements have not been satisfied in a timely manner.

(54) Upon receipt and review of the PASRR eligibility information packet, the LOCEU may, in coordination with the Oklahoma Department of Human Services (OKHDS) area nurse, re-evaluate whether a Level II PASRR assessment may be required. If a Level II assessment is not required, as determined by the LOCEU, the area nurse, or nurse designee, documents this and continues with the process of determining medical eligibility. If a Level II is required, a medical decision is not made until the area nurse is notified of the outcome of the Level II assessment. The results of the Level II assessment are considered in the medical eligibility decision. The area nurse, or nurse designee, makes the medical eligibility decision within ten working days of receipt of the medical information when a Level II assessment is not required. If a Level II assessment is required, the area nurse makes the decision within five working days if appropriate.

(b) **Pre-admission Level II assessment for PASRR.** The authorized official is responsible for consulting with the OHCA LOCEU in determining whether a Level II assessment is necessary. The decision for Level II assessment is made by the LOCEU.

(1) Any one of the following three circumstances will allow a patient to enter the nursing facility without being subjected to a Level II PASRR assessment:

(A) The patient has no current indication of mental illness or mental retardation or other related condition and there is no history of such condition in the patient's past;

(B) The patient does not have a diagnosis of mental retardation or related condition; or

(C) The patient has indications of mental illness or mental retardation or other related condition, but is not a danger to self and/or others, and is being released from an acute care hospital as part of a medically prescribed period of recovery (Exempted Hospital Discharge). If an individual is admitted to an NF based on Exempted Hospital Discharge, it is the responsibility of the NF to ensure that the individual is either discharged by the 30th day or that a Level II has been requested and is in process. Exempted Hospital

Discharge is allowed only if all of the following three conditions are met:

(i) The individual must be admitted to the NF directly from a hospital after receiving acute inpatient care at the hospital (not including psychiatric facilities);

(ii) The individual must require NF services for the condition for which he/she received care in the hospital; and

(iii) The attending physician must certify before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. The nursing facility will be required to furnish documentation to the OHCA upon request.

(2) If the patient has current indications of mental illness or mental retardation or other related condition, or if there is a history of such condition in the patient's past, the patient cannot be admitted to the nursing facility until the LOCEU is contacted to determine if a Level II PASRR assessment must be performed. Results of any Level II PASRR assessment ordered must indicate that nursing facility care is appropriate prior to allowing the patient to be admitted.

(3) The OHCA Level of Care Evaluation Unit authorizes Advance Group Determinations for the MI and MR Authorities in the categories listed in the following categories listed in (A) through (C) of this paragraph. Preliminary screening by the LOCEU should indicate eligibility for nursing facility level of care prior to consideration of the provisional admission.

(A) **Provisional admission in cases of delirium.**

Any person with mental illness, mental retardation or related condition who is not a danger to self and/or others, may be admitted to a Medicaid certified NF if the individual is experiencing a condition that precludes screening, i.e., effects of anesthesia, medication, unfamiliar environment, severity of illness, or electrolyte imbalance.

(i) A Level II evaluation is completed immediately after the delirium clears. LOCEU must be provided with written documentation by a physician that supports the individual's condition which allows provisional admission as defined in (i) of this subparagraph.

(ii) Payment for NF services will not be made after the provisional admission ending date. If an individual is determined to need a longer stay, the individual must receive a Level II evaluation before continuation of the stay may be permitted and payment made for days beyond the ending date.

(B) **Provisional admission in emergency situations.**

Any person with a mental illness, mental retardation or related condition, who is not a danger to self and/or others, may be admitted to a Medicaid certified nursing facility for a period not to exceed seven days pending further assessment in emergency situations requiring protective services. The request for

Level II evaluation must be made immediately upon admission to the NF if a longer stay is anticipated. LOCEU must be provided with written documentation from Adult Protective Services or the nursing facility which supports the individual's emergency admission. Payment for NF services will not be made beyond the emergency admission ending date.

(C) **Respite care admission.** Any person with mental illness, mental retardation or related condition, who is not a danger to self and/or others, may be admitted to a Medicaid certified nursing facility to provide respite to in-home caregivers to whom the individual is expected to return following the brief NF stay. Respite care may be granted up to 15 consecutive days per stay, not to exceed 30 days per calendar year.

(i) In rare instances, such as illness of the caregiver, an exception may be granted to allow 30 consecutive days of respite care. However, in no instance can respite care exceed 30 days per calendar year.

(ii) Respite care must be approved by LOCEU staff prior to the individual's admission to the NF. The NF provides the LOCEU with written documentation concerning circumstances surrounding the need for respite care, the date the individual wishes to be admitted to the facility, and the date the individual is expected to return to the caregiver. Payment for NF services will not be made after the respite care ending date.

(c) **PASRR Level II resident review.** The resident review is used primarily as a follow-up to the pre-admission assessment.

(1) The nursing facility's routine resident assessment will identify those individuals previously undiagnosed as MR or MI. A new condition of MR or MI must be referred to LOCEU by the NF for determination of the need for the Level II. The facility's failure to refer such individuals for a Level II assessment may result in recoupment of funds and/or penalties from CMS.

(2) A Level II resident review may be conducted the following year for each resident of a nursing facility who was found to experience a serious mental illness with no primary diagnosis of dementia on his or her pre-admission Level II to determine whether, because of the resident's physical and mental condition, the resident requires specialized services.

(3) A Level II resident review may be conducted for each resident of a nursing facility who has mental illness or mental retardation or other related condition when there is a significant change in the resident's mental condition. If such a change should occur in a resident's condition, it is the responsibility of the nursing facility to have a consultation with the LOCEU concerning the need to conduct a resident review.

(4) Individuals who were determined to have a serious mental illness (as defined by CMS) on their last PASRR Level II evaluation will receive a resident review at least within one year of the previous evaluation.

(d) **Results of pre-admission Level II assessment and Resident Review.** Through contractual arrangements between the Oklahoma Health Care Authority and the Mental Illness/Mental Retardation ~~authorities~~ Authorities/Community Mental Health Centers, individualized assessments are conducted and findings presented in written evaluative reports. The reports recommend if nursing facility services are needed, if specialized services or less than specialized services are needed, and if the individual meets the federal PASRR definition of mental illness or mental retardation or related conditions. Evaluative reports are delivered to the ~~Authority~~ OHCA's LOCEU within federal regulatory and state contractual timelines to allow the LOCEU to process formal, written notification to patient, guardian, NF and significant others.

(e) **Evaluation of pre-admission Level II or Resident Review assessment to determine Medicaid medical eligibility for long term care.** The determination of medical eligibility for care in a nursing facility is made by the area nurse (or nurse designee) unless the individual has mental retardation or related condition or a serious mental illness (as defined by CMS). The procedures for obtaining and submitting information required for a decision are outlined in this subsection. When an active long term care patient enters the facility and nursing care is being requested:

(1) The pre-admission screening process must be performed and must allow the patient to be admitted.

(2) The facility will notify the local county office by the OKDHS ~~form ABCDM 83 Form 08MA083E~~, Notification Regarding Patient in a Nursing Facility, Intermediate Care Facility for the Mentally Retarded or Hospice and ~~ABCDM 96 form Form 08MA084E~~, Management of Recipient's Funds, of the ~~client~~ member's admission.

(3) The local county office will send the NF the OKDHS ~~form ABCDM 37D Form 08MA038E~~, Notice to Nursing Care Facility or LTCA Regarding Financial Eligibility, indicating actions that are needed or have been taken regarding the ~~client~~ member.

317:35-19-14. New admissions, readmissions, interfacility transfers, and same level of care program transfers

The Preadmission Screening process does not apply to readmission of an individual back to the same NF following a continuous medical hospital stay. There is no specific time limit on the length of absence from the nursing facility for the hospitalization. Inter-facility transfers are also subject to preadmission screening. In the case of transfer of a resident from an NF to a hospital or to another NF, the transferring NF is responsible for ensuring that copies of the resident's most recent PASRR ~~LTC 300A Form LTC-300R~~ and any PASRR evaluations accompany the transferring resident. The receiving NF must submit an updated ~~LTC 300A Form LTC-300R~~ that reflects the resident's current status to LOCEU within ~~30~~ 10 days of the transfer. Failure to do so could result in recoupment of funds.

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317:35-19-16. PASRR appeals process

(a) Any individual who has been adversely affected by any PASRR determination made by the State in the context of either a preadmission screening or an annual resident review may appeal that determination by requesting a fair hearing. If the individual does not consider the PASRR decision a proper one, the individual or their authorized representative must contact the local county OKDHS office to discuss a hearing. Forms for requesting a fair hearing (OKDHS ~~form H-1~~ Form 13MP001E, Request for a Fair Hearing), as well as assistance in completing the forms, can be obtained at the local county OKDHS office. Any request for a hearing must be made no later than ~~30~~ 20 days following the date of written notice. Appeals of these decisions are available under OAC 317:2-1-2. There is no distinction between the Medicaid SoonerCare and ~~non-Medicaid non-SoonerCare~~ patient; therefore, all individuals seeking an appeal have the same rights, regardless of source of payment. Level I determinations are not subject to appeal.

(b) When the individual is found to experience ~~MR or MI~~ MI, MR, or related condition through the Level II screen, the PASRR determination made by the MR/MI authorities cannot be countermanded by the ~~state Medicaid agency~~ Oklahoma Health Care Authority, either in the claims process or through other utilization control/review processes, or by the ~~state survey and certification agency~~ Oklahoma State Department of Health. Only appeals determinations made through the fair hearing process may overturn a PASRR determination made by the MR/MI authorities.

317:35-19-18. Change in level of long-term medical care

(a) When a ~~client~~ member is receiving Personal Care services and requests nursing facility care or when a ~~client~~

member is in a nursing facility and requests Personal Care services, a new ~~UCAT~~ Uniform Comprehensive Assessment Tool (UCAT) is required. The UCAT is updated if the ~~client~~ member is in the nursing facility and requests ADvantage waiver services. No new medical decision is needed. Also, no new medical decision is needed for admission to a nursing facility from home if the period of absence from the nursing facility is less than 90 days. No new medical decision is needed if the ~~client~~ member loses financial eligibility but maintains medical eligibility by having a current medical decision and by remaining in the facility during the period of financial ineligibility.

(b) When there is a decision that a ~~client~~ member approved for one level of long term care is eligible for a different level of care, the local office is advised by update of the file. If the change is from facility care to Personal Care, a new UCAT, Part III care plan, service plan, and other required forms are submitted to the area nurse, or nurse designee. If the Personal Care ~~recipient~~ member requests a decision regarding facility care prior to admission to a facility, the LTC nurse is responsible for submitting the UCAT, Part III, and ~~LTC-300A Form~~ LTC-300R to the area nurse, or nurse designee for a decision. When the area nurse, or nurse designee, determines that a nursing care ~~recipient~~ member no longer needs this level of care, payment may be continued while the ~~recipient~~ member, or other responsible person, makes other arrangements. The length of such continuation of payment depends upon the circumstances, but must allow time for the appropriate advance notice to the ~~recipient~~ member and cannot exceed 60 days from the date of the decision.

[OAR Docket #07-1324; filed 7-24-07]

Permanent Final Adoptions

An agency may promulgate rules on a permanent basis upon "final adoption" of the proposed new, amended, or revoked rules. "Final adoption" occurs upon approval by the Governor and the Legislature, or upon enactment of a joint resolution of approval by the Legislature. Before proposed permanent rules can be reviewed and approved/disapproved by the Governor and the Legislature, the agency must provide the public an opportunity for input by publishing a Notice of Rulemaking Intent in the *Register*.

Permanent rules are effective ten days after publication in the *Register*, or on a later date specified by the agency in the preamble of the permanent rule document.

Permanent rules are published in the *Oklahoma Administrative Code*, along with a source note entry that references the *Register* publication of the permanent action.

For additional information on the permanent rulemaking process, see 75 O.S., Sections 303, 303.1, 303.2, 308 and 308.1.

TITLE 158. CONSTRUCTION INDUSTRIES BOARD CHAPTER 30. PLUMBING INDUSTRY REGULATIONS

[OAR Docket #07-1316]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 5. License Types, Bond Requirements, and Display of License Number and Firm Name

158:30-5-1. License types [AMENDED]

158:30-5-3. Display of license number and firm name [AMENDED]

Subchapter 9. Examination Procedures, License and Registration Fees and Duration of Licenses

158:30-9-1. Examination procedures [AMENDED]

AUTHORITY:

Construction Industries Board; 59 O.S. §§ 1000 through 1023.1 et seq. and 1689.

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SUPERSEDED EMERGENCY ACTIONS:

Superseded rules:

Subchapter 5. License Types, Bond Requirements, and Display of License Number and Firm Name

158:30-5-1. License types [AMENDED]

Gubernatorial approval:

March 29, 2006

Register publication:

23 Ok Reg 1147

Docket number:

06-691

INCORPORATIONS BY REFERENCE:

"n/a"

ANALYSIS:

158:30-5-1 (b). The purpose of this rule change is to adopt this emergency rule, approved during the second session of the Fiftieth Legislature, into permanent rules. 158:30-5-3 (b), (c) The purpose of this rule is to assist

the citizens of Oklahoma seeking the services of legitimately licensed contractors to identify said contractors through advertising or bids or contracts. 158:30-9-1. this rule will provide an alternate means to qualify applicants for licensure examination by modifying the experience requirements. This rule makes permanent the emergency rule adopted during the second session of the Fiftieth Legislature.

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A) WITH AN EFFECTIVE DATE OF AUGUST 25, 2007:

SUBCHAPTER 5. LICENSE TYPES, BOND REQUIREMENTS, AND DISPLAY OF LICENSE NUMBER AND FIRM NAME

158:30-5-1. License types

(a) Apprentice plumber.

(1) Apprentice plumbers must be under the direct supervision of a licensed plumber when engaged in plumbing.

(2) A maximum of three (3) apprentice plumbers can work under the supervision of a licensed plumber.

(3) Apprenticeship registration is effective upon the posting of the application and evidence of such posting shall be a copy of the executed application form with proof of tender of the proper fee which may serve as evidence of registration for a period not to exceed thirty (30) days.

(b) Journeyman plumber.

(1) To engage in the act of plumbing, a journeyman plumber must be employed or supervised by a licensed plumbing contractor.

(2) A journeyman shall not contract or furnish labor and/or labor and materials.

(c) **Plumbing contractor.** Plumbing contractors must notify their surety of any municipalities wherein plumbing work will be performed.

158:30-5-3. Display of license number and firm name

(a) All contractors shall, on all vehicles used to transport materials and tools in the operation of the business, display the plumbing firm name and the contractor's license number

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bearing the initials "OK" preceding that number issued by the Administrator. Such names and numbers shall be printed in letters and numerals at least two (2) inches in height in a conspicuous location on both sides of each vehicle in contrasting color to the background color.

(b) The Plumbing Contractor State License Number must be displayed on all advertising, contracts, and bids. Advertising for the purposes of this section shall not include uniforms or promotional items including but not limited to pens, pencils, key chains, tape measures, and the like.

(bc) The pocket license issued by the Administrator shall be on the plumber's person while on the job.

SUBCHAPTER 9. EXAMINATION PROCEDURES, LICENSE AND REGISTRATION FEES AND DURATION OF LICENSES

158:30-9-1. Examination procedures

(a) The plumbing standards for the plumbing examination shall be the International Plumbing Code as adopted in 158:30-1-4.

(b) Any previously certified examination may be used to meet an examination requirement.

(c) Examination for a plumber's license shall include, but not be limited to, written questions and drawings and/or charts.

(d) The maximum grade value of each part of the plumbing examination shall be 100 points. An examinee must make 70% or more on each part, above, to pass the examination.

(e) Attendance at an approved technical school with specialization in the plumbing skills may be substituted for experience or employment on an equal time basis. Substitution of education for experience shall be limited to a maximum of one half the experience requirement. Applicants must present to the Administrator for approval records of schools attended, grades and/or certificates of completion if education is to be substituted for experience.

(f) Applicants for the plumbing contractor examination must be capable of reading English without assistance. A person who cannot meet this requirement may request a hearing before the Committee to request reasonable accommodations.

(g) Except as authorized by the Plumbing Examining Committee, no person, other than examinees, shall be permitted in the examination area.

(h) An examinee who is caught cheating during the course of an examination shall be deemed to have failed the examination.

(i) Applicants for the journeyman examination must be eighteen (18) years of age or older and have either

- (1) three (3) years experience in the plumbing trade—~~or~~
- (2) a verifiable out-of-state plumbing license that must be:

- (A) current, and
- (B) in good standing.

(j) Applicants for the contractors examination must be eighteen (18) years of age or older and have four (4) years experience in the plumbing trade.

(k) The fees for both examination and license must be on deposit with the Administrator in advance of the examination.

(l) If the applicant fails to meet the minimum qualifications to take the examination, the application fee will be forfeited.

(m) Applicants failing to appear for their examination on the date scheduled shall forfeit the examination fee unless notification is received by the Administrator at least 24 hours prior to examination date.

[OAR Docket #07-1316; filed 7-13-07]

TITLE 158. CONSTRUCTION INDUSTRIES BOARD CHAPTER 50. MECHANICAL INDUSTRY REGULATIONS

[OAR Docket #07-1317]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 5. License Types, Limitations of Licenses, Contractor Special Requirements and Display of License Number and Firm Name

158:50-5-4. Display of license number and firm name [AMENDED]

Subchapter 9. Qualifications for Mechanical Licensure, License and Registration Fees, Duration of License, Mechanical License Application, and Apprentice Registration

158:50-9-1. Qualifications for mechanical licensure [AMENDED]

158:50-9-5. Apprentice registration [AMENDED]

AUTHORITY:

Construction Industries Board; 59 O.S. §§ 1000 through 1023.1 et seq. and 1850.1-1860 et seq.

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SUPERSEDED EMERGENCY ACTIONS:

Superseded rules:

Subchapter 9. Qualifications for Mechanical Licensure, License and Registration Fees, Duration of License, Mechanical License Application, and Apprentice Registration

158:50-9-1. Qualifications for mechanical licensure [AMENDED]

Gubernatorial approval:

March 29, 2006

Register publication:

23 Ok Reg 1149

Docket number:

06-693

INCORPORATIONS BY REFERENCE:

"n/a"

ANALYSIS:

158:50-5-4 the purpose of this rule is to assist the citizens of Oklahoma seeking the services of legitimately licensed contractors to identify said

contractors through advertising or bids or contracts. 158:50-9-1 this rule will provide an alternate means to qualify applicants for licensure examination by modifying the experience requirements. This rule makes permanent the emergency rule adopted during the second session of the Fiftieth Legislature. 158:50-9-5 this rule requires Mechanical Apprentices to be directly supervised by licensed Mechanical Contractors or Journeymen during performance of their work duties for the safety of the public.

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A) WITH AN EFFECTIVE DATE OF AUGUST 25, 2007:

SUBCHAPTER 5. LICENSE TYPES, LIMITATIONS OF LICENSES, CONTRACTOR SPECIAL REQUIREMENTS AND DISPLAY OF LICENSE NUMBER AND FIRM NAME

158:50-5-4. Display of license number and firm name

(a) Each person issued a contractor license shall display the mechanical firm name and the contractor license number bearing the initials "OK" preceding that license number issued by the Administrator on all vehicles used to transport materials and tools in the operation of the business. Such names and numbers shall be printed in letters and numerals at least two (2) inches in height in a conspicuous location on both sides of each vehicle in contrasting color to the background color.

(b) The pocket license issued by the Administrator shall be on the mechanical person while on the job.

(c) The Mechanical Contractor State License Number must be displayed on all advertising, contracts, and bids. Advertising for the purposes of this section shall not include uniforms or promotional items including but not limited to pens, pencils, key chains, tape measures, and the like.

SUBCHAPTER 9. QUALIFICATIONS FOR MECHANICAL LICENSURE, LICENSE AND REGISTRATION FEES, DURATION OF LICENSE, MECHANICAL LICENSE APPLICATION, AND APPRENTICE REGISTRATION

158:50-9-1. Qualifications for mechanical licensure

(a) **Application.** A person desiring to be licensed under this Chapter shall file an application with the application fee, examination fee, and the initial License fee to the Administrator. The fees must be received no less than three (3) working days before the examination date. If the applicant fails to meet the minimum qualifications to take the examination, the application fee will be forfeited.

(b) **Experience.** All persons applying for a license must provide proof of experience in the mechanical trade.

(1) Applicants for a journeyman license must be at least eighteen (18) years of age and have:

(A) either three (3) years of verifiable experience in the mechanical trade in the category for which he is applying or

(B) have an associates degree or Vo Tech diploma certifying completion of an educational program consisting of 1000 hours or more from a school, approved by the Committee, which exhibits knowledge of the trade in the category of license applied for and one (1) year of verifiable experience in the mechanical trade; or

(C) have a VoTech diploma certifying completion of an educational program consisting of 600 hours or less from a school, approved by the Committee, which exhibits knowledge of the trade in the category of license applied for and two (2) years of verifiable experience in the mechanical trade, or

(D) have a verifiable out-of-state license in the mechanical classification for which the applicant is applying. The license must be:

(i) current, and

(ii) in good standing.

(2) Applicants for a contractor license must meet the same requirements as a journeyman with an additional one (1) year experience.

(c) **Examination.** A license cannot be issued until the applicant has passed the appropriate examination for the license type and category. Examinations and the passing score for each examination shall be approved by the Committee. Applicants for the Ground Source Piping category shall provide proof of being certified in the proper installation of ground source piping by an organization approved by the Committee.

(1) If the applicant does not pass the exam, the applicant may reapply for the exam and pay an additional retesting fee. However, no person will be allowed to re-take an exam within 30 days of the first failed exam nor within 90 days of the second or subsequent failed exam.

(2) Any person suspected of cheating during an examination shall be immediately notified of the suspicion and shall not be allowed to finish the examination. He shall be called before the Committee during the next scheduled meeting for discussion of the incident. If the Committee determines that the person did in fact cheat, the examinee's application for licensure shall be denied and the Committee shall determine when the applicant can next apply for an examination.

(3) No person shall be allowed any assistance in reading the contractor's examination, nor shall any persons other than the examinees or the Committee members be allowed in the examination area. However, an applicant may request that the Committee make reasonable accommodations for any disability.

(d) **Outstanding fines.** A license cannot be issued until the applicant has paid any and all outstanding fines due and owing to any department of the Construction Industries Board.

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158:50-9-5. Apprentice registration

(a) A person may register as a mechanical apprentice if the person does not meet the qualifications for licensure but wishes to learn or perform mechanical work. An individual licensed in any category shall be permitted to work as an apprentice in any category for which they are not licensed by complying with the requirements of this chapter for ratio and direct supervision.

(b) The apprentice will be registered if a completed application form with the application and registration fee listed in 158:50-9-2(a)(4) for a one (1) year period is submitted to the Mechanical License Unit along with verification of enrollment in an approved school or training course or a statement of employment by the licensed mechanical contractor who arranged for employment of the apprentice.

(c) The apprentice must perform mechanical work in the same category as the licensed mechanical person who is supervising the apprentice.

(d) An apprentice who participates in activities inconsistent with the provisions of the Act and the rules of this Chapter shall be subject to the sanctions described in 158:50-11-3.

(e) Apprenticeship registration is effective upon the posting of the application and evidence of such posting shall be a copy of the executed application form with proof of tender of the proper fee which may serve as evidence of registration for a period not to exceed thirty (30) days.

(f) Mechanical apprentices must be under the direct supervision of a licensed Mechanical contractor or journeyman when engaged in Mechanical work.

[OAR Docket #07-1317; filed 7-13-07]
